In Graduate Health Science and Medical Education and a special thank you to Dr. Lisa Meeks who has shepherded this series. I'd like to take a few quick minutes to introduce our speakers today. Dr. Joan Bisagno. Joan is the Assistant Vice-Provost and Director of the Office of the Accessibility Education and Schwab Learning Center at Stanford University and is on the steering committee of the Coalition. Joan is a contributing author to Medical Students with Disabilities: Resources to Enhance Accessibility published in 2010 by the Association of American Medical Colleges and is a contributing author to A Guide to 65 Tests for Special Education published by Pearson Education. We also have Miss Barbara Hammer from the University Missouri. She is the director of the Office of Disability Services and she is an author on the forthcoming:The Guide to Assisting Students with Disabilities: Equal Access in Health Science and Professional Education and president for the Missouri Chapter of the Association of Higher Education and Disability.

We also have with us Miss Neera Jain. She's the co-developer of this webinar series, and co-editor and author of The Guide to Assisting Students with Disabilities: Equal Access in Health Science and Professional Education. Formerly the Director of Student Disability Services at the University of California-San Francisco, she continues to work with UCSF as a consultant on research initiatives and complicated cases. Neera is the co-chair of the Association on Higher Education and Disability, otherwise, known as AHEAD, Graduate and Professional School, Special Series Interest Group and a policy advisor for the Coalition. She joins us today from Auckland, New Zealand where she runs the Auckland Disability Law Center. We also have Tim Montgomery from Northwestern University. Tim is the Assistant Director of Accessibility NU at Northwestern University Chicago Campus. He is also one of the cofounders and the current president of the Coalition. Tim is also an author on the upcoming book and is a seasoned Health Science provider. You've heard Tim before on our previous webinars, as you were the speaker. Now, we look forward to you joining our webinar. Jamie, are you going to address this slide?

Sure. Sorry, Tim. For those of you that are joining on the call, there is no speaker. If you do have a question, please use the Q&A panel located on the right hand side of your screen to submit your question. You can send it to all panellists. Thank you so much, Jamie. Once again, the Coalition would really like to thank the AAMC for their generous support in developing this series. It's such a tremendous collaboration and an invaluable opportunity to get our message out to both disability service providers as well as medical professionals in facilitating access into our programs. We'd also like to point out that this webinar and the others were developed for health sciences and medical programs, and we feel the information is transferable to some programs outside of this scope but may not be for all. We hope you'll benefit from this webinar regardless of your focus and we're very excited to deliver this information today. Our topic today is Separating Fact from Fiction: Debunking Disability Myths and Addressing Legitimate Concerns. We wanted to highlight that behind every myth, there are some real and legitimate concerns. Today, we'd like to break down some of those myths and really strive to address and discuss those legitimate concerns in a more inclusive, proactive, and collaborative way. With that, I will turn the webinar over to Barb Hammer from University of Missouri.

Thank you, Tim. Let's start with a simple statement to help set the stage for what we're going to discuss today. On the slide, you'll see a quote "Possibility is ultimately defined by an individual. Whereas limitations are often defined by society. -- Christopher Reid worked as an Assistive Technology Specialist at the University of Virginia until this past year. It just so happened that as I was perusing various resources online, I ran across his blog site and was fascinated to read his account of how that particular institution was managing to accommodate a medical student who's deaf. What really struck a chord, though, was this statement. It's so compellingly reflected my own belief that the limitations, individuals with disabilities experience are not from within but from the environment in which they operate. Today's webinar will address four prevailing myths about students with disabilities studying medicine. We will present information that will dispel each myth by addressing the reality of the experiences of students with disabilities as opposed to what is often assumed, address legitimate concerns that underlie the myths after all they came from somewhere and explain best practices to provide access for the students without diminishing outcomes for either the students, their peers or for the patients and without degrading the integrity of the learning process. We will allow time for questions at the end.

Myth 1: Students with disabilities cannot fulfil the rigorous requirements of medical programs. Let's start by acknowledging that misconceptions about disability are not uncommon and those misconceptions often drive decisions about how we work with, teach and support students with disabilities whether it's a person with a seizure disorder, a specific learning disability, or a student who's blind. It's important to set aside the inaccurate assumptions and make decisions based on facts both related to the disability and to the program requirements. Let's address this myth. All students with or without disabilities are expected to meet the same academic and technical requirements and standards. For students with disabilities, the qualifier is that they must meet the same standards as their non-disabled peers with or without accommodations.

Accommodations are what provide the access, their modifications or adjustments that do not alter the essential requirements of the program and are, depending on their nature, determined through a deliberative review. Academic and technical standards provide guidance to both students and disability services providers regarding what is deemed essential within a program. As they pointed out during our last webinar, Disability Law 101, and I hope you were fortunate enough to listen in, schools "shall not impose or apply eligibility criteria that's screened out or tend to the screen out an individual with a disability unless criteria can be shown to be necessary".

So well-crafted technical standards focus on the what is to be learned or accomplished, not the how. How students will meet those standards of competencies is where the discussions about accommodations should begin. At times, faculty's first response will be that an accommodation just can't be made, but why? Is this based on history because it has always been done that way, because you learned it that way yourselves? As a disability services provider, I have often found myself respectfully posing that question often more than once. Why? What is essential about how it is always been done? Can it be done another way? And who has made that determination? When an accommodation is believed to be unreasonable or impossible to implement, it's critical that a careful review, a reasoned deliberation be undertaken to determine two things: (A) Would this accommodation fundamentally alter an essential component of the program?

And if so, (B) is there another way to accommodate? Who should be involved in this careful review, this reasoned deliberation? As a disability services provider, I can provide the expertise to explain the nexus between the disability and the request of accommodation, why it was identified as an accommodation in the first place and how it has been used in the past if it has. Within a program, members of faculty, those responsible for curriculum development as well as key decision-makers should be at the table to help ensure that an objective, thoughtful analysis is made. In other words, this isn't a decision to be made lightly and certainly not by one individual, for example, a single faculty member. Consideration of alternative accommodations should be included. How would an alternative work or why not? The process should first focus on identifying the essential learning outcomes for the course, activity or practice, for which the accommodation has been requested. If strong technical standards exist, this step should be straightforward.

Once those essential components have been identified, then comes the determination of whether those outcomes can be met using an alternate but equally effective manner. Those involved should take care to explore all possible options and once a decision has been reached, document. Document the process, the options that were considered, and why they were rejected or chosen. Let's explore an example of how this process can work effectively. Let's focus on the student first. Prior to starting medical school, this student requested the following accommodations: leniency and absence policies, make-up exams and homework for time missed, and extra tutoring to cover missed material. The student had a well-documented history of a chronic health condition that resulted in frequent, extended hospitalizations for treatment. The student had previously qualified for infrequently used accommodations. The disability services provider, after the interactive process, determined that the request for flexibility with respect to attendance was appropriate based on the disability services provider's understanding of the student's medical condition.

This did not, however, mean that the accommodation would automatically be embraced by the medical program. There were many questions with respect to how this would work given the nature of the curriculum at the school. Now for background regarding program requirements. An M1 student is required to attend all patient-based learning, PBL small group sessions, the introduction to patient care small group sessions and all laboratory sessions. Attendance is required for the group to which the student is assigned. An excused absence must be obtained for student who is requesting temporary assignment to another group.

Excused absences may be granted for a maximum of five days over the course of an eight-week block. In this situation, the consideration of the student's requested accommodation was through an interactive process and involved two associate deans for curriculum and assessment and for student programs, three clinical faculty members, two basic scientists and the disability services provider, so it's a small committee. Information were shared with the committee regarding certain aspects of the student's disability without disclosing the specific nature the disability such as that the student had experienced and may continue to experience periods of absence lasting anywhere from 2 to 5 days because of hospitalization. The nature of the condition is that it's unpredictable but historically episodes requiring hospitalization averaged once per month.

The student was open to and had suggested options such as using technology such a Skype to access and participate in group discussions and activities when possible. Consideration was given to the following points. If the student missed more than five days as per the handbook, the student would receive an unsatisfactory facilitator grade for the small group session. For absences of more than five days, the student could opt to request a leave of absence for health or personal reasons. Upon return, the student would need to repeat the block to complete coursework. Given that the curriculum is based on a PBL method, attendance in the small group sessions is critical. Students who miss even half of the permitted absences within the nine-week block are hindering not only their own learning but also the learning of their peers.

Attendance or lack of attendance has a substantial effect on the group. In the PBL environments, skills build on attendance throughout the time during the block, and arranging special sessions for missed components is rare. It's difficult to make up for work missed and almost impossible to make up small group experiences. Consideration must be given to how the student's absence would affect the group particularly if two to three days are missed consecutively for more than one time period within a nine-week block. Random absence could throw off the dynamic of the group, thus, the learning process, and even with technology, there may be difficulties in addressing the random nature of the absences. Concern was expressed regarding the disruption to the cohort of the students as a whole. For example, what would their responsibility be to fellow students to help the student catch up? Is that expecting them to go above and beyond, and would that create a disadvantage for them and take time away from their studies?

Also considered was whether there were alternative ways to accommodate besides simply granting more absences. The group, the committee, believed that in a different style of curriculum, when not using PBL, there might have been more flexibility literally in considering her request but the impact on her cohort had to carry significant weight in their decision. Alternatively, the group took quite seriously the fact that the student had a long history of having managed this accommodation throughout undergraduate work and had an excellent academic record. The group took time to deliberate on all the factors they just listed, long list, and in the end, decided that it was reasonable to grant flexibility with respect to attendance. They did this by allowing the student a modification to the permitted absence per block to seven rather than five. It was a balanced perspective and it allowed the students to move forward into the program. Now, I'm going to hand this off to Joan Bisagno at Stanford for myth number two. Joan?

Thank you, Barb, for that presentation, and good afternoon, everyone. We're going to examine myth number two now and this is Providing Accommodations to Students with Disabilities Compromises Patient Safety. Patient care and safety are crucial in medicine, and rigorous safeguards for patients are the highest priority in all healthcare settings. The word 'disability' itself connotates limitation and

impairment, so it's not uncommon for people to believe incorrectly that the practice of medicine precludes a student with a disability.

Let's examine some aspects of disability within the context of Patient Safety. First of all, any disabling condition exists on a continuum of severity, duration, impact, and status whether the condition is stable versus progressive. It's a long discontinuum, we need to assess a student individually. Not all students with the same disability will need the same accommodations nor will all accommodations be appropriate for all situations in all settings. Two students with the same condition can vary widely in their functioning and their need for accommodation. It's always necessary and required by law to perform a case-by-case analysis of individual's needs for accommodations. For instance, let's take Student A with a hand impairment. He or she may have compensated by switching hand dominance to the unaffected hand, thereby, being able to perform writing tasks without the need for any further accommodation. He or she may also have learned to perform two-handed tasks using a one-handed technique.

Thus, Student A is able to perform clinical procedures like suturing or manual muscle testing without risk to a patient. Student B with a hand impairment may use assistive technology devices for note-taking like a Livescribe pen, handheld recorder, and, perhaps, speech-to-text software for writing. To perform clinical procedures, there are a number of supports, splints or other orthopedic hand and finger-holding devices, so proficient user of such devices would again meet patient safety requirements. Let's say the student has a limb amputation, so Student C is fitted with a myoelectric hand with many functions such as a positional thumb, multiple grip patterns, different grip speeds and force, individually powered fingers and movable joints and multiple programs to tailor functions to individual abilities and requirements. In these examples, we have student A and B, they have hand impairments, and C has an amputation.

For each student, we've made an individual assessment of his or her particular functional strengths and limitations. By performing an individualized evaluation, we're able to evaluate their abilities in a non-discriminatory way. In other words, we've made no supposition that a hand impairment per se poses a health or safety risk based on hypothetical, presumed, or stereotyped assumptions about their particular disability. To determine and assess potential harm to a patient, a risk must be something serious and substantial that can't be eliminated or mitigated. It must pose likely harm, pose a direct threat to health and safety of patients, and be grounded on a fact-based inquiry.

A final but critical point to emphasize is that because safety stakes are very high in the healthcare environment, there are many well-established protocols and safety mandates that must be followed by all healthcare workers, disabled and non-disabled alike, and several regulatory agencies monitor health care facilities very closely and there are serious consequences for violations of safety rules. Now, we'll look at slide 13. depending on the nature and particular limitations of a student's disability, determining accommodations for various clerkships might bring together a team of professionals that includes the disability specialist, the clerkship director, the student's advisor, and of course, the student. Collaborative and innovative thinking are often required when solving an access issue that involves safety concerns. It's also the case where accommodations there are appropriate in one clerkship setting may not be permissible in another rotation or later on in the program. For instance, a service animal may be allowable during the psychiatry clerkship but not acceptable during a critical care or surgical clerkship.

A student with a very serious mental health condition, who requests limiting the working day may be accommodated in an ambulatory care setting by extending the total length of time in the clerkship, but this may not be possible in a critical care clerkship with more intense time demands. In this instance, the student may need to reschedule taking the clerkship during the period where symptoms of the mental health disorder are less impactful and the student's condition is more stable. Another example, use of the cell phone to provide access to phone calls during rotations for a deaf student may be fine in most settings but may be prohibited in areas where it is not appropriate in a hospital clinic setting due to interference with monitors. Now, I'd like to turn to a case scenario. A student I'll call Ryan was diagnosed toward the end of his second year with Bipolar 2 Disorder and this is characterized by major depressive episodes that alternate with hypomania, a milder form of mania. Typical depressive symptoms were

marked by symptoms of low energy, slowed mental and physical capabilities, fatigue and difficulty concentrating. Hypomania symptoms include decreased need for sleep, talkativeness, irritability, and feelings of euphoria.

Academic accommodations for exams were fairly straightforward: extra-time and rest breaks. Ryan did seek treatment with a psychiatrist with whom the disability specialist had regular contact. Initially, he took a leave of absence from medical school, entered the mental health treatment center for three months. Currently, he's returned to school and sees a psychiatrist weekly and his medications include Lamictal, which is prescribed for his depression, and lithium carbonate, a mood stabilizer. His medication side effects include a mild headache, some sedation, but significant lithium-induced hand tremor. What considerations are there for Ryan as he approaches clerkships that involve direct patient contact? His medication-induced tremor may well interfere with procedures requiring manual skills such as surgical knot tying, simple suturing techniques, venipuncture, insertion of urinary catheters, and so on. Some of the possible options we can think about for Ryan. First, collaborate and consult with his treating psychiatrist.

She considered a gradual dose change in reducing the serum level of lithium while maintaining its therapeutic efficacy. The psychiatrist also considered using a beta-blocker, propranolol, which has demonstrated efficacy for controlling persistent tremors during continued lithium therapy. Working with the student and consulting with the medical school advising team, the disability specialist asked about the option of a different order of clerkship rotation starting with the clerkship like psychiatry and delaying rotation with significant hands-on direct patient contact. This would allow the psychiatrist time to determine if a drug-related alteration or enhancements could decrease the frequency and severity of Ryan's tremor to an acceptable level to be able to perform manual tasks. Let's consider for a moment that there isn't a treatment to eliminate Ryan's tremor.

An alternative to perform in a manual procedure requiring direct patient contact might be for him to demonstrate the required skills using mannequin-based simulation. Using a similar, Ryan could practice in how he demonstrated competency and obtained a level of proficiency comprable to other medical students. While immerses in simulation-based training provides an intensive form of active learning without risk to a patient, an institution would need to consider whether this kind of modifications fundamentally alters the technical standard requirements of its program. Another option an institution could consider is to modify the requirements for manual tasks to emphasize the cognitive aspects - recognition of abnormal findings, the development of differential diagnosis, treatment plan, and a detailed description of how to perform the specific procedure rather than the ability to perform to task itself, or as mentioned previously, extensive simulation experiences could be combined with this more cognitive-based approach to meet the course standards. Some institutions may also allow for the use of physician extenders such as a nurse practitioner or a physician assistant as an intermediary to perform certain tasks.

Again, careful consideration needs to be given to any adaptation that alters the essential requirements of a program. It's technical standards. As for Ryan with careful monitoring and adjustments, his psychiatrist was successful in reducing his lithium level, maintaining the therapeutic efficacy while simultaneously reducing his tremor so that it was non-interfering with manual tasks. Now, I'd like to turn it over to Tim. Hi. You're actually turning it over to Neera.

Hi, everyone. Sorry. That's okay, and I'm going to talk about Myth number three, which is Accommodations in a Clinical Setting Do Not Prepare Students for the Real World. This is a common concern we hear from faculty who wonder if students receiving accommodations won't be adequately prepared for the real world of work. If they receive accommodations, are we just setting student's up to fail in the future? Let's dispel this Myth. It's important to remember that universities are educational institutions not employers, so our scope when we are considering accommodations is that educational setting. We must face decisions about accommodations on stated educational requirements and technical standards, not a hypothetical future. Accommodations need to be decided based on the specific learning outcomes that are identified for each clinical rotations. Reasonableness as Joan mentioned may differ from didactic to clinical setting or from rotation to rotation. For example, provision

of extended time and rest breaks that's perfectly reasonable for an academic or didactic exam setting will need to be re-evaluated for the clinic or for standardized patient exam. This one's illustrated in the OCR letter to Spokane College in 2006. That college had a blanket policy that accommodations weren't considered for clinical rotations, and this was in their respiratory therapy program.

One rational that was provided by the school was that once graduated, students would be expected to do their jobs without accommodations. The OCR explained in their response that a college must engage in an interactive process, and that's what you've been hearing Joan and Barb explain, thus far, to determine whether an accommodation is available that would allow an otherwise qualified student with a disability to participate successfully in an educational program. They said and I quote, "A blanket policy against accommodation during clinical rotations is fundamentally and fatally at odds with federal requirements."

It's important to note that accommodation that are indeed available in the workplace and are determined in a similar way to those in the academic setting but using their own standards for expectations on the jobs such as a job description. In most cases, we cannot deny an accommodation simply because it may not be available in the workplace. Similarly, we don't deny accommodations because they might not be available on a licensing exam such as the USMLE Step 2 CS, the clinical skills portion of the USMLE. Of course, there's no guarantee that accommodation will be provided in future settings but our job is to make a sound decision at this level, which is often reasonable in future setting. What are the legitimate concerns that we should attend to? It isn't to say that all accommodation requests will be determined reasonable particularly if a student is requesting an accommodation that would lessen the technical standards or key learning objectives.

This is why these standards need to be current while developed to ensure they aren't discriminatory and grounded in the real world requirements of a professional in the field. This was illuminated in a recent case, which was Palmer College of Chiropractic versus Davenport Civil Rights Commission and Cannon. The court found in that case that in the real world, 20% of chiropractors contract out reading radiograph. Therefore, it's not actually essential the academic requirement was out-dated. While technical standards and learning objectives are current, they should outline the kinds of skills and abilities that students must have in order to become employed. Without being able to learn them or do them, workplace opportunities would be extremely limited if possible at all. I think we're on the wrong slide, so if we can move to the example slide please? Next slide. Thanks. Nope, we're on the next slide.

Great, thanks. Let's look at an example where the question of preparation for the real world is often rave and that standardized patient exam, sometimes called (inaudible). At UCSF, we've had students request extended time for these exams, and sometimes because they've always had extended time and they just automatically ask for it. What we need to do is really explore this very specifically because the standardized patient exam is evaluating some things much different from a written exam. It's performance-based. Many DS providers report that their schools unilaterally deny accommodation on standardized patient exams and they cite a few reasons. The first in the real world, doctors are responsible for managing patients and with insurance requirements, they need to be able to move your patient assessments quickly and think on their feet. You can't possibly give them more time. Schools also cite the USMLE Step 2 CS.

Surely students wouldn't get more time on this exam. Finally, those report that the logistical complexity of giving some students extended time, which is impossible to manage as a very detailed matrix schedule would need to be changed for a student with accommodation. What we did at UCSF was engage in an interactive process that included several key players - the directors of standardized exams and the curriculum, the assistant deans, and key faculty. We wanted to make sure that we broke down the exam and the thorough investigation of what is that exam measuring and the reasonable nature of both current request and thinking about future request. First, we needed to look at the exam. What was it really measuring and what did it entail? The stated objective of the standardized exam is to get a broad evaluation of student's ability to perform a focused evaluation and make a differential diagnosis. At the same time, these exams also measured the student's communication and professionalism skills.

The exam measures whether or not the student asks specific questions of the standardized patient and takes up on specific clinical clues and communicates well with the patient.

The exam consists of three distinct sections so we worked with the school to examine each of them independently. There is a pre-reading preparation fee sometimes called the door notes. There's the actual patient encounter, and there's the charting, recording, or recording phase. We also (inaudible) the reality of providing extended time. In some instances, making a six-minute exercise if you're breaking it up into sections of six minutes and turning that into a nine-minute exercise, that's 50% extended time, but when we're talking about three-minute difference, the concern that it would fundamentally impair a student in a real clinical setting would reduce. If you consider a normal human variation, some days you're on and able to produce at a high rate, higher rates than your baseline, and there's other days or without coffee maybe, you might perform slightly below your average.

No one person can perform exactly the same each day, as well certain patients call for more time or less. Surely, the human variation and patient variation means having three more minutes for a history and physical seems more reasonable, but more importantly, OCR would not see this as unreasonable. In the end, what we determined was that it was reasonable to provide accommodations for this exam. Like any accommodation request, we look at each student's case individually. Does their disability and related functional limitation support the need for accommodation on this exam? Is it truly needed for all parts of the exam or perhaps just for the reading and writing portion? At UCSF, we provide distinct accommodations for each section of the exam. We evaluate each section separately. We also look at whether there are other accommodations or assistive devices that would help the student instead of or in addition to extra time.

For example, a smart pen to support note-taking, use of an iPad instead of a pen and paper to take notes, things like that. The accommodation of extended time on patients, and that's the one I think people most often feel strongly about. We found really maybe reasonable on a case-by-case basis. For example, a student using sign language interpreter, there might be a delay in communication or a student with a physical disability might require more time to maneuver in the room and may also be that a student with significant processing speed disorder or traumatic brain injury might need a few extra seconds to process what the patient says would also receive extra time. Now, as a standard practice, we book an additional day for testing to allow for accommodated extra time exams and that's to address that scheduling concern. Now, I'm going to hand it off to Tim to take you through myth number four.

Thank you, Neera.

Myth number four, 'Students with disabilities cannot handle the intensity of health sciences programs'. We wanted to emphasize that we do understand that health sciences and medical programs are inherently demanding and intense, and they are high-stakes programs with a lot of pressure inherently built-in. Students with disabilities face the same challenges are their non-disabled peers along with an entire other set of challenges of facing those challenges with their disabling condition. The intensity of the schedule, stressors, and demands of these programs can at times intensify their struggles in their personal relationships. Financial responsibilities may well be more pressing at this level as they may have families and their financial aid may not cover their needs completely. In addition, they all tend to have extremely burdensome debt to manage upon graduation.

Students at this level may be more likely to have family living with or depend on them. They may be caregivers or responsible to provide for members who might be ill or with health challenges. They also may be acutely aware of the sacrifices their families make or have made to send them to medical school and health sciences program. Quite possible that some for the first time are facing academic struggles when they have been so successful their entire academic careers. Then on top of that, to begin to discuss the possibility that they might have a disability is extremely difficult for them to process and accept. Students who have been previously diagnosed have the experience of knowing how to handle their condition and, therefore, most likely will have developed some compensatory skills and be more prepared to advocate for themselves versus a student who's newly diagnosed with a condition. Disabled students also tend to be acutely aware of biases and feel pressure not to disclose their need for

accommodations for fear of repercussions from their peers in courses and programs and in denial of future opportunities.

When programs proactively address these needs, the support then becomes more the norm versus the exception. It's so important for medical professionals to not stereotype or make predetermined assumptions regarding a particular disability. We hear statements such as the student suffers from or is afflicted by a condition. That thinking further defines the student's abilities by their disability versus identifying each student's competencies and not their limitations. People with disabilities prefer to view themselves as living with these conditions not suffering from them. Also be really cautious to not generalize a disability being the same for everyone with that condition (inaudible) available and accessible for all students.

When student struggles in challenges that are discussed openly and respectfully and the resources are available and students are encouraged to utilize them, the stigma around needing support becomes significantly diminished and resources will be much more accepting to that student. The students want so badly to hear, the students who are struggling want so badly to hear the medical professionals - their dean, their instructor, their mentor - to say to them, "It is okay to go seek help and here is where you can go." -- I think there are fewer things more powerful for a student struggling in these programs to hear that that information from the people that teach them and guide them. It is also critical for schools and programs to proactively address many of the areas of student life that they are facing challenges. Mental health, academic struggles, again, maybe for the first time, self-care or lack of self-care and physical health, all need to be emphasized and openly addressed.

There are some schools, St. Louis University, Marshall, Vanderbilt, and here at Northwestern that have begun to develop curriculum-based models to openly and proactively address challenges and concerns for all students. At Northwestern Feinberg School of Medicine, they've identified some concerns that I think we all see - stigma around mental health issues potentially impacting residency and licensure, higher risk of depression, burnout, dropout, and suicide ideation, procrastination, perfectionism, addiction to success, and use of substances. Their emphasis in philosophy is quote "To become physicians who care for others, one must learn who they are and how they best need to care for themselves to have long productive medical careers and healthy balanced personal lives." -- I love that. Their goal in phase 1 which is for M1 and M2 is to provide a form for students to discuss professional and personal issues.

To demystify some of those silent struggles such as depression, perfectionism, relationship issues, and substance abuse, to teach concrete solutions and provide resources to make positive and lasting change. It creates an acceptance and an approval to make behavioral changes and need and seek out support. The doctors said, they also feel doctors who understand how difficult it is to make changes will be more empathetic to patients who struggle with changing. The scenario I wanted to share with you was shared with me by a colleague at a university and the scenario is basically a student went to medical school. The students had his family living with them and by family, I mean everyone, his parents, his spouse who at that time was handling or dealing with some temporary health issues herself, and some young children, two young children. All of the household responsibilities wound up falling on this student's shoulders.

As you might imagine, there was limited time to study and prepare academically, and as the student began to struggle academically, it really impacted him because so much of his identity was around his academic success and his family's identity of him was around that. There were some financial limitations because his wife was not able to work and some restrictions, the financial aid didn't cover, and the student then was also seen as the primary provider for his entire family. As you might imagine, the student began to feel immensely overwhelmed and began to contemplate suicide. I listen to this and I just felt like it was a perfect storm of struggles and challenges. The student was alerted to resources and supports through his medical school, and they have been openly and proactively discussed and encourage and made available. The students sought out support and was able to address these struggles. Financial aid was able to be increased to alleviate some of the financial struggle and although

it added to his debt, it did relieve some of the immediate financial struggle. Mental health support was made available, which the student accessed.

Academic support and disability accommodations were implemented to assist with some of those academic difficulties and the student was allowed to take a short leave of absence while his spouse's medical needs were addressed and relieved. It's important to know the student was able and more importantly willing to address his significant struggles because the medical school made not only the resources available but encouraged all of the students to utilize them. I'm happy to report as of last check-in, the student was progressing very nicely towards completion of his M2 year. I think that's it for mine.

I think we'll go back to, I think, Elisa and open up the webinar for some questions. Great. Thank you so much to all of our presenters. This is really a wealth of information. Anybody who is having trouble taking notes throughout, be assured that you can revisit these on the website of the AAMC. They'll be posted. This whole webinar will be posted as well as the slides, so you can go back and review anything that you were having trouble taking notes on. We did get at least one comment about that. I have some great questions here and if you've got more questions, you all just feel free to go ahead and type them into the Q&A box now. I will note that if there's a question about a specific type of disability in how to accommodate it, that's probably a little bit outside what we want to focus on today, although there is an upcoming webinar that will talk about more specific clinical accommodations, and those questions might be better suited for that or they might be answered during that webinar. The first question I'm going to start with today have to do myth 3, so I'm going to toss it to Neera and the question is, what if a clinical site is not allowing an accommodation saying, "No, we won't provide that accommodation," even though the school knows they need to provide it? How does the school massage the working relationship with the site while at the same time providing the student with the accommodations that they need?

Thanks, Elisa. That's a great question and let me tell you I've been there and I know a lot of us have been there. So this is a really good questions to start out with. What I would say is, first, hopefully, you've worked with your clinical directors, your school to get buy-in for that interactive process to make sure that everyone's on board that this accommodation is definitely necessary. What I would say is, first, you've got your allies in the school to help you to explain this to the clinical site. Where I would start is really understanding what their concerns are, where are they coming from, what are they grounded in, and that should help to give you a little bit of time to hear them out and see what can be done. Maybe you can address those concerns directly. I would also use your school to make sure that they're helping as well in that process, so it's not just coming from you. Sometimes let's be honest, a doctor talking to a doctor can really help on that to move forward.

Another strategy you might use is to work with the clinical sites' employee disability office, and this is usually more applicable if it's within a hospital setting, so actually be an office where they're determining accommodations for their staff. Someone from that office might be a good partner in being able to say, "Hey, we're already doing this with staff around the hospital. Of course, we should do this," and that might help to bridge that (inaudible). I think ultimately, if a clinical site refuses to provide accommodation, you're going to need to find another site for the student and you might want to think about whether that site is appropriate because if they're saying no to providing accommodations, if they're denying a student accommodation, that's discrimination and ultimately the school should consider whether or not they should work with that site. There's a lot of massaging, I think, that can go a long way beforehand working through that with your schools and with the clinical site.

Does anyone else have anything to add there? I would like to add one thing real quick. I think it might be really important for you to, if you're not part of the Coalition, to join and ask what other schools are doing with students in those particular programs and with those particular disabling conditions. Sometimes, it's really helpful to be able to take that information to that clinical site and say, "Hey, Northwestern's doing this. UCSF is doing this. Other schools are doing this," and I think sometimes those sites may not realize what other people are doing. One of the nice things about the Coalition is we now are able to share some of that information, but I think a lot of the clinical sites are not maybe always able to share that information. So they may not know what's going on at other sites or what other people are doing to

accommodate certain things. That gives you a little bit of ammunition and information, if you will, to take back to them and say, "Well, other people are doing this and maybe we can try that."

That's great point, Tim. Great, so the next question that we have has to do with schools that have multiple geographically separated campuses, and the question is, what is the thinking about requiring a student to be at a particular campus solely because it's easier for the institution to accommodate the student at that location versus the others even if that location isn't the student's first choice of where to take their classes? I would actually expand this question to apply as well to clinical locations, clinical sites when there are multiple places a student can be placed, sometimes it's easier for the institution to provide accommodations at one of them, but the student would actually prefer to be doing their experience at a different site. Does anyone want to address this? Maybe Barb, maybe someone else? Hi, this is Barb.

This is Barb. Sorry. I had it on my speakerphone for a minute. I'm going to jump in here. I've been pondering this question since I looked at it and I think the question I would have for the institution is why it would be easier on a particular campus? Everything that we do and everything we talk about when it comes to working with students with disability is that it's case by case and we want to try to create the conditions that are going to work best for the student to participate in the learning process. My concern would be that we would be expecting a student to travel extra distance to be working in a clinical area that may not necessarily fit what he or she would be preferring, and so, I would be going back to the institution and saying, "Why would it be easier and how can you replicate that to the site that the student would prefer?-- Anyone else want to throw in there?

This is Neera. I just wanted to add that this has come up periodically when we have a student, for example, who has a chronic health condition or some type of disability that precludes their ability to drive, but the school has a clinical site that provides a very unique kind of learning experience, maybe a clinic that works with a very specific population and the student really wants to work with that population. There's a question about transportation maybe, and it would be easier to accommodate a student close to home or maybe something on a public transport that something is easier access by public transportation.

What we've had to talk about is do we provide the transportation for that student do we fund that because there is a unique learning experience that the student's entitled to participate. You wouldn't want to be making a decision based on what's easy unless it's completely impossible to do it, and that would take a lot I think to say it's too administratively complicated. If there is a simple solution like, let's just pay for taxi fare the student could get to that clinic, we should be doing that. I would add that institutions need to be careful not to limit a student with the disabilities opportunities and unique clerkships and need to exhaust exhaustive search of what possibilities there might be to fulfill the student's desire. Absolutely.

This is Neera again, and I would say just repeating what Tim said earlier, the List-serv for the Coalition is a really amazing place to do some of that exhaustive searching because as Tim said, there are so many schools that have done creative things and we've been able to share ideas that maybe people wouldn't have thought of before. The fact that another school has done it makes it doable all of a sudden that's like, "Oh, if Northwestern is doing it, then surely we can do that, too," That really goes a long way with helping make decisions with the higher ed. Great. Thanks so much, you guys. Here's a question about technical standards. I think this was addressed briefly in a previous webinar, but perhaps you guys could address it briefly again. The question is, if you could provide one or two examples of how technical standards could be reworked so that accommodations could be provided? How to reword the technical standards so they're not discriminatory, I think is the question. Does anybody have a quick answer to that one?

This is Joan. I have a few thoughts. I think it's the way technical standards are written. Sometimes you'll see technical standards state categorically, "No intermediaries are possible for accommodations," and some will say, "Limited use of intermediaries." When you're dealing with someone with low vision or someone that may need some interpretative visual information, it may be possible at one school and not

possible at another. I think if each institution, the medical authorities in that institution state and write the technical standards and they determine whether or not they will allow a use of intermediary or some modification, let's say, simulation-based experience for actual doing of a procedure. It really is up to each institution to decide that.

This is Barbara. I'm going to jump in and just say, yes, that I think that's the key is that the -- Because at our institution, we just recently went through the process of revising technical standards and the approach was to look at the wording as whether or not it had an exclusive nature to it. In other words saying you must do these specific things in this specific way, and by changing it so that it's stating again what needs to be accomplished but not how. Going through that deliberative process of deciding where certain lines need to be drawn based on the nature of the curriculum there, that helps. I think that's what makes the difference.

I'll just throw in, this is Neera, a quick example of some wording that might be discriminatory. if a technical standard was, 'Must hear breath sounds,-- that might be discriminatory because there might be someone who can't hear breath sounds that might be able to distinguish breath sounds by using an alternate stethoscope. The example would be instead of saying "Must hear breath sounds" versus "Must distinguish breaths sounds" that would be a change in language that would achieve the same results but allow for accommodations to be in there. Thank you so much all the panelists. I see that we are out of time and there are more questions to answer.

For example, I saw two different schools posing questions about color blindness, and so those questions and others can be addressed to the List-serv. If you go on to the Coalition's website, which is -- Neera, do you know the website offhand? That's okay. It'll be posted on the AAMC's website. If you sign up with the List-serv and join there, you can post those questions and you'll get experts from schools all over the country who are gladly pitching in to answer questions about how they've done specific accommodations in the past. I know that color blindness and accommodating it, especially looking in microscopes and that kind of thing is something that has come up at schools, and there are answer for how that's been done in the past. Please join the List-serv. Ask your questions there if we didn't have time to get them today.

Thank you so much for your participation and we look forward to seeing you at the next webinar. Here you go. Here's a List-serv contacts. I'll leave that up for a second so anybody can jot that down, send an email to Lee Collie and she can get you on there. Then be sure to register for our next webinar which is about specific clinical accommodations and this is a kind of place where you might get answers to some of your very specific questions about very specific types of disabilities. We are happy that you joined us today. Thank you so much and we hope that you'll join us next time. Take care.