--Jan Serrantino-Cox from the University of California, Irvine. Jan is the Director of Disability Services at the University of California, Irvine; and she is the primary service provider for students with disabilities in the Schools of Nursing, Pharmacy, and Medicine. She has worked in the field of disability services since 1989 as a K through 12 teacher and administrator, university faculty member, and student advocacy consultant. She serves on the UCI Mental Health Task Force and the University of California Electronic Access Ability Leadership Team. And also, Lisa Meeks, Ph.D., from the University of California, San Francisco School of Medicine. Lisa is on staff at UCSF School of Medicine, where she is a primary provider for students with disabilities and directs research initiatives around best practices and disabilities. She also consults with other health science programs -- medicine, dentistry, pharmacy, and nursing -- around innovation methods and inclusion and access.

Lisa specializes in disability and a form of diversity, culturally competent education and professional communication. She is particularly skilled in clinical accommodations in both hospital and clinical settings and is the Co-Founder, Vice President of Research, and President Elect for the Coalition for Disability Access in Health Science and Medical Education. Currently, her work focuses on developing computer simulation for use in remediating medical students' communication skills. So without further ado, we're going to go ahead and start the presentation. I will let all of you know that this presentation can be found in both PDF form and PowerPoint form on the website: www.aamc.org/gsa. We will also have a recorded version after the webinar if you'd like to share or review it at the end. Thank you again, and I will turn it over to Elisa. Hi, sorry about that; I was on mute. But I think, actually that Neera Jain is our first speaker today. Neera, do you want to take it over?

Thanks, Elisa. If you'd like to ask questions, provide feedback, or make comments about the webinar today, you can use the Q&A box in the lower right-hand corner of your browser. Be sure to select Ask All Panelists. We're adding an additional webinar at the end of this series to answer questions that we aren't able to address during the Q&A periods of these webinars. So look for more information online at that AAMC website that Jamie just provided. And after the next webinar, we'll also provide more information about the dates for that. The Coalition would like to thank the AAMC for their continued and generous support. We invite you to revisit the entire webinar series; as Jamie said, it's available on the AAMC and the Coalition websites. More information about the Coalition is provided at the end of this webinar.

So let's get started with an overview of what we'll cover today. We'll start with the process for determining accommodations in the clinical setting. Then we'll discuss a number of considerations to make during the process. Next we'll discuss potential accommodations and apply the process to three complex cases. Finally, we'll review some principles to guide your practice and make time for questions. I'm going to turn it over to Jan to get us started. Hi, it's Neera again. Jan, do you want to unmute your microphone? Can you hear me now? We can hear you now, great. Thank you; I'm so sorry. So we're going to be talking about this first slide and the interactive process. Before we dive into clinical accommodations, let's take a step back and review how decisions are made. As reviewed briefly in Webinar No. 2, making determinations about accommodations always includes an interactive process.

So what does this look like when making decisions about accommodations in the clinical setting? During the interactive process, the DS provider gathers information about the student's disabilities, functional limitations, history of the disability, and previous accommodations. DS providers take into account the program requirements, including technical standards and learning outcomes, and may need to consult with faculty and colleagues in the field asking questions like: Will approving the accommodations fundamentally alter the technical standards, or, what accommodations have been successfully applied to a similar case at other institutions? DS providers should engage in the interactive process with multiple faculty members and others, as needed, in a reasoned and systematic discussion. Courts have frowned upon a single faculty member arriving at this determination. DS providers must consider, when denying accommodation requests, whether this is an alternative accommodation that is both reasonable and effective in meeting the student's needs.

Again, consultations with faculty, colleagues in the field, and the student, will help in identifying these alternatives. Finally, DS providers must consider if approving the required accommodation affects

patient safety. If this is a concern, DS and medical providers should engage in an individualized assessment of the safety concerns. This assessment team must consider: Are standard precautions already in place that address or remove the concern? Are safety precautions embedded in the technical and core standards? Decisions about safety must be made in light of current medical knowledge, or at least the best available objective evidence, and the reasonable judgment of the team in order to reject a request based on the basis of patient safety. You must be able to prove that an actual safety concern exists -- not just a perceived safety concern. As you can see, the interactive process calls for creative thinking and meaningful discussions with the student and the school. There may very well be multiple communication exchanges needed during this process. Neera?

Great, thanks, Jan. Now let's dive below the surface and take a look at important considerations that must be addressed when engaging in this interactive process. First, don't make assumptions. It's important to conduct a case-by-case analysis of each student's situation when determining accommodations. You don't want to make assumptions about a student's level of ability based solely on their disability type or category. If you've met one student with a disability, you've just met one student with a disability. You can't assume that because you've worked with a student with a similar disability before you'll know exactly which accommodations they will need.

So do let previous experiences inform your work and expand the possibilities of the accommodations you can make, but don't let previous experiences limit your work or creativity. Be sure to do a full assessment with each student, each time, to ensure you're taking an individualized approach to ensuring access. Second, know your programs. It is so important for DS providers to educate themselves about their programs. Most DS providers work with a liaison; that's a person within the program who is knowledgeable about the program specifics and the clinical work. So you don't need to be an expert, per se; but you should understand program basics in order to better support students and uphold the program standards.

For example, DS providers should have an understanding of the curriculum structure; technical standards; the lexicon or language of the program, including the acronyms that students and faculty will use; clinical structure; placements, including how placements are made, what is required in the rotation where those placements are, and what the cultures are of the different rotations that students are going to do. Some ways that you can develop this understanding are to spend time with clinical directors, spend time reading student handbooks and school websites, and spend time shadowing at the various sites and rotations so you have an idea of what a day in the life is like for a student. This will help you to help the student anticipate what they might need; and it also helps foster your credibility with the school, clinical faculty, and students. Next, students don't know what they don't know.

So you can expect students to know exactly what barriers they will face in the clinic or what accommodations they'll need. This will be true for students who have a new condition or those who have never used accommodations before. But for all students, it's likely they haven't ever been a medical student in the clinic before. So you'll have to work with students to help them think through what they might need; and that should happen, ideally, well in advance of entering the clinic. You may need to go so far as to talk through the technical standards and clerkship checklist with students to help them understand the specific requirements and think through potential barriers. When you come across something you or the student don't understand, you should get more information from your faculty or liaison, develop the shadowing opportunity to see the environment live or in a SIM lab, and use this information to develop accommodations.

Next, take a pragmatic approach to your process. Don't get over overwhelmed when a complex accommodation situation arises. Start with that framework for effective decision-making that Jan just described, collect the information you need, and trust the interactive process. Don't let a student's historical behavior or your feelings about their situation color your decision-making; keep it objective. Following a clear process will help to keep your accommodation decision-making objective. And, of course, make sure to document all aspects of that process and your interaction with others for future reference. Next we really recommend that you communicate early and often. Take a proactive approach to engaging students about clinical accommodations. I usually broach the subject with students in my

first meeting with them, even prior to their starting the program. There will also be new students who have never registered with DS before who will need accommodations in a clinical setting.

So it's advisable to send reminders about the process and ideal timelines for effecting accommodations to all students several months before a clerkship placement occurs. If there's a clinical orientation, it's a good idea to get some time on the program to speak to all students. This helps to demystify and legitimize the process for faculty, staff, and the student's peer group. In that discussion, I usually share that some students may need accommodations for the first time in the clinical setting and invite students who are unsure to come in and have a conversation with me to explore their concerns. Make sure that the process for requesting accommodations is discussed in the clinical handbook, and review it annually to ensure it's up-to-date. Jan?

So the next thing we want to look at is consideration during this process. We would need to gather information. And this is so important -- to get the key information, including the history and prognosis. It's so important to know about the history and prognosis of the student's disability. For example, is this a new disability, a new diagnosis? Is the diagnosis stable? What is the prognosis? This determines the depth of planning that needs to occur with the student, including some Plan B scenarios like taking a leave of absence. Because students often require weekly or bi-weekly appointments to maintain good health for psychological, chronic health, or mobility disabilities, it is important to gather information about treatment frequency and location of treatment in relation to clinic sites. You should also gather information about historical use of accommodations. What was effective in the past and what was not effective?

Anticipating barriers -- finally, you should ask the student about their biggest concerns and discuss any anticipated barriers, including those you can anticipate; and that's another reason to really understand your program. One way DS providers can support students is by taking a proactive approach and thinking critically in order to anticipate needs in advance. Talk with the student openly about what could go wrong and develop an action plan if that happens. Generally, this will not overwhelm the student. Honest conversations help students recognize and anticipate their own needs. Most students appreciate this type of planning and have responded by saying, "Thank you; no one has ever taken the time to help me think through this in an honest and proactive way and then provide options for me. I feel so much better knowing I have a plan and a proactive way to provide options for me. I feel so much better knowing I have a plan." If we don't guide the student to be proactive, they often ruminate about what will happen during the clinical years and are often just too afraid to ask. We want to be creative, especially around episodic conditions.

And you're going to want to think creatively about meeting technical standards, learning outcomes, and attendance requirements. It is helpful to consider how students with a temporary injury are supported, say, a broken leg. Just because someone is unable to perform a task for a few days or one week does not mean that they cannot perform the task. Think about how the student might demonstrate competency once the flare subsides; such as, use of SIM labs and mannequins. Lastly, student support is essential. If you become aware that a student is not functioning well, is not attending scheduled clinic hours, or is not maintaining a professional demeanor, encourage the student to seek a leave of absence in order to stabilize their health; and work with them on a re-entry plan that includes appropriate accommodations and support. Lisa?

Thanks, Jan. DS providers also need to know their program technical standards and the learning outcomes for specific courses. It's important for providers to work with the school to ensure that technical standards are not discriminatory and that learning outcomes are communicated to all. The technical standards should focus on outcomes, not process. For example, if the technical standard reads, "The student must be able to hear a breath sound," it's really focused on process, the process being hearing a breath sound. Where the actual learning outcome or what the student needs to know is the student's ability to evaluate the breath sound and, of course, to identify clinically-relevant findings. This outcome can be met using what we like to call "functional equivalent." And so that might be a digital stethoscope. Technology, like the digital stethoscope, is already being used in telemedicine and for physicians with partial or complete hearing loss.

Next, DS providers need to understand the policies of their programs. This is in order to counsel students around that pre-planning that Jan talked about and to determine if an accommodation is reasonable or not. Among the most important policies include the attendance policy. DS providers should absolutely understand what the expectations are around attendance and for each clerkship rotation. From there, you can begin to explore whether there is any reasonable consideration for a student with a disability to have more absences if their condition warrants the absence. Another policy that's critical to understand when working with students who might require time off or an extension of the program is the time to degree. In other words, is there a specified time limit on degree completion? You also probably want to look at board exams and statewide exams for that as well because some of them do have time limits on passing board exams.

Finally, DS providers should absolutely be aware of the leave of absence policy. Any leave of absence policy should be in writing; and it should be followed consistently, regardless of whether a student has a disability or not. This should be for all students. In some cases -- and I know this is the worst case scenario for many -- but sometimes a student is just not qualified. So what does that mean? It means that despite everyone's best efforts, the final determination could be that the student is not able to meet the technical standards of the program with or without accommodations. If you've determined that an appropriate and reasonable accommodation can't be identified and you've got through this process that Jan was talking about, if the learning outcomes and technical standards cannot be met, then they must be upheld. When making this determination, it's really important that DS providers carefully and thoroughly document the decision-making process. You want to document who was at the table, what was discussed, the experts that you sought opinions for, the faculty members, the DS individuals. You should note also any alternative accommodations that were offered to the student. So if you've followed and documented your process, including consulting with legal counsel, you can feel confident that you've made a good decision regarding clinical accommodations. Neera?

Thanks, Lisa. We've presented some information on the process and key considerations; now we'll move to some potential accommodations for the clinical setting. Remember, there's no one-size-fits-all accommodation; so the appropriateness of each should be evaluated individually. What we'll review is not an exhaustive list of the accommodations possible in the clinic, just some of the accommodations we've successfully implemented. Advances in technology and creative providers, like I'm sure all of you listening today, are continually expanding our understanding of what's possible to provide access in the clinic. Lisa, do you want to go ahead?

Thanks. The first thing that we need to discuss in our area of clinical accommodations is scheduling. In some cases, students require that the location of their clerkship is what's accommodated by ensuring that they are placed within a set geographic area and ensuring proximity to, say, a treatment team or to minimize travel time or to ensure that their placement locations are on public transportation routes. This is a process of exclusion rather than specific placement. DS providers should identify what accommodation is needed and then work with the placement coordinators to exclude placements that do not fit within the specifications required. Once this is complete, traditional placements methods, such as a lottery, should run normally. This accommodation might also require an adjustment or consideration of the order of the clerkship. Three historically grueling clerkships in medicine include OB/GYN, surgery, and medicine; and accommodation can be made to spread out these clerkships so that they are not in successive order. One thing that's really important is that clerkship accommodations that include placement must be sorted out well in advance. DS providers should absolutely work with their program to come up with an ideal timeline and publicize this widely to the students.

Accommodations can be considered when some form of leave is needed. A student may require release from overnight calls as an accommodation. In most cases, this is a reasonable accommodation for chronic health or psychological conditions; or good sleep hygiene is essential to a student's functioning. Generally, the student is required to complete the same number of hours in the clinic but complete these hours during the day in lieu of overnight calls. Or, perhaps the student completes the hours during additional weekend daytime calls. The student meets the same learning outcomes as their peers, just at a different time. Earlier today, we talked about the frequency of treatment. This will help you to

understand whether the student needs to attend weekly appointments that would require a release from clinic to attend disability-related treatment appointments. These appointments could be planned in advance and scheduled at the end of the day, perhaps after charting is complete. Students should confer with their preceptor or attending to arrange make-up hours. This arrangement supports the attendance requirement, albeit in a modified way. If transportation or distance to travel for treatment is prohibitive, then consider providing a private location and a short, for example, one-hour leave or remote Skype or phone appointments with their care team if that is sufficient, depending on the type of care. Lisa spoke before about understanding the standard program attendance policy.

For some students, you may need to consider modification to the attendance policy as the accommodation. Once you understand the standard attendance policy, you'll need to understand the length of the clerkship. Is it two, four, six, or eight weeks? This will help you define how many absences might be reasonable for each clerkship block, working with your liaison and clinical faculty. You also want to work up how disability-related absences will be implemented. For example, a student who would not normally go to the doctor each time they have a Crohn's-flare-related absence, will they need to provide a doctor's note; or can they simply state they are using a disability-related absence? Neera?

Thanks, Jan. When students experience a barrier in the clinical setting, it may be that they need to develop a modified approach to demonstrating their ability to do that clinical skill. Some ways to approach that is practice in the SIM lab with a clinical instructor and DS provider can really help students to develop that modified approach. For example, a student who uses a manual wheelchair, they need to practice their technique n the SIM lab for maintaining a sterile field while maneuvering in the treatment room before they start in the clinic. Or, a student with limited dexterity may need to develop alternate for completing vena puncture, administering catheters, or conducting a digital rectal exam. Frequently, barriers in the clinic can also be addressed through the use of assistive technology. Students may already be proficient in using specific technology that allows them to effectively read, take notes, listen, and communicate.

So ideally, for those students, you'll be able to implement the same technology seamlessly into the clinic. So you'll need to work with onsite IT to implement things, such as reading or voice recognition software on existing computer systems, particularly when electronic health records are in use. For students who are not yet using assistive technology, or for barriers that aren't yet addressed by the technology they use, an assistive technology assessment should identify possible solutions. Some examples of assistive technology that students have used effectively in the clinic include smart pens or mobile devices for taking notes, automated blood pressure machines, and visual or amplified stethoscopes. A variety of accommodations can be made for students that affect their communication. As with any accommodation, it's important to start by assessing the environment, understanding what types of communication are required, and what the factors are involved. For example, communicating with patients if students have to do rounds where there is (inaudible), they have to communicate by telephone or pager, you want to know that as well as the student's preferred method of communication, and then you can identify possible accommodations. Sign language interpreters, amplification devices, and carts can be used in the clinic to facilitate in-person and phone communication, including the variety of apps on mobile devices.

However, communication by phone can get really tricky for students with some residual hearing who need amplification devices. You'll need to evaluate the types of phones used in the clinic. Because the built-in amplification features on phone systems often vary between sites in their availability and effectiveness, we've found that purchasing a cell phone for use in the clinic that we know plays well with the student's hearing aids, is a useful accommodation to address telephone communication across clinical sites during the clinical years. Having a text pager instead of a standard pager assigned to the student can also be helpful, depending on the communication standards of the clinical team. For some students with speech, learning, or sight disabilities, early notification of patient presentation can be helpful to give a student more preparation time or the ability to use technology, such as an iPad, to generate speech. Now let's apply what we've discussed so far to three complex cases so we can see how they work in terms of the process, considerations, and potential accommodations. Jan will walk us through Case Example No.1. Case 1 involves a medical student with a physical disability, who is in a

wheelchair with limited arm strength. The student requests several accommodations, including an intermediary or assistant to perform lifting and positioning of patients. She also requests a waiver of the CPR requirement. The student explained that her planned specialty is going to be psychiatry, which is not a physically-demanding profession. She argues that the need to lift or position patients and perform CPR is not a critical learning objective.

On the surface, her request may appear reasonable. So what do we need to consider? We must follow the interactive process to make an accurate, case-by-case determination. The DS provider is aware that other medical schools allow an assistant to perform lifting and positioning of patients. First though, let's remember the questions that should guide the interactive process. Is the requested accommodation reasonable based on the student's functional limitations? Does the requested accommodation fundamentally alter technical standards for learning outcomes? Would approving the accommodation risk patient safety? What experts should be consulted if faculty or Disability Services believes the request is an alteration to a critical aspect of the curriculum?

Should legal counsel be involved in this discussion? And what additional information do I need, as a DS provider, from the student or the student health care provider? The second piece of this puzzle is the School of Medicine's perspective. The technical standards clearly stated that they offer an undifferentiated degree program, meaning that they prepare all students to enter all residency programs, including emergency medicine. Also, the motor skills technical standards require students to be able to perform basic life support and to lift and position patients. Learning objectives include being able to perform CPR. The third piece of the puzzle is research and creative thinking. Is there an accommodation that will remove the barrier and create the needed inclusivity? We'll want to understand the ways patients are lifted or positioned in hospitals and rehabilitation centers. Could an accommodation, such as a Hoyer lift, apply? Could the student develop a modified approach in order to successfully perform CPR or other clinical skills? Gathering information from the student and faculty will be invaluable in making the determination.

Finally, the last piece of the puzzle is determining the reasonableness of an accommodation or modifications in the clinical setting with respect to established learning outcomes that must be met by the student. Will the accommodation substantially or fundamentally alter the technical standards? Or would the accommodation allow the student to perform solely in a different way? Think again about process versus product. And perhaps most importantly, will granting an accommodation compromise patient safety? The overall goal is to approach the request and make a determination with an understanding of multiple perspectives. That includes the student, the school of medicine, the clinic, and the patient. Well, what are the outcomes in this situation in this case? Case No.1 actually reflects the specifics of McCauley v. The University of Kansas School of Medicine.

By way of background, the University of Kansas School of Medicine provides an undifferentiated medical degree, preparing physicians for a wide range of practice, often in emergency situations where assistance is unavailable. Several months prior to the student arriving, the University of Kansas entered into a deliberative process to determine if providing a modification -- that is, giving McCauley the requested accommodations -- would substantially alter technical standards or the program. It was decided in this case that McCauley was not a qualified individual; that is, she was not able to perform the technical standards or learning outcomes of the program. The Court held that the school has the right to set its own curriculum, and the ADA does not require that a school make substantial changes to its curriculum as a disability accommodation. The Court did note, however, that not all medical schools have such physically demanding technical standards and suggested that the student may succeed in another medical school.

Now I'll turn it over to Neera to present our second case study.

Thanks, Jan. In our second case study, we'll look at a scenario of a student with a chronic health condition. The student had a long-term chronic health condition that had previously been relatively stable; but since starting medical school, she was having periodic flares. So needing accommodations was a very new concept in general and particularly for the clinical setting. Her flares were resulting in

difficulty straightening her hands completely, some joint pain, and difficulty standing for long periods or walking distances. In some cases, the pain would affect her attendance, but only for a day or two while she adjusted to a flare. She had necessary physical therapy appointments that happened weekly. And when she came to me, her main concern was transportation and travel time, as she anticipated that the commute to and from the clinic would prove physically taxing. She was unsure what other accommodations might be needed. For this student, there were a few different areas to consider. First, with a student who has a chronic health condition, I find it essential to get a good picture of their experience of the condition -- how it affects them on an average day, week, month, and year.

And that helps us to identify what might happen in the clinic. You want to have a good understanding if there are any clear triggers for flares. In this case, the student's triggers were heightened stress; lack of sleep; and changes in temperature. You also want to find out what helps to prevent or minimize flares. For this student, having that regular physical therapy, good sleep hygiene, and managing her stress through counseling and meditation were all very helpful. And then you want to understand, to the extent possible, what happens when a flare comes on. Does the student usually need to be hospitalized? Can they self-administer treatment? Do they need an urgent medical appointment? What is the duration of the flare, and how frequently does it happen? Are there predictable changes in functioning during the flare? And are there conditions better or worse at different times of the year or day?

And are they affected by changes in seasons? Given this student's situation and her periodic difficulty with prolonged standing and traveling distances, I also wanted to understand whether a mobility device had ever been used and whether she was open to using one. So in addition to understanding the physical factors, I needed to understand the academic requirements. Since there were some period issues with manual dexterity, I needed to work with the student and clinical directors to understand the learning outcomes for each rotation; and I knew they were going to be different between rotation. And I knew that there were skills checklists of the skills that students needed to complete during the rotation, so I needed to understand how these worked. Do students actually have to do all the tasks on the checklist or only if the patient happens to come in? What is essential? Because the student's flares were unpredictable, I needed to work with the student to ensure they understood the school's policies about attendance, leaves of absence, and reschedule of clerkships in case something came up. We also wanted to think about what other possible concerns might we not yet be thinking about. So what were the outcomes in this case?

Given the student's endurance and mobility concerns, we approved clerkship placement on public transportation routes within a specific geographic boundary to limit travel time. We spaced out physically taxing clerkships --like OB-GYN, surgery and medicine, like Lisa was talking about before -- so they weren't back-to-back. We loaned the student a university-owned mobility device to use on the boards when flares were active. And we organized a plan that should a flare occur and the student isn't able to complete an essential skill, the student would complete this outside of the rotation in a SIM lab after the flare had passed. We organized for the student to have a stool available in clerkships where extended standing was required, so in places like OB-GYN and surgery, with brief breaks as needed so that she could sit down. The student was provided release from overnight calls to support her sleep hygiene, and the student was given weekly release from clinics to attend physical therapy sessions. We need to keep an eye on things, as her status is a bit of a moving target; and I've let her know to see me if things change.

Now I'll turn it over to Lisa, who will discuss our third case study.

Thanks so much, Neera. In Case No. 3, we're working with a student who has a psychological disability. The psyche disability is well-managed; the student is functioning well and has a stable medication regimen. They also have a really strong support team, and that's important. The student is requesting no overnight call, weekly release for therapy appointments, and an exclusion of a very specific ER site where they were previously an inpatient. So what are the considerations the DS provider must address? Well, we've talked about these a lot in the last few cases; so I'm going to go over them very quickly. We want to discuss what accommodations are reasonable; what are the technical standards/learning outcomes; what is the standard attendance policy; the frequency and location of the disability-related

treatment appointments that the student is requesting, the weekly release for therapy; the purpose of overnight call in our particular clerkship at our school; and then the medical leave policy. We also want to look at options for psych and ER rotations for the student, so they don't have to do their neuro psych clerkship rotation at that specific hospital. Let's look at the outcomes in this case. We went with approval of overnight calls.

And with this accommodation, the student typically leaves the clinic by 10:00 p.m. so that they can get adequate sleep hygiene. In implementing this accommodation effectively, the student must provide the clerkship coordinators with their accommodation letter far in advance of the rotation starting because these clerkship coordinators really plan their schedule months in advance. We also agreed to release from clinic once per week for appointments. The student was released to attend these appointments and maintain their wellness. They were advised, however, that morning appointments are disruptive due to rounding and that when possible, appointments should occur on the same day and time of the week during that particular clerkship -- so for example, release at 4:00 p.m. each Wednesday. A good deal of discussion around professionalism and communication happens with these types of accommodations. We really talk to the students about making sure they communicate well and often. Clerkships plan far in advance, like I said, for this coverage; and they really need to be alerted early to ensure proper coverage and to arrange for the student to make up time.

Making up the time is something that's negotiated between the student and the supervisor; and this can involve extra readings, returning to clinics to finish charting, staying late one day per week, or even coming in on the weekend. We made sure that the clerkship locations were in close proximity to their treatment team, so that they reduce the amount of time needed to get to and from the appointments and could maintain these appointments. And finally, the psych rotation placement was approved; and we worked with another school to make sure the student had access to another psych neuro site. Neera? Thanks. We've put together some overarching principles to guide your practice when determining clinical accommodations. First, don't make assumptions about what a student can or can't do. Be proactive; try to plan ahead for work case scenarios. It will help in the long run, but roll with it when things happen at the 11th hour; and we know they do. Use a pragmatic approach to determine what will and won't work.

Be systematic and document your process. Know your policies and guiding documents. Go back to what is in writing to govern decision-making about what is essential. Make sure these are reviewed regularly, with an eye towards discriminatory language or policies. Make sure DS is at the center of any conversations about accommodations; they're your campus experts. Consult your colleagues in the field; you may not need to reinvent the wheel. It pays to see what others have done and lends persuasive credibility to accommodation options. And finally, make sure you have a good relationship with your campus counsel. When you run into walls or you're preparing to deny an accommodation, make sure you've run the scenario by your legal counsel to ensure that they are in agreement with your decision-making. They may also be helpful in facilitating those difficult conversations you might have to have with your faculty. I think with that, we'll turn it over to Elisa, who is going to moderate some questions for us.

Thanks, Neera. If you all have any questions, as we said at the beginning, please go ahead and type them into the box; and I will try to sort through them and get as many answered as we can in the minutes that we have remaining. The first question that we have is regarding a service animal in a clinical setting. Lisa, do you want to address this? As far as a service animal is concerned, as you all are aware, there are only two questions you can ask. Is the animal a service animal, and what task does it perform? Beyond that, the service animal needs to be allowed to come into the clinical setting. There are restrictions that you can place on specific areas of the hospital, where the dog may not be allowed or the miniature pony.

And that would be something where people have a compromised immune system or a surgical suite, things of that nature. When you have a student that has a service animal, it's really a good idea to work with the student; communicate your policies and procedures that of course you already have together in writing and posted to your website. And make sure that everyone is on the same page as far as

expectations. Another thing that's really helpful is to give the ward nurse manager, or whoever else is in charge of the particular floor that the student will be on during that particular clerkship rotation, a heads up. And work with them to educate everyone that's going to be around the animal, so that people understand why the animal is there and they understand that they're not supposed to approach the animal -- that it is there to provide a service. Wonderful, does anyone else want to chime in on that before I move on to the next question and the other panelists?

Okay, so the next question that we have has to do with instructions for students about how to request accommodations, particularly in the clerkship portion of their education. We know that students are given information about how to access accommodations in the didactic portion, but is there a specific approach to make sure that students in the clinical portion also know that accommodations are available if they're needed and how they might request them? Neera, do you want to take that question? Sure, I guess the quick answer is that information should be everywhere and easy to find. I think Lisa and I use a standard of maybe two or three clicks to find information that students need on your website. So it should definitely be on your website, Disability Services website, if you identify where students usually get information about the clinic.

So if the medical school has a website about how the clinic works, there should be information about clinical accommodations there. If there is a handbook, it should be in there. It should be everywhere that's appropriate. If there's a clinical orientation that students go through, Disability Services should be talking at that orientation and giving information about the clinic. And also at the general student orientation, when students first start in the program, I talk about it then as well because sometimes people will think, oh, yeah, accommodations in the classroom, I understand that -- but surely not in the clinic. And so I make it really clear during that orientation presentation that, yes, we do make accommodations in the clinic; if you have questions, come talk to me. And I can't tell you how many students have come to me after that to say, "Oh, I saw you at orientation; and I'm just thinking about something."

And 9 times out of 10, that turns into a student that's registered with us who does use an accommodation in the clinic. I don't know if anyone else wants to add to that. I'll jump in for a couple of comments. One of the things that we talked about early in the presentation was getting to know your school, your faculty, the policies and procedures, and especially having a great relationship with the faculty liaison in the school. The more that you have exposure to the faculty and the clinic site, the more that faculty will be the ones to make that known to students -- that accommodations are available or to at least seek out a chat with Disability Services. So maintaining those really good relationships with faculty is really important. Anyone else? That's a great point, Jan; I'm glad you made that. Yeah, and I have to say, that's one of the great things. We're an integral part of the School of Medicine. Nothing is really considered without bringing Disability Services to the table.

So I think you also have to have your faculty and administration onboard, looking at all of this very proactively and just assuming that it's part of everything we're going to do, whether it's curriculum-based or clinic-based. Thanks to everyone for those great answers. The next question we have has to do with whether any of you at your schools have ever had to accommodate a student who is functionally a quadriplegic -- a medical student in particular. I think maybe, Lisa, that has come up for you in the past? Yeah, that's actually -- and I'm just going to offer this online for this particular person. If you have detailed questions, you can call me; or you can call Tim Montgomery. We have both worked with students very similar to this. And there are a lot of devices to assist with meeting the technical standards. And the answer is so detailed and gets very nuanced that I don't know that everyone would benefit from that. So I'm happy to answer that question offline.

But I do want to make sure that I say more broadly that students that are functional quadriplegics can absolutely attend medical school; can absolutely meet the clerkship requirements for the majority of medical school technical standards that are out there; and that we do have a host of things that Tim and I have used to work with these particular students. And I'm happy to say that my student is now in a surgical residency; so never say never. We always say, never say never when you first encounter a situation. I do want to go back really quickly. There is one follow-up question to the service animal, and I

think a lot of you are probably thinking this; so I want to go ahead and answer this. Plus it comes from the great state of Ohio, so go Cavs. The question is: What do you do if the patient is allergic to the service animal? Well, if you get those kinds of situations, you need to deal with this on a case-by-case basis. We have a situation where the patients are alerted before the animal enters the room, and they're told that a service animal will be accompanying their caregiver. And then the patient is able to, at that time, voice any concerns, any allergies, any fears or phobias; and we can make a switch with patient rooms. I was just having this conversation today; and I think that if you're in a large teaching hospital, OCR would have a hard time believing that you couldn't find an alternate patient to substitute in for the patient that is allergic to the service animal. I hope that answers your question. Great, thank you. Jan or Neera, did you want to jump in on the question about accommodations for a student who is paraplegic or functionally a quadriplegic in medical studies?

This is Neera. Oh, I'll let Jan go. Go ahead, Jan.

I'll just add really quickly that looking at the technical standards far in advance of choosing the medical school and looking at this situation, like we talked about in Case Study No. 1. The program, the technical standards, and the school really needs to be considered long before decides to go there because as I mentioned in that University of Kansas School of Medicine case study, the judge did note that there were other campuses, other medical programs, that had very different technical standards or ones that the student could obviously meet. So it's just so important to encourage your medical schools to make sure that those technical standards are readily available to all students that want to apply to the program. Neera?

I just wanted to make the point -- you both make really good points. The other thing is just, again, not to make an assumption that a student can or can't meet the technical standards because each student with paraplegia or with quadriplegia or with tetraplegia is going to present differently with various skills and abilities. And you need to assess that student individually and really be working with them early to see what's needed, what can be done. And then definitely talk to Lisa and Tim to see what they've done that's worked and take it from there.

Thanks so much for that, Neera. That was really helpful and circled us right back to the guiding principles you provided about not making assumptions about students and their abilities. So that's a perfect way to wrap up the questions right now. And I'm going to go to Lisa for our final words. Great, so as promised earlier, information about joining the Listserv. If you'd like to join the Listserv, if you're not part of Coalition already, you can find out more information about the Coalition at: www.sds.ucsf. edu/coalition. And if you decide to join, you can do so by contacting our Membership Chair; and that's Leigh Culley at lculley@pitt.edu. We also have a book that's coming out next month. And just so you don't think that I'm trying to force or sell the book, all of the proceeds from the book have been donated back to the Coalition to go into doing activities just like this today, to provide free education for other disability providers so we keep it going and pay it forward.

To order the book, you can do this at Springer; and there's a 20% discount with this promotion code. You can also get it on Amazon.com. And then the next webinar that we're hosting is on August 20th; and it's, Putting It in Writing: The Value of Creating Clear and Effective Policies for Students with Disabilities. The details and registration are available at: www.aamc. org/gsa. This is super exciting because we haven't done this on any of the webinars so far. But we are actually going to have a packet that's going to go out to every participant that will include, vetted by multiple schools, syllabi statements; statements to put on your application; statements to put on your acceptance letter. We're going to give you a lot of really hands-on tools to use in your institution and, of course, specialized to your particular type of school. But we'll be providing a lot of what we feel are really helpful tools and tips. So we hope to see you then.

And, please, at the end of the webinar, you'll get a little e-mail that will ask you to give feedback. I want you to know that we look at the feedback, especially the comments. And we take them very seriously and we really try to provide you with the information that you need in a timely manner. And again, as Neera said, we're going to have a Q&A; and that will be Webinar No. 7. It will be in October; we haven't

solidified the date yet. But we're going to take all of the questions from all six of the webinars, and we're going to respond to them. So anyone who has ever asked a question on this webinar series will have their questions answered. And we'll also hold half of the time for new questions that people have. And I know sometimes it's helpful just to be able to call in and just ask the questions that you have specifically on your plate, so we're happy to do that. Thank you so much for participating. Again, we can't thank the AAMC enough, especially Jamie who is on vacation and calling in from vacation. Thank you, Jamie, for all of your constant support and enthusiasm; and we are really glad that you were here with us today. Hope to see you again.