

Exploring the Barriers to Inclusion for Medical Trainees with Disabilities
Evaluating Underperforming Trainees with Disabilities
Webinar Transcript

Peter Goodwin (PG): Good day, everyone. And welcome to the Josiah Macy Jr. Foundation's webinar. Barriers and Belief Systems: Evaluating Underperforming Trainees with Disabilities. The second in a three-part series. I am Peter Goodwin, Chief Operating Officer and Treasurer at the Josiah Macy Jr. Foundation. Before we get started, a few housekeeping items. This session is being recorded. The audio and video portion, as well as the presenter's slides will be available next week on the Foundation's website, www.macyfoundation.org. The chat function on your zoom screen is currently disabled and will be throughout the presentation portion of the webinar. We will enable the chat function once we start the question-and-answer portion of the webinar. At that time, you will be chatting with all attendees and the panelists. Please feel free to use the chat function to share information or best practices, or to comment on responses to the questions. The Q&A function on your Zoom screen is active and will be throughout the webinar. Please use it to post questions to the panelists that relate to the content of this webinar. And finally, we encourage you to continue the conversation on Twitter using the hashtags, #EquityInClinicalLearning and #DocsWithDisabilities. And now I am pleased to introduce the president of the Josiah Macy Jr. Foundation, Dr. Holly Humphrey.

Holly Humphrey (HH): Thank you, Peter. And welcome everyone. Let me begin by introducing today's panelists. Dr. Lisa Meeks is Assistant Professor in the Departments of Learning Health Sciences and Family Medicine at the University of Michigan Medical School. She is also director, Docs With Disabilities Initiative and co-host of the Docs With Disabilities podcast. Dr. Meeks is an expert in disabilities in medical education. As an administrative leader and researcher, she is helping to inform policy and best practices in the area of disability inclusion for medical education, training and practice. In addition to Dr. Meeks, I'd like to introduce Dr. Michael Argenyi, who's an Addiction Medicine Fellow at Wake Forest School of Medicine in North Carolina. He is board certified in preventive medicine. Upon completion of his fellowship, he will be joining the faculty at the University of Iowa Hospitals and Clinics. He previously completed a residency at the University of Massachusetts Chan Medical School and earned his MD degree at Creighton University. He also earned an MSW and an MPH at Boston University. His academic interests focus on harm reduction in the interplay between sexual health and substance use such as chemsex, building off his previous work in both clinical and population level HIV and STI prevention and treatment. He holds a faculty appointment at the University of Massachusetts School of Public Health and Health Sciences. And as a physician with hearing loss, he has a long history of advocacy for disability inclusion in medical education. And finally, I'd like to introduce Dr. Ray Curry, who is the Senior Associate Dean for Educational Affairs at the University of Illinois College of Medicine and Professor of Medicine and Medical Education at the University of Illinois at Chicago. As Chief Academic Officer at one of the nation's largest medical schools, he oversees educational programs across the college's campuses in Chicago, Peoria and Rockford, Illinois.

HH: Now let me say a few words about today's webinar. I will begin by providing an overview of how this webinar series came to be. And then I will turn it over to today's panelists to describe the assessment of trainees with disabilities when a trainee is underperforming and what we can do to better ensure the success of trainees with disabilities. We aim to leave a significant portion of today's webinar to engage with all of you in a question-and-answer conversation. So let me begin with some background. In February of 2020, a group of faculty, residents, students and leaders from medicine, nursing and other health professions came together in Atlanta, Georgia to create a set of recommendations, to help achieve a very ambitious vision, which is that our nation's health professions learning environments from classrooms to clinical settings to virtual spaces should be diverse, equitable, and inclusive of everyone in them, no matter who they are, every person who works, learns or receives care in these

Exploring the Barriers to Inclusion for Medical Trainees with Disabilities
Evaluating Underperforming Trainees with Disabilities
Webinar Transcript

places should feel that they belong. I also want to mention that July is Disability Pride Month, and we would like to honor and celebrate the many current and future docs with disabilities among us. I would specifically like to thank Dr. Lisa Iezzoni, Professor of Medicine at Harvard Medical School and a conferee at that 2020 conference that I just mentioned. Dr. Iezzoni brought attention to this topic during our conference, and she helped us not only outline the challenges in the issues but helped us identify a way to honor our commitment to creating inclusive learning environments, especially for those with disabilities. We are very honored to sponsor The Exploring Barriers to Inclusion: A Three-Part Webinar Series. And on the next slide, you will see the Three-Part Webinar Series featured. We've already accomplished webinar number one, which you can find in a recorded format on our website, along with a list of resources that accompany that recording.

HH: And you see in front of you, the webinar topic for today, as well as the final webinar in this series scheduled for July 26th at three o'clock Eastern Time where our panelists will include practicing physicians who have not only navigated the medical education terrain but are practicing as physicians today. So, this series is one way in which the Macy Foundation is supporting the inclusion of trainees and physicians with disabilities and elevating their stories. Each webinar is informed by and includes people with disabilities. The Macy Foundation believes that disability is an important part of medicine's greater commitment to diversity, equity and inclusion and we invite you to engage with the multitude of resources available on the topic of disability and inclusion in medicine, many of which are included in the resource listing and which will be available after today's webinar. We are all responsible for disability access and inclusion. And we must all do our part to change the landscape and the mindset from one of exclusion and deficit to one that truly celebrates the talents of our colleagues and of our patients with disability. Thank you for being here today and for helping the Macy Foundation advance these important conversations. And now it gives me great pleasure to turn the podium over so to speak to our distinguished panelists beginning with Dr. Lisa Meeks.

Dr. Lisa Meeks (LM): Thank you so much. And thank you for your kind words. We are all celebrating Disability Pride this month. And I think for all of the panelists, we echo the appreciation for Dr. Lisa Iezzoni, truly a pioneer in this space. So today we have some learning objectives for you to describe the accommodation determination process and some standard accommodations in medical training. To describe the process for evaluating underperforming trainees with disabilities. And then to describe the process for responding to a disability disclosure during a promotions committee review, I'm sure something that many of you have had. So as always, we want to begin by recognizing that there's so much to learn on this topic, but don't worry, we're all learners in this space. And we thank the Macy Foundation for their generous and thoughtful three-part webinar series on the topic. Each webinar builds on the next. So, if you haven't watched webinar one yet, we really encourage you to do so. And as Holly said, that is recorded and on the Macy website. And then we invite you in just a little over two weeks to join us for the panel of physicians. Definitely not something to miss. Many resources are available. You will receive a handout, but you can also visit the Docs With Disabilities Initiative website at docswithdisabilities.org, which will be the first URL that is posted in the Q&A. And just a little disclaimer here, while we are reporting on legal findings and legal implications for some of the actions, we are not attorneys, none of the panelists are attorneys. We are drawing on our personal experiences with the legal requirements for access and the literature on best practices for evaluating disabled trainees. We have attempted to balance this with the full knowledge and understanding that medical training has historically excluded disabled trainees. And that ableist structures still present today, often

Exploring the Barriers to Inclusion for Medical Trainees with Disabilities
Evaluating Underperforming Trainees with Disabilities
Webinar Transcript

keep individuals from identifying as disabled and requesting the accommodations that they need, thus, they don't receive the necessary supports to fully engage in the program.

LM: All right, so today's webinar is informed by two articles and one book chapter, you'll recognize some of the names that are here with you on this panel today. But I also want to recognize and thank the co-authors of these resources for their permission to share this information with you today. And so right now you'll be receiving links to the articles and chapters, I believe it's going to come through the Q&A, and these will also be part of the resource list. And so also a big shout out to our friend Rahul Patwari.

LM: All right, so let's get started. Medical trainees with disabilities may underperform for an academic, behavioral, personal or disability related reasons. And when disability-related barriers are present, faculty and supervisors who do not understand the interactive process may just think that this underperformance is a normative part of being an individual with a disability. And in fact, they may equate disability to inability. As a result, they may fail and often do fail to engage in a robust interactive process to determine whether reasonable accommodations are needed or whether reasonable accommodations need to be updated. Alternatively, when a trainee with a disability underperforms, faculty may be reluctant to fail the trainee out of some sense of misguided empathy or, more often, fear of legal repercussions. It's important to remember that accessibility to a program is about equity. Ensuring that a trainee with disability has access to every portion of the curricula and clinical experience. And then once disability-related barriers are removed through reasonable accommodations or other mechanisms and trainees have full access to things, then they should be evaluated as you evaluate their peers. Alright. So, the interactive process for determining a disability involves multiple steps, but where most of the discomfort comes is in step six. And honestly, this is where many people fail to engage in the system. In fact, step six is looking at the efficacy of an accommodation. And so many times you'll go through the process, and you'll determine accommodations, employ those accommodations but you fail to check and make sure that they're effective. So, this particular wheel of the interactive process is coming to you from the 2018 AAMC report. And indeed, that AAMC report outlines the interactive process in a lot more detail than we'll outline today. Today, we're really going to be focusing on step six. So, one of the issues is that faculty, if accommodations are already in place, may believe that they should fail a learner that is underperforming because accommodations are in place, not recognizing that the efficacy of accommodations need to be reviewed in this step six.

LM: So, you can think of step six as like a cycle within the interactive cycle where we look at whether the accommodation is effective. And if not, we go through a process of reviewing the accommodation, looking to see if there are any other potential accommodations that are available and doing a trial to see if those accommodations are effective. If they are not, we continue to go through the cycle until all reasonable accommodations have been identified or exhausted. But one misstep that can happen here is sometimes people disagree on what's reasonable. So today we're going to talk to you a little bit, we'll just touch on some of these vetted reasonable accommodations in UME and GME. And I've delineated this by the undergraduate and graduate training environment. And we'll give the appropriate cautions for each. So, it is quite reasonable, excuse me, in undergraduate medical education to have a learner that if they have appropriate documentation and appropriate need, be assigned no overnight call or no switching from days to nights. This same accommodation is actually reasonable and quite well vetted in GME, but here, it really depends on the size and the service needs of the residency program. Another well vetted accommodation in UME is protected time for medical appointments. In fact, I just want to take a moment to point out that both the LCME and the ACGME require this, both in the UME

Exploring the Barriers to Inclusion for Medical Trainees with Disabilities
Evaluating Underperforming Trainees with Disabilities
Webinar Transcript

environment and the GME environment. So protected time for appointments, while we may look at those as an accommodation, those are actually things that are supposed to be employed for all trainees across the medical training continuum.

LM: Alright. In UME, we have decompression of clinical curriculum. So, once you get to that clinical state where people are going through rotations, decompressing that as needed and appropriate, if the disability calls for it is something that is well vetted in UME. In fact, many schools have just adopted that option for all trainees. Isn't that wonderful? In GME, extending residency is also a vetted accommodation, but here again, there are some caveats. It depends on the size of the program and the service requirements of the program. Across UME and across GME sign language interpreters and captioning are well vetted. And I'll just put it this way. There's probably no reasonable way to deny these accommodations. In fact, we have a lot of case law and OCR findings that support that this is reasonable and effective in the clinical space. Alright. For UME, Dragon Dictate on all systems, which is the preferred, because this builds a universal design model such that everyone can benefit from having Dragon Dictate or access to Dragon Dictate. Oftentimes the physicians will have access, but the learners will not. Or you can take the approach of building an accessible WOW, or a workstation on wheels. And this means that the learner can take this with them everywhere. And they have a station that is individually built for them that they can access to build the efficiency of their charting and accessing information. This same accommodation is reasonable and vetted in GME.

LM: So, the old standard of time and a half or double time on exams, which I think is what everyone thinks about when we talk about accommodations certainly is well vetted in UME but it's also well vetted in GME. And there are some distinctions that are too nuanced to address today in this webinar that have to do with what you are measuring in that particular assessment. But I will say this, you must evaluate every portion of the curricula, every assessment, every interaction, including patient interactions individually, to see if that accommodation is reasonable. And then for UME we do a lot of this actually. Evaluating learners in a simulation lab or having them practice in a simulation lab as an alternative way to meet competency. Now in residency, that's not as widely used as would make sense, because in residency, you are training on some specificity there within your field. But for learners in medical school, it is not uncommon to go ahead and do an evaluation in a simulated setting. Alright. And with that, I'm going to turn it over to Dr. Michael Argenyi.

Dr. Michael Argenyi (MA): Thanks Dr. Meeks. So Lisa is correct when trainees with disability underperform, identifying the root cause can be challenging. Faculty who are unfamiliar with disability-related barriers or accommodation, may falsely attribute performance struggles to the trainee's disability. Conversely, fear of legal action may prompt inappropriate promotion of a struggling trainee, or lack of attention to proper remediation, what we have called "failure to fail" in this webinar already. When trainees with disabilities underperform despite the provision of accommodation, supervisors have to determine the root cause of a trainee's academic clinical underperformance to determine whether the trainee requires remediation; revision of accommodation; a referral to appropriate counseling, disability or learning services; probation; or ultimately dismissal. A clear understanding of the origin of difficulty requires a structured review. Going through such a process increases transparency, trust and collaboration. This is especially important when considering how the trainee may receive an undesirable outcome like probation or dismissal. Patwari and colleagues developed a disability-informed diagnostic model of remediation, here split into two images, for trainees with disabilities allowing programs to address underperformance through a systemic, objective and informed process ensuring programs meet

Exploring the Barriers to Inclusion for Medical Trainees with Disabilities
Evaluating Underperforming Trainees with Disabilities
Webinar Transcript

their legal obligation for engaging in an interactive process described by Dr. Meeks, especially important step six, while providing a higher level of trainee support. In his model, trainees with disabilities who fail to meet the milestone or competency, take a diagnostic OSCE, also known as an Objective Structured Clinical Exam, to identify the source of the trainees' difficulty.

MA: If a disability related issue is identified, then you can revise the trainee's accommodation as reasonable and then through a new accommodation, address the gap in access. Why do we use an OSCE? It's important for a simulation lab to identify the root cause of the deficit because it provides a controlled environment for the trainee. And it allows the trainee to contribute to the evaluation. Identifying when and where they're struggling in the process. This collaborative approach allows evaluators to determine disability-related barriers, quickly implement new accommodations, and immediately evaluate the efficacy. This process is iterated until all accommodation options are exhausted. If a knowledge or clinical skill deficiency is discovered, the trainee should receive remediation in line with the program standards. If the trainee completes the remediation with an opportunity to employ the new accommodation and continues to struggle, they can be reevaluated with another diagnostic OSCE. If then the trainee fails to meet competency or performance expectation, then the program should employ their policy for trainees that fail to remediate. This diagnostic model is important because the approach to remediation for clinical skills related to underperformance requires academic remediation. While underperformance related to a disability required the full exploration of the reasonable accommodation and any assistive technology that may reasonably remove any barriers that are remaining for the trainee.

MA: Implementing the diagnostic OSCE for a disabled trainee, ensures compliance with the requirement to engage in an interactive process and exhibits a robust, good faith effort to provide equal access that is both trainee-informed and trainee-centered. The process also evokes confidence in the next steps. Trainees who successfully complete the diagnostic OSCE can return to the clinical environment with new, more effective accommodations. Those who are unable to perform to standards with appropriate and comprehensive accommodations may be evaluated knowing that all actions have been exhausted. Faculty also should be comfortable referring an underperforming trainee with a disability to this evaluation, knowing that it will lead to a robust disability-informed assessment with the goal of identifying the root cause of underperformance. And that accommodation will be reevaluated. Following the evaluation, faculty should have the confidence to make decisions about the trainee performance knowing that all disability related barriers are hopefully removed by the process. Finally, the total investment in time and resources for this approach to underperforming trainees is minimal. Far less than the alternative legal action that is often taken following the dismissal. It is also the right thing to do when any trainee is struggling. The loss of any trainee in medicine is difficult, and it is likely the programs who employ this approach could find reasonable, effective accommodations that allow trainees to thrive in training and beyond.

Dr. Ray Curry (RC): So thank you, Michael. And we'll start now following Michael and Lisa's explanation about how these processes should work for every trainee receiving accommodations. To focus on the underperforming trainee and start with the fact that the processes described by Lisa and Michael, as we've tried to illustrate here with this little runaround are all too often not followed. We'll explain how this can impede the ability to determine the difference between under performance due to academic, behavioral, personal or disability-related reasons. And one of those disability-related reasons being as Michael has just established, the lack of effective accommodation strategies. When these distinctions

Exploring the Barriers to Inclusion for Medical Trainees with Disabilities
Evaluating Underperforming Trainees with Disabilities
Webinar Transcript

are not made early on, the unfortunate result can be a situation that the book chapter we've included in the background resources calls the Zero Hour Disclosure. This refers to disclosure of a disability by a trainee when they discover that they are at risk of dismissal failing out of a program or not having their contract renewed.

RC: So, Zero Hour is used to describe these declarations because they often occur either during the final meeting to determine a trainees' fate in the program, or during an appeal after the dismissal decision has been made. There are two common scenarios. Many trainees may not consider that they have a disability until they encounter failure. Indeed, many times, and this is actually well-documented in medical education, symptoms of a disability will not present until such time as the challenges that the program exceeds someone's ability to self-accommodate by finding their own workarounds. This does often happen in the transition from college to medical school. For these trainees, receiving a new diagnosis or a label of disability can be difficult, or trainees may have a preexisting disability determination. And may in fact have had accommodations in the past, but for a myriad of reasons, many of which are grounded in fear of stereotype, stigma, bias, they choose not to disclose. When a failing trainee engages in a Zero Hour declaration of disability, faculty and administrators may perceive those disclosures as contrived or manipulative. However, in retrospect, the institution may also discover that the trainee was displaying deficits consistent with the disability all along but was unaware of the disability. Or that the trainee disclosed to individual teaching faculty rather than through the prescribed channels of disclosure. The program may also come to realize that non-disclosure was driven by gaps in the way they communicate disability accommodation processes to their trainees.

RC: During medical school or any other sort of degree program, Zero Hour disclosures often occur as part of the promotions committee process whereby a trainee discloses a disability and attributes poor performance to this fact. This begs the question, what is the role of the promotions committee when confronted with a Zero Hour disclosure? Here, we highly recommend that promotions committees avoid the following three pitfalls. The first is armchair diagnosis. This is a particular risk for committees composed largely of clinicians, because our first instinct, when someone for whom we have professional responsibility presents a problem is to diagnose them. In a more general sense and related to the armchair diagnosis, allowing empathy to guide decision making, diverts the committee from its responsibility to ensure that all graduates achieve all of their program's competencies. Then there's the tendency to predict the trainee's ability to complete the program. The prognosis that they go along with the diagnosis. Committee members must recognize that they themselves may hold implicit biases about the potential for a student with disability to successfully complete the program. So, we'll now go on to describe the committee's and the program's responsibilities to trainees in a variety of circumstances. But for the moment, the take home point is that a promotions committee must focus on the trainee's performance in the program. It is not the responsibility, nor is it appropriate under law, for the promotions committee to make a determination of disability, to act under the supposition that the trainee has a disability or to suggest accommodations.

RC: So, then what are the program's responsibilities? The program's responsibilities to provide accommodation only begin once the trainee discloses and requests accommodation. The case of Chenari versus George Washington University in 2017 describes the outcome of a Zero Hour disclosure of ADHD by a medical student. The court granted summary judgment in favor of the university in this case, because the school twice offered Chenari counseling and therapy, despite the fact that he had never requested accommodations. The court cited the efforts of the university to inform students of their right

Exploring the Barriers to Inclusion for Medical Trainees with Disabilities
Evaluating Underperforming Trainees with Disabilities
Webinar Transcript

to accommodations, in keeping with best practices for disability inclusion in the health sciences, specifically through the following actions. The disability resource professional for the university addressed all first-year students and informed them that if they have a disability and need to request an accommodation it's the student's responsibility to go to their office and pursue it. The program also included disability-related information in the first-year survival guide for medical students. And the office of disability support services maintained a website that walks students through the process for obtaining reasonable accommodation, including specifically ADHD. So, the court noted that Chenari never followed the established procedures for requesting accommodations, and also noted that the university's proactive and transparent measures were part of their decision. And they granted summary judgment for the school. The court stated that the Rehabilitation Act requires nothing more than that from the university.

RC: Next, we have the case of Doe versus Board of Regents of the University of Nebraska, which also helps illustrate the impact of the Zero Hour disclosure. Here a medical student was dismissed for academic deficiencies. He first disclosed his diagnosis of depressive disorder during his appeal of the dismissal claiming he had not understood his rights under the ADA. The Supreme Court of Nebraska held that the university was not required to consider his late disclosure as the ADA does not require "clairvoyance" on the part of schools. The court noted in particular that when a university provides designated channels for reporting a disability in requesting accommodations, the school cannot be held liable when the trainee fails to avail himself of those channels. And thirdly and finally, in terms of the illustrations we'll give here, in Zimmeck versus Marshall University Board of Governors, the plaintiff medical student did not disclose her depression and request accommodations until after she'd been warned several times and then dismissed for unprofessional conduct. The court found for the university, holding that the ADA does not require a school to reconsider or excuse performance that is only later claimed to be due to a disability. So, you're likely starting to understand why transparency of the process is critical to demonstrating that the program met its legal obligation to inform the trainee. In these three cases however, the trainees did not disclose until forced to do so under threat of dismissal.

RC: So, in this context, perhaps the most important issue is to ask why these trainees felt they could not disclose or request accommodations. Programs should consider the possibility that they're messaging, whether it's overt or covert, may suggest that the program is not open to disabled trainees or that they may face bias within the system. When this happens, the trainee may be fearful of disclosing their disability. Programs should evaluate all the messaging on websites and various documentations of policies to make sure they're not perpetuating an issue of nondisclosure. You can reference the first webinar and the 2018 AAMC report on disability for more guidance on appropriate messaging. These cases are important then for a few reasons. One of which is to illustrate that the failure to intervene early, as we've been describing earlier in the presentation may have adverse consequences for the institution and also for the trainee. Medical training moves at an unforgiving speed. An undiagnosed disability may quickly lead to trainee underperformance. Many programs have mechanisms in place for early detection of when a trainee is struggling and offer screening for learning disabilities or mental health issues with their mental health disability or academic support offices. When disability is likely, programs should consider temporary accommodations say for a period of six months or less, that provide a stop gap solution for trainees as they embark on the diagnostic process. Because that process may take several months from first appointment to final diagnosis and recommendations. In the absence of a safety net like this, a trainee could reasonably fail out of a program despite the ability to

Exploring the Barriers to Inclusion for Medical Trainees with Disabilities
Evaluating Underperforming Trainees with Disabilities
Webinar Transcript

perform the work had they been properly accommodated. These situations then result in a loss for the program and the profession as well as for the trainee. I'll turn it back now to Dr. Meeks.

LM: Thank you, Ray. Although there's no legal requirement for educational programs to consider a late request, there's also no legal obligation to ignore such a request in appropriate cases where information about how to disclose a disability was not readily available or when a trainee has a newly diagnosed disability. So, in reviewing cases of underperformance, serious attention should be given to whether or not the messaging and the culture around being a trainee with a disability influences the choice not to disclose. Poor messaging or misinformation even contributes to a climate that discourages disclosure and amplifies fear of bias toward disability in medicine. So once accommodations are in place standard policies for dismissing students who fail to meet competencies will apply. However, when a trainee with a disability fails or under performs and is subject to dismissal, the promotions committee may want to move this back down to the disability resource professional so they could engage in a secondary analysis **Re: Patwari** to ensure that the trainee had equal access to the curricula and whether existing accommodations were effective. So again, this is the full Patwari model. And ideally the program will engage in this diagnostic model of remediation to ensure a robust evaluation of the root cause of the failure, so that we're not dismissing trainees kind of preemptively when they could, with reasonable accommodation, fulfill the requirements and the competencies. If the secondary review or diagnostic OSCE determines that the accommodations were ineffective, the trainee, and this is important, may also still have gaps in their knowledge that would impact their trajectory through the remaining portion of the program. So, if you find that, it's important to look at the foundational work that may also need to be remediated. And when determining the best course of action regarding cases in where a trainee with a disability fails or under performs and asserts that this under performance or failure is related to disability, sometimes programs want to look and see whether this is a newly diagnosed disability, or if the person knew about their disability.

LM: So, it's reasonable to conclude that some of these questions may be helpful. One, to engage in a process, if there's a newly diagnosed and acquired disability, to engage in an interactive process to determine what accommodations may be reasonable. Also, to decide if the functional limitations of the student negatively affected their performance. So in other words, is the disability directly tethered to the performance issue? Is there a reason to conclude that reasonable accommodations would've been helpful in this case? In other words, would they have reduced the barriers to learning for the trainee? Is the level of competency and knowledge sufficient to progress in the program or does the learner have significant deficits or gaps that would cause disruption in future assessment? And if so, consider remediating. We've actually remediated students in an entire year, which I'm sure many of you have as well. And importantly, does the trainee have a plan that is reasonable, that is actionable, and is likely to end in an improvement of performance? So, all right. If there is a history of disability prior to entering the program, things get a little bit different. You want to know why the trainee did not request accommodations. Was this something to do with your environment or did the trainee not take responsibility for going through a process that was well-articulated and easily accessible? Is this a professionalism issue? Does the student have good insight and good self-regulation? Is it reasonable to conclude that the disability and functional limitations affected the trainee's performance? And is there reasonable evidence to conclude that the assigned accommodations would remove barriers to the trainee's ability to perform? And again, does the trainee have a plan that's reasonable, actionable, and likely to increase performance?

Commented [YL1]: I don't think this belongs unless she misspoke?

Exploring the Barriers to Inclusion for Medical Trainees with Disabilities
Evaluating Underperforming Trainees with Disabilities
Webinar Transcript

LM: Alright. Arguably medical training will never achieve full integration of trainees with disabilities until they commit to going beyond legal requirements and they provide clear, transparent policies about disability disclosure and request for accommodation. The legal requirement of the ADA should serve as a floor, not a ceiling. And when it comes to ensuring equal access for students with disabilities, we will have to take a far more proactive approach to change both our climates and our cultures. Alright. So, I'm going to turn it back over to Macy. And I realize I didn't have my video on, I apologize. I'm also running the PowerPoint, so I'm multitasking over here, but we are excited for your questions. And so please do use the Q&A function to ask questions.

PG: Thank you, Dr. Meeks. Just as a reminder to all of our attendees, the chat function on your Zoom screen has been enabled and we encourage you to use that to share information of best practices or to comment on any of the responses to the questions which we will now get to. The first question flows from the slide about vetted accommodations I believe. And this question simply is, does the program, whether it's UME or GME provide the funds for a sign language interpreter?

LM: Yes. So that question is actually a more nuanced answer. The easy question is yes, you will provide the funding for assigned language interpreter, but that funding should come from a centralized funding source that oversees the entire institution. So, if you're GME, it should be a hospital-based centralized funding budget line. If you are UME-based, it could be an entire university's budget line, or it could just be the entire medical school, depending on how your funding structure is set up. But yes, you are absolutely responsible for that. And I took that question because I see Michael's face and I wasn't sure if he wanted to, if that was a, "I want to answer this", face or, "I don't want to answer this", face.

MA: Yeah. I have some personal experience with that. And also, there is some other case law that gets involved with that as far as the employment level as well. And generally the answer is that the institution is responsible. It is a challenge, I know, especially when it comes to institutional politics whether the program and the institution may have the same value of having a trainee with the disability, but it is ultimately the institution's responsibility.

LM: And I might add, there's a lot of case law, some of which will be very familiar to this panel, but there's a lot of case law that backs that up. So, this is not something we're saying, even though we do think it's the right thing to do, it's also been shown just across the country to be what the courts will say is the required thing to do. And that goes for captioning as well.

PG: Thank you. This next question, I believe should go to all the panelists and it's about your experiences. Your experiences that you've had testing out accommodations for disabled trainees ahead of time. This came up during Michael's portion of the presentation and the query comes from someone who has had some difficulty doing it at their own institution. So, could you speak to your experiences in testing out accommodations ahead of time?

LM: Oh Rahul, Dr. Patwari and I think that this should be done for every student with a disability. You have learners that are coming to your environments. They've never been in medical school. They've never been in medical training, clinical spaces. They don't know what they don't know. They don't know what they need. Hopefully you have a specialized disability resource professional to help navigate those things and to help identify proactively some of the potential barriers, but you should absolutely be working side by side with your simulation folks, in your clinical labs, in your skills labs, and you should be

Exploring the Barriers to Inclusion for Medical Trainees with Disabilities
Evaluating Underperforming Trainees with Disabilities
Webinar Transcript

trying out accommodations. It is unfair to say to a learner, "Why don't you just try to go through and we'll figure it out as you're kind of going along." Because if you think about it a week in medical school is a month in anything else, and it doesn't take very long for someone to get in a deficit cycle. And so actually, it can be very harmful to a student who might require accommodations beyond that time-and-a-half to not have access to some mechanism to review what will be effective. We don't know what will be effective. Michael, Raymond, right?

RC: Yeah. So, I might take this a little further with respect to the aspect of the question that was implying that it was inequitable for the student with a disability to have this experience where others didn't. First of all, I don't think it is, personally. You're doing focused problem solving for people who need it the most, but I would also point out that this is a good opportunity, and you alluded to this Lisa, that no student or few students know coming into medical school exactly, what's going to be required of them as they hit the clinical rotations, even if they've got some sort of shadowing experience or the like. So, returning back to the earlier webinar and talking a little bit about technical standards and the like, this is why many schools and in fact, it's now the expectation that the expectations, the technical standards be reintroduced to students at various points along the way especially before you start the clerkship years because a student that may have no barriers in the largely classroom-based portion of the curriculum may for example, have some limitations to their stamina or something that as they begin to realize what's required in terms of time on your feet in the clinical clerkships. They may in fact be looking at what's required there and say, "Wait a minute, I need to approach the disability services offices about accommodation." So, in a way, what we're talking about when we're talking about providing the simulation experience or any other kind of informational guidance, it's something that really should be thought of for the entire class and becomes one other use of the universal design concept, right? It's something that every student faces and when a student has a defined disability that may need to be further evaluated before they come to clerkships, we should do it.

MA: I want to also add to this and kind of come back to something that Dr. Meeks and I strongly believe in and that the best practice is to have with disability specialists either at the institution, or like as a consultant, because this is exactly ties into what Ray is talking about that people coming in, not knowing what they can do or what kind of accommodation might make sense or how the clinical environment is going to impact their abilities in a new way. And so, the disability specialist, if that person that can kind of go, well, let's take a step back and kind of objectively look at this and bring in information that, even I, or the person with the disability, I don't know anything about accommodating people with vision deficits or with mobility deficits in the clinical sphere, and I don't think that's necessarily my responsibility. What is my responsibility is to figure out how to get that person resources, whatever those are. So that's what we support.

LM: Yeah. And I want to point out that the Patwari article is written about an actual case. And in that case, the finding was actually that it wasn't disability, that the deficit wasn't disability-related that it was a fund of knowledge issue. And the student was given the opportunity to withdraw or find another program. And in that scenario, there was a disability specialist for the institution, Marie Lusk, and myself and Rahul Patwari. And within minutes of setting this up, you instantly knew what was happening. It's almost like the ability to isolate everything else and focus on the particular competency or skill in a controlled setting, allowed you to quickly identify what was needed. There were some disability-related accommodations that were needed, but we could instantly employ those and retest. It was like being in an innovation lab, trying to figure out what would work, what would remove the barrier. At the end of

Exploring the Barriers to Inclusion for Medical Trainees with Disabilities
Evaluating Underperforming Trainees with Disabilities
Webinar Transcript

the day, doing this, like what you said, Michael, that it's not only the right thing to do, but it builds trust. And at the end of the day, I would say that this learner felt really, really supported and felt supported in their exit from the program and reentry into another type of health science career. One that was more suited for the learner. But this, the thing I love the most about this case is it's not this case about this triumph, which we have these, and we need them, and they're wonderful, but it was actually a case where at the end of the day, it just wasn't a good fit. There were a lot of deficits that had nothing to do with disability. And so, I really believe in this system that was created and encourage people to use it. And again, Michael and I, and I'm sure, Ray as well, can all attest to the \$150 it takes to use the time in the SIM lab is nothing in comparison to the \$200,000 debt that you get a learner in when they're in third year and they're struggling, or if you have to support litigation or response to litigation. So, I just really encourage people to take a look at that article and take a look at that system.

Peter Goodwin: Thank you.

MA: If I could add one more thing just ever so briefly. I had the opposite experience of what Patwari is describing, so I had an experience where we did not really have a clear, trustworthy or iterative process. And so, I ended up having a really difficult time with my medical education, because I kept trying to say that I needed further accommodations that weren't supported. And so that really eroded my trust in all of my medical training from that point on which I have slowly rebuilt during a much more iterative and supportive environment during residency and fellowship. But it really, from a trainee's perspective, it really is necessary.

LM: And I'm going to hype... We keep building on this but I'm going to hype Dr. Curry's new technical standards for UIC for a moment because they're the only technical standards that I'm aware of. In fact, I remember when I was reviewing them, and I think I was pretty giddy in my response. They're the only technical standards I'm aware of that distinctly call out that this process is not only interactive, but it is iterative. And that is something I have not seen in any other set of technical standards. And it states very boldly that we're not going to stop. If we don't find something that's effective, we're going to continue the process. So just a little shout out for the new, I don't know if they're up yet Dr. Curry but...

RC: They are.

LM: Okay.

RC: medicine.uic.edu.

PG: Thank you. We are approaching the top of the hour, so I'm afraid we'll only have time for one final question before we wrap up. An attendee asks, what would be some practices for students who have not been diagnosed until later in their UME medical education and now have a record of poor past performances on their transcripts, which occurred prior to the diagnosis? Thoughts?

LM: Yeah.

RC: I suppose having seen a lot of medical student performance evaluations involved in a lot of residency applications, I'm front and center for this one. I would equate that to probably any other sort of circumstance where someone has a gap in their record or leave of absence for some reason, or

Exploring the Barriers to Inclusion for Medical Trainees with Disabilities
Evaluating Underperforming Trainees with Disabilities
Webinar Transcript

something else that might raise questions in the minds of interviewers and the like. And I think it's very common then for the trainee, for the applicant to just simply be prepared to explain what was happening during that time. Now, granted that as I'm saying that, that implies that we're forcing disclosure, which is something we don't routinely want to do, but they would certainly have that option. It is true though, I think you bring up a real dilemma because as we've been saying throughout the webinar, one can't retroactively change student's performance assessment once the disability is identified and accommodated. But I think that's really where they are left at that point in time. Lisa, if you want to say something.

LM: Yeah, I would. So, I think we have this thing we're completely in sync because I went straight to the MSPE as well. I think the big thing is triangulating the story. So, in these cases, many learners will lean in and be open about the struggle, whatever that particular thing was. Again, you're not required to do that, but many people find and identify a strength within them at the same time that they're diagnosed with what we would say is a disability. And they see the beauty and the strength and the possibility in that. And they change the narrative, right? In their individual responses to residency application. And I think it's that triangulation of having the MSPE confirm the same story that the learner is giving and to have the other letters of recommendation, also speak to that same narrative of, "Yes, this learner struggled. We identified the root cause, as my goal is pointing out, of the issue. We accommodated that. The learner is obviously more than capable of graduating from our program, meets all the competencies. And here are all of the things that are wonderful about this particular learner. And here's the way that disability is going to bring strength to their practice in medicine and in informing medical education, medical training, and patient care in general." So, I think really using it, if the learner's comfortable, really leaning into it, I find that the truth is always the best approach to everything. That's just my personal approach. But again, I think that it is the confirmation of that same narrative in all of the pieces that are going to the residency program. And many of my learners, my previous learners, now colleagues, I'm so excited to call them colleagues, said I think with a lot of conviction, I don't want to train in a space that doesn't want me. I have a lot to offer. I bring a lot to that space, and I want to be authentic. And if a place doesn't want me, that's fine. That's not a place for me to train.

HH: Lisa, I think that is a wonderful characterization of a very healthy response on the part of a student about to be a resident in terms of really trying to find the best fit. And one of the things that we spoke about in our first webinar, and we'll likely return to in our third webinar, is the importance of the counseling and guidance for which type of residency might be best. And I think that goes without saying, based on the comments that Ray made and that you made, Lisa that along with trying to explain this transcript, which is very real for all the reasons you outlined, identifying not only the skills of the trainee, but what kind of residency, what kind of specialty is very, very important in terms of counseling and that topic could occupy an entire webinar. I do need to wrap things up for today though. And first of all, acknowledge that there are several terrific questions in the Q&A that we're not able to get to today, but I think we will have a chance to perhaps get to some of these in the third webinar coming up on July 26th. So, if you have not yet signed up for that or registered for it, just a reminder that on July 26th at three o'clock Eastern Time, we will have the third in a three-part webinar series where we will have three physicians join us, who, as I said earlier, have navigated the medical education and training system and are today practicing physicians.

HH: I also want to remind everyone that today's webinar will be posted on the Macy website next week. The full recording with a list of resources will be available on our website. So, I encourage you to take a

Exploring the Barriers to Inclusion for Medical Trainees with Disabilities
Evaluating Underperforming Trainees with Disabilities
Webinar Transcript

look there. And most importantly, I really want to thank today's panelists. They have an incredible wealth of personal and professional experience that I think we all learned from. And I know I myself learn every time I'm in their presence. So, a big thanks to all three of today's panelists. Peter, back to you.

PG: Thank you, Holly. This concludes today's webinar. I thank all of the attendees for joining us today and our panelists, and please have a good day.