

**Review of the Medical Leave and Hospitalization Policies  
Massachusetts Institute of Technology  
Fall 2016**

**Summary and History**

During the summer of 2016, Chancellor Cynthia Barnhart and Medical Director Cecilia Stuopis formed an ad hoc committee of faculty, students, and staff to review MIT's policies on hospitalization and medical leave for both undergraduate as well as graduate students. This work proceeds from the Committee on Academic Performance's review of the leave and return policies for undergraduates, which led to substantial and positive changes within the Institute, including the creation of a new category of leave. In that report, the CAP called for a deeper investigation into MIT's policies on hospitalization and medical leave because the MIT community expressed fears that current practice seemed to be a disincentive to seeking care. A committee was formed to fulfill this recommendation during the 2016 summer, and members were chosen for their knowledge and connection to the issues.

The committee was comprised of four faculty members (including, a former member of the CAP<sup>1</sup>, a head of house, and ethicist), two undergraduate students (including a member of the Undergraduate Association), two graduate students (including a member of MIT's EMS and the former president of Warehouse Residence Hall), and administrators who oversee current processes or are involved with medical leaves (Dean of Graduate Education's office (ODGE), Dean of Student Life's (DSL) office including Disability Services, General Counsel, and MIT Mental Health & Counseling).<sup>2</sup> After the formation of the committee, they reviewed current MIT policies, read the CAP's report on Leaves and Returns, and reviewed the student survey and meeting notes from the CAP's process. The Committee wanted to ensure that those who wished to contribute further information, in addition to the stakeholder meetings and surveys conducted by the CAP, would have another opportunity to do so. They, therefore, released a survey to the entire MIT community, held two open forums for students (one for undergraduate and one for graduate students), committee members reached out for feedback from faculty members, deans, and student groups (each committee member individually reached out to at least three different MIT groups), and met as a group seven times to review current policies and make recommendations for change.

The Committee quickly realized that while that the questions and issues surrounding hospitalization and medical leave had no easy solutions, those responsible for the current policies and their execution are professional and thoughtful. MIT has many devoted and knowledgeable people who provide support to MIT students through very difficult times; the quality of MIT's support staff is consistently very high. Many individuals and groups on campus are already

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<sup>1</sup> Report can be found here:  
<http://web.mit.edu/faculty/reports/CAP%20Report%20re%20Undergraduate%20Withdrawal%20and%20Readmission%20Practices%202015-2016.pdf>

<sup>2</sup> Please see appendix, p. 13, for full Committee roster.

committed to, and engaged in, improving support services for students. Indeed, many of the concerns described to the committee are already being addressed.<sup>3</sup>

We further note that health crises, by definition, are unpleasant and stressful experiences. Institutional policies and practices can make a real difference, but cannot make the experience completely ideal. Many aspects of the stressful nature of the process are outside of the Institutes' purview or control. The care received in a hospital for example, may be stressful or unpleasant, but cannot be changed by MIT.

Despite the facts that the Committee was not able to reach all students who have been through hospitalization, and the feedback we received was likely not representative of everyone's experiences, we did hear a wide range of concerns from students and the community regarding both the process and policies around hospitalization and involuntary medical leave at MIT. These issues warrant clear action and solutions. In particular, we aim to increase students' trust in support services, reduce their fear and suspicion, create a climate in which students who need help are most likely and able to seek it, and to improve students' experience even in these difficult circumstances.

Over the years, well-intended policies were created to handle specific situations, but suffered from inconsistent implementation due to their bottom-up evolution. Policies had unintended consequences, which eventually led to a sense that students avoided seeking treatment because they feared the system in place. During the Committee's work, we discovered that ours was the first official review of MIT's hospitalization and medical leave policies.

MIT's involuntary leave policy was first conceived in early 2000 and became official policy in 2010. While the truth is that only one student has ever been put on involuntary medical leave, the threat of it has led even the voluntary medical leave, according to the survey and focus groups, to feel coercive. The committee discussed at length the need to transform policies, practices, and procedures to ensure that students feel confident in seeking care. This report will examine at length the recommendations the Committee has debated during the fall semester. These are a few of the most pertinent recommendations:

1. The creation of a clear and transparent resource (i.e. handbook, roadmap) with information about the process of hospitalization for mental health treatment.
2. A more personal and humane response to students in crisis, including the new Coordination Assistance and Response Team (CARE) team<sup>4</sup> but also extending to changes in police wellness checks, in-person mental health evaluations, and choice of transport to hospital.

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<sup>3</sup> Since the release of the CAP report, the process for leaves and returns has been transformed, leading to an even higher percentage of students being granted return after a leave. There have been major changes to the administrative processes of leaves and returns. One example of change has been the increased efforts to publicize the numbers of students taking leave, rates of return, and the measure of academic success among students returning from leave.

<sup>4</sup> The CARE Team (Coordination, Assistance, and Response) is a team of three staff who support undergraduate and graduate students through difficult times they may experience while at MIT. One thing the CARE Team does is support students during hospitalizations, discharge, and with follow up care.

3. A new "Medical Leave and Return policy" that includes only one category of Medical Leave, and faster and simpler return from Medical Leave, thus simplifying the procedures for students.

### **Charge to the Committee from the Chancellor and Director of MIT Medical**

The specific charge to the committee is as follows:

As you are aware, Chancellor Barnhart charged the Committee on Academic Performance to review the withdrawal and readmission policies for undergraduates. Among other recommendations, their work led them to recommend to MIT Medical and the Chancellor's Office a further review of MIT's medical leave and hospitalization policies and procedures.

While MIT has policies and procedures for involuntary medical leave for both undergraduate ([http://web.mit.edu/uaap/s3/leaves/med\\_policy.html](http://web.mit.edu/uaap/s3/leaves/med_policy.html)) and graduate (<http://odge.mit.edu/gpp/registration/changes/medical-leave-procedure/>) students, they are intended to be used only as a last resort. The CAP learned, however, that the specter of an involuntary medical leave creates anxiety in many students. As this is a clear and pressing issue for the community at large, we, MIT Medical Director Cecilia Stuopis and Chancellor Cynthia Barnhart, have worked to identify a direct charge and establish a committee to review our practices. Specifically, we are asking the committee to address the below issues and present their recommendations and findings this academic year:

- 1) Do the current involuntary medical leave (and the broader medical leave) policies adequately express the approach that MIT should follow for students who present a danger to themselves, to others, or who otherwise are not able to participate in campus life due to mental or physical health issues? If not, how should they be revised?
- 2) Are the procedures set by MIT for the implementation of the policies, including procedures for returning from a leave, adequate? Are they clear? If not, how should the procedures be revised?

In addition, every year MIT students (undergraduate and graduate) are hospitalized for mental health-related concerns. Even in the best of circumstances, these hospitalizations disrupt the students' lives and academic performances. Moreover, they affect the students' friends and community. The ramifications of each hospitalization raise questions that should be addressed by the committee:

- 1) While recognizing that the decisions to hospitalize and release a student from the hospital are medical decisions, what practices should the Institute implement to minimize uncertainty, fear, and distrust surrounding the process of such hospitalizations? Related questions the committee may wish to consider include:
  - a. What are and should be the privacy and confidentiality policies, including sharing of information with parents, by MIT support and mental health services up to and including hospitalization?

- b. How do we communicate the process of evaluating a student's readiness to return from a hospitalization?
  - c. What procedures are in place to ensure that students who are hospitalized feel that they have agency in the hospitalization, discharge decision, and aftercare plan?
- 2) What procedures are in place, or should be in place, to ensure that students who are hospitalized are supported by MIT?
- a. What measures are or should be taken to address needs of a student that arise due to the hospitalization?
  - b. How does MIT facilitate the transition out of the hospital and back to MIT (or home)?
  - c. What procedures are in place to ensure that the concerns of the hospitalized students' friends and community members are addressed?

### Issues of Concern

The MIT community, including students, faculty, and staff, reported consistent concerns throughout the review. In this section, we will outline the major concerns raised in the following categories.

- A. Psychiatric Hospitalization
- B. Involuntary Medical Leave
- C. Broader Medical Leave Policies
- D. Trust and Care Seeking

#### A. Psychiatric Hospitalization

We have clearly heard that **the process of psychiatric hospitalization can feel opaque and unpredictable**. It is difficult to find answers to questions about the process. Once a student is hospitalized, these feelings of confusion are exacerbated by the multitude of interactions at MIT, Massachusetts General Hospital's psychiatric emergency room, and ultimately McLean or another local hospital. Each of these organizations have different administrative structures and policies, resulting in conflicting information being given to a student in crisis.

It is no surprise then, that **the process of hospitalization can feel disempowering**. If a student does not begin the process of hospitalization in the physical location of MIT Medical or through self-transport, then the standard procedure for the arrival of an ambulance also brings the police. The arrival of uniformed police to conduct wellness checks and transfer students to the ambulance are both disruptive to living communities, as well as unnerving to the student seeking help. This is further exacerbated by what the Committee heard was the standard practice of local Massachusetts ambulances (with the notable exception of the MIT EMS), which require the use

of a “section 12,”<sup>5</sup> declaring that the student is being transported or admitted involuntarily, even for students voluntarily seeking treatment.

**The process of making decisions about whether a student needs hospital level care can feel impersonal.** During hours when there are no clinicians on campus, decisions to send students to the emergency room are often made without in-person contact with an MIT clinician. Although the Committee is not questioning the clinical judgement, we questioned if this procedure could be improved upon to reduce the experience of confusion and disempowerment. Moreover, when students wish to ask for help or advocacy there is a lack of clarity about whom they should approach with questions, concerns or complaints about the process.

**While in hospital, students report feeling abandoned by MIT.** Students who had been hospitalized had no consistent method to gain access to belongings, classwork, friends, contact professors, arrange to make up for missed work etc. Transitioning back to campus and schoolwork can also feel burdensome; students want help to streamline the process.

Students told the committee that **the decision-making process regarding the hospital discharge is unclear.** Specifically, some students felt that after they were cleared for discharge from the hospital, they were still required to remain hospitalized until they received a second level of clearance from an MIT Medical clinician. While there is no official requirement for a second clearance by MIT Medical for discharge from the hospital, there is often a second clearance for return to campus. This is confusing for students, and creates a situation wherein seeking care adds additional procedural burdens.

When the committee spoke to the Heads of House, we heard consistently that **hospitalization and return put stress on the community as a whole, but especially on the house team.** House teams need to be prepared and well informed to help students reintegrate upon return, and voiced frustration at poor communication. They also expressed concern for the rest of their community; other members of the affected student’s communities report feeling stressed by a student’s sudden disappearance, especially when it is preceded by police presence. Amongst the various feedback we received from the community, there was some confusion and discomfort about the training for GRTs on how to respond during a mental health crisis.

## B. Involuntary Medical Leave

While MIT has only employed involuntary medical leave once, **students report feeling coerced into a “voluntary” medical leave.** Students and some staff reported that the notion of an involuntary medical leave is used as a threat to pressure students to take a “voluntary” leave. Thus, even though “involuntary medical leave” has only been used once, its presence looms large in the community, and discourages students from seeking treatment. Moreover, **the current criteria<sup>6</sup> for involuntary medical leave are too vague and too broad:** the policy

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<sup>5</sup> M.G.L. ch.123 §12; allows emergency restraint and hospitalization of persons posing a risk of serious harm by reason of mental illness. Moreover, see link for protocols: <http://www.mass.gov/eohhs/docs/dph/emergency-services/treatment-protocols-2016.pdf>. It is the committee’s understanding that other ambulances require the section 12 document as a matter of business practice.

<sup>6</sup> MIT has two policies in place for Involuntary Medical Leave, one for graduate and one for undergraduate students.

would be employed if "it is established that a student is unable to participate in campus life, including but not limited to, an inability to complete or make satisfactory progress towards academic requirements." As the policy currently reads, it would apply to a large number of students. In addition to concerns about being forced into a leave, **the consequences of being on involuntary medical leave are unclear**. Students perceived that involuntary medical leave is of greater duration, or involves different or higher bars for return, compared to voluntary medical leave.

### C. Broader Medical Leave Policies

Throughout our process, we learned that **medical leave for graduate students raises specific issues, and that the prior work done by the CAP in the Leave and Return Review solely addressed undergraduate leaves**. While many positive changes resulted from the undergraduate review, these did not apply to graduate students and it is clear the issues for graduate students differ. For example, the semester-based timing for leave and return may not make sense for advanced graduate students who are mainly conducting research in labs. Graduate students are also more likely to have dependents, including children, who are adversely affected by medical leave. Graduate students who have advanced to the research stage of their work have told the committee about their concerns in regards to their research advisors. The graduate advisor may have a conflict of interest, such as time sensitive funds for researchers, so these should be understood when input is sought in decisions about medical leave for graduate students. Indeed, the CAP was in agreement with the current committee, as they recommended that "the Dean for Graduate Education sponsor a review of [leaves and returns] as they relate to graduate education at MIT."

**Medical leave for international students similarly raises unique issues**. For example, students may lose their visa status if they take a medical leave. There are also concerns that they may be less likely to find and receive quality treatment in their home countries.

While graduate and international students' have special concerns, **the role of MIT Medical in return from leave remains unclear for all student populations**. Students reported feeling uncertain about the role of MIT Medical clinicians in their return from medical leave. Clearance

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The graduate student policy: <https://odge.mit.edu/gpp/registration/changes/medical-leave-policy/>. The pertinent sentence reads, "A student will be placed on involuntary medical leave when a decision is made by ODGE in concert with MIT Medical that, due to mental or physical health reasons: A student poses a significant risk to the health or safety of self or others; and/or it is established that a student is unable to participate in campus life, including but not limited to, an inability to complete or make satisfactory progress towards academic requirements."

The undergraduate student policy: <https://studentlife.mit.edu/s3/requesting-leave/undergraduate-medical-leave-policy>. The pertinent sentence reads, "A student will be placed on involuntary medical leave when a decision is made that due to mental or physical health reasons, a student poses a significant risk to the health or safety of self or others and/or it is established that a student is unable to participate in campus life, including but not limited to, an inability to complete or make satisfactory progress towards academic requirements. In addition, a student may be placed on involuntarily leave for medical reasons if a student does not cooperate with efforts deemed necessary by the Institute to determine if the student poses a significant risk to the health or safety of self or others."

to return is provided by MIT Medical, by reviewing information from the student's physician and in some cases by speaking to the student and/or clinician. Students felt uncertain if the clinical opinion was a criterion for return to campus, if private medical information was shared with the CAP or the ODGE, and if an appointment with MIT Medical clinicians was for the purpose of continuity of care or for providing input to CAP or ODGE's return decision.

#### D. Trust and care seeking

The Committee universally heard that there were **concerns that the hospitalization and leave processes could act as a disincentive to care seeking**. Specifically, students were afraid of being coerced into care they did not want (e.g. into involuntary hospitalization), and/or of having their privacy violated (e.g. by having sensitive medical information shared without their consent). In particular, students feared that information about mental health conditions or treatment was shared by MIT Mental Health & Counseling with CAP, Dean for Student Life, ODGE, and others, during decisions about discharge, return to campus, and return from leave. These fears were cited by some students as reasons to avoid seeking help (e.g. as reasons to avoid going to MIT Medical) or to avoid honest communication with MIT associated care providers.

### Recommendations

#### 1. Communication about the hospitalization process is key

The Committee clearly saw a need for better and more robust information for students who are hospitalized, as well as for the MIT community who might support such students. The Institute, led by MIT Medical, should develop and provide a clear resource for students considering or undergoing hospitalization for mental health treatment. The committee considered making this guide available in the form of a handbook, a map, a set of FAQs, or all of the above. One model of effective communication that MIT should review in developing our own resources is Princeton's FAQ about hospitalization.<sup>7</sup> This resource should further be maintained and overseen by a specific service group (possibly MIT Mental Health & Counseling and/or the CARE Team), so that there is accountability and ownership, and to ensure that it remains up to date. The resource should:

- be easily accessible by internet;
- be linked from the pages of multiple different service groups (e.g. Mental Health & Counseling, CAP, Student Support Services, Graduate Personal Support, and Student Disability Services);
- be reviewed by students (and other participants in the process) after hospitalization, on an ongoing basis, to ensure it accurately reflects their experience;
- include a contact person or group, for students with further questions;
- and cover questions including: What symptoms merit hospitalization? Who will make the decision? Who will transport me? Where will I go? How long will it take? When do

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<sup>7</sup> <https://www.princeton.edu/odus/services/well-being/FAQs-Jan-2017.pdf>

miscommunications and confusions arise? If I change my mind, can I leave? What is section 12? What is the difference between voluntary and involuntary hospitalization? Which hospital will I end up at? How long will I be in hospital? Who decides when I am ready to leave? With whom will information regarding my hospitalization be shared and how much control do I have over who is privy to it? What will happen with my schoolwork?

Similar to the recommendation in the CAP report, to combat the impression that students who seek treatment are often coerced to leave, we recommend greater publicity about the statistics of students hospitalized, on medical leave, returning from medical leave, and successfully graduating. This should be readily available and updated annually.

We further recommend that consideration should be given to reimagining the mental health liaison program<sup>8</sup>, which Heads of House have reported to be only variably effective, to foster stronger communication links between Mental Health & Counseling and the residential communities. Possible changes include:

- more clinician face-time in the dorms and FSILGs,
- evening drop-in sessions,
- and greater collaboration between clinicians and house teams.

## 2. The response to a student in crisis, on or off campus, needs to be personal and humane

We heard consistently from students who had been transported to the hospital from their living groups, as well as from Heads of House and their teams, that the process of transport is traumatic for the student in crisis and the community. When Emergency Medical Services (EMS) is called, uniformed police officers always accompany them, which is unnerving for students seeking medical assistance. As this is a standard procedure for all emergency calls, we recommend:

- MIT Police officers responding to a mental health crisis should have special training for such situations. We recommend an emphasis on reducing stress (possibly by having the responders be non-uniformed). MIT should consider implementing a focused training program to prepare first responders to deal with mental health crises. One example for consideration is the Crisis Intervention Team (CIT) model<sup>9</sup> for community policing, which is used by other university and municipal police services. CIT programs enhance communication, identify mental health resources for assisting people in crisis and ensure that officers get the training and support that they need.
- For students being hospitalized voluntarily, when possible, preference should be given for transport that does not require a declaration of involuntary hospitalization ("section 12") when the student is being transported willingly. Specifically, our committee understands that the MIT EMS does not require a "section 12" declaration for voluntary transport to hospital, whereas we hear other ambulance services often do. If so, MIT

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<sup>8</sup> This program pairs mental health clinicians with a living group to be a familiar face, source of information, and direct contact for referrals and consultation.

<sup>9</sup> <http://www.nami.org/Law-Enforcement-and-Mental-Health/What-Is-CIT> and <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3769782/>



medical clinicians and affected students should be aware of this difference between the MIT ambulance and third party transport services.

To reduce the trauma around emergency transport, and to provide more personal care:

- It would be beneficial to have a MIT mental health clinician available to see students in-person 24/7 by broadening their existing on-call coverage. The committee recognizes the challenges inherent in this recommendation: the medical building is closed 11pm-7am, and in-person appointments during those hours are not typically provided by community clinicians. Still, the committee recommends that MIT evaluate options for ensuring a face-to-face meeting prior to hospitalization. These options might include (i) offering incentives to clinicians who provide overnight call, such as subsidized on or near campus housing; (ii) cooperating with other area universities or clinics to jointly support an overnight call; (iii) arranging face-to-face meetings with a dean on call or student support professional; and/or (iv) improving video-conferencing capacities.
- Students should further be encouraged to involve a trusted loved one or support resource from the beginning of the process. If students have chosen a support person (with that person's consent), that support person should be included as much as possible in discussion of support plans for the student, to increase transparency and coordination.
- Parents should be contacted only under three circumstances: with the student's consent, in serious emergencies (e.g. possible death), or as otherwise required by law.

### 3. Students in the hospital need a warm, available, and consistent point of contact

As follows from the previous set of recommendations, the process of hospitalization should be as humane and personal as possible. In addition to revising practices for transport, it is similarly important to ensure that hospitalized students have access to information and personal needs are met.

- The Committee is very pleased to recognize the new CARE Team within DSL, who is responsible for improving the experience of students during hospitalizations and the return to campus. The CARE Team's role is to provide a clear and consistent point of contact for students, to reduce the confusion, miscommunication, and disempowerment experienced by students in the past. The CARE Team also works with the residential life teams to reduce the stress on the community, and help support the communities and reintegrate students.
- Because trust between the students and the CARE Team is the foundation for successful outcomes, the CARE Team should ask for students' permission before sharing any sensitive medical information (e.g. about hospitalization or treatment plans) with anyone including residential life teams.
- The CARE Team should focus on empowering students, and helping them to retain agency even in difficult situations. For example, one stressful issue for students is uncertainty about the spread of information during an emergency; after the acute crisis has passed, the CARE Team should help the student get back in control of choosing whom to inform or involve in their support.

- The CARE Team may need additional resources to be sure that there is sufficient and personalized support for both undergraduate and graduate students. The resources of the CARE Team should be reviewed after two years.

#### 4. All admitted students, even hospitalized students, are a part of our community

- We reiterate the statement from CAP Report that all admitted students are a part of our community, including those in hospital or on medical leave.
- Students expressed the perception that few students return to campus after hospitalization. The Institute should address this misperception, by making clear that most hospitalized students (80-90% in recent years) do return to campus, and those that do not choose to take time away from the Institute. The Institute expects almost all students who wish to return to campus to do so. Ideally, from the outset, the hospital and MIT Medical should work in collaboration with each other and the student to plan for treatment and next steps after discharge. This way, when the discharge date approaches, everyone is aware of the procedure. As such, students should not be required to remain hospitalized once their attending clinician has deemed them appropriate for discharge. The criteria for access to MIT resources (e.g. living in dorms, working in labs) should remain the same for students before and after hospitalization. If a student is discharged from hospital, but does not meet the criteria for returning to their dorm (for example because of ongoing behavioral issues), MIT should help to find an alternative place to stay temporarily.
- MIT should consider developing a step-down/step-up/respice resource. Specifically, a small number of rooms near MIT Medical that are available for students (at the student's request) to stay overnight for a few days, providing easier access to the MIT Medical clinic. This could be used for students who need to be close to MIT Medical because of mobility limitations (e.g. after surgery) or who need additional support away from a living situation (e.g. after a hospitalization).

#### 5. We must reduce the anxiety, and perception of coercion, created by our Involuntary Medical Leave Policy

The existence of involuntary leave has given even the mention of it an unintended power of coercion. As mentioned previously, students have reported that they took a medical leave because they feared being placed on involuntary leave. We recommend changes to the process to remove even the perception of coercion so that students seek the medical help they need.

- We reiterate the statement from the CAP Report, that the threat of being placed on involuntary leave should never be used to coerce students to take a voluntary medical leave.
- MIT should eliminate the existing Involuntary Medical Leave Policy, and replace it with a newly written "Medical Leave and Return Policy" that clearly states the conditions under which a medical leave would be mandated by the Institute.

- The Medical Leave Policy should clarify that medical leave is typically initiated at the request of the student. However, the Institute may consider requiring a student to take medical leave only if the student exhibits certain behaviors including:
  - Harming, threatening to harm, or seriously endangering any person, including him/herself; or
  - Repeatedly disrupting the educational, residential, and other activities of the MIT community; or
  - An unwillingness or inability to engage sufficiently in treatment while maintaining participation in life at MIT.
- The decision to mandate a medical leave should be made by a committee of senior level administrators including the Dean for Graduate Education, Dean for Undergraduate Education, and Vice President and Dean for Student Life. This committee should consult with additional resources as appropriate.
- MIT should clarify in its policy that students are only mandated to take medical leave (i) based on an individualized assessment of observable functional criteria, (ii) after other preferred approaches (e.g. reduced courseload) have been evaluated and deemed infeasible, and (iii) only with careful consideration of the student's specific circumstances. The "step-down" rooms described above may offer another approach to try before requiring "medical leave," allowing the student to remain on campus while having a break from a living situation.
- Mandating a student to take "medical leave" could have extremely negative consequences for some groups of students, including international students (e.g. loss of visa) and students with dependents (e.g. loss of childcare). MIT must be clear that these consequences will be carefully considered before a decision to require a "medical leave" is made.
- MIT should continue the practice of not explicitly recording the type of leave a student takes on the external transcript, with the exception of disciplinary leaves by Committee On Discipline (COD).
- There should be one category of medical leave. MIT should clarify that once a student is on medical leave, criteria to return to MIT are the same regardless of how the leave was initiated. That is, a student who was required to go on medical leave is still expected to return, using the same criteria and process as any other student on medical leave.
- The duration of medical leave should be flexible, and designed to meet the student's specific situation. That is, students should be on leave for the duration required to address the specific medical issue that caused the leave.
- Students should be encouraged to find someone they feel is an advocate or supporter in the process. Just as students going through a COD process are given an institutional support, students should be confident that their preferences have been represented in any discussion of requiring a medical leave.
- There must be a clear and timely process to appeal a decision to require a student to take a medical leave. We suggest such appeals be reviewed by the Chancellor.

6. Requirements for return from medical leave should be clear, and focus on addressing the cause of leave

Students have reported the requirements for return after medical leave feel punitive. As we wish students to focus on medical treatment, our requirements for return should speak only to the reason why the student left. Moreover, the process to return should be transparent and confidential.

- There should not typically be any external coursework required for undergraduates to return from medical leave. Students leaving for medical reasons should be presumed eligible to return when those medical issues have been addressed.
- The return requirements for sufficient medical treatment should be described clearly at the time of leave. MIT should make a good faith effort to ensure that these criteria can be met in the students' home state/region/country.
- The process for return should minimize the sharing of medical information, and increase transparency, using a two-step process. First, a Medical Leave Return form should be filled out by the treating home clinician and sent to MIT Medical. After asking consent from the student, this form should be reviewed MIT Medical clinician(s) to confirm that the medical issue that caused the leave has been sufficiently addressed to allow the student to return. If so, MIT Medical should send a standardized form to CAP or ODGE, recommending “return” with no additional information. Blanks of both forms should be available online for students to see (and print).
- We note that the process of determining that the medical issues have been addressed, and the student is ready to return, is a moment when communication between the student (or their home clinician) and MIT Medical clinicians is potentially confusing. The clinicians charged with this task should be especially aware of the potential for miscommunication at this stage, and therefore be careful to (i) indicate clearly and transparently when a conversation is for the purpose of evaluating readiness to return, as opposed to for arranging continuity of care; and (ii) assure students that all of the content of these conversations, regardless of their purpose, are strictly confidential.

#### 7. Follow up with the community and mechanisms for accountability

The Committee carefully reviewed MIT’s current policies, listened to the MIT community’s concerns, and deliberated recommendations to improve the process. We understand, however, that our recommendations are the first step in a longer process, and thus wish to set an expectation of on-going review and assessment.

- MIT should report back to the community on efforts to improve policies and practices around hospitalization and medical leave after two years. Students affected by hospitalization, or who take a medical leave (mandated or not) should be involved in this review process.
- All students who return from medical leave or hospitalization should be offered the opportunity to complete an anonymous survey about their experience. In particular, the survey should check whether issues of concern identified by this report are persisting despite the recommended steps to address them.
- MIT should conduct another assessment of the Medical Leave and Return Policy and hospitalization process in two years, to ensure that these changes are having their intended effects, and that students no longer feel coerced into voluntary leave. If the

current revisions do not have the intended effects, at that time MIT should consider eliminating the possibility of mandated “medical leave.”

## Appendix

### **Committee on Hospitalization and Medical Leave**

Prof. Rebecca Saxe, Co-Chair

*Brain and Cognitive Sciences*

Prof. Laura Schulz, Co-Chair

*Brain and Cognitive Sciences*

Prof. David Andrew Singer

*Political Science*

Prof. Tamar Schapiro

*Linguistics and Philosophy*

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Jaren Wilcoxson, Esq.

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*Office of the Dean for Graduate Education*

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Ms. Tamar Weseley, Student '17

Mr. Taylor Sutton, Student '17

Mr. Kyle Kotowick, Student G

Ms. Joy Louveau, Student G

Ms. Kimberly Benard, Staff to the Committee

*Office of the Dean for Undergraduate Education (UAAP)*