

AAMC
Students with Psychological Disabilities Continuing the Conversation 3.10.16

Good afternoon. My name is Jayme Bograd, and I represent the AAMC. We are excited to have almost 200 of you registered for the webinar today. Before we begin, I'd like to remind you that the Disability webinars, including this one, are recorded and available by visiting: www.aamc.org/gsa.

Additionally, if you have questions during the presentation, please ask them through the Q&A feature on the right-hand side of the panel; and we will answer as many questions as we can at the end of the presentation.

The presenters' views and opinions are their own and do not necessarily reflect the position of the AAMC. We are very thankful that this webinar, and the previous six webinars, were made possible by our wonderful colleagues with the Coalition for Disability Access in Graduate Health Science and Medical Education. And a special thank you to Dr. Lisa Meeks, who shepherded this series with the AAMC.

Our presenters today are Lisa Meeks from the University of California San Francisco, where she is the Director of Medical School Disability Services and Assistant Professor of Medicine. She is also a Co-Founder and President Elect of the Coalition for Disability Access in Graduate Health Science and Medical Education Co-Chair of the Association of the Higher Education and Disability Autism Spectrum Disorder Special Interest Group.

Lisa is a published author of multiple books on the Autism Spectrum Disorder, and is the co-editor and author of the Guide to Assisting Students with Disabilities: Equal Access in Health Science and Professional Education.

We also have Dr. Maxine Papadakis from the University of California San Francisco. She is Professor of Medicine and a practicing Internist at the San Francisco Veterans Administration Medical Center. She is the Associate Dean for Students in the School of Medicine at UCSF and a leading investigator in the field of professionalism. Some of her current work addresses the role in remediation in professional lapses. She is catalyzing the educational community to identify best practices for remediation and then to test these interventions.

She is a member of the Ethics and Professionalism Committee at the American Board of Medical Specialties. And recently, Dr. Papadakis has turned her attention to studying the performance of medical students with protected disabilities, focusing instead on their abilities.

We also have Dr. Joseph Murray. Dr. Murray is the Associate Dean of Student Affairs and Equal Opportunity Programs, and an Associate Professor of Clinical Psychiatry, at Cornell Medical College. He is a summa cum laude graduate of the University of Scranton, where he majored in biology, English and philosophy. He graduated from the University of Pennsylvania School of Medicine and completed an internship at Johns Hopkins Bayview Medical Center and a residency in psychiatry at the Payne Whitney Clinic of the New York-Presbyterian Hospital.

Without further ado, I'm going to first turn it over to Dr. Murray.

Thank you, Jayme.

We're very excited to be here and -- if you can advance the slide -- on behalf of the Coalition for Disability Access in Health Science and Medical Education and the UCSF School of Medicine, we really wish to thank the AAMC for their generous support in developing this webinar series.

Today we will be, in this webinar, aiming to work through a case study where participants will come to understand the current state of psychological well-being in medical students; disability accommodations for psychological disabilities; what OCR defines as "reasonable"; best practices in policies, procedures and appropriate accommodations; and the need to support student well-being.

Medical school is hard for everyone, including faculty and staff sometimes; but it can be especially hard for students. Lotte Dyrbye from the Mayo Clinic has written extensively about the phenomenon of burnout

AAMC
Students with Psychological Disabilities Continuing the Conversation 3.10.16

in medical students. Burnout can affect up to 50% of medical students. And in her study, 10% of students experienced suicidal ideation within the past year. Numbers can go as high as 15%.

The suicide rate among medical students is higher than the age-matched population. Depression rates are higher than age-matched peers. So something about the medical school time correlates with worsening mental health and well-being.

In OSCEs, we should look at the culture of medicine. Students hear about and strive to become the physician who places their needs secondary to that of their patients. The selfless and noble physician is heralded as the ideal. So how does one get there?

We've all been regaled by tales of our physician forbearers, who have worked longer; harder; for less pay; with fewer elevators, slower elevators or, heaven forbid, no elevators; few days off; AND minimal vacation. And they often cite these adversities with their medical training as being key to the formation of their character and skills.

If you are struggling in any way, it can feel very alienating for you as a student to feel far away from that mythic ideal. Within the culture of medicine, this culture of medicine, any type of disability could be viewed by the student and by others as a sign of weakness. Medical students are smart and perceptive. They pick up on stigmas of depression and mental illness. They worry that having a mental illness can harm their chances of residency, licensure, success; they don't want to be perceived as weak.

Medical school is the start of a new chapter in the lives of our students. Even if a student had treatment for a psychological condition in college, she or he might opt not to seek treatment or accommodations because they're reluctant to disclose in this new setting, in this new chapter.

Today, we'll explore how one can work with a student with a psychological disability. Some students enter medical school with one, but some develop a psychological condition while in medical school.

Stuart Slavin at Saint Louis University has written about wellness and ways of improving student mental health – the mental health of all students directly – through curricular changes, resilience and mindfulness experiences and wellness programs.

I spoke earlier about the culture of medicine. We need to change it. We have to normalize discussions of stress, anxiety and burnout. We need to value taking care of one's own health, including mental health. We need to acknowledge the reality that students will struggle with mental health issues and normalize the need for treatment and understanding.

Dr. Papadakis will talk about the need for support and the need for research.

Thanks, everybody.

I want to echo Dr. Murray's concerns about the state of the well-being of all of our students and, I think, particularly those students with protected disabilities. It is an extra layer, if you will, of things that they need to navigate and negotiate actually.

It would be wonderful if we had research that showed that students who disclosed their known disabilities earlier, and certainly received the appropriate support for that, would perform better than their peers. And that seems intuitive. But if we had data like that, it would inform students and, I think, would help normalize the process.

We need to look at outcome measures of improved retention for our students with protected disabilities, and equally so in terms of their navigational skills. We need to help them build resilience and self-advocacy in addition to building empathy for psychological disabilities. This is an extra layer. It certainly is. All our students have much less reserve than they did when they're not in medical school simply because of the workload and the psychological stress of being in such an environment, where you're

AAMC
Students with Psychological Disabilities Continuing the Conversation 3.10.16

seeing people sick all the time and where the performance measures and competition between students is really so great, no matter what kind of pass/fail that we have.

So it would be wonderful to have research that looked at the different measures. And we do know, at least in a small study from UCSF, that students with disabilities do perform similarly to others in certain clinical settings and certainly in measures of professionalism and fund of knowledge.

So we don't really know what an appropriate accommodation is for medical students. Accommodations are made and are informed by research that is brought in from other fields. But wouldn't it be wonderful if we really knew how to better target the accommodation for our medical students in their various settings in order, again, to do the right thing, to help them build resilience, and to help them succeed so that they will take the best care of the patients that they can.

So let's look at a case. A third-year student is having difficulty in the wards. He disclosed a psychological disability, bipolar disorder, that is well-managed; but states that the long days and overnights on an OBGYN clerkship are causing disruptions to his sleep. He no longer has the flexibility to keep and attend his appointments. This inability to keep appointments and lack of sleep are exacerbating his condition. Let's learn a little bit more about him on the next slide.

Your student shares with you some of his background. We can imagine that he filled you in on this when he arrived in medical school. Some students start giving me paperwork during the summer before they arrive or even soon after acceptance. Here's what he tells you.

Five years prior to starting medical school, he was hospitalized at your school of teaching hospital. The hospitalization began with a psychiatry emergency room evaluation and then admission to the inpatient psychiatric unit at your school. He did well in college and successfully gained admission to your school; and since arrival in medical school, he's also done well. His mental health has been stable, and he's on a good medication regimen. He's had no more hospitalizations. He adheres to his medication and his psychiatric visits, and he's been seeing the same psychiatrist for the past five years since that admission.

As his comment in treatment for bipolar disorder, he and his psychiatrist have worked to identify some triggers which can lead to exacerbation of symptoms and can be harbingers of an early relapse. They've identified lack of sleep and periods of high stress as triggers that can lead to mood difficulties. So what could we do now?

Well, from this student we learned that he's been stable, with good support; and he has performed well through medical school. He is requesting three things: an alternate site for the psychiatry emergency room and psychiatry clerkship, given his prior hospitalization here; no overnight call; an ability to see his psychiatrist weekly.

Now, this case is a good example of how early disclosure can be helpful for the student. It is possible that potential problems could be preempted or solved earlier. Identification of triggers might have led to a discussion with the Disability Services provider and his psychiatrist about some of the triggers, like poor sleep, and how they relate to overnight call. And even before starting clerkships, it's good for one to know how one can get to medical appointments during clerkship year.

Well, I believe we've set the stage with this case. So how do we think through this? I'm turning this over to Lisa.

Great, thanks, Joe.

So what would your institution do in this case? How might this case come to your attention, given your current role? What would a referral system look like at your university? And is there an expert on campus? Is there an internal referral system – say, between your learning specialist team, your deans, your faculty, directly to the DS Office? These are questions we're going to answer going through the series individually.

AAMC
Students with Psychological Disabilities Continuing the Conversation 3.10.16

Question one – Joe?

Sure, thanks, Lisa.

Do the requested accommodations challenge the technical standards learning outcomes of the clerkship?

And my answer is no – and why not?

First, it's helpful to know what your school's technical standards are. Then it's important to know what the learning objectives or the learning outcomes of the clerkship are. Now, I have to admit that sometimes the learning objectives of the clerkship are not clearly written. Sometimes the learning objectives seem very specific; for example, a student must complete three overnight calls. But when you look at a learning objective like that, it's not really a learning objective. It defines the means by which a student can learn something, overnight calls. But what are the specific things that one learns?

And it describes a quantity or a frequency or a dose of the activity; in this case, three calls as opposed to two or four. So sometimes we have to look more closely and see what is being taught, what skills are being learned, and what the right dose is.

First let's look at overnight calls. When we do that in this case, we see that some of the skills learned and knowledge gained from an overnight call include working with a skeleton crew and cross covering more patients and having to prioritize and triage. That's one of the key things of an overnight call.

Well, these skills can be learned at times other than overnight call; for example, on a weekend day where there might be less staff or a weekend afternoon or evening.

Let's look at his request for an alternate site for not having to work in the psychiatry emergency room or the psychiatry inpatient unit where he was hospitalized. The learning objectives could be met at alternate sites. If your school doesn't have an alternate site, you might consider partnering with another school and having the student rotate there.

If there's no other place to do psychiatry emergency room calls, for example, you might then look at the learning objectives of what an emergency room call is. And these might include being the first person to see a patient in crisis. And consider whether or not going to an urgent care center or doing emergency consults on patients within the hospital might actually meet that learning objective.

And then as we think about his request to be allowed to see his physician weekly, when you think about the day-to-day goings on in a clerkship, there is a lot of times that's unstructured. There are some things which occur – like some talks or tutor groups or standardized patient exercises – where if you miss it, there may not be an easy chance to make it up, especially the standardized patient OSCEs, which can sometimes rival a Broadway production in hiring and prepping the standardized patients, creating the scenario, videotaping parts of it, and timing it so everyone in the clerkship can do it.

But short of those things, there's generally considerable leeway to see one's physician. And if something is urgent, seeing one's physician could trump anything. This is a relatively easy accommodation.

When we're aware of this need, we sometimes have tried to have the student rotate in hospitals which are actually closer to their physician. Alternately, some of our student mental health psychiatrists will actually just do phone sessions; and all the student needs is a quiet space in the hospital, which actually may be harder to find than you may believe.

All three of the student's requests – no overnight calls, alternate site for psychiatry and psychiatry emergency room, and the ability to get to see his MD – do not challenge the technical standards or learning outcomes; and they're accommodatable.

AAMC
Students with Psychological Disabilities Continuing the Conversation 3.10.16

Let's go to Question No. 2.

Thanks, Joe. I'm still laughing, giggling, at the Broadway production analogy. I can't wait to share that with our OSCE team.

On Question No. 2, the question is: What assistance might be helpful for students with psychological disabilities?

And certainly I think that the things that Joe has mentioned as far as accommodations are relevant to things that we do here at UCSF as well. And finding that private room – that's a great way to allow a student access to their provider. We've actually had students go out and get in their cars for privacy and take phone calls that way, so it's certainly something that we suggest.

What other types of supports can you provide to your students?

Well, we're lucky enough here to have what we call the Medical Student Well-Being Team. We have a psychologist and a psychiatrist available to see our students; and, of course, their schedules work with our students' schedules. They have hours at night, early in the morning, and sometimes on weekends to meet the needs of the students.

Student health and counseling – I think most of our universities have a general student health and counseling center. And certainly connecting students to that resource is imperative, especially for crisis situations.

Disability Services – of course you should always be partnering with Disability Services, if the student is willing to disclose, to make sure that you have accommodated the student, that the student is being well-supported in the clinic, and that everything that the student discloses is being kept confidential by that office.

One thing that we do here for Disability Services is we'll use the Simulation Lab as a method of practicing an accommodation or getting used to the environment. This is especially helpful in reducing stress for students who have high levels of anxiety that all contribute to a rise to the level of a disability.

The other accommodation that is really helped by this particular intervention is students who stutter. When you have a student who stutters, being able to be in the environment – again, it reduces the anxiety and it allows them an opportunity to practice.

Putting into place accommodations – like Joe said – release from clinic to see their provider, whether it be stationing students in clerkships that are close to their provider so that they don't have to miss a lot of time from clinic. Every once in a while, we'll space out the clerkship; so the heavier clerkships, like surgery and general medicine and OBGYN, we'll make sure that those are spaced out to give the student a little reprieve.

General support from the Disability Office – I think it goes a long way for the student to understand that they're not the only one and to kind of validate what they're going through.

And then planning – we work with our students to plan; we call it kind of planning for Plan B. If there is a high potential – and in this case the student has been hospitalized, although they've been doing fine since – but if there is a high potential that a student might be readmitted to the hospital, we really try to work with the student to follow the more traditional route of clerkships so that if they have to step out and they wind up going into the hospital that they have the option of reentering the clerkship and not having to wait a full year.

And making sure, again, that the student has access to all of the resources available to them – and this might include things you don't normally consider, like the learning specialist. The anxiety could be coming from a place of not being able to organize their thoughts, organize their time, or effectively deal with the

AAMC

Students with Psychological Disabilities Continuing the Conversation 3.10.16

material that's coming to them and being able to synthesize the material. So oftentimes – and we're lucky, we have two wonderful learning specialists – but oftentimes, just meeting with a learning specialist and putting into place some strategic learning approaches could be very helpful in reducing that anxiety as well.

And then finally, financial aid – a lot of times we don't think about financial aid as being the support office. But if a student is having to take a step out or take a leave of absence, they really need to be informed about what help they can get through financial aid and, if you offer disability insurance, how to go ahead and tap into that resource as well.

Max, on to you for Question No. 3.

Right, Question No. 3 is really: What should the institution know about students who are going on a leave of absence?

Well, clearly, if a student is requesting a leave of absence, for all students one would want to have a one-on-one discussion about the reasons for it. And many times, students will articulate that someone has recommended that they take a leave of absence – their mental health provider or someone else. But the students are reluctant to do so because of fear or stigma and all the things that have been discussed already.

I think it's important to stress in those situations that should a student continue under circumstances where he or she is not at her best that the student's performance will suffer. And that will outweigh what the student's concern is about taking the leave.

In terms of information for a leave request, the physician's attestation should only state that the student needs to take a leave of absence. It should never state a diagnosis; and the diagnosis, quite frankly, is not the Administration's business. It is performance-based, if you will, only that a student needs a leave of absence for medical reasons and not the reason to do so. That will guard against stigmatizing for certainly mental health.

In terms of the ERAS application and accounting for leave, it is helpful to have a one-on-one meeting with the student to help him or her navigate this. The student can choose to discuss the reason for the leave in the personal statement or not; and if the student chooses to do so, I think it's important for the student to stay through the personal statement that the leave has been particularly beneficial and provide some evidence that the student is now doing well.

Students also need to understand that a leave of absence is not something rare, and that more and more students are needing a leave of absence or taking a leave of absence for ongoing needs. We are actually supportive of leaves of absence.

The Disability Services rule for the leave of absence is to help the student navigate. Certainly the Disability Officer may know the diagnosis; but, again, the Dean's Office does not have a need to know of that diagnosis. Disability Services can also help educate the student about when a leave would be helpful, provide some examples of students who have, I think, performed well when they have come back – again, to show the students that a leave is very much in his or her best interest for a bunch of reasons – for the students health at this moment and for the student's long-term performance.

The Dean's Office role is to support and facilitate granting a leave and, I think, to be really quite generous in granting a leave when requested. On the other hand, the school may have some policies or parameters about how long a leave can be. I think generally leaves are one year and may be renewable. But certainly at UCSF, we have put in place a maximum leave of two years over the duration of a baseline program. So if students are medical students and not in an MSDP Program, the Medical School curriculum is four years; and so they will need to graduate by six years.

AAMC

Students with Psychological Disabilities Continuing the Conversation 3.10.16

Should students need a longer leave than that, then a conversation should take place about the student withdrawing and likely in good standing. And the school cannot guarantee that the student will be readmitted, but that it would be highly likely so; and it would be in the student's best interest to take a prolonged leave.

Great, thanks, Max.

For Question No. 4: Who makes the decision about the accommodation request? The DS Provider, the Case Manager or the Dean of Students or Committee or Clerkship Directors? I want you to think for a moment about how your school goes about making these decisions on whether or not to approve an accommodation request.

DS providers should be the people who collect and determine the accommodations. This is done in consultation with the School of Medicine, but we want to do this without sharing this more sensitive documentation with School of Medicine Deans.

Potential litigation can occur when decisions are made by, say, a committee or an individual, such as a Dean, that perhaps has an evaluative role over the student and winds up having this sensitive information. So we want to minimize the opportunity for a claim of discrimination when working with a student with a disability.

The student's disability is confidential; and like Joe and Max said, only the accommodations need to be shared with faculty and deans. Questions about the learning outcomes or technical standards – so in other words, if faculty or the deans have questions about whether or not this student's particular ask would be something that challenges the technical standards or challenges the learning outcomes, then that is a conversation that everyone can have without talking about the specific mental health issue. We can talk about the barriers to the program and how this is presented when determining accommodations.

We can also present information in a de-identified manner. A lot of times, I'll go to the Administration and say, "I have a student that I'm working with, and these are some of the barriers that we're seeing," without even saying who the student is. So we can have a conversation without even really needing to know who the student is because if you think about it, we're really, really focused on those barriers.

The same decision should be made for all students. And when you approach decision-making in that way, you are building a case and a decision process that certainly is more legally defensible against something like discrimination, especially when no one involved except the DS provider, is aware of who the student is.

You want to be very, very – and I caution you, there is a citation here to an article that I urge everyone to read by my colleague, Elisa Laird-Metke, beautifully done on the potential risks of making determinations by committee. And I won't go into great detail because you have access to that article. But let me just say that when people who come together on a committee and have an evaluative role have access to documentation – especially of a sensitive nature – about a student, and this could be psychological, this could be about a chronic health issue. When you have access to that type of information at that level of depth, it can cause you to switch or change your perception of that student whether you consciously are aware of this or unconsciously.

And so again, this might impact how you communicate with a student, how you view the student – say, if the student is brought up before the Promotions Committee. It's just really important to have as little information about the student's actual disability as possible and to really just focus on the disability accommodations that have been approved by someone who is a specialist in this area.

Individuals as well – individuals who evaluate students or write the MSPE have a conflict of interest and should really opt out of any information or dealings about whether or not the student is approved for these accommodations because that is a person who will be communicating about the student's performance; and we should keep that very performance-based.

AAMC
Students with Psychological Disabilities Continuing the Conversation 3.10.16

And then protecting individuals' confidential information is critical. This is the only way to make students feel supported and safe around disability needs. And I think that you create a culture, and students are very aware of whether information is being shared or not shared. And to be quite honest, I think a lot of the information that they get is from other students. So other students' experiences help inform whether or not other students in your program will disclose, and they won't disclose if they don't feel confident that their information will be kept confidential. So that's very important.

I'm going to hand it over to Joe to review Question No. 5.

Thanks, Lisa.

What is the best practice around communicating accommodation needs?

Well, the first point is that this should be on a need-to-know basis only. Not everybody needs to know about a student's accommodations. I like to do it through a formal letter of accommodation. And I use a form letter that says the student has been approved for the following accommodations. Again, it doesn't say what the diagnosis is; it just says what the accommodations are. And the communication should be through the Disability Services provider.

Now, how do you help students communicate their accommodation needs? Well, since Lisa passed the slide over to me, I feel free to plug something that she wrote.

There is a Communication Guide written by her and Neera Jain. It's in the book *The Guide to Assisting Students with Disabilities*, edited by Lisa and Neera Jain. The Guide is an appendix in the book. And attached on here is going to be a link so that you can have a copy of the guide. It's a fantastic guide, and it's something well worth reading.

It's really written for Disability Service providers, and it's written for students. And it works with them on how to speak with their own clerkship directors or other people as it relates to accommodations. It shows examples of good ways of requesting, good ways of reacting, and some not-so-good ways. And it's very readable and well-written, so kudos to Lisa.

I would like to say from a little bit of this case that we talked about is that I think that for a case like this that we just reviewed, one of the best ways to navigate students with any type of disability is to keep an open mind – not to immediately think, no, this is impossible, it's not going to happen. You want to keep an open mind. You want to keep your eyes and ears open to see and hear how things are going. Keep an open mind of communication with the student.

Working with students with psychological disabilities is often an iterative process, where you learn from the student what's working and what didn't work and where new data from a student's lived experience or their evolving medical condition helps you think about the next steps.

So at this point, I think we're going to turn this over to Jayme, who is going to facilitate questions.

Actually, this is Maxine. If I can just add one more thing about the need-to-know basis, I would like to underscore that the Promotions Committee or whatever the committee is that has oversight of student progress, when Course Directors report on student performance, that is not a place where a Course Director should say, oh, the student used accommodations, didn't use accommodations. That oversight committee is not a need-to-know committee.

That's a great point, Maxine.

So as Dr. Murray said, now we're going to hopefully answer some questions you have. And for those of you that were at the AMCC Annual Meeting where Dr. Papadakis and Dr. Meeks spoke, there was such

AAMC
Students with Psychological Disabilities Continuing the Conversation 3.10.16

great conversation and questions that came up and really is why this webinar developed – so that we could continue this conversation.

For those of you that do have questions, please feel free to use the Question and Answer write-in on the right-hand side of your screen; and we'll get to those questions as we have time.

[Pause for responses]

And actually, currently we don't have any questions—

I actually see a question that was directed straight to me; I don't know if everyone else can see it, but I'll answer it if that's okay. The question is: Can you give some examples of how a longitudinal third year might look?

And I think this is a great question because I'm always reminded that not every school has longitudinal programs. We do; we have several options for students to engage in these longitudinal programs, which can be wonderful options for students who need more consistency working with the same team.

The issue with a longitudinal program is that oftentimes – depending on whether it's four blocks, five blocks, six blocks – there's little wiggle room should a student have a crisis that requires intervention, whether that's hospitalization or intensive outpatient treatment. So that is a conversation that I have with students often while we're going through the third-year process.

And I'm not sure how everyone does their third-year selections. Our students – we have a system that they fill out their preferences, and it's a lottery system. The computer does its magic, and people are placed. We would work with the student to identify any programs that act as a barrier based on their disability. And so a longitudinal program might actually become a barrier if the student is performing okay, but there still is a chance that they might have to be hospitalized or seek intensive treatment in the future.

And so in that case, we might exclude a longitudinal program from being in the lottery system. We never place students directly into a program, but we might remove that program as an option. And that's really where your relationship that you build with a student is so important because when students come and they register and we've developed this relationship over a course of two years now before they head into their third year, I have a pretty good sense of how they're functioning, either myself or us as the wellness team. And we can give the student some feedback on what we think might be best. Ultimately it's his decision; but it gives us a chance to really get to know that student, understand their triggers, identify what might be some barriers in the clinic. So I think it's really important that whoever is in that DS role or whoever does the DS work is not only familiar with the clinic and the structure of the longitudinal and regular clerkship years, but also is really familiar with the student and how that student functions.

So I hope that answered the question of how we deal with the longitudinal placement, but I hope it also encourages folks to really build that relationship with the student so that there is a trust there on how to manage things going forward. And with regard to trust, I think that's also an important concept; and Maxine alluded to this earlier. When students trust that their disability-related needs are going to be taken care of and that they're going to be kept confidential, they are more likely to disclose. And we really want students to disclose should they need accommodations or need that support because the last thing we want is a student to have a mental health crisis in the hospital and no one knew that it was coming – or in the wards.

We really want to engage students and encourage students that when they've hit that point where they feel like they're not functioning as well that they do that help-seeking behavior. Whether that be at the level of just tapping into one of our providers or talking to a mentor or coming to Disability Services, we want students to feel confident that their health and safety is our No. 1 concern; and we want to support them through the process.

AAMC
Students with Psychological Disabilities Continuing the Conversation 3.10.16

So going back to what Joe and Maxine were saying, normalizing this entire process is very, very important.

Let me also add another perspective about the longitudinal clerkships. And longitudinal is also – we are talking really about the integrated third-year resident discreet blocks for clerkships. I think it also depends on the severity of the illness. I could imagine that a student who simply needs to keep regular appointments and continue to get the support that he or she has been getting all the time might do very well in one of these integrated longitudinal third years.

And the reason for that is that they will be at the same location for an entire year. And as Joe said, they would then be potentially closer to their provider. And that longitudinal program might offer more flexibility since at Week 8, one doesn't have to change and go to a different clerkship.

So I would calibrate that depending on the individualized needs of the students. It could be something that would be quite advantageous or something that could potentially be very disruptive to their curriculum.

Absolutely, and there is a spectrum of assistance that is necessary. And like I said, having that relationship with the student really helps to inform where they are. And many of our students – and like many people in general, so it's not always about having a disability – many people will have a mental health issue that they deal with on a daily basis. And they're fully employed; they're fully functional; and they just need to continue their course of care. And many times, that includes therapy.

So if that is the case of your student, it could be as simple as having a release from call for an hour, an hour-and-a-half depending on travel, each week to maintain that therapy. And that's so important.

Thank you, Maxine, for expanding on that.

Now the questions are coming in, so I am going to try to turn these over to who I believe should answer them. And it seems like you all can jump in when necessary.

The first question I have I'm going to point at you, Lisa: "We have struggled in the past with working with extended time on OSCEs in terms of exploring how and when an extension may violate a technical standard. Apart from the OSCE that's related to emergency situations or trauma, what's your view?"

Well, I'll try to answer all points of that question. I think that for most people, the patient interaction is where the concern around technical standards is going to come into play. When we're talking about just reading the door notes before engaging with a patient and the write-up of notes after, I think we would be very hard pressed for anyone to prove that that violates any type of technical standard within the amount of time that is normally given to a student – so time-and-a-half, double time.

We're literally talking about minutes. And I think most providers would attest that in the clinic, although you try to plan your day and you may be on a 10- or a 15-minute patient allotted time, there are patients and situations that take longer; and there are patients and situations that take shorter times. So it's a spectrum of time, really, that you're going to be dealing with once you get into clinic. And I think from a legal perspective, we would be hard pressed to prove that not affording a student accommodations is appropriate in those cases.

When you get into working with the actual patients, then we start to look at things like what is the actual disability and how is there a barrier in the clinic. And so if the student has a physical disability or requires assistive technology of sorts, it may be that it just takes an extra minute to be able to tap into the specific tool that they need to assess the patient. So that might be a stethoscope that gives a readout; instead of having the student actually hear through the stethoscope, they look at a visual readout. And that might add 30 seconds to the case. Those are things that need to be addressed really case by case and getting very specific about what the barriers are and then exactly how much time that would take.

AAMC

Students with Psychological Disabilities Continuing the Conversation 3.10.16

And I know that I have consulted with other schools, saying go into where you're doing the OSCEs or go into the field and really look at how much time a specific task takes. So that's one way to measure the amount of additional time that might be needed.

So if hooking up a device to be able to have a readout takes approximately 45 seconds, then it seems reasonable to me, and would seem reasonable to the Office of Civil Rights, to afford the student 45 seconds of additional time to be able to put that tool into use.

Does that answer the question?

Lisa, there are some great points in there. And I think the other thing to think about – and this came up in our coalition listserv, is that this is a great opportunity pre-OSCE for a faculty member teaching physical diagnosis to work with a student as an entire student. And the student going into that room with their disability, with their strengths, with whatever accommodations they need, and to work with the student on how to actually do this; to work with the student on how to maximize efficiency, how to have quality, how to feel comfortable with it.

And this may take a little extra work; but when you're working with a student with a disability, it really is not enough, I think, to just say, well, here's how it should be done; go ahead and figure out how to do it. It really is incumbent upon us to work with them. It's a great opportunity; and as physicians, you learn so much from this experience.

Absolutely.

And to keep the questions going, I'm going to change the subject a little bit. But can you address how you've handled experiences with third year subjectively of evaluations on rotations and the type of student who needs accommodations to stay well? Specifically, maybe a student that needs to go to a medical appointment weekly. The student will be approved and accommodated, but students worry that others will question and still be judged negatively for leaving.

I'll take a stab at that one. I think it's a very great point because it focuses on the student's perception. And the student is very worried that anything that deviates from what their peers are doing will be viewed by the resident and the attending as slacking off or shirking or hanging out in the library studying for the Shelf exam when they should be on the floor. I think students are very mindful of that.

But when we communicate with the clerkship director about whatever accommodations need to be done for that student, I have spoken with all of our clerkship directors that when a student has an accommodation that they have to go to weekly doctor's appointments that it's very important when they get the evaluation that if the evaluations do say "student disappeared periodically," that the clerkship director would get a little bit more clarity from the resident about that and that the clerkship director would be mindful that this was an excused absence.

And I do think that part of it is an enculturation; but clerkship directors actually will, I think, pay more attention to evaluations that may point out something negative when they're aware that an accommodation was already granted and try to almost immunize the student's evaluation from that. So it's not foolproof, but there's a possibility of a culture change.

And I want to go back to what Maxine said. Students certainly have anxiety about utilizing accommodations in clinic. But at the end of the day, if a student is not functioning well and they need the accommodation in order to maintain their functioning, the potential for problems is so much greater in the absence of that intervention than they are taking the intervention.

And like Joe said, the program director would be privy to the fact that this was an approved accommodation and, I think, would buffer against those types of reports from, say, the resident or whoever the preceptor is to say that, well, that can't be counted against the student.

AAMC

Students with Psychological Disabilities Continuing the Conversation 3.10.16

Now, I do want to make sure to not conflate issues and to say if a student is not performing well in the clinic or if a student has a professionalism issue because they are disappearing and going down to the cafeteria to get food or disappearing and going to call their significant other on their cell phone every hour, those are other issues. And those do need to be addressed. And we never want the fact that a student has a disability to then completely keep them from any type of feedback that might be critical, as long as it's not focused on the disability or approved accommodations.

And I think that's where people find the area so gray and tend to do one of two things. They either are so scared to give any type of critical feedback that they give nothing, even when there is critical feedback that should be given. And we've seen through cases what happens when we have professionalism issues that get to the very last hour and are being addressed then.

And then the other thing is to be hypercritical of the student, knowing that they have a disability and kind of feeling like they're getting some sort of advantage by being able to leave clinic. So we want to buffer against both of those extremes and get people – like Joe said, we need to really educate people and get people onboard with the idea that once the accommodations are in place, everything else then should be measured the same way. But the student should not be critically examined because they took the accommodation, they used the accommodation.

Lisa, what about if we advise students at the beginning of the clerkship, or even a couple of weeks in advance of that, to get the schedule for the clerkship – find out what when their off days are or so forth and try to schedule doctors' appointments on their off time. Is that considered a reasonable accommodation – if we urge them to take their accommodation when they're—

That's a great question. I'm glad you brought that up because what we do – and again, I hate to keep harping on the relationship – but we actually do that. I tell students that they cannot have a release of clinic in the mornings; they can't do it. It's not reasonable to miss rounds; it's just not – they miss so much.

So the way that we have ours set up is that students do get that schedule far in advance. I work with the clerkship directors, who are lovely. And when we do it far in advance enough, we're able to go ahead and if there's a release of call or if they need to work days versus nights for OBGYN, we get that on the schedule so far in advance that actually no one else winds up having to know that there was even a consideration for the schedule because it's just built into the regular schedule.

Students also are made aware of specific clerkships and when those downtimes might be so they can take that under consideration. One of our programs has something called "white space," and so we encourage students to have their appointments during that white space. We can't mandate that students take their appointments at a certain time; but what we can do, and what we do do here at UCSF, is to have a discussion about the impact on their career and the impact on their learning and the impact on professionalism. And that is, yes, they do need this; but it's also their responsibility to do it at a time that's least impactful to their peers and to the program.

And so we get them hooked up with providers in the area who do weekend appointments and night appointments. That's one of the considerations we'll make for the third-year placement, is to keep them in the area that their provider is to reduce the amount of transportation that is needed. Say, for example, somebody could walk across the street from our hospital at Parnassus to their provider across the street in five minutes. Versus if we had placed them 30 minutes out, we would be talking about a lot of time. So if their provider only has five o'clock as their last appointment, the student is able to leave clinic quite literally at 4:55 p.m. and make it to their appointment.

And then to go back to what Joe was saying about communication, it is also important that the student learn how to communicate their needs in a professional way so that the perception on the part of the preceptor or the clerkship director is, wow, this student is really professional. They have this need; the accommodation is in place; they're contacting me to make sure that it's done at the least impactful time; and we've made this arrangement for the makeup time; and everything is a go. And all of that, ideally, is

AAMC
Students with Psychological Disabilities Continuing the Conversation 3.10.16

determined before the student sets foot into Day 1 of the clerkship. And so then it becomes more of a non-issue.

Thanks, Lisa. You also alluded to the work of Elisa Laird-Metke, who we had the pleasure of having on our webinars earlier this year, about committee models and determining accommodation. And someone really just wants to dive a little bit deeper, if we have the time, to talk more about the possible or potential litigation with the committee model in determining accommodations if you have any information that you could share.

Sure, really quickly, I'll just give kind of the summary. I saw that question come through; I think it's more about the litigation risk, and so I'll just address that. But I do encourage everyone to read her article, and you can find that quite easily through Google Scholar. And we can find a way, Jayme, I'm sure, to post that information as well.

The potential risk that comes from making a determination decision as a committee occurs when a committee decides that a student does not have a disability, placing its medical judgment ahead of the student's own physician or own documentation that they're providing. And documentation provided by a student, while we don't necessarily have to take it at face value, we can certainly prompt for more questions or more information. That is that student's provider.

And so we get concerned when people slip into the provider role and say, well, that doesn't seem to make sense; or that doesn't add up. And then they're making a determination that's more medical than administrative or disability.

There's also a security or a confidentiality risk when people, like I said before, who are in an evaluative role, have access to this really highly-sensitive information. And so then if they are overseeing the student down the road and something goes wrong – the student doesn't pass a course – we see this more in clinic where the evaluation is more subjective -- that the student could counteract that by saying that there is a bias on the part of the preceptor. That the preceptor sat on the committee to determine their accommodations and that the preceptor is aware of their disability and, for whatever reason, does not believe that this student can be a provider given their functional limitations. So that's a concern as well.

And I do encourage everyone to read the article. I hesitate to go into more about that and how to not give more legal advice, which I am not qualified to give. So if that is an appropriate or acceptable answer, then I can just steer you in the direction of that article. And I encourage everyone, actually, to talk to their campus counsel as well.

I think that people form committees because we all believe that making a decision by a committee is a better decision because we have multiple stakeholders informing that decision. And while I do believe that is usually the case, in this case, when people are not educated about disability per se and that's not their specialty, it gets trickier.

We only have about three minutes left, and so I hesitate to go into some of these because they're a little more difficult, I think, to answer with the time we have. But I'm going to try to get to one more. And I don't know if you're going to be able to answer this, but you might also be able to point to some literature that can help answer this question:

"We have some students who request additional written time and the ability to take tests in separate rooms to minimize distraction, secondary to a psychological disorder. Can you point to any evidence that supports this type of accommodation?"

Any evidence that I could speak to right now would be purely anecdotal. But I do think that points back to Maxine's point that we need research in this area desperately. We need clear data to show what these effects are so that we can focus on the most appropriate and reasonable and effective accommodations for students with disabilities.

AAMC
Students with Psychological Disabilities Continuing the Conversation 3.10.16

I do want to say, there was one question about microaggressions. If you go to that link, Joe has given everyone the link to the *Communications Guide*; that is free. You can access it for free. Please share it. It is intended to get into the hands of providers and students. We want it to be useful information. There is some discussion in that about microaggressions and what those might look like. I never think anyone is purposely doing anything to be aggressive towards students with disabilities. But there are things that providers do; the nicest faculty are guilty of this. And so it's really important that faculty be made aware of some of these types of things that could be considered microaggressions towards students with disabilities.

Well, thank you, Lisa and Dr. Murray and Dr. Papadakis for joining us today.

I want to remind everybody that this webinar was recorded. It will be available on our website. We'll also send an e-mail link once it becomes available. If you just want to view the PowerPoint or the plain text version, you can do that now; it's already available on our website.

And again, we appreciate all the time that you guys took to learn more about this important topic.

I also want to remind you that our next webinar is titled, Disclosure at all points: UME, GME and Exploitation, will be on April 7, 2016, at 3:00 p.m. Eastern Time. I believe many of you could have already registered for that because you can register for the series at one time. So if you'd like to attend that or share that with your colleagues, welcome you to learn more.

Thanks, everyone.

I know we talked a little bit about this as well, but we have resources available for you; and they're here on this website. We've talked a little bit about the Coalition, which I believe many of you are already a part of. You can also join their listserv, which has been super helpful. They have a book, and that's the book that Lisa alluded to that has the PDF for you guys as well.

All the references – again, this is already available on our website; so you can look at these references. You can refer to the points that Dr. Murray and Maxine made and Lisa provided, so that you can go back.

Again, we really appreciate the joint efforts with UCSF and, of course, with Dr. Murray today. So have a wonderful day, and we won't keep you any further.

Bye-bye.