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PROFESSION

Able to practice: Physicians with disabilities do what it takes to thrive

■ From residency to employment, these doctors demonstrate their capabilities.

By MYRLE CROASDALE (HTTP://WWW.AMEDNEWS.COM/APPS/PBCS.DLL/PERSONALIA?ID=MCROASDALE) — Posted Jan. 17, 2005

A strobe light flashes in the exam room of Carolyn Stern, MD, alerting her that a patient has arrived. Dr. Stern doesn't use a receptionist at her solo family medicine practice, and patients press a button on the waiting room wall as they come in. As Dr. Stern ushers the patient back to the exam room, she introduces herself, explains she is deaf and tells the patient it's important for her to look at her when speaking so she can lip-read. Dr. Stern's husband, who manages the practice, serves as her interpreter and can track her down for emergencies.

Dr. Stern asks why the young woman has come in and starts taking her history. She faces the patient, pausing at times to type notes into a laptop. When her hands are free, she signs; otherwise, the only other indication that she's deaf is a distinctive pattern to her speech.

Working with a disability

Dr. Stern is one of a small percentage of physicians with sensory or physical disabilities practicing medicine in the United States. Their practice situations run the gamut, as does their reception from colleagues. Some work within large institutions; others are in group or individual practices. A few find they are sought after, while others struggle to prove they won't be a liability to their peers or to their patients.

Statistics on the number of physicians with a disability who are practicing medicine are scarce. A study published in the *American Journal of Physical Medicine & Rehabilitation,* based on data from 1996, estimated that 0.2% of medical school graduates have disabilities.

Most physicians who are practicing with a disability acquired that disability during their career. Despite the enactment of the American with Disabilities Act in 1990, which prohibits discrimination against a qualified applicant who has disabilities, few students with disabilities enter the profession. In part, this is because medical students must be able to perform the essential functions of being a doctor, and each school determines for itself what these criteria are.

Dealing with reality

Throughout their training, these future physicians are striving to learn the practice of medicine while demonstrating that they're capable of being competent doctors.

For Michael Cummings, MD, a psychopharmacology consultant and associate director of forensic psychiatric training at Patton State Hospital in Patton, Calif., his disability meant making a big change in his career plans. He lost his sight right before he was to begin a neurosurgical residency. Dr. Cummings also teaches medical students and residents, some of whom have had disabilities as well.

"You have to do better than average to be accepted," he said. "In a sense that's wrong, and everyone should be weighed on the same scale, but the truth is you do have to do better. That's the way it is."

Dr. Cummings has a wall of teaching awards attesting to his strengths as an educator and hasn't had difficulty finding positions. His skills and connections open doors. But he had to prove himself early on and, at times, when he meets a new patient, he senses they might be questioning his abilities. "A disability adds a layer of curiosity and doubt," he said. "From my perspective, I'm not offended by doubts."

All Dr. Cummings has sought is the opportunity to demonstrate his abilities, and now that he's the teacher, he offers the same opportunity to his medical students. He can offer his own insights to those with disabilities, but he doesn't compromise his expectations.

"On one hand, you want to give people [with disabilities] a chance," he said. "On the other hand, you want doctors who are safe to the public."

One of these students was Jeff Lawler, DO, a recent graduate of Western University of Health Sciences' College of Osteopathic Medicine of the Pacific. Dr. Lawler lost his sight before medical school. Textbooks on tape, lecture notes via e-mail and a guide dog helped him navigate through school.

Initially, he chose physical medicine and rehabilitation for residency. Dr. Lawler matched with a physical medicine and rehabilitation program but failed to land the required internship in general medicine. He called more than 30 programs, but they all turned him down. "All I could think of was it was the blindness," he said.

Dr. Lawler had to give up his match, but as the enormous pressure of getting through medical school faded, he reconsidered his options. Psychiatry and neurology also were areas he was interested in. He did an externship with Dr. Cummings and now is interviewing for residencies again.

"My responsibility is to educate them about my abilities," Dr. Lawler said of his interviewers. "It's too easy for people to come up with reasons for why you can't do things. I know I can do it, I just need to convey that to them.

"I think program directors want all of their candidates to be autonomous, team players and to be able to accomplish a multitude of things," he added. "I try to assure them that I'm not going to be making everyone else's job harder or taking funds away from the program. The accommodations I require aren't that expensive."

Mehri Brown, MD, who is on the psychiatry faculty at the University of California, San Francisco, School of Medicine, didn't need special accommodations for her cerebral palsy while she went through the accelerated medical program at Brown Medical School in Providence, R.I. Her big shock came after medical school, when she failed to match in a pediatric residency. Through a friend, she was able to land a one-year internship in internal medicine, but a second try for pediatrics was also unsuccessful.

Later, Dr. Brown learned through a colleague that the school had accepted her with the idea that she would go into administration and not actually practice. "That was difficult," she said. It also left her wondering if these unspoken expectations were partly why she'd gotten so little career guidance during her clerkships.

Landing a residency is not the last challenge physicians with disabilities face. As new physicians, often they still feel the need to earn the respect of their colleagues.

Scott Smith, MD, MPH, a developmental-behavioral pediatrician for ViaHealth at Rochester General Hospital in New York, is deaf and does not verbalize for himself. He has a interpreter for the 24 hours a week he is directly involved in patient care.

"I believe I tend to overdo the quality of my work as compared to my hearing peers, partly because I really care about my patients and otherwise because I feel that I need to be perfect or at least very good to avoid any criticism related to the fact that I'm a deaf doctor," he wrote in an e-mail.

He also feels he ought to generate more income to offset the cost of his interpreters, which the practice covers.

Underlying advantages

Melanie Rak, MD, a physiatrist at the Rehabilitation Institute of Chicago who uses a wheelchair, sees her disability as an asset. "I think that people may not realize that people with disabilities can bring something to their patients that physicians without disabilities don't."

When a patient with disabilities experiences discrimination, Dr. Rak can share how she has dealt with it, as well as offer a list of resources she has garnered through her own experience.

"One patient's father said his son was having a hard time finding a suit to wear to the prom," Dr. Rak said. "I pulled up a mail-order company that specializes in clothing for those in wheelchairs, and they had a tuxedo."

For family physician Michael McKee, MD, being deaf gives him an advantage in treating those who don't hear. Rochester, N.Y., has a large deaf population, and he and his partner, who is hearing but knows American Sign Language, share a practice focused on treating the deaf. They see both hearing and deaf patients, but their ability to communicate directly with deaf patients is clearly a draw.

Dr. McKee also sees his deafness as a plus in treating hearing patients. Looking at them face to face while lip-reading gives them a sense of being listened to and cared for, he said, something that's harder to communicate if you're busy taking notes.

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ADDITIONAL INFORMATION

Practice assistance

Modern technology offers several aids for physicians practicing with disabilities. Those who are deaf can use amplified stethoscopes or stethoscopes with a visual display. Digital cuffs can be used to measure blood pressure. Text pagers that vibrate facilitate phone calls, and the federal government fully subsidizes phone and video translation services for the deaf.

Carolyn Stern, MD, a Rochester, N.Y., family physician who is deaf, says that when her office manager isn't available to interpret phone calls, a video relay is her backup solution. She contacts the video relay operator through her computer. The operator speaks with the other party and interprets the response for Dr. Stern. Dr. Stern lip-reads the operator's video image, and a camera connected to her computer sends Dr. Stern's picture back to the operator. Those she is calling don't need any special equipment, since the relay operator is interpreting. A teletype device does the same thing with text. The operator reads the text message for the hearing party and types the response for the deaf caller. The teletype device ranges from $200 to $600, and a video camera for the computer can be less than $100.

Sign language interpreters cost anywhere from $30 to $80 an hour or more. Salary for a full-time interpreter could run around $30,000 to $35,000 a year.

Michael Cummings, MD, a forensic psychiatrist who is blind, has an assistant to help him navigate his hospital's campus and to read patient files for him. He estimates that she is paid $10 to $15 an hour, which the hospital covers. He bought his computer and equipped it with a screen reading program that allows him to read electronic documents and surf the Internet.

Melanie Rak, MD, a physiatrist who uses a wheelchair, relies on an exam table that raises and lowers. It costs roughly $2,000 more than a regular exam table.

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