

DocsWithDisabilities Podcast #13

Dr. Monica Wood

Introduction: Lisa Meeks

Doctors with disabilities exist in small but measurable numbers. How did they navigate their journey? What were the challenges? What are the benefits to patients and to their peers? What can we learn from their experiences? My name is Lisa Meeks, and I am thrilled to bring you the *Docs with Disabilities* podcast.

Join me as I interview Docs, Nurses, Psychologists, OT's, PT's, Pharmacists, Dentists, and the list goes on. I'll also be interviewing researchers and policy makers that ensure medicine remains an equal opportunity profession.

Lisa Meeks:

In this week's Docs with Disabilities Podcast, we tackle a new topic: doctors with disabilities who are unable to continue practicing medicine. To date, we have talked to clinicians who, despite having a disability, have managed to stay in medicine, as faculty, administrators, or retraining into another specialty. We now shift our focus to physicians who cannot continue to practice. Today, you'll hear the story of Dr. Monica Wood, her journey to becoming an orthopedic surgeon, and how this journey was cut short with the diagnosis of MS.

Monica Wood:

I always wanted to be a hand surgeon. I was about 11 years old when I said I was going to be a surgeon, and I worked my entire life to do so. I finally graduated in 2007 with my fellowship in hand surgery and started practice. It was only four years later that things started to change. The first thing I noticed was feeling drained. The fatigue started. I felt like I was very sick and had difficulty doing call responsibilities but really had no idea what was going on. It took a bit of time to get in to see a primary care physician, and after simple tests, it looked like I had mononucleosis.

One of my friends said that that was pretty unlikely since I'd had mono as a teenager, and we started looking into it further. It wasn't for a couple more months before I started having reproducible neurologic symptoms. I had numbness and tingling in my left hand and my left leg. And I thought, oh gosh, you know, I must have a cervical disc. So I went to primary care again and this time still a different physician. And I said, well, you know, I just need an MRI of my neck. I'm sure you know, it's a disc. She was the first person who suggested it might be MS, and she ordered the brain MRI too.

And things got very hairy from there. I didn't have lesions in my brain. I had a big lesion at the level known as c four in the spinal cord, so in the neck area. And I actually had a lesion outside of the spinal cord, but near the spinal cord in the spine, making it a very confusing picture. It was very unclear what was going on. I ended up going to tumor board. Lumbar puncture, more tests. And it wasn't until the following year, March of 2012, that it was clear that the diagnosis really was multiple sclerosis with a new lesion, a lower down in the spinal cord at the C6 level, which is also in the neck. So most of my disease was actually outside of the brain but affecting limbs, especially.

Lisa Meeks:

I asked Dr. Wood about her first thoughts following the diagnosis, how she married her new identity as a patient and a provider, and how she would address the impact of this diagnosis on her career. She discussed all of those things and the ethical responsibility she felt to ensure that she remained a competent physician while practicing.

Monica Wood:

So when my doctor discovered the new lesions and told me that I had MS, my first thought was of my career. I had worked my whole life to do this and it really is the most important thing. My father has MS, so this is not a strange notion. I was familiar with progression and disability. I was very terrified about losing my career. And I was also very much afraid of malpractice implications. Having a progressive neurologic disorder and being a surgeon are incompatible. So one of the things people don't talk about a lot with multiple sclerosis is the cognitive symptoms. I was having an enormous amount of fatigue and brain fog, and I didn't want to lose that acuity of thought that helps you think on your feet while you're doing the difficult procedure. And I didn't want anyone accusing me of being unfit for work and causing harm.

So I went to one of the university physicians and did the neuro psych testing and it all came out very well. So that was a nice baseline for me to go from moving forward. One of the problems with the neuropsych testing is that you can learn the test and so in order to keep it relatively valid, we came up with a plan to do it every two years and to check my function unless I had a problem in the meantime. So the idea was that I would kind of recertify that I was functioning well every two years.

When I was first diagnosed, I really didn't have any idea what the prognosis might be. It could have been 20 years of full function or it could have been progressive. We really had no indication. My first role was to get on a medication, get something to stop the progression, get something to try to save my career. My diagnosing physician talked to me about a variety of medications. We started immediately on a Beta interferon called Avonex. I had no idea what this would mean for my career, but I did know it put it at risk, and my main goal was to practice as long as I possibly could.

Lisa Meeks:

Dr. Wood needed to focus on her health, but there are very real financial and emotional consequences when one knows that there will come a day when they cannot practice. Dr. Wood's decisions in internship and throughout her training and practice helped to mitigate the financial implications of her disability. Listen or read along as she describes how early planning and participating in a disability insurance program can help physicians who later find themselves unable to practice.

Monica Wood:

One of the things I had done proactively as a resident was to take out a disability insurance policy. I've always been the plan ahead sort of person and you don't know what the future might bring. We had a financial planner talk to us, I think it was my fourth year of residency and talk to us about own occupation policies. So I purchased one as a fourth year resident. And then as I finished my training and went through the early years of my practice, I increased the amount of the policy and of course the corresponding payments for that policy. But I really tried to push that policy up as much as I could, as fast as I could so that I could protect my income.

So when you're suffering from a condition that the primary symptom is fatigue, one of your goals is to put a lock on your schedule, to make sure that you are not getting overtaxed and overly tired to the point where you are going to make mistakes. That becomes a significant challenge. If I was early in my career, I suppose one option would be to do a different specialty. I always wanted to be a surgeon. I don't know that I would have made that decision, but it certainly is one that someone earlier in the process could have made. So you can always pick a different specialty. Being where I was in the process, it was a matter of finding a practice situation that was more accommodating. I ended up changing practices and moving down to Modesto with a group that was very understanding and very accommodating. We had a very large trauma call group so that I took about four weekends a year, which made it much easier. And then we also had one night of coverage, but because there was a trauma group, the one night a week was only whatever patients were in the hospital electively for our physicians. So it was a very light call schedule. And that made a very big difference in being able to get a good night's sleep most nights and manage the fatigue as much as I could.

Lisa Meeks:

The realization that you will have to quit practicing can be difficult. Dr. Wood notes that she wished there was an organization that worked with physicians with disabilities to help them find meaningful, non-clinical work as they transition out of clinical practice. The Society of Physicians with Disabilities is one resource available to help physicians, and it provides free resources and support for its members.

Monica Wood:

So, when it comes to deciding what to do moving forward, if you're early in education and training, then you have more options. You can select a specialty or a training program that fits your abilities and your schedule. And I talk more about abilities than I do disabilities because it's not about what you can't do, it's about what you can do. So what are my abilities and where do they match? Once you're further in your training, there's a saying that it's easier to change careers than it is to change specialties. Truly just to change specialties for most of us means going all the way back and being a first or second year resident again and going through all of the complexities of training, which often means very long hours and extensive call schedules. So retraining is often not an option. So then you need to think about, well, what other career can I do? Can I go into administrative capacity? Can I go part time? Can I be a nonoperative surgeon? Can I teach? Can I do research? What are the other abilities that I have and how can I still keep my head in the game but not put the demands on my body that it's unable to rise to?

So one of my options, if I were to decrease my clinical practice and give up the surgical part would be to be a clinician. A clinic-only orthopedic surgeon. That would mean seeing and evaluating patients, maybe doing some injections, but it would be giving up entirely the procedural part for the actual fixing the patient. For some people, particularly later in their careers, that can be a very good option. For me, that was giving up the whole reason I went into surgery in the first place. So I didn't want to be a part time non-operative surgeon. It didn't fit with who I was. But that's still a good option for people who are later in their career or for whom their reasons for becoming a surgeon might have been different than the fix it mentality that I associate with surgery.

When I stopped practice, it was not by choice. I had been fighting vertigo for a few months, and I was unable to fight it any longer. I literally collapsed face down on an exam table, vomiting, everything in spasm and unable to move from there. My walking completely deteriorated. I could barely hold my head up. I couldn't put dishes in the dishwasher without the world spinning. I couldn't fold laundry. I was completely incapacitated for an extended period of time. I went through vestibular rehab. I went through physical therapy. I did a lot to increase my abilities, but it was never enough to go back to practice. So for me it just wasn't an option to even go back to a part time clinical practice, at least not initially. And I really had to just stop clinical practice altogether.

Lisa Meeks:

As Dr. Wood's condition began to worsen, she realized she would have to look at a gradual exit from clinical practice. Thankfully, she had maxed out her occupation-disability policies, such that with each increase in salary she could increase her benefits. This proved critical to her financial and overall wellbeing. Dr. Wood offers advice for physicians who acquire a disability and who are tapering down their practice.

Monica Wood:

I knew I was getting sick. I knew I needed to cut back. I knew that fulltime surgical practice was foolish. And around January of 2014, we started talking about a partial disability claim. Partial disability claims are much more difficult than total disability. And one of the points that someone made to me along the way was not to change my work activities before filing a claim. So you really have to file your disability claim before you cut your hours, before you go back to just clinical and not surgical. Before you make any significant changes to your work environment, you need to make sure you have notified your insurance company that this is a disability that's causing me to change my practice, not just a lifestyle option.

What then happened is that I got very sick, I was faced down, it was all over in an instant and instead of having a partial disability claim, I now had a total disability claim, and those claims actually got processed and approved first round, which is almost unheard of. So I was very, very lucky and because I had been so vigilant about insuring myself well, I did not have a significant hit to my income. I was able to pay my mortgage. I was able to maintain a reasonable way of life.

I tried working for an IRB for a period of time. I review articles for the Journal of Hand Surgery. I'm doing lectures whenever I can. It is difficult to keep your head in the game and put your training to good use. One thing that I did was keep in touch with mentors. One of my mentors has plugged me into the Journal of Hand Surgery articles. And so that has

kept me active and involved. I do go to the annual meetings. I maintained my credentials. I maintained my licenses. You know, getting the CMEs and just staying in touch with people helps move things forward and helped me find a way of transitioning. To be honest, in the end I'm really moving away from that direct connection to medicine. I ended up starting a business and I'm actually working on a mosquito repellent, which does have ties to medicine with vector diseases and such. But it is kind of a very different realm that I'm working in.

Lisa Meeks:

We asked Dr. Wood what advice she would give to those in the pipeline to health sciences. Her response was beneficial to all medical students, trainees and providers--not just those with a disability.

Monica Wood:

So for people who are earlier in the process, like medical students or people early in their training, my advice is to take absolutely nothing for granted. It can change in an instant. I have an example, one gentleman I was working with, became ill quite quickly with type one diabetes. I got a phone call, "Can you take call tonight? So and so is very sick." And I was like, you know, thinking he had cancer or something. It turned out it was type one diabetes. But at that moment, he became uninsurable. He had not made the preparations that I had, and he was also at a point where his income was a training income, not a practicing income. So even if he had, he would be locked at, you know, what is it, 66% of your current income, which is 66% of a resident's salary.

So being prepared, having that insurance before you have a disability is utterly important and getting it as high as you can at every opportunity so that you're as protected as you can be. That was the one thing that I did that really made a huge difference in my financial situation and my stress level.

The other thing not to take for granted is the things you enjoy. When you're in training, you think your whole life is about learning and the program and certainly all of my reading during training was technical reading. I vowed to myself, when I got into practice, I was going to read fiction because I was just anxious to read something that wasn't technical. But you still need to do some things that you enjoy. You still need to take that time off and use it to go hiking, go biking, garden, do whatever it is that you love because if you don't do it, in the future you may not be able to and you will really regret it.

The summer before I got really, really sick, we took a trip to Yosemite and I hiked out to Mirror Lake and we hiked to another lake and we went up to the falls. And I look back at that trip, and I am so grateful that we did that while we could because now I wouldn't be able to do any of it. So don't let life slip by. Make sure that you're making time for your hobbies, making time for your interests and making time for your friends because at some point you may not be able to and you'll want to look back and have no regrets in there.

I would say that one of my frustrations in going through this process was that I wanted something like a physicians-in-transition. I do think that all of the years that I spent in education and training are being wasted, and there were so many more things I might've been able to do if I had had more resources to get plugged into teaching, to get plugged into ways of using my skills. I actually had proposed a physicians-in-transition subsection and got turned down. But what's happening is as people leave the physician workforce due to disability or maybe it's just a woman who is taking maternity leave or has a sick child, elderly physicians with arthritis or with other, you know, limitations as they age still have a wealth of knowledge and a wealth of experience to share. And there isn't a good mechanism for capturing these people and keeping them involved. We already have a physician shortage and physicians who are teaching and doing other things may be taking time from other activities that might be more valuable to them and to other people. If you can take these physicians in transition and put them into these spots and use our physician supply more effectively, we could extend what we already have. It's not going to solve the physician shortage, but we can at least not make it worse.

Lisa Meeks:

The Docs With Disabilities podcast is grateful to Dr. Wood for her honesty and for sharing her story. This story will benefit many physicians who, upon hearing it, may elect to get disability insurance and decide to embrace life outside of medicine a little more fully.

Kate Panzer:

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