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## **Guidance on Medical Students' Participation in Direct In-person Patient Contact Activities**

This document updates and replaces guidance issued by the AAMC on March 17, March 23, March 30, and April 14, 2020, regarding the participation of medical students in direct in-person patient contact activities.

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**This guidance document is intended to add to, but not supersede, an academic medical center's independent judgment of the immediate needs of its patients and preparation of its students. The medical school dean has the authority and responsibility to make such decisions regarding medical students.**

**Background:** The impact of COVID-19 continues to vary widely among AAMC-member medical schools depending on location. The pandemic's impact is also fluctuating considerably over time across the United States. Since the AAMC released guidance on April 14, 2020, knowledge about SARS-CoV-2, the virus that causes COVID-19, has continued to advance daily. There has also been substantial progress in the development of therapeutic approaches to and testing for COVID-19. Challenges remain, however, in access to personal protective equipment (PPE), COVID-19 testing capacity, and implementation of contact-tracing programs. The extent of these challenges also continues to fluctuate across locales and over time.

As the nature of transmission of SARS-CoV-2 has become better understood, our medical schools and clinical teaching sites have implemented extensive policies, guidelines, and procedures to minimize the risk of COVID-19 for all individuals in these environments. However, community spread is ongoing across the country, and experts anticipate that a vaccine will not be generally available in the United States until 2021 at the earliest. In this uncertain environment, which is likely to continue for months ahead, the AAMC is releasing updated guidance regarding medical students' participation in direct patient contact activities. This guidance is based on both immediate and long-term public health needs as well as PPE needs and COVID-19 testing availability.

In our current health care system, medical students are not essential health care workers on a day-to-day basis; there is no defined set of responsibilities for which there is a "medical student" position that must be filled around the clock, 365 days a year. However, medical students are *the*

*essential, emerging physician workforce.* This guidance is based on recognition that to address ongoing national physician workforce needs, the clinical education of our medical students — including their involvement in direct patient contact activities (which may involve patients with and those without known or suspected COVID-19) — must continue, with appropriate attention to safety, in the context of the constantly evolving conditions that define the COVID-19 pandemic in the United States. Close and ongoing collaboration between medical schools and their clinical partners is particularly critical to ensure that these national workforce needs continue to be addressed.

The COVID-19 situation remains fluid and may change frequently and rapidly on a local basis. Medical schools, **with their clinical partners' knowledge and input**, should carefully evaluate their local conditions, including the extent of community spread and local mandates and directives (among other considerations), on a regular basis to make determinations about their medical students' participation in direct patient contact activities. Medical schools should also ensure regular, ongoing communication and dialogue with all their medical students (as with all other individuals working in the health care environment) about the COVID-19 situation locally and nationally. These discussions should emphasize that minimizing personal risk of SARS-CoV-2 exposure and subsequent quarantine and/or contracting COVID-19 requires individual compliance with current guidelines in all professional and educational activities, as well as in all personal activities that are not work- or school-related. In non-school-related activities, medical students have a particular opportunity to serve as role models in their communities in this regard.

### **Section I: PPE**

Medical students' PPE needs should be included in supply planning for PPE at each medical school's clinical sites. Responsibility for the provision of PPE to medical students at each clinical site should be determined prior to the start of students' arrival at the site. If availability of PPE is *not* adequate to fully meet medical student PPE needs, medical students should not be involved in any direct in-person patient care activities for which their roles require PPE, whether in the context of curricular direct patient contact activities or as volunteers to help meet critical health care workforce (HCW) needs.

### **Section II: Medical student participation in direct in-person patient contact activities as part of required clinical experiences/assessments in the MD-degree program core curriculum.**

When there is adequate PPE to fully meet medical student PPE needs, an adequate patient mix and volume for students to meet goals and objectives of required clinical experiences and assessments, and adequate faculty supervision, the AAMC suggests the following considerations regarding medical student participation in direct patient contact activities, including patients with and those without known or suspected COVID-19, as part of required clerkships or other required clinical experiences and assessments in the MD-degree program core curriculum. The AAMC recommends that medical schools ensure: (1) reasonable safeguards are in place to minimize medical students' risk of contracting COVID-19, and (2) medical student participation in the required clinical experiences and assessments aligns with the school's educational program objectives. Medical schools should also implement medical student direct patient contact

activities in alignment with the school curriculum committee's identification of those clinical experiences and assessments that can only be met through direct patient contact.

1. Medical students participating in direct patient contact activities as part of required clerkships or other required clinical experiences and assessments should be able to do so in an environment that appropriately mitigates their (a) risk of transmitting SARS-CoV-2 in the community, (b) risk of transmitting SARS-CoV-2 to patients for whom they care, and (c) personal risk of infection and illness.
  - PPE supplies should be sufficient for medical students to have consistent access to appropriate PPE for all situations in which PPE use is needed. The school should document that students have been specifically trained and assessed in PPE use and safety precautions in the context of the current COVID-19 pandemic.
  - SARS-CoV-2 PCR testing, with a reasonable turnaround time for results, should be readily available to medical students, patients, and all health care providers. Identification of individuals with COVID-19 among those tested should occur expeditiously so appropriate care and quarantining of these individuals and others with whom they had contact can be promptly initiated. Optimally, an active COVID-19 tracing program should also be in place to determine potential exposure to students and others.
  - Results of SARS-CoV-2 PCR testing among medical students and graduate medical education (GME) trainees should be closely monitored for any increase in incidence of COVID-19 among students and/or GME trainees. If the incidence is increasing, there should be an evaluation of whether students are being provided with adequate training and appropriate protective resources. Steps that could be implemented for the protection of medical students, other health care personnel, and the patients for whom they care *may include temporary suspension of medical students' participation in direct patient care activities on a site-specific basis.*
2. Medical students participating in direct patient contact activities as part of required clerkships or other required clinical experiences/assessments should be able to do so in an environment in which the patient population, teaching and supervision by faculty and residents, and administrative/staff support, are all adequate to ensure (a) medical students have sufficient opportunities to meet the goals and objectives of the required clinical experiences, and (b) the required clinical experiences and assessments occur in alignment with **all applicable LCME accreditation standards** (i.e., including those that pertain to student safety, student access to health services, and policies and procedures regarding student exposure to infectious and environmental hazards, etc. in addition to those that pertain to the curriculum *per se*).
  - Limitations in patient volume and/or clinical diversity alone may temporarily preclude meaningful medical student participation in direct patient contact activities as part of required clinical experiences at some clinical sites and/or in some disciplines.

- Availability of faculty and residents for supervision and teaching, and adequacy of administrative staff, may vary by clinical site and/or discipline and should be regularly considered within each required clinical experience. Limitations related to faculty, residents, and/or administrative staff may temporarily preclude medical students' participation in direct patient contact activities at some clinical sites and/or in some disciplines.
- In making decisions about the participation of medical students in direct patient contact activities as part of required clerkships or other required clinical experiences and assessments, medical schools should seek guidance and support from clinical sites' leadership and the GME program directors whose trainees teach and supervise their medical students.

**Section III. Medical students' voluntary (outside of the required core curriculum) participation in direct in-person patient contact activities to address local HCW needs.** (For guidance regarding participation in required curricular direct patient contact activities, refer to **Section II**, above).

If there is a critical HCW need locally, we suggest that medical schools and teaching hospitals consider the following principles and guidelines when deciding if, when, and how it is appropriate, under the purview of the medical school, to include medical students on a voluntary basis (not as part of their core required curriculum) in the HCW caring directly for patients (including patients with and those without known or suspected COVID-19).

1. Current medical students are students, not employees. Although they are on a path to becoming licensed MDs, they are not yet MDs.
2. Medical students' participation in direct care of patients *in this capacity, outside of the required core curriculum*, should be **voluntary**, not required. Schools should document with their medical students that their participation is purely voluntary for public service or humanitarian reasons only and will not be compensated. To the extent practicable, such voluntary activities should not disrupt students' continued participation in any core, ongoing learning activities. Core curriculum academic credit should not be offered to students volunteering to participate in direct care of patients in this capacity; if elective academic credit is offered, nondirect patient care opportunities for the elective academic credit should also be offered.
3. To ensure patient and student safety, students must always be appropriately supervised by faculty and other health professionals acting within their scope of practice. Schools must be clear in policies, language, and actions to consistently and genuinely convey that students' participation in this capacity is voluntary. More specifically:
  - a. Clear and consistent messaging from institutional leadership, including education and student affairs deans, is essential to ensure students do not experience any sense of social coercion to volunteer to participate in the direct clinical care of patients in this capacity.

- b. Such messaging should recognize that individual students have different personal and family situations (which may or may not be known to others) and that this is a time for students to treat their peers and colleagues with care and respect and to scrupulously respect other students' confidentiality.
4. Opportunities to volunteer in direct patient care activities in this capacity should be offered to students *only* if there is a critical HCW need for them to do so. To the extent possible, schools should align the number of student volunteers with the critical HCW need and expand the number of student volunteers and their functions only as needed. Decisions about assignments should be based on the competence of the student to take on the responsibilities involved rather than on the student's particular year in medical school; there may be responsibilities for which any medical student, regardless of their year in medical school, can be trained (e.g., checking vital signs).
5. Medical school leadership should ensure that the appropriate institutional offices (e.g., student health services, occupational health) actively participate in screening potential student volunteers, including considering (a) the responsibilities involved and (b) the student's current health status and the presence of chronic health conditions or other safety risks.
6. The medical school should ensure that student volunteers are fully trained (or retrained) for whatever specific clinical roles they are asked to assume in this capacity in the direct clinical care of patients. Such training should include safety precautions specifically in the context of COVID-19 exposure and the current COVID-19 pandemic. The school should also confirm and document that student volunteers have been informed, to the extent possible based on current knowledge, of all risks associated with the clinical care of patients during the pandemic, particularly of patients with known or suspected COVID-19, including (a) procedures for care and treatment and a definition of financial responsibility should exposure occur and (b) the effects of subsequent infectious and environmental disease or disability on future medical student learning activities and progression to graduation.
7. The medical school should review health care insurance coverage for their students to ensure that if student volunteers take on any specific clinical roles in this capacity, volunteering will not inadvertently cause the student to lose the health insurance coverage they have.
8. PPE supplies should be sufficient for medical students to have consistent access to appropriate PPE for all situations in which PPE use is needed. The school should document that students have been specifically trained and assessed in PPE use and safety precautions in the context of the current COVID-19 pandemic.
9. SARS-CoV-2 PCR testing, with a reasonable turnaround time for results, should be readily available to medical students, patients, and all health care providers. Identification of individuals with COVID-19 among those tested should occur expeditiously so appropriate care and quarantining of these individuals and others with whom they had contact can be promptly initiated.



10. Results of SARS-CoV-2 PCR testing among medical students and GME trainees should be closely monitored for any increase in incidence of COVID-19 among students and/or GME trainees. If the incidence is increasing, there should be an evaluation of whether students are being provided with adequate training and appropriate resources. Steps that could be implemented for the protection of medical students, other health care personnel, and the patients for whom they care *may include temporary suspension of medical students' participation in direct patient care activities.*

In considering this guidance document in its entirety, each medical school should determine how to best prioritize the needs of all their medical students in making decisions about student participation in direct patient contact activities. The above considerations may be helpful to schools making decisions about elective as well as required core clinical experiences. Schools should continue to refer to LCME COVID-19 guidance documents ([lcme.org/covid-19](https://www.lcme.org/covid-19)) in making decisions about appropriate approaches to the structure, content, and duration of required clerkships and other required clinical experiences in the context of their school's educational program objectives, course and clerkship learning objectives, and required clinical experiences. Schools should also continue to refer to other AAMC resources for medical schools during the COVID-19 pandemic for considerations regarding medical students' participation in volunteer and paid clinical work settings beyond the purview of their own medical schools ([aamc.org/coronavirus/medical-education](https://www.aamc.org/coronavirus/medical-education)). Given the magnitude of the COVID-19 pandemic's disruption to all aspects of life, including medical education, changes to the order of clinical experiences; a shortened duration of direct patient contact time; the expansion of alternative, nondirect patient contact clinical activities; and altered progression through the required clinical curriculum likely will continue for many students.

The AAMC will update this document, dated Aug. 14, 2020, as needed.