Disability Visibility Podcast

Episode 95: Black Doctors with Disabilities

Guest: Dr. Justin Bullock

Host: Alice Wong

Transcript by Cheryl Green

For more information: DisabilityVisibilityProject.com/podcast

Introduction

[radio static, voices singing with hip-hop beat]

LATEEF MCLEOD: This is the *Disability Visibility Podcast* with your host, Alice Wong.

ALICE WONG: Hi there! Welcome to the *Disability Visibility Podcast*, conversations on disability politics, culture, and media. I'm your host, Alice Wong. In today's episode, I'm in conversation with Dr. Justin Bullock. Justin is currently an Internal Medicine Resident in San Francisco, California. You'll hear Justin talk about experiences disclosing his disability at work, the process he had to go through to prove his fitness to serve as a physician because of his disability, the systemic ableism and racism in medicine and medical education, and the benefits and risks of telling your story and being visible. You'll also hear Justin talk about article he wrote in the *New England Journal of Medicine* titled "Suicide—Rewriting my story," which describes his battle with Bipolar Disorder and suicidality during undergraduate and graduate medical education. Please note, our conversation took place in September, 2020, and there will be discussions of hospitalization, death and dying, suicidality, suicidal ideation, and trauma. Are you ready? Away. We. Go! [electronic beeping]

ELECTRONIC VOICE: 5, 4, 3, 2, 1.

ALICE: OK. So, Justin, thank you so much for being on my podcast tonight!

JUSTIN BULLOCK: Thank you for having me. Like I said, I'm super excited to be here.

ALICE: Well, I'm super excited too. As a UCSF alum, it's really exciting to talk to other people who're just changing the game!

JUSTIN: [chuckles]

Treating patients and practicing self-care in the middle of a pandemic

ALICE: So, I was wondering just before we dig into things, how are you doing right now as a doctor who's treating patients in the middle of a pandemic? And what has it been like for you and your colleagues at UC San Francisco?

JUSTIN: Yeah, I think it's been...it's definitely been both very challenging and also very rewarding, I think. I guess I'll start with the more positive side. You know, one of the things I think a lot about is the fact that I'm very fortunate to have a job, and I have had a job throughout the entire pandemic. And it's one in which I have the privilege to try and help people. That being said, I think there definitely is...you know, I think in medicine, just like everyone else in the world, there's a lot of things like isolation and sort of our normal routines being very disrupted. And then I think the sort of additional trauma, I guess that I would say, from COVID. And I think seeing people, you know, a lot of my colleagues have seen a lot of people die because of COVID and really feeling very powerless. I think that's been something that's been very challenging for sort of healthcare professionals and loved ones worldwide. So, I'd say I'm doing OK, hanging in there.

I think our program has had a lot of changes to try and accommodate the sort of fluctuating COVID numbers that've been coming through. And overall, I think San Francisco is in a decent place compared to other places in the country. But we're definitely still on guard for, yeah, for what is to come.

ALICE: Yeah, and I'm wondering just how you are taking care of yourself as well, like just trying to stay safe, but also, really trying to take care of your own well-being and practicing self-care.

JUSTIN: Yeah. Definitely one big one for me is exercise. I'm fortunate to be able to run. There was a short period time where I wasn't because of the fires that have been out here. There's many various disasters, I guess, that've happened recently. But for me, that's a really big thing. Exercise is a very big thing for me, for maintaining my mental health. And then also really trying to spend time with people in a safe way. I'm definitely, I like to talk! [chuckles] I can talk to a wall. And so, it's trying to find ways to hang out with my friends that's also safe right now.

ALICE: That's great. Also, I saw recently that you tweeted that you just completed your internship. So, congratulations.

JUSTIN: Thank you very much.

ALICE: So, how was your internship in terms of just what you learned and what was challenging? And what are the next steps in your training?

JUSTIN: So, intern year was a roller coaster, I think, to say the least. So, my intern year was actually a little bit more than a year. So, it was 441 days. And in that time, I think first from the medicine side, I actually had a lot of fun. I had really, I love being in the hospital. I love getting to take care of patients and talk with families and learn medicine. All that was good. And I'm really into medical education and got to do a lot of kind of cool stuff and presentations and papers I got published over the year. So, that was pretty good for me.

And the other sort of roller coaster-y part, so I have Bipolar disorder and really struggled this year with respect to my mental health. I've had mental illness for a long, for over 10 years, and I can't quite say that it was a surprise that I struggled this year. But I think even knowing that I was likely gonna have some challenges, I don't think I was fully prepared for sort of what was to come. And yeah, I'm happy to talk more about that as we go along. But now, I'm fortunate to say that I'm in a pretty good place. I feel stable. And I was out of work for three months, and now I'm back. And I've been back now for almost three months. So, yeah. Feeling pretty good now.

[upbeat electronic music break]

Educational timelines and structure can be a barrier for disabled med students

ALICE: I imagine one thing that's really a barrier for a lot of disabled students to wanna be doctors is the fact that they are very rigid kind of timelines in terms of training and medical education. So, that's very difficult for people who have crises or just, say, may need to take time off. That that's one of the responses I hear that this program is structured in this way, and everybody kinda has to follow it, or you're gonna risk falling behind.

JUSTIN: Yeah, I think that first, I'll say it's definitely possible, and I am living proof that it is possible. I'm still in residency, and I was hospitalized twice during the last year. And I think one of the important things for me was there's certainly a lot of stigma around mental illness, but I was fortunate to come to UCSF for med school and really be in an environment that was very sort of welcoming and encouraging. They encouraged help seeking. And I think, and when I sought help, I felt like I was sort of treated in an appropriate, healthy, humane way. And so, I think that really sort of helped me as I moved into residency. And I was very transparent with my program and told them I have Bipolar. I disclosed it before I began residency. I made sure that I had appointments, I had sort of accommodations so I could go to my appointments. And that mostly worked! But it ended up being a little bit— I think that unfortunately, the sort of graduate medical education landscape is a little bit different than the undergraduate medical education.

So, in med school, so, undergraduate medical education's med school. And so, residency, you sort of are now more into the worker category. And I just found that the sort of policies and procedures that were followed were much less...they were much more stigmatizing and much more, for me, harmful than that which I had been exposed to in the past.

ALICE: Yeah, I think disclosure is still really tricky for anybody with an apparent or non-apparent disability, even in the application process to med school or just within a workplace setting, where you need to be forthcoming. And I think one of the things that's still kinda the burden on us is you have to do a lot of canvassing and explaining and just so much kinda invisible labor. These are that don't get any sort of compensation, but it really just as a survival technique. So, it's one of kinda the frustrating aspects, or just maybe there's rewarding aspects of just communicating with other people that you're gonna be working with or the people that supervise you.

JUSTIN: Yeah. I'll answer your question, but I'm gonna take a long way to get there. So, I first wanna say something that, in relation to what you were saying. So, Lisa Meeks, Dr. Meeks, she's a researcher. She's at the University of Michigan now, but she used to be at UCSF, and she used to run the Student Disabilities Office. And she had published a book that was basically talking about disability and inclusion. And one of the things that she talks about is with respect to disability and inclusion, there are these ideas of compliance. And so, there are three kind of big ways to think about compliance. So, first is strict compliance, which is when institutions just do that which is the minimum required by law. And then there's the spirit of the law, where institutions sort of give more accommodations than what is the legal minimum, but people still have to apply for accommodations. And that in of itself is a barrier because many people don't wanna disclose their disability or their illness. And then finally, there's the transformative sort of perspective, which basically creates so, for instance, if you think about like appointments, basically protects two hours out of the week for everyone so that you can do whatever you need to do to take care of yourself. So, if that's go for a run, you can do that. If it's to go to see a psychiatrist, you can do that. If it's to go to see your neurologist, you can do that.

And so, I think many, many, many institutions exist on the strict compliance and sometimes the spirit of the law. And so, then moving into your question, which I have now forgotten, because I was just on a little tangent, some of the things that I found challenging and rewarding. So, for me, I have Bipolar II, which means that my sort of periods of elevation are hypomanias, and that usually manifests as me being super productive and me sleeping less. And kind of it's usually very channeled to be, to do more work. And I think that's in contrast to what a lot of people think often of mania, where people are sort of very impulsive, irrational, grandiose. They'll even have poor judgment. And what happened was I've been very transparent about my mental illness, and I wrote this perspective piece that was in a big medical journal about my Bipolar. And so, everyone kind of knows I have Bipolar.

And I think when I ended up getting hospitalized, I think people really questioned my judgment or my ability to do my job safely. And I've always been very, very conscientious about I call out of work if there are ever periods where I don't feel that I can focus or do my job appropriately. I've never had any dings on my sort of clinical or professionalism. And so, I really felt like I was being very strongly singled out. And I was forced essentially to go through a what I consider to be pretty traumatic evaluation with drug testing and disclosing of all of my psychiatric records and many other things. And yeah, for me, that was very harmful because this is not the UCSF that I was used to. And I love UCSF. I have repped UCSF so hard for as long as I've attended this institution. And so, this was really, for me, discordant with the image of this institution that I love so much. And from there, there was a lot of— And I was sort of very, very, very vocal about the fact that I felt that this was wrong in so many ways.

And I'm fortunate to know a lot of the high-up people at UCSF and had many sort of very serious conversations with many people and was a part of a petition that was created to ask for reform of the Well-being Committee and Fitness for Duty process. And that ended up being signed by over 600 residents, presented to many of the high-up people. And it seems like those advocacy efforts actually are making a pretty big difference. I was actually told recently that the Fitness for Duty process was just discussed in the Chairs' meeting of all the departmental Chairs at UCSF and have been promised by some pretty high-up people that there are gonna be quite substantial changes made. And so, I think that that makes me hopeful.

I would say, on one hand, for me, it's a little bit sad because it doesn't particularly help me 'cause I sort of have already been harmed. But, you know, I sort of accept things as they are and try to change them to make them better. And hopefully, no one else has to sort of go through the same process that I went through.

And the last thing I'll say about this is, I think that there was a lot of.... So, the process that I went through was classically made for people who have substance use disorders. And I think it's very apparent in the way that they sort of do things. And for me, there still were massive problems, even though I do not have a substance use disorder. And one of the arguments that I was often told was, "Well, no one's complained about this before." What I tried to remind people is that folks who have stigmatized conditions, be they mental illness, substance use disorder, or what have you, they don't want the world to know that their fitness for serving as a physician is being questioned, you know, and they won't speak up. But if you look at the objective facts of the things that I've pointed out, I think everyone would agree that you should have a committee that is diverse and that represents the population that they are assessing and potentially removing the ability to work from. So, yeah. I'll stop there.

[upbeat electronic music break]

People in med school and medicine not reflecting the communities they serve

ALICE: So many of the structures and things that are not questioned, that are just considered par for the course are in particular racist, ableist, sexist as hell.

JUSTIN: [laughs]

ALICE: And to fight that, I think more people are pointing these things out. I'm really here for all of the reckoning and the revolution in the medical profession.

JUSTIN: Yeah, and this is why I think what you're doing is so amazing. Because one of the things that unquestionably helped me so much in this process was the fact that I am not ashamed at all to be Bipolar. I literally, for me, it's a part of me. It's like I'm Black, I'm gay, I'm Bipolar. That's just like so fundamentally intertwined in who I am. I try very hard to sort of contain it and make sure that it is not sort of ruling my life. But I think that the lack of role models of people who are like, "I have a serious mental illness, and I'm an exceptional physician." You know, that just like, that's not a message that we hear. And I think that's true of so many forms of disability. And I think that's often because institutions push those people out. And not necessarily that it's always intentional, but that they're just, the structures are just so inherently toxic against people with disabilities that people leave because why would you stay?

ALICE: As you and I know, disabled people are incredibly unique in terms of just the talents and the perspectives we have. And this is much like the medical profession is really driving away people of color because they may be able to maybe, let's say, make it into medical school, but they're not maintaining students of color for a whole host of reasons. And this really speaks to, again, this huge gap in the workforce where there aren't people who are reflective of the communities that they're serving. And this is, you know, there's a huge cultural competency issue in that disabled doctors of all types could really just help so many people. I just feel like that's the loss, because I think we're still not seen as, our community, ironically, it's still kind of radical to say disability is part of diversity, even though it's pretty basic for you and me, I think.

JUSTIN: Yeah. I resonate so strongly with everything you just said. Yeah, and I think one of the other things that, for me, felt sort of very frustrating is that the only reason that I ended up being listened to was because I sort of had to disclose my story in very explicit detail. And for me, that's just a huge problem. You know, I'm very open, and I'm totally transparent. Anyone who knows me knows that I will answer any question, and I'm very vocal about things. But I don't think that people should have to share their story in order for, if someone says something is wrong, I think that we should listen to people and look into it. And one of the things I often said, like this petition that we signed, that we wrote, we were like, you don't have to believe us. Please do an independent investigation for yourself. And we believe that you will very clearly see all of the many issues that there are. And so, yeah, one of my hopes in being visible and in disclosing is that other people don't have to in order to sort of be treated like a person.

ALICE: Well, isn't that the dream? I feel like that's, again—

JUSTIN: Yeah. Yeah!

ALICE: —like one day, nobody should have to be forced to tell their story, or just again, relive their trauma, right? Time and time again, I think people with disabilities are expected to go into way too much personal detail just to get sort of taken seriously.

JUSTIN: Yeah.

ALICE: And there are times when people do it, and then they're still not taken seriously. So, it's like, you do: you're damned if you do, you're damned if you don't. And I just wanna bring up the essay that you mentioned. It's titled *Suicide—rewriting my story*. It was published in the *New England Journal of Medicine*. And why was it important for you to tell your own story in your own words? Because there are gonna be always people kinda telling your story for you, and it's very different when you tell your story. So, can you tell me a little bit more about what prompted you to write this? Because it's a very public and a major journal that a lot of your colleagues are gonna read. So, that's pretty amazing.

JUSTIN: It's something that I've wanted to do kind of for a while, to basically, to me, this feels like, you know, I always talk about, I mean, I came out as gay. I was like, this was my coming out story with respect to my mental illness. And everyone, my friends and family, anyone close to me already knew. But this was really, as you said, very, very public and very visible. And I think one of the things that I find with my particular disease is that when I get very depressed, I sort of become connected to this artistic writer-y side of myself. And it's always very, and sort of one way that I sort of cope when I'm depressed or suicidal or having a rough time is to write until. I often find that I'm able to communicate things by writing that I'm unable to through speaking.

So, this particular piece I actually wrote when I got hospitalized in December. And so, basically, in it, I talk about the process of me— And it was a voluntary hospitalization, which actually for someone like me, that's actually a huge success. 'Cause, tha means I didn't actually hurt myself to go into the hospital and that I agreed to go. And so, suicidality is something that I've lived with and struggled with intermittently throughout my entire life. And really just really mostly when I'm depressed. I'm not really suicidal when I'm not depressed. But I've been depressed many times in my life. Yeah. So, I basically wrote it when I was in the hospital. And part of that's 'cause when you're there, you're just like going crazy 'cause it's so boring. Because someone like me who's used to doing, I'm used to flying at like 1,000 miles an hour. And then you're sent to like smack into a wall and just have to sit there. Writing is kind of one way to express my energy that I can't when I can't run as well.

One of the things that I always felt like was missing from pieces in the big journals like this was I feel like people sort of start to talk about their depression and maybe mention suicidality, but then they run away from it. And I think that's because they don't want to, because the sort of environment for physicians with serious mental illness is very unfavorable. And I think they don't wanna write anything that incriminates themselves too much. But to say, obviously, the pieces that I've read in places like the *New England Journal* or *JAMA* are amazing and are really writers putting themselves out there. But I kind of wanted to push, push that line a little bit more. And so, in it, I really sort of talk about some of the suicidal thoughts kind of in detail that I have and try to do it in a way that's not glorifying suicide, but to actually be realistic about my experience. And then I also talk about the fact that I also had like, objectively, I had a really good intern year and had a lot of cool accomplishments. But that sort of doesn't protect me from being Bipolar. And so, yeah, I just really wanted to share this form of sort of art that felt very intimate and for me, honest, but not too, too raw for. Because I think if you go too overboard, these types of places can't, they're not ready for it yet. But to really just move a little bit closer to where we can have this sort of radical transparency around topics like mental illness.

[upbeat electronic music break]

Addressing medical racism and other -isms

ALICE: It's beyond surprising to me during this pandemic, especially when it first kind of really started to emerge and all the data about how Black and brown and Indigenous, older, disabled people are the most disproportionately impacted. And the fact that medical racism was still something that was like surprising to a lotta people?

JUSTIN: [laughs] Yeah.

ALICE: I think it was just bananas to me because I think that’s such a basic fact of medicine and healthcare. What are some of the ways that you think the work is headed to really kinda not just address the disparities, but clearly about this very long history of racism and white supremacy, which is also bound up with ableism, sexism, and homophobia? Because there have been so many groups that’ve been straight up harmed, gaslit, traumatizes. So, speaking to other future doctors or just your colleagues, what is the responsibility of doctors to truly listen and learn from patients?

JUSTIN: So first, I think the first thing that I’ll say is obviously, we need to diversify, and we are failing to, for many groups. I think medicine has made a lot of strides with respect to gender in medical students. But then when you go up and you look a full professors and Chairs and Deans, then we still have these same huge, massive disparities. And, you know, one of the— I’m a pretty, I like to tweet a lot, and something that I tweeted that I put out recently was basically saying, you know, I see a lot of male Chairs of departments putting out tweets, “Her time is now.” But I basically don’t see anyone offering to step down so that a woman can take his place. And many people debate whether or not that’s the right thing to do. But the point that I’m trying to make is that as long as we have men who continue to occupy these sort of positions, women can’t fill them. And I think that applies to any of the -ism categories.

One thing that we often talk about in interpersonal level is this idea of stepping up and stepping back. And sometimes there are times for people to step back. And for instance, so, I’m really, like I said, I’m really interested in medical education. And I’m actually working on this project right now, which I find super interesting, which is looking at how medical students want their supervising attendings or residents to respond to microaggressions in the clinical workplace. And it’s a really cool study because we basically have people walk through various scenarios. So, some with some sort of like gender-related microaggression, one disability-related microaggression, a race-related one, one like a cultural-related microaggression. So, I think this is one, this is like one very small but actually very tangible thing that people can do is, if we wanna sort of create more favorable environments to reduce the leakiness of this pipeline, we need to create more favorable environments. And one of those things, that includes responding to microaggressions.

And people often think that this is not a big deal. But it actually, you know, I’ve been fortunate to be involved in a series of studies that would strongly suggest otherwise, and that when people have microaggressions, when microaggressions happen in the clinical workplace, then that basically occupies students’ cognitive load so they have less space to think about the tasks at hand. And it causes students to experience stereotype threat, which is basically when students become aware of stereotypes about their group, and then they see fear fulfilling those stereotypes. And that has all sorts of impacts on performance. So, I’m basically saying that to say I think we can think on the big, structural level of increasing recruitment and admission and duh, duh, duh, all that stuff. But then once people actually get admitted to these places, we need to make sure that they’re supported and have opportunities to thrive. Because the worst thing would be if you just admit these people, and then you just sort of abandon them, expect them to thrive in these all white, all male spaces that are not made for them to thrive. And then say, “Oh! Well, these people aren’t, like they can’t do it. They’re not cut out for it.” When in reality, they just weren’t given a fair opportunity to have a safe learning environment to learn and demonstrate their learning.

[upbeat electronic music break]

ALICE: Yeah, and I think that's what allyship or co-conspiratorship is all about, because it can't just be the work and the burden of marginalized people in these spaces. That we really do need people who have the privilege and power to really just call stuff out and also to be really actively involved and transparent and accountable. Because that's a real way to show what you stand for. If you clearly do believe that black lives matter, are you gonna step up when you, you need to step up when you're called out, frankly. And for people to like, I think one thing that bothers me all the time is a lot of this lip service and just very kinda transactional nature of allyship, where it's just like, I'll be your ally as long as it doesn't cost me anything. And I feel like that's often the times where it's like very hollow. That people that you think should have your back really don't have your back. So, there's that, too.

Thoughts for the future, career, activism, and more

So, what about your future? What do you see in terms of your career? And what do you wanna do with your life in terms of treating patients and your activism, your writing, just everything that you're passionate about?

JUSTIN: OK. First, as far as my career, I'm not entirely sure. I'm strongly leaning towards being some sort of generalist in internal medicine. But we will see. So, I have a little bit time left to decide in residency. Like I said, definitely, I love my medical education research and definitely wanna continue doing that. And I do a lot of work in assessment and equity and equity in assessment. So, I definitely wanna continue to do those things. You know, it's interesting. Before, probably, I've always been very vocal about reducing stigma around mental illness, but I guess I would never have called myself an activist around mental illness-related things until this last six months. And then I've become a very sort of very, I've done a lot of activist work. And I think I really just follow my heart. I kind of just like to do things that I think are important and interesting and then just keep going. And so, I really don't know.

One of my sort of internal things that I've been mulling that I'm not quite sure how I wanna best attack it is, I think the big sort of elephant in the room that needs to be taken down are the way the state medical boards question people about their health conditions. Because it's very disproportionately skewed. It's bad in many ways, but it's very disproportionately skewed for people with mental illness. And so, that's something that, that's like a dream goal that I have that's like, I think it's like if I see a window, then I will go for it. And in some small way, I view what I'm doing now as starting to work my way up towards that. But yeah, I think that's kind of my big for now.

ALICE: Hey! I'm ready to burn it down.

JUSTIN: [laughs]

ALICE: Burn it all down and just restart, have actual, oh, you know, disabled doctors actually forming policies and be the leaders. That's, what a novel idea, right?

JUSTIN: Yeah. You know, and I think one of the nuances that I've been that I do appreciate is that the purpose of the state medical boards is to protect patients. I think everyone agrees about that. I think the thing that I strongly debate is what is protecting patients, and what is best to protect patients? Because I would argue that making people afraid to get care or to disclose their disability, I don't think that that's protecting patients! I think people will always have disabilities and just hide them or do the best they can or not report them to the state medical board. And yeah, I think that just creates a very toxic environment.

I’m hopeful that, you know, a lot of, there are some institutions across the country who are really starting to dig in in the sort of disability world. And I’m hopeful that if we can get some of the big name, big power places to support it, then we can make a make a big push.

ALICE: Well, I think with you and just the more other docs with disabilities, such as the campaign created by Dr. Lisa Meeks, that this, a form of community organizing. And it’s so important to let people know that you all are there, you all exist, and to also send a signal to younger generations that they could do it and that there are people just like them who are doctors. And I think that’s so needed right now.

JUSTIN: This is so random, but my sister and I were just having a conversation, and we were talking about how back in the day in Civil Rights era, you know, imagine those little kids who, when there was like bussing and the first Black student in a all-white school and how much hate and terribleness those people experienced. And my sister and I were talking like, why would anyone ever do that? Like, why would someone send their kid into that? Or why would any student wanna do that? And I think, and in no way do I feel that I am in that same environment. But I think at least for me, what I feel pretty strongly is I feel like we belong. I think I’m a good doctor. Am I the best doctor? No. Am I a very good doctor? I think so. And can I empathize with patients in a way that other people can’t? Absolutely. That is one thing that I definitively know that I do better than a lot of people. And I think that we deserve a space here. And that’s why I stay. And that’s why I want more people to come. Because when we have more people sitting at the table with us, people can see the myriad of ways that we improve our community and improve patient care.

I actually like, I think everyone’s always like patient care, patient care, patient care, which it is definitely the most important thing. And I would, I very, very, very strongly personally believe that—I don’t have any data to prove this—but that docs with disabilities, I think, provide, I would argue, higher quality care.

ALICE: Yeah. I mean, this is anecdotal, but I think it’s absolutely true. And time will tell as we have growing numbers of doctors who identify as disabled and we can actually maybe do studies. Who knows.

JUSTIN: Yeah, yeah.

ALICE: But I think you and I know, and I think that’s why the lived experience is so important. And for all of the tradeoffs and the risks of being visible, that’s often why visibility is important and representation is important. Because it really does send a message that we’ve been here all along, and also, we belong unapologetically. Which is, I think, one of the things that really needs to be emphasized again and again until people finally sort of get it.

JUSTIN: Yeah.

ALICE: So, I wanna be mindful of your time, and is there anything else you’d like to share that we didn’t get to talk to, that you just would like to talk about?

JUSTIN: I think the only thing that I’ll, and I’m sort of repeating something, but I just wanted to say it very explicitly, is that I think...I’m hopeful that, at least within my institution, there’ll be change. And I think that change only came because people were willing to fight. You know, there were many people who told me to sort of trust the system and that the system will do the right thing. But I just don’t actually believe that that’s true, especially when you have a marginalized identity, whatever that identity is. And I really encourage people to fight. I think you can do it in a diplomatic way. I think you can fight without burning your bridges, you know.

I think for us in healthcare at least, we all want safe learning spaces, have great, high quality patient care, and for people to feel safe. Yeah. And I think that's a uniformly agreed upon thing. And so, just to remind people of how whatever the current structure is does not meet that, I think is one way to sort of bring in people as opposed to sort of pushing them out.

ALICE: Well, Justin, thank you so much for being on my podcast tonight.

JUSTIN: Thank you for talking to me, for letting me talk [laughing] for so long!

Wrap-up

[hip hop]

ALICE: This podcast is a production of the Disability Visibility Project, an online community dedicated to creating, sharing, and amplifying disability media and culture. All episodes, including text transcripts, are available at DisabilityVisibilityProject.com/Podcast.

You can also find out more about Justin on my website.

The audio producer for this episode is me, Alice Wong. Introduction by Lateef McLeod. Theme music by Wheelchair Sports Camp.

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Thanks for listening! And see you on the Internets! Byeee!