AAMC.
We're excited to have you on the call today.
We have around 130-some odd attendees registered for the webinar today.
Before we begin, I'd like to remind you that all of the disability webinars, including this one, are recorded and available on our website at www.aamc.org/gsa.
Additionally, if you have questions during the webinar, please use the Q and A feature on the right-hand side of the panel, and that way, at the end of the call, we'll go ahead and answer all the questions that we have time to answer.
This webinar was made possible in part by our wonderful colleagues at the Coalition for Disability Access in Graduate Health Science and Medical Education, and a special thank you, as always, to Dr. Lisa Meeks, who shepherded this series since the beginning.
Our two speakers today are Dr. Lisa Meeks, from the University of California, San Francisco.

She's currently on staff there, and she's the director of the Medical Student Disability Services and an Associate Professor of Medicine.
She is also co-founder and president-elect of the Coalition for Disability Access in Health Science and Medical Education, and the co-chair of AHEAD, the Association of Higher Education and Disability, Autism Spectrum Disorder, and she's also the Autism Spectrum Disorder Special Interest Group.
Lisa's 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 with us Dr. Dan Giang, and who is a practicing neurologist at Loma Linda University School of Medicine.
In addition to his practice, he's the Associate Dean for Graduate Medical Education, the designated Institutional Official, and the president of the Loma Linda University Health Education Consortium.
He also serves as a committee member on the AAMC Group on Educational Affairs, and is currently serving on the MSPE Task Force.
Dr. Meeks, I'm going to turn it over to you.

Well, thank you so much, Jayme, and I just want to clarify, Jayme gave me a little bit of a, promotion, I'm only an Assistant Professor of Medicine, (laughing) not an Associate Professor, so I just wanna correct that really quickly, in case my boss is listening.
And, as always, the Coalition and UCSF School of Medicine is just so grateful to the AAMC for their generous support in developing this webinar series and we're really glad to be able to bring this type of support and information to all sorts of providers in medical and other health science programs.

This is Dan, and I'm really grateful for the opportunity to participate.
I want to emphasize that I don't consider myself an expert in this area, the way Lisa is, but I'm happy to help discuss this aspect of graduate medical education that's really important.
Our learning objectives, you can read them online, but we hope that you have a greater appreciation for disclosure, perhaps a little bit on how to do it, and especially how professionalism of the applicant student, resident, shapes this disclosure process.

So, when we talk about disclosure, we're really talking about how the applicant, in the case of a student moving into residency, or a new resident moving into a new phase in their graduate medical education, or a medical student in medical school notifies the institution that they are an individual with disability.
This is a process that's governed by the Americans with Disabilities Act, among numerous other laws, and one of the things we would like to remind folks is that we don't have a lawyer on the call, and there

are oftentimes state laws that impinge upon this process, so please be aware of that and consult your local institutional officials.

Great, and if we could go back one slide, great, perfect, why is disclosure important?
Well, what are the benefits of seeking support for the learner?
Certainly, coverage under the law, and this helpful for both the learner, so that the learner is provided equal access to the program, but it's also helpful for the program in that it mitigates risk down the road.
And receiving accommodations, you know, certainly that is a helpful part of disclosure.
We want, you know, accommodations are to level the playing field, certainly, and a lot of times, it's just a different way, a smarter way of getting from Point A to Point B for the individual with a disability, obviously yielding in the same results, but using the energies and being more productive about how they meet that particular competency or meet that particular goal.

Certainly, it reduces the suffering in silence, and one of the things that is so prevalent, right now, among learners, so that is, students and residents, trainees, alike, is burnout.
We've seen as much as 10% of students in recent, in the literature in recent surveys, that have felt suicidal ideation or experienced suicidal ideation in the last year, and up to 50% of them positively endorse feeling burnt out, so I think this is especially critical for someone who has a psychological disability, that, you know, through getting accommodations and disclosing, they can reduce the suffering in silence by being able to leverage the support that they need.
Disclosure is also really helpful in explaining any gaps in either education or previous training, and Dan will speak on that in more detail later.
And then planning for clinical accommodations.
While a lot of clinical accommodations can be put into place relatively quickly, there are others that require a lot of coordination, either with outside agencies, like a sign language interpreting firm, or in ordering specialized equipment.

So when someone discloses in a timely manner, it allows for that pre-planning versus the "putting out fires" type of approach.
This also allows for problem-solving for unique accommodation needs.
Some of it may be placement, some of it, again, may be the specialized equipment or specialized personnel, but this allows the interactive process to really take hold and be comprehensive, and so when you disclose in advance it encourages this problem-solving.
And then it enhances communication and trust, and, certainly, when the student takes responsibility for disclosing their accommodation needs, the program entrusts that the student is doing everything that they need to do to meet the technical standards, the learning outcomes, and, most importantly, to make sure that the patient is getting the best care possible.

Lisa, can you also tell us about what options students have to disclose, some pathways to disclosure?

Sure, well, when it comes to students, they can either disclose and, through the American Medical College Application system, if they are a student that's going on into residency, they can disclose through ERAS.
I think that one of the most important things that programs can do to aid students in the disclosure process is to provide the information about how to disclose, whom to disclose to, on their website, so making sure that that, that information is present on the website for the, either potential student or potential resident, and then through orientation.
I certainly support all schools mentioning disability as part of their orientation.
This really serves to normalize the process for everyone.

A lot of times students will disclose through mentors or advisors.
They tend to have more direct contact with these individuals, and these individuals are in roles that are monitoring the student's performance, and also the student's wellbeing, so a lot of times we'll see referrals coming out of those mentors or advisors.
Certainly, faculty are another source of disclosure.
Students will oftentimes disclose to faculty through a process of discussion whereby, perhaps, the student's not doing well, the faculty and student are having a discussion about their performance, and then all of a sudden it, it comes into the conversation that the student perhaps has a learning disability or ADHD or something of that nature, so, through faculty, students are often referred to our office.
Learning specialists are a great resource, a great referral source.

A lot of students, as a first line of defense, will go and see the learning specialist if they are in their program, and the learning specialists are individuals who are uniquely qualified to look at documentation that the student may have, testing that the student may have undergone, previously, in undergrad or in high school, but they're also uniquely situation to observe how the student is learning, and so, for someone who has not been diagnosed, it may be that learning specialist who's the first person to identify that there might be a problem that rises to the level of a disability and either refer that student to testing and/or to Disability Services.

And then, finally, of course, students can directly disclose to Disability Services, and, you know, I think that this is dependent on how prevalent Disability Services are on your campus, how accessible it is, how much people talk about it, how much they know about it, so sometimes Disability Services providers are situated in the campus hole, so if your medical school is part of a larger campus, it may be that that's something that happens on the undergraduate campus, or, like we have here at UCSF, Disability Services is situated directly in the medical school as part of the Wellness Team.
So students certainly have direct access to us.

Dan, how about with residents?

So, with residents, of course, there's a wide variety of different sizes of residency-sponsoring institutions, anywhere from a tiny small hospital with only a family medicine residency program, to giant academic medical centers.
One of the things that we can suggest is that, for incoming residents to a sponsoring institution, that they provide information on the website of the programs, and we're giving, as an example, the University of Connecticut's example.
Oftentimes, the first place that a new potential resident has to discuss issues of this nature, or any issue, is with his or her program director or prospective program director.
That's a bit daunting, because it's really a job interview in that case.
Because we are an employer, we all have, in one way, shape, or form, a Human Resources Department where disclosure of potential disabilities and the discussion for accommodation needs to really be housed in, and we have certainly encouraged all of our program directors, when they have any questions on this area, to immediately involve our Human Resources folks here at our academic medical center.
Employment orientation is another place that this can come up.

As many of you know, that happens just before the start of active residency, and so one of the things that, it would be nice and ideal is if any discussions need to take place, they take place between the time of the match for a PGY1 resident and the time that they actually enter employment.
The Performance Improvement Plan is, oftentimes, where issues come up, and it is certainly ideal, and enhances trust, if there is a need for accommodation or a potential disability, that this is addressed in advance of any kind of disciplinary or performance improvement type of situation.

It's in, one thing that is of interest to note is that the Americans with Disability Act does not automatically erase past poor performance, and so this is another reason why it is nice to have any needed accommodations or other issues, that those be addressed prior to the outset of any kind of negative evaluations.

Oftentimes these issues come up, in our institution and in others, through the Ombuds Program, or through other types of employee counseling, like the Employee Assistance Program.
Finally, on the Electronic Residency Application Service, there actually is a location where the applicant can disclose this, and we show you a slide of what that looks like to the actual applicant, and it appears in a somewhat abbreviated form that can be seen by the residency program when they receive the resident or the applicant's application through ERAS.
But this is the actual question that, um, users of ERAS actually need to answer as part of their application.
In reviewing residency applications, I can tell you that I have never actually seen somebody answer this question either as "No Response" or "No," they all are answered "Yes," uniformly, but nevertheless, this is the question that is asked of the applicant.

So, from a pragmatic standpoint, we certainly hope that applicants, once they are matched, will bring forth any issues for all the reasons that Lisa mentioned, because that allows the residency program and sponsoring institution to engage any additional personnel that are needed or purchase the equipment that are needed to help the resident succeed.

You both have mentioned some of the laws, we haven't detailed them out.
So when students or learners disclose, what legal obligations do administrators have to abide by?
I think, Lisa, can you help us answer this question?

So, for the UME, and I just want to, quickly, for those out there that are not familiar with the medical school terminology, undergraduate medical education is, the first four years of medical school and then GME is the graduate portion, so this is the residency, I just wanted to clarify that.
So, in UME, you're guided by the ADA and FERPA, and at the core, the Americans with Disabilities Act is a civil rights legislation that prohibits discrimination.
So, it's more of an equal opportunity law for people with disabilities.
Those that are qualified persons for the program shall not be discriminated to base on their disability, and we need to make the program accessible to them if they can meet our technical standards with accommodations.
FERPA is more of the privacy portion of this, and this, because, in UME, students are students, they fall under FERPA, as far as disability goes.

And this, this law prohibits the improper disclosure of personally identifiable information derived from an educational record, and while a lot of the documentation that comes into our office would be considered HIPAA documentation and covered under that, it then becomes covered under FERPA because we are not providers, and that's the, the line that's drawn with FERPA and HIPAA.
So we are not providers to the student directly.
We are required to provide certain privacy protections for educational records, and it's called a "need to know law," because we're only allowed to share this information to people that have a, a genuine need to know, so what does that mean?
When can we share information?
Well, UME programs should always protect, at the core, what the disability is, of the student's.

So, you know, whatever category they fall into, whatever the diagnosis is, should never be shared.

The information that needs to be shared is how to accommodate the student.
So when we talk to, when I talk to clerkship coordinators or core course coordinators, we're always talking about, this is the accommodation, here is how it needs to be implemented, and that is okay to share.
When I'm having, or going through the interactive process with an administrator or a faculty member and we're trying to determine what accommodations can be reasonable, then the sharing might include what the functional limitation is.

So what is the barrier to the educational process, or, the content, or the clinic, to determine what would be a reasonable accommodation.
But, again, the disability itself should never, specifics should never be shared.
One of the things that we've provided to you as part of this webinar is the UCSF FERPA disclosure form, and I want to give credit to Neera Jain and Elisa Laird-Metke, who helped draft that form, and I do want to second Dan's comment about, we're not lawyers, we were kind of joking about that as we were putting together the webinar.
We do encourage everyone, for all of these processes, to always seek approval for any documentation or policy through your own general counsel.
So Dan, what about the laws that govern GME?

So, one of the confusing things in the world of graduate medical education is that our learners are not only students in the sense that they are when they're in undergraduate medical education, but they're also employees, and they're also physicians, and, unfortunately, there are three sets of laws that govern these different roles that they play, and they don't always neatly jive, and this is why graduate medical education, oftentimes, is a fertile ground for misunderstanding and confusion as to what we ought to be doing.
Certainly, as educators, residency programs respond to many of the same legal standards as Lisa just mentioned, but as employers, we have the Americans with Disabilities Act, and, in many cases, specific state laws that relate to employees with disabilities, and here in California we have our own set of protections that are afforded employees.

But then, finally, graduate medical education programs also are analogous to medical staff, that is, we are responsible to select physicians who are safe to care for patients, we're responsible for monitoring physicians for their continued safety, and we also have an obligation on reporting physician competence to state licensing agencies, and also, to the hospital medical staffs, or other hospitals where our graduates end up going after their residency programs.
So these three regulations sometimes coincide and sometimes they interfere with one another.

On the next slide, we go into a little bit of what we, how we try to operationalize this, and one of the key things to remember is that, for almost all graduate medical education programs, the residents need to become licensed during their time of residency.
This is not true of every state, but most states either provide for a training license or they require the residents to become licensed, and that is true for Lisa and I in California.
That is, by the time most of our residents finish their first 24 months of training, they must actually become licensed.
And so the requirements for physicians as they approach their licensure is to demonstrate that they are safe to care for patients to their state licensure boards.
And in doing that, most residency programs try their best to help their residents demonstrate this safety and professionalism that each of the residents is going to present to the licensing board in their state to allow them to continue their education.
So, that makes murky who exactly needs to know, in a graduate medical education program, for what, for any potential accommodations or disabilities.

One of the other interesting things that happens in residency programs is that many residency programs rotate their residents into affiliated institutions, and so an accommodation that is put in place as part of the employment picture also needs to function at the VA hospital, at a county hospital, at an FQHC clinic, wherever that resident goes, that accommodation is following them, which makes it exciting to try and credential any additional people who might need to be involved in the accommodation or to provide the equipment that is needed for those different settings.
Finally, at the end of training, all residency programs are required to provide a letter or recommendation that describes the quality of care and any health issues that could interfere with the quality of care for patients to the next hospital or a state licensing board, and we are used to doing that in terms of the ACGME six general competencies, and this always includes any health issues that might impair practice. This disclosure is provided under state law, usually, that requires us to provide that information to the next institution that the physician may be going to.

Thanks, Dan.
Now that we have a grasp, I'm not sure that, it's still a little murky, of course, but now that we have a little bit of a grasp on that law, can you talk a little bit more about some real-world scenarios and best practices that might help us understand a little bit better as well?

Well, first I want to say, you know, listening to Dan, it reminded me that, while developing this webinar, Dan and I spent a lot of time talking and educating each other about the expectations and the processes for disability disclosure at the UME level and then at the GME level, and we were remarking the other day that we've learned so much from one another, and it made me think that, I think one of the, the practices is not on here, but that I would encourage people to do, is to work with your GME folks, to contact them.

After Dan and I had our initial conversation, I contacted Amy Day, who runs our GME program here, and we sat down for two hours and had this really rich discussion about all of the layers that come into play at the GME level that, as a UME person, I was not familiar with, and so I think it really helps inform how we practice and how we advise our students to understand how things are going to work at that GME level or getting, you know, through getting licensure, and one of the things that was so interesting to me was that the qualifications for licensure in different states and the questions for licensure in different states, and so I feel like I've learned a lot through this process, even though Dan and I are the ones on the webinar, and so I would encourage everyone at the UME level to reach out to your GME folks and to, to set aside some time, get some coffee, and just have a conversation about the expectations, because I know that, in doing grand rounds and other talks, when I have residency directors come into these talks, very frequently their question is, "We didn't know anything about this, "we've got this resident, and now they need x, y, and z, "and nobody told us," and trying to convey, you know, the privacy laws from the UME perspective have been difficult, and so now that I understand how things work at the GME level, it helps me articulate more clearly what we're doing at the UME level and really, and Dan and I agree completely, that it really helps us to focus on the professionalism piece, and Dan will talk to you about that later, and the expectations for both the, for the program and the student or the trainee, so the learner, in this process.

But getting back to your question, Jayme, and focusing just on the UME part, I think one of the biggest things that we can do to encourage disclosure is to build a culture where disability is viewed as part of diversity.

So, when we talk about the diversity initiatives that are happening across the country in multiple medical institutions, and I would assume for other health science professions, diversity is embraced, it's celebrated, and that's where we need to get to with disability.
We need to understand the uniqueness of having an individual with a disability in our programs and how that's going to inform both their peers and the faculty and the broader public and, certainly, in patient care, so we really need to work towards more of a celebration and making disability part of diversity.

I think, it's also really, really important that we set clear guidance for students, and that we do that in multiple ways, right?
So, that could be through our website, how we communicate to students in acceptance letters, certainly, once they arrive, and they're part of our program, whether that be through an orientation or through a referral system, we want to make sure that students understand how to disclose, that the process is crystal clear.

We also want to make sure that we empower faculty to refer students, so we want ensure faculty know that when a student comes to them and discloses a disability that they don't have to solve any problems, they don't have to come up with any accommodations, they don't have to, you know, none of that is being put on their shoulders, that there's an office that takes care of that and supports the faculty by ensuring that the student has full access to our curriculum.
And so the faculty's main job, first job, is to simply refer the student.
I suggest that faculty do that, you know, certainly to the student directly, but also follow up via email, in writing.

And, finally, I think, and perhaps most importantly, is that we engage in conversation during orientation that normalizes the process.
We're very lucky here at UCSF that, you know, diversity is a huge issue for us, we believe that disability is part of that diversity initiative, we have that conversation during orientation, we acknowledge that we have students with disabilities and that we embrace it, we talk about what we've learned as a result, how we've improved the curriculum using, you know, principles of universal design and instruction, and how much richer we are as a result of having these students, you know, we have a population here, about 10% of our class identify as students with disabilities.

We're also really lucky that the students have other opportunities for specific disabilities to have that normalized, whether it's a psychological disability, and through part of our Brain, Mind, and Behavior series, we have "Mental Health Among Us," we have "Suffering in Silence," these are programs that really encourage students to talk about wellness and mental health and encourage them to seek help if they need it, and so knowing that psychological disabilities are our largest category of disabilities across the nation, you know, I think it's really important that we make the conversation one of normality, that this is a, this is a normal process, you're in medical school, this is a tough time, if you have a psychological disability that rises to, or a psychological illness or mental health issue that rises to the level of disability, that there are these supports in place, and certainly if you have a learning disability or ADHD or a physical disability, chronic health, whatever the case may be, that, you know, that's okay, and that's all part of, you know, the differences among us and that we want to support whatever it is to make the curriculum accessible so that, like all of your peers, you can go about your education and move forward.
Dan, how about in GME?

Well, let me just parenthetically say how much I learned from talking to Lisa and engaging in all these fun discussions, and it certainly is something that, I think, that even beyond the world of disability, if the GME folks and the UME folks talked more about this transition in learning from learners going from undergraduate medical education to their first job as a physician, that we could probably all benefit from and do a lot better job.
One of the things I learned is the University of Connecticut guidance, and the need to make sure that, right on our websites, as learners or as potential applicants are looking for residency programs, they can see what is expected and what their resources can be, is certainly something that we need to do a better job in my program and also probably through many programs in the country.

One of the things that we learned is that program directors are concerned about any discontinuities in training that show up on the person's application.

This is something that is drilled into practicing physicians, that any discontinuity needs to be explained and explained as fully as possible.
This is something that, in credentialing practicing physicians, medical staff organizations pay very strict attention to, it is certainly something that licensing boards pay strict attention to.
So when you have an application from a medical student that demonstrates a discontinuity or an extra time period within medical education, program directors would like to know what it is, and how to disclose that in the appropriate way is a real art form that I think needs to be entered into with the medical student/applicant and his or her advisors.
I can give an example of one that I ran across in a new resident who's coming into our program this year.

The MSPE in his case was very bland and simply said that he took a year off between his third and fourth year of medical school to attend to personal issues, or I think it just said personal leave, but he chose, in the section that is provided on ERAS, that invites applicants to discuss any discontinuities, the following, and I will quote, "I elected to extend my fourth year education "to take a medical leave.
"During medical school, I was seeing multiple cardiologists "for symptomatic cardiac conduction problems.
"With intention of fully committing myself for residency, "I decided to undergo a procedure, "along with medical management, to control it.
"I have completed all clinical requirements "with no limitations ever since, "and I fully expect this will not affect "my future performance in residency.
"Meanwhile, I was able to take extra electives."

So that illustrated a number of really positive things that I think would make his future program director very much sensing that this is an individual who's transparent, who's professional, who I can trust.
He explained exactly what the issue was, he explained what he did to try and avoid that issue from recurring during residency, and he demonstrated that he recognized that his particular medical issue could have an impact on the safety of his patients, and therefore he demonstrated that he felt that his patient safety was his problem, his issue, and that he wanted to take charge of that.

So I thought that was a good example of a disclosure done right in ERAS that probably helped other program directors recognize this was an individual who was trustworthy and would be a great resident for their program.
I think, on the next slide, we're going to go into this a little bit more.
So this is an illustration of how, how maintaining the physician's own health is part of the whole aspect of professionalism, and by disclosing any health issues or accommodation needs upfront, when possible, the resident can actually help increase the amount of entrustment that is given him or her by the program.

On the other hand, of course, programs also need to look at disability in a positive way.
They should provide clear policies and procedures for disclosure, ensure that people who do disclose feel respected and their privacy is maintained, and, of course, engage in the good faith interactive process that is not only professional but also required by the ADA.

Thanks, Dan, and so what, what results what appropriate disclosure takes place?
Well, devotion to the patient, as Dan was talking about, the student who really needed to make sure that he was able to perform at his best before he was going to be able to serve his patients well, if you think about it, if a student comes into a situation where, or a trainee comes into a situation where they're nervous, they don't feel safe disclosing their disability, they therefore don't receive accommodations if they are needed, and I do want to stress that not everyone needs accommodations based on their particular disability, then that may inhibit the person from performing to their true potential, and in addition the experience, if you think about it, is a drain of cognitive energy on, you know, anxiety or fear of being outed, that could be placed in research or, you know, guided towards patient care.
In this case, the patient would miss out on the best possible service from this trainee.

However, when an individual with a disability feel confident disclosing, they're well supported, and, if needed, they receive reasonable and appropriate accommodations that allow them access to patient care, whether that be, you know, it could be something as simple as, you know, having the EMR work with a screen reader so that they can easily and quickly get through charting, but when they receive this care, then they can perform at their best, and we know that that ultimately benefits the patient.
Another result of appropriate disclosure is this devotion to diversity that I was talking about before.

You know, stigmas and stereotypes continue, unfortunately, to misinform our understanding of people with disabilities, and when people with disabilities go through the process, disclose appropriately, and get accommodations, the performance is better, and the process is a more pleasant process for all parties, and so having these individuals then enter into the medical field and into the clinic promotes diversity throughout all of our program.
Improved access to medical care.
Certainly, you know, we can talk about the inequality or disparities in medical care now for individuals with disabilities, and, you know, it is believed that, like with other diverse populations, having providers that have firsthand experience with disabilities will improve access to medical care.
It will actually have those individuals be evaluated differently by their peers, and in turn will have future providers look at their patients differently, so I think it was Lisa Iezzoni at Harvard who said, you know, the best way to counteract this is to have patients or to have, have peers with disabilities be in the classroom while peers and trainees are learning, right?

And so, the assumption then moves from "People with disabilities do not lead full lives, "they're not able to engage in things, "they might not be able to take care of themselves, "they might not be able to be employed," more of that medical model that we need to fix something, to "Wow, I had a peer in medical school "that was legally blind," or "I had a peer "in medical school or in my residency "that was a wheelchair user" or "I had a peer "in medical school that was released from clinic "once a week to maintain their wellness, either, "for whatever reason, physical therapy, "psychological therapy, and they're a great physician," and, you know, so that then changes the mind, changes the assumptions of the providers, and trickles down to changing healthcare in the way that we view individuals with disabilities, and I think that's really important.
Finally, the maintaining the learners' rights.

So, at all levels, you know, we are under federally mandated law to ensure access to our programs, and I think, you know, it's very important to make sure that people are not discriminated against, that they have access to the programs, and that they're able to fully engage in whatever level of training that they're in, and so we want, we want to do that, both from an institutional perspective, and from the student perspective.

Before we begin questions, I just want to say thank you, Lisa and Dan, for informing more about disclosure.
I always enjoy, you know, finishing with those real-world scenarios and those practices and I always have the "Aha!" moments, and I feel like, Lisa and Dan, you described, during the conversation and the development of these webinars, you had those too, so really hope that all of you have these moments and then can go back to your institutions and, you know, even if there's one change that you can make or one lesson that you've learned here, we really hope that you've learned from this webinar.

Before I go into questions, because there are a lot of them, I want to remind you of our next webinar on supporting students' requests on high stakes exams, and that's on May 12th at three p.m.
Eastern time, so please feel free, if you haven't already, to register for that.

And with that, I am going to start taking questions.
Again, if you do have them, on the right-hand side of the panel, there's a Q and A feature that you can type your questions in.
I will get started because they are rolling in.
So the first question I have, I am actually going to turn this one to Lisa, and Dan, if you would like to speak too, feel free.
The question is, if a medical student with a mental or behavioral health issue has to receive lengthy treatment, does the ADA allow the institution to require that they withdraw and apply for re-admission if they were receiving ADA accommodations for that condition?

The quick answer is "no," the ADA is not going to, the ADA doesn't mandate any type of action on the part of the institution with regard to withdraw and reapplication.
What it does is just protect the student from from discrimination.
So, in this case, and we've had this case, I've worked at several medical schools, this is not an unusual case, so I think it's definitely worthy of taking some time to answer the question.
A lot of our medical students have mental or behavioral health issues, that's how the question is worded, and need to take a step out to receive care, and in that instance I want to first make sure that everyone understands that, no matter what, under these conditions, the student's health and safety is the number-one concern, period.

It is our belief, and I'm speaking from a UCSF perspective, and Dan, maybe you can give some perspective from the GME level, but it is our belief that we need to do everything we can to facilitate the student receiving care.
With that being said, what we do is, the student is allowed a leave of absence for a year.
And the leave of absence, we don't need to, we don't need any documentation, we simply need the physician of record to say the student needs a leave of absence, and we make it happen, it's a very simple process.
The student steps out and receives care.
It is our hope that after one year of either hospitalization, intensive treatment, what have you, that the student is able to come back and re-engage with us.

We do provide additional supports to Disability Services, so whether that be, you know, continued support for, for seeing a therapist, or placement into a particular type of clerkship so that they're in geographical, at a reasonable geographical distance from their provider, we will continue to support that student.
In the off chance that, after one year, the student is unable to return, we would then extend the leave of absence for another year.
We have a six year-to-graduation policy, and I think that a lot of medical schools have that same policy, so if the issue was not either under, was not resolved and/or manageable after the two-year leave of absence, what we would do is ask the student to withdraw and reapply.
If the student was able to get care and become stabilized, there's a very good chance we would readmit the student.

But because we have the two-year limit, we would have to have the student withdraw after that second year, but that is not a, that's a School of Medicine policy issue and not an ADA issue, and that would not be considered discriminatory under the law to follow that policy.
You know, when you're dealing with clinical curriculum, things change very rapidly in medicine, and so the student would need to be exposed to the particular curriculum within a certain amount of time.
So that is how we would handle it at UCSF.
I don't know, Dan, how you might handle that within the scope of a clerkship?

So, certainly --

Or, I'm sorry, a residency.

(laughter) I was going to just say, at Loma Linda, that's exactly what we would do, for the same reasons, that is, you do need to have the curriculum be completed in a reasonable amount of time, because things do change, the curriculum itself changes, and so if you cannot get the student through in a reasonable amount of time, then probably, actually, the best thing to do in terms of getting a residency position for that student is to be able to tell the residency program, "I took care of any issues, and I then went through "medical school in the normal amount of time, "thus showing that I am ready to go for residency." And so, from that standpoint as well, withdrawing and then being readmitted is probably the best course.

Now, from the GME standpoint, we have another issue, and that is, these people, when they're in residency, they're learning, but they are also considered contracted employees.
So all residency in the United States is defined as a series of one-year contracts, so that you have, you're a contracted employee for one year, and therefore, if you hang over that one-year period, you actually need to have your contract re-adjusted to reflect the extra time, and each sponsoring institution that has to figure out ways of paying for these folks has policies related to that.
Certainly, what I tell my program directors is if you see a resident who is not progressing toward competence in the specialty at a reasonable rate, and once again, we sort of use as a rule of thumb that they can at least get to that level one year after the normal time, then we need to figure out, is this something that we can make work for both the learner and for us.

And I just want to follow that up, thanks, Dan, that makes a lot of sense, because I'm re-reading the question, and I just want to make sure that, that it's clear that you should not ask a student to withdraw just because they need lengthy treatment, and that the first course of action should be to offer the student a leave of absence.
I think that if, should you ask the student to withdraw, and again, I want to go into my, I'm not an attorney, but if you were to ask the student to withdraw simply because they had a mental health issue and needed to receive treatment, I think that, in the eyes of something like the Office of Civil Rights that that might be considered, at the very least, micro-aggression, at the most, discriminatory, because you're asking them to leave the program because they have a new or acquired mental health issue.

And I think, just from an ethical perspective, you know, when we accept students into our programs, we make both a financial, a professional, and an ethical, moral commitment to them, to support them through the learning process, and, you know, it's unfortunate but realistic that not everyone is going to make it through, but I think that it is incumbent upon us to do everything that we can to support students through the process and that students who are otherwise qualified to get through the process but for these blips would be afforded the opportunity to do that, and I just had a situation where a student was in an accident and needs to take a step out, not for a mental health issue, but because they have, now, a physical issue that's going to require rehab, and so what I would say is, you know, these are essentially two people who need to take a step out to deal with a medical issue, and I wouldn't want to treat one differently than the other.
I hope that makes sense.

Absolutely.
I also want to answer some more questions, because we only have about eight minutes left.
We, someone has a statewide campus, and they're asking if there's best practices for reaching out to such a broad swatch of ever-changing faculty and educating them on their role in implementing accommodations.
Before I ask either Lisa or Dan to step in, I do want to highlight that that's one major reason why we are still conducting these webinars, is really to reach out to you as members and educate you, and so we

know that many of our members have simply passed on these webinars to all of their faculty to review after the sessions, so that they can have a quick review of what's going on in disabilities.
But Lisa, do you want to comment at all about other ways to educate faculty?

Sure, I mean, short of mandated training, which we already know we have mandated training in a million different areas, we have decided that it is, that the best approach is small, short training modules for faculty.
We feel like getting in front of different committees, so here at UCSF we have a committee for the core courses, where all core course directors have to attend so many meetings per year, so you've kind of, as the provider, going to where they are, and addressing them all at once.
We also have our core clerkship directors that come into meetings at different points in the year, and so I get in front of those two committees at least once a year, but that doesn't cover all of the clinical faculty that are working in our multiple campuses, nor does it cover the residents, which, I think, might be the, you know, the scariest part, that there are multiple residences coming from multiple different informed programs.

So, you sometimes, you know, I think the, trying to capture everyone might be very difficult.
I think if you can capture the course and clerkship directors' attention, and that is to say, if a student discloses to one of your attendees or one of your residents, then the university is put on notice, and, you know, at what point, the clock starts running, at what point does that student get to the right place, at what point do they get to the place where they're supposed to disclose?

And I think that it's really important to make it very clear to the people at the top how important it is, because they will be the ones then that disseminate that information down to all of the multiple people who are, who are in the clinical settings.
The other approach, so that's for, you know, approaching the faculty and, you know, all of the clinical faculty and part-time volunteer faculty and all of the different people who will have hands-on students.
But the other approach that we've talked about multiple times during this webinar is targeting, oh, I hate that word, but directing our resources towards the student.

So I think that is one area that you can control, and so if you're, if you're constantly letting students know how to disclose, the odds are greater that they will disclose in the appropriate way through the right channels than they would otherwise do.
So you can take this kind of two-pronged approach.
I do want to let everyone know, who's listening, that UCSF, as part of a, in conjunction with the coalition, and as part of a devotion to this area, we are building modules.
They are 10, 15-minute modules that train faculty administrators and DS people on very, very discrete topics within disability.
It is our feeling that these should be made available broadly and to the public at no expense, so we are making these open-access videos, and the first few are coming online between April and June, and we have a series of six that will be coming online.

And one of those is being developed by our director here, Tim Montgomery, and it's titled "What You Need to Know About Working with Students "with Disabilities," or something to that nature, but it's basically, here are the things you need to know.
Very, very quick, very to the point, these are the things that you do do, these are the things that you don't do.
And I believe the run time on that is something like 12 minutes, and so, Tim and Dot Mishoe from Duke are putting that, that module together and that should, that's going to be the first one that goes online.

But it is our hope that these very short modules will be used, I know we're going to use them in our training for faculty, as a mandatory training, but it is our hope that other institutions will use this free resource to train their faculty and to train their DS providers as well.
And that will be, that will be posted to the coalition's website and to, to the UCSF Disability Services website and, you know, for the people who are doing it, like Duke, it will be, you know, a copy will be on their website, but they'll be widely available.

That's great to know, Lisa, appreciate it.
Also, if a student is identified with a substance abuse problem, has been treated, and is now under PhD monitoring, is this an ADA disability, and should it be disclosed, and are there possible discrimination issues because of this?

I'm going to quickly, I'm going to really quickly say two things, and then turn it over to Dan.
One is, active substance abuse is not covered under the ADA.
In this case, it's, somebody in recovery, if the substance abuse has caused cognitive damage or some other, you know, or the medication that the student is taking to, you know, treat the depression that led to the substance abuse, whatever the case may be, they would be qualified under disability services, and so, with that being said, Dan, I know you have way more experience with this?

So, in a way, yes, the, you know, certainly from the standpoint of once they're in residency, moving onto the next hospital, absolutely, the answer is yes.
What about that interface between undergraduate medical education and graduate medical education, and here's where I think that there needs to be real interaction between the student and his or her advisors as to how to disclose this, what to disclose.
For their, in one sense, I can say, this is an area where it is the easiest for residency programs to have confidence that they can handle, because each hospital has a mechanism for handling physicians with substance abuse, potential impairment.
And this is mandated by the Joint Commission, and a number of other organizations, so this is an example of a place where most teaching hospitals would be able to look at an individual with those kind of issues and say, "We can handle that, we have the resources "that we need to do a good job "with this particular learner."

So in that sense, it de-escalates the issue.
Most states, California being one of the exceptions, have state programs where this would feed into.
Obviously, the medical board of every state would want to know this and want to have the physician be engaged in a program of health, and monitoring, if necessary, and this is probably the prime example of why somebody in my position desperately wants to know, as soon as possible, that this has been an issue, because then we can immediately start helping the resident build a strong case that they will present to the medical board that they are not only safe but they are also professional and that they take their patients' safety, their patients' safety in very high regard, is to start building this kind of a case for them to help them get their license as speedily as possible.

Well, thank you Dan, and thank you, Dan and Lisa, I know that we do have a couple more questions, but we really try to stick to our time of an hour, so if there are questions, I know that we are all available to help answer those questions offline.
There's also, I didn't mention it, Lisa, but there is also a LISTSERV.
Would you be so kind, quickly, to go over the Coalition's LISTSERV, so people can get acclimated to that as well?

Sure, the, so the LISTSERV is part of membership in the Coalition, and you can go to our, oh, you can go to our website, which is meded.ucsf.edu/coalition, and there's just a wealth of resources.

We're really committed to uploading not only resources that we've created but resources from other organizations across the country, Nurses with Disabilities, Health Providers with Hearing Loss, there's a multitude of information in there, books, articles.
We also, the LISTSERV is fabulous, and so joining the LISTSERV is something that comes along with becoming a member of the coalition, and then the LISTSERV also carries a repository, and so you can search old posts to get information, and I would say that, with everything that I hear from our membership, this is the resource that they talk about the most, is the LISTSERV.
Being able to get, you know, answers within hours from multiple providers across the country, it's been a really great resource, and we've enjoyed hosting that.

Thank you so much, and again, thank you, Lisa and Dan, we look forward to hearing from some, or seeing some of you on the webinar again on May 12th at three p.m.
Eastern Time on supporting your students' requests on high stakes exams.
Have a wonderful day, everybody.

Thank you.