

# MEDICAL EDUCATION AND INDIVIDUALS WITH DISABILITIES: REVISITING POLICIES, PRACTICES, AND PROCEDURES IN LIGHT OF LESSONS LEARNED FROM LITIGATION

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## *Abstract*

*In the thirty plus years since the Americans with Disabilities Act was passed, there have been a significant number of lengthy and costly judicial disputes involving medical school admission and enrollment of individuals with disabilities. This article reviews the history of medical education and provides a description of the evolution of the educational curriculum for medical school and how it has changed in recent years. It provides the legal framework of statutory and regulatory requirements for the application of federal disability discrimination law to medical school applicants and enrolled students. A synthesis of these cases (many lasting several years from incident to resolution) sheds light on what must be done, what can be done, and what should be done by medical school policy makers and administrators in response to the admission and enrollment of individuals with disabilities. The article suggests ways that medical schools could revise their evaluation procedures and practices both at the admissions stage and during medical school. The article stresses the importance of key top medical school leadership and medical school legal counsel in ensuring that this framework is implemented. The primary audience for this article are top administrators and legal counsel in institutions that set these policies and implement them.*

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## INTRODUCTION

When section 504 of the Rehabilitation Act was enacted in 1973, almost all medical schools became subject to the mandate not to discriminate on the basis of disability and to provide reasonable accommodations because medical schools were almost all recipients of federal financial assistance from research and other grants and student loan support. It has been almost fifty years since that mandate. Over that time, medical schools and other health care institutions have struggled with the challenges of implementing the section 504 mandates and the even more comprehensive requirements of the 1990 Americans with Disabilities Act (ADA) in carrying out their educational programs.

The fact that there have been a significant number of lengthy and costly judicial disputes involving medical school admission and enrollment of individuals with disabilities is a reflection of the high stakes involved in such programming.<sup>1</sup> Medical school involves perhaps the highest stakes of all higher education programs, as described in more detail below.

This article reviews the history of medical education and provides a description of the evolution of the educational curriculum for medical school and how it has changed in recent years. It describes the admission and enrollment process and connection to licensing, and provides an overview of the accreditation and other professional entities that set the framework for medical education and licensing. The article also provides the legal framework of statutory and regulatory requirements for the application of federal disability discrimination law to medical school applicants and enrolled students, and reviews and synthesizes the lengthy litigation addressing disputes by applicants and students who have been rejected or dismissed. A synthesis of these cases (many lasting several years from incident to resolution) can shed light on what *must* be done, what *can* be done, and what *should* be done by medical school policy makers and administrators in response to the admission and enrollment of individuals with disabilities.

This is a particularly good time to do that examination because of issues that have been highlighted by the COVID epidemic and the changes in the last decade regarding approaches to medical school education. The case law synthesis will analyze what guidance there is from the judicial interpretation, and whether a framework is possible to guide decisions at the admissions stage,<sup>2</sup> at the educational

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1 The primary focus of this article is on medical school (including osteopathy). The analysis can be a framework for other health care professional programs. Additional study of other health care professional programs, particularly nursing, may well raise the same issues, but the stakes are highest in medical/osteopathy school settings. The cases discussed in this article are primarily drawn from medical school contexts, but other health care professional program judicial decisions also provide insights.

2 It considers whether medical schools (and other health care professional programs) can or should base their decisions about whether to admit a student with a known impairment/disability on whether that individual could be licensed to engage in practice. The question is about whether an existing impairment (or a potential impairment in the future) would or might prevent the licensing of the individual after completion of the program or result in an undue burden or fundamental alteration of the educational program after admission.

enrollment stage,<sup>3</sup> at the readmission stage,<sup>4</sup> and at the licensing stages<sup>5</sup> of such programs.<sup>6</sup>

Finally, the article suggests ways that medical schools could revise their evaluation procedures and practices. Revisions are needed at both the admissions stage and during the educational process in light of the lengthy and costly dispute history.

The framework will be not only on what is likely to be legally permissible (what *must* be done), but also on whether policy, practice, and procedure change should address some of these issues (to respond to what *can* be done and what *should* be done). The conclusion of the article highlights two documents that suggest a framework for professional education programs and adds the importance of key top medical school leadership and medical school legal counsel in ensuring that this framework is implemented.

This analysis and synthesis may guide policymakers in health care professional programs to make changes that not only ensure the goals of nondiscrimination and reasonable accommodation, but also patient safety, while avoiding protracted litigation that could be prevented by changes in policies, practices, and procedures. The primary audience for this article are top administrators and legal counsel in institutions that set these policies and implement them. It is written from the personal perspective of the author's having focused broadly on issues of higher education and disability since 1980 and particular focus on medical education for much of that time.

### I. Complexity and Importance of the Topic

This is a complex topic for a number of reasons. First, professional health care education is in a state of flux in terms of infusing clinical training (involving direct patient contact) earlier in the educational process. Second, the limitations of some impairments (particularly sensory impairments) can be addressed through new technology.<sup>7</sup> Third, impairments/disabilities include a wide variety of conditions—sensory (vision/hearing); mobility; substance use/abuse; HIV and other contagious and infectious diseases; learning disabilities; mental health conditions (including

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3 This analysis considers what procedures should be in place at all stages to ensure appropriate decision making about these individuals and the impact of their disabilities on their ability to function as a medical professional. In considering these procedures, how does a program ensure that individuals with disabilities are treated fairly and with consideration, while balancing the interests of patient safety and maintaining institutional standards?

4 As the cases demonstrate it is often in the third year of medical school when the student begins to show deficiencies in performance in the context of some disabilities.

5 This discussion addresses the responsibilities of institutions related to the National Board of Medical Examiners (NBME) testing process that are intertwined throughout medical education in terms of accommodating students with disabilities.

6 These stages in medical education and entry into the profession raise issues about notice before application, notice upon admission, educational programming during the academic coursework, clinical rotations, and residency placements.

7 This is an area where artificial intelligence developments can be relevant to consider because they may ease some performance requirements.

depression, bipolar disorder); neurological impairments (including seizure disorders); neuroendocrine impairments (toxic stress); neurodevelopmental impairments (including autism spectrum conditions); psychological (such as depression); and health impairments (such as chemical sensitivities)—which manifest themselves in different ways that might affect the ability to be licensed. Toxic stress can also have an impact. That term usually refers to experiences during childhood, which could continue to affect students while they are in medical school. It is also noteworthy that toxic stress is created by the medical school experience. Fourth, licensing is a critical aspect of health care professional practice, but hospital privileges,<sup>8</sup> continuing qualification, and later employment are also relevant to this discussion.<sup>9</sup> Finally, the “history of medical education [shows] that it is inextricably intertwined with healthcare delivery and broader societal norms,”<sup>10</sup> making consideration of these complex market forces a critical aspect of this analysis.

## II. Scenarios That Frame the Issue

Before providing the institutional and legal framework for the issue, it is useful to consider the types of situations that might arise. The following are only some examples but can make the review of the material in the article less abstract.

Doctors and medical students with disabilities are found in television and movies.<sup>11</sup> Stories about real individuals are also highlighted in the media.<sup>12</sup> Events occurring during COVID highlighted the need for more physicians as a result of front-line challenges during peak pandemic periods, and raised the question about the impact of current practices that exclude individuals with disabilities who could offset some of those deficiencies.

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8 Hospital privileges are increasingly becoming linked to state medical board certification.

9 For example, if a blind applicant to medical school can be denied admission because vision is determined to be an essential requirement for licensing, how does this impact a physician who becomes blind after receiving a license to practice medicine? Should it matter at what stage one becomes impaired?

10 L. Maximilian Buja, *Medical Education Today: All That Glitters Is Not Gold*, 19 BMC MED. EDUC. 110 (2019), <https://bmcmededuc.biomedcentral.com/articles/10.1186/s12909-019-1535-9>.

11 Although many of these are unrealistic portrayals, they can give a sense of what doctors do and how an impairment might impact their work. *The Good Doctor* (ABC 2017–21); *ER* (NBC 1994–09); *House* (Fox 2004–12); *Grey's Anatomy* (2005–21); *Chicago Med* (NBC 2015–21).

12 See Elana Gordon, *Doctors with Disabilities Push for Culture Change in Medicine*, NPR (Aug. 6, 2018, 5:38PM), <https://www.npr.org/sections/health-shots/2018/08/06/635414552/doctors-with-disabilities-push-for-culture-change-in-medicine>; Dhruv Khullar, *Doctors with Disabilities: Why They're Important*, N.Y. TIMES (July 11, 2017), <https://www.nytimes.com/2017/07/11/upshot/doctors-with-disabilities-why-theyre-important.html>; Jack Wolstenholm, *Empowering Doctors with Disabilities: Essential Resources in 2021*, <https://www.leveragerx.com/blog/doctors-with-disabilities/>; Tim Gilmer, *Disabled Doctors: Healing the Medical Model?*, NEW MOBILITY (Mar. 1, 2019), <https://www.newmobility.com/2019/03/disabled-doctors/>; Cheri Blauwet, *Are You My Doctor? Toward a World Where a Physician in a Wheelchair Is No Big Deal*, STAN. MED. (Spring 2018), <https://stanmed.stanford.edu/listening/time-that-doctor-with-disability-seen-ordinary.html>; Stacy Weiner, *Paving the Way for Physicians with Disabilities*, ASS'N OF AM. MED. COLLS. (Nov. 25, 2019), <https://www.aamc.org/news-insights/paving-way-physicians-disabilities>; Ace Ratcliff, *America Needs More Doctors with Disabilities*, HUFFINGTON POST (Oct. 19, 2018, 12:32 PM), [https://www.huffpost.com/entry/opinion-america-needs-more-doctors-with-disabilities\\_n\\_5bc9e59de4b055bc947feebd](https://www.huffpost.com/entry/opinion-america-needs-more-doctors-with-disabilities_n_5bc9e59de4b055bc947feebd); SOC'Y FOR PHYSICIANS WITH DISABILITIES, <https://www.physicianswithdisabilities.org/> (last visited Aug. 17, 2021).

The following scenarios, based on both fictional and actual settings, provide a context for the types of issues that can arise involving medical school applicants and students with disabilities. These are provided to highlight the range of issues (for example, cost, fundamental alteration, safety, and practicality) that arises in these settings.

Scenario 1: **Deaf applicant** seeks interpreters for classes (similar scenario for **blind** applicant).

- Such a service might be costly.
- It might have an impact on speed of processing information and acting on it in patient treatment and diagnosis settings.
- It might raise questions about whether an individual would be able to perform the essential requirements of the program, even if the service were to be provided.
- Must this service be provided if student cannot be licensed ultimately?
- Must this accommodation be provided if no clinical placement will accept these students and, thus, they can never complete the academic requirements?

Scenario 2: Medical school applicant with **learning disability** or **autism** can be accommodated in academic programs (primarily during the first two years of medical school), by providing additional time for exams or providing a reader.

- Can the student be accommodated in clinical rotations?
- Or be admitted to practice?
- To what extent is “speed” of processing information and acting on that an essential function? Is the ability to read and synthesize information quickly essential? In all settings or only in some settings? Does that matter?
- To what extent is the ability to engage in critical analysis of information required as essential?
- Who makes that determination?

Scenario 3: Medical school student with **mobility impairment**<sup>13</sup> meets academic requirements. After two years, upon entering clinical rotations, limitations may affect certain abilities.

- Are these disqualifying? Can they be accommodated?
- Is it permissible to consider those at the point of admission?

Scenario 4: Medical school student with **psychological, neurological, or related impairments**<sup>14</sup> meets academic requirements.

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13 This could be quadriplegia, paraplegia, other partial limitations in range of motion, etc.

14 This could include borderline personality, narcissistic personality disorder, Aspergers/autism, depression, attention deficit disorder, attention deficit hyperactivity disorder.



- After two years, upon entering clinical rotations, behaviors and conduct (including problems interacting with patients and other staff members) become significantly troublesome.
- Should medical schools include **personality** qualifications for admission?<sup>15</sup>
- Are such conditions even “disabilities”?

Scenario 5: Medical student who becomes **HIV positive** seeks to enter a surgical residency program.<sup>16</sup>

- Are the potential risks of transmission to patients valid reasons for denying admission to that residency?

### III. High Stakes Issues

Professional education in health care areas (particularly for medical school) generally involves high stakes for both the individual and the institution providing the professional training—in terms of money,<sup>17</sup> time,<sup>18</sup> and societal benefit.<sup>19</sup> The potential risk or threat to patients by health care professionals resulting from impairment or competency is an essential consideration in training and licensing health care professionals. Providing reasonable accommodations for disabilities to medical school students can be burdensome (costly in finances and administrative time and the burden on supervising faculty members) particularly for certain conditions. Such accommodations might also be a fundamental alteration of the program.

#### A. Cost to the Individual—Time and Financial

A medical school education generally takes a minimum of four years. Individuals enrolled in medical school forgo other opportunities to work and do

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15 There are challenging ethical questions about personality testing at any stage and care to be taken to avoid self-fulfilling prophecy. This issue is discussed in the 2021 HBO documentary *Persona: The Dark Truths behind Personality Tests*, <https://www.imdb.com/title/tt14173880/> (last visited December 1, 2021).

16 While this is not as significant an issue as it was in the past, it is still important to consider.

17 Appreciation is extended to Kathryn Meador, Brandeis School of Law graduate class of 2020) for her research on this issue.

18 See Section VI. Judicial Interpretation (by Type of Impairment) which demonstrates that these cases often take as long as ten years to resolve, and even if the medical school wins the case (which they generally do), it has expended enormous resources in time and litigation costs, and sometimes even reputation of the school is affected.

19 While not the primary focus, this article raises the issue of whether medical professional licensing agencies can/should/must change their requirements for admission to practice as an accommodation to health care professional program students with disabilities? Also noted, but not the primary focus, are the following issues: the increased need for physicians (particularly in certain fields, such as rural medicine) and the model of financing health care that impacts how medical education programming is delivered. Many family medicine programs have added a rural track curriculum that is separate from the traditional residency track. This article was written during the spring 2020 COVID pandemic outbreak. During that time, the importance of health care professionals as essential workers in American society (as well as throughout the world) became front-page news.

other things. Generally, they have made the calculation that the “lost time” is worth it because treating patients can provide significant personal and financial benefits.

The financial investment (and lost opportunities to engage in other employment) is significant. In 2018, the median educational debt reported for students who graduated in 2017 was \$192,000.<sup>20</sup> The cost of attendance of medical school includes tuition, fees, and living expenses. Additional costs to students include the cost of applying to medical school, cost of licensing exams, and cost of applying to residencies.<sup>21</sup>

Medical school students must also take a series of exams in order to become licensed physicians. That involves an additional cost in both time and money.<sup>22</sup> While not as high, other health care programs also involve high costs for both the individuals and the institutions providing the programming.<sup>23</sup>

20 Education debt includes the combined debt students incur in both undergraduate and graduate school. James Youngclaus, *An Exploration of the Recent Decline in the Percentage of U.S. Medical School Graduates with Education Debt*, ASS'N OF AM. MED. COLLS. 18 ANALYSIS IN BRIEF (2018), <https://www.aamc.org/system/files/reports/1/september2018anexplorationoftherecentdeclineinthepercentageofu.pdf>.

According to a survey conducted by the Association of American Medical Colleges (AAMC), the average cost of tuition, fees, and health insurance to a first-year student in 2019–20 was \$37,556 for a student attending an in-state public medical school, \$60,655 for a student attending a private school, and \$62,194 for an out-of-state student attending a public university. Additionally, these numbers were a 2.2%–2.7% increase from the previous year and are expected to rise in the upcoming years as well., *Tuition and Student Fees for First Year Students Summary Statistics for Academic Years 2012–2013 through 2019–2020*, ASS'N OF AM. MED. COLLS. <https://www.aamc.org/data-reports/reporting-tools/report/tuition-and-student-fees-reports>.

21 Before applying for admittance, students must perform well on the Medical College Admissions Test (MCAT), which cost \$318 to register in 2018. This does not include any courses or supplemental materials students may wish to purchase to help them study for the MCAT. In order to be accepted, students must go through two rounds of applications and a round of interviews per school. The average primary application fee is \$170 for the first school and \$39 for each additional school. Secondary application fees typically range from no cost to \$200 per application. Ken Budd, *7 Ways to Reduce Medical School Debt*, ASS'N OF AM. MED. COLLS. (Jan. 30, 2020, 9:27 AM), <https://www.aamc.org/news-insights/7-ways-reduce-medical-school-debt>. If the student is invited to interview, they must pay their own travel and lodging fees as well. Thus, the cost of the application process can easily rise to \$500 or above and likely reaches upward of \$1,000.

22 These exams are Step 1, Step 2, Step 1 and 2 Clinical Knowledge, and Step 3, and are taken at various points throughout medical school and during a student's residency. The registration costs for these exams are \$645, \$645, \$70, and \$895 respectively. *USMLE Examination Fees*, NAT'L BD. OF MED. EXM'RS (Jan. 29, 2020, 9:23 AM), <https://www.nbme.org/students/examfees.html>; , *USMLE Step 3*, FED'N OF STATE MED. BDS. (Jan. 29, 2020, 9:43 AM), <https://www.fsmb.org/step-3>. These costs do not include cost of additional study materials students may wish to purchase. *The Cost of Applying for Residency*, ASS'N OF AM. MED. COLLS. (Jan. 29, 2020, 9:45 AM), <https://students-residents.aamc.org/financial-aid/article/cost-applying-medical-residency/> (last visited December 1, 2021). These costs include the cost of applications, payment for travel expenses incurred in the interview process with residency programs. According to the AAMC, these costs can vary from \$1,000 to \$7,300 with the median cost being \$3,700.

23 For nursing schools, bachelor's degree costs are similar to most bachelor's degrees. The average total cost (including tuition and other costs) of a bachelor's degree in 2018–19 was around \$86,000 for public in-state universities, \$150,000 for public out-of-state universities, and \$193,000 for private universities. For average published charges in 2018–19 and 2019–20 (Jan. 30, 2020, 3:39 PM), see <https://research.collegeboard.org/trends/college-pricing/figures-tables/average-published-charges-2018-19-and-2019-20>. Nursing students pay additional lab fees as well as equipment costs for scrubs and

### ***B. Cost to the Institution***

The cost to the institution for educating medical students is similarly high.<sup>24</sup> These costs include instructional costs, support for research, providing scholarships, patient care, and facility maintenance. There is also, of course, the initial cost of constructing the facilities. Because of the intensive supervision by medical school teaching faculty, which results in a low faculty to student ratio, there is a high cost for each student admitted and enrolled.<sup>25</sup> When comparing this to legal education, the addition of several more students to an entering law school class, for example, may not present significant additional costs to the institution. The institution covers the cost of medical education in a complex variety of ways that include tuition and also federal government support through Medicare and Veterans Administration (VA) programs.<sup>26</sup> Patient paid services also support the cost.

Costs for accommodations in an educational setting vary widely depending on the disability and type of accommodations. Auxiliary aids and services, such as interpreters, readers, and adapted educational materials, can be quite expensive. Allowing for additional time on an exam is primarily an administrative cost. It is beyond the scope of this section to flesh out those costs, but in considering the education of a student with a disability, there may well be additional costs beyond the traditional costs allocated to each student. While the costs for the academic portions of the program may be easier to estimate, during the clinical rotations, it is much more difficult to anticipate and plan for what these costs might be because of the individualized issues for varying impairments and the type of clinical program.

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other tools such as stethoscopes. Many nurses who receive their bachelor's degree go on to earn their master's degree in nursing as well. Some choose to attend school online. In 2012, online nursing master's programs ranged in tuition from \$35,000 to \$60,000. See Kelsey Sheehy, *Weighing Costs of an Online Master's in Nursing*, U.S. NEWS (Jan. 30, 2020, 3:40 PM), <https://www.usnews.com/education/online-education/articles/2012/01/12/weighing-costs-of-an-online-masters-in-nursing>. The median cost per year for private optometry schools in 2018 was \$40,421, which included tuition and fees. The median cost for public schools was \$27,839 for regional students and \$41,525 for non-regional students. Southern College of Optometry, USA Optometry Schools (Jan.30, 2020, 3:46 PM), <https://www.sco.edu/optometry-schools-in-usa>.

24 For information on the costs of medical education, see <https://students-residents.aamc.org/financial-aid-resources/top-10-questions-premeds-should-ask-medical-school-financial-aid-officers> (last visited December 1, 2021). Instructional costs include professor salaries and other costs related to teaching. In implementing the teaching in clinical settings, there are additional costs that include supporting research, providing scholarships, providing patient care, and maintenance of facilities.

25 The complexity of funding sources makes it difficult to determine actual costs because institutions receive funding from grant entities and other sources. Jessica Townsend, *Financing Medical Education*, MEDICAL EDUCATION AND SOCIETAL NEEDS: A PLANNING REPORT FOR THE HEALTH PROFESSIONS ch. 10 (1983) <https://www.ncbi.nlm.nih.gov/books/NBK217691/>.

26 Medicare subsidizes all graduate medical education. In 2015, the federal government spent over \$10 billion through Medicare and over \$2 billion through Medicaid on graduate medical education training. The federal government also spent nearly \$1.5 billion in graduate education through the VA program and nearly \$250 million on training in in children's hospitals. In total, the federal government spent a little over \$14.5 billion on graduate medical education.

Residency and fellow costs are paid by Medicare, the VA, and the military. FEDERAL SUPPORT FOR GRADUATE MEDICAL EDUCATION: AN OVERVIEW (Congressional Research Service Report, updated Dec. 27, 2018), <https://sgp.fas.org/cts/misc/R44376.pdf>.

The standard for when an institution may take cost into account in deciding whether to admit a student can apply an undue burden analysis. The cases that address cost issues may consider both administrative and financial burden. Cost is rarely discussed, however, in most of the judicial decisions because the institution rarely raises it as an issue.

### C. Costs and Benefits to Patients

The patient's primary interest, of course, is to obtain quality health care services and to do so at an affordable cost. The complex issue of health care costs to individuals is beyond the scope of this article, but it should be recognized that whatever charges are paid by patients incorporate costs for malpractice insurance.<sup>27</sup> Such insurance costs are risk spreading, and insurers will be concerned about the possibility that a physician with an impairment might be more likely to commit medical malpractice. That may be a factor taken into account by entities that employ or allow admitting privileges to physicians, and those costs will be passed on to patients. This increased malpractice insurance rate is possibly more likely for physicians with impairments related to substance abuse. It would be quite difficult to make an assessment of the increased cost of malpractice insurance due to physicians with disabilities.

There are significant benefits (both to the individual and to patient care) in having medical professionals with disabilities.<sup>28</sup> For example, for a deaf patient having a deaf physician might be life changing. Similar benefits have been raised with respect to other diversity areas—gender, race, ethnicity, sexual orientation.<sup>29</sup> While this is an important issue, it is beyond the scope of this article to discuss in depth.

## IV. Medical School Education, Licensing, and Regulatory Framework

As noted at the outset, the primary focus of this article is how disabilities can impact the educational and placement experiences of a medical student and how a medical school should plan for and anticipate that in its policies, practices, and procedures. Related to that is how the relationship of professional licensing and

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27 See Michelle M. Mello et al., *National Costs of the Medical Liability System*, HEALTH AFFS. (Sept. 2010), <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3048809/>. A 2020 study on the cost of the malpractice system reported that preventable medical injuries are estimated to cost \$17–\$29 billion per year. *Id.*

28 See generally Lise Mogensen & Wendy Hu, "A Doctor Who Really KnowsæΩ..." *A Survey of Community Perspectives on Medical Students and Practitioners with Disability*, 19 BMC MED. EDUC. 288 (2019); (study of attitudes in Australia regarding inclusion of individuals with disabilities in medical school); Bonnielin Swenor & Lisa M. Meeks, *Disability Inclusion—Moving beyond Mission Statements*, 380 NEW ENG. J. MED. 2089 (2019) (advocating for more proactive steps to include physicians with disabilities in medical education and in the profession); Lisa M. Meeks & Neera R. Jain, *Accessibility, Inclusion, and Action in Medical Education*, ASS'N OF AM. MED. COLLS. (Mar. 2018), <https://sds.ucsf.edu/sites/g/files/tkssra2986/f/aamc-ucsf-disability-special-report-accessible.pdf>.

29 Anjali B. Thakkar et al., *Addressing Mistreatment in Medical Education*, 180 JAMA INTERN. MED. 665 (2020).

employment to the professional education of doctors<sup>30</sup> affects individuals with different types of disabilities at all points in the process. To understand this issue, it is essential to set out the history of medical education and then to clarify the general framework for each stage of medical training and licensing and practice, including recent trends that might also be relevant.

### A. General Framework for Medical Education and Residencies

#### 1. The Flexner Model

The current model for medical school was developed in the early 1900s. Abraham Flexner is known as the architect of medical education for his model developed in 1905 that recommends university-based medical education that contemplates “minimum admission requirements, ... a rigorous curriculum with applied laboratory and clinical science content, and ... faculty actively engaged in research.”<sup>31</sup> William Osler was the other early influence with the added guidance encouraging “bedside teaching, bringing medical students into direct contact with patients, and learning medicine from ... direct experiences under the guidance of faculty clinicians.”<sup>32</sup> The model adopting these two components (basic science and clinical education) was closely followed for almost a century.

The report about the 1905 original model for medical school education was issued by the Carnegie Foundation in 1910.<sup>33</sup> It was based on research by Abraham Flexner and is often referred to as “The Flexner Report.” Although not a physician himself, Flexner’s model was based on his model of educational principles and the general practice of medicine at that time.<sup>34</sup>

The Flexner Report model only began to change in 2010. The report evaluating changes to medical education was released by the Carnegie Foundation in 2010, almost exactly a century after it released its initial report about the 1905 Flexner model. The original model was a two-year basic scientific foundational classroom-

30 There are currently approximately 155 schools of medicine. *Enrollment Up at U.S. Med Schools*, ASS’N OF AM. MED. COLLS. (Dec. 16, 2020), <https://www.aamc.org/news-insights/press-releases/enrollment-us-medical-schools>. Additionally, there are thirty-seven schools of osteopathy in the United States. *Osteopathic Medical Schools, 1 in 4 Medical Students Attends an Osteopathic Medical School*, AM. OSTEOPATHIC ASS’N, <https://osteopathic.org/about/affiliated-organizations/osteopathic-medical-schools/> (last visited Aug. 20, 2021). There are also a number of foreign schools from which individuals seek to be licensed.

31 Buja, *supra* note 10.

32 *Id.*

33 ABRAHAM FLEXNER, *MEDICAL EDUCATION IN THE UNITED STATES AND CANADA: A REPORT TO THE CARNEGIE FOUNDATION FOR THE ADVANCEMENT OF TEACHING (1910)*, [HTTP://ARCHIVE.CARNEGIEFOUNDATION.ORG/PUBLICATIONS/PDFS/ELIBRARY/CARNEGIE\\_FLEXNER\\_REPORT.PDF](http://archive.carnegiefoundation.org/publications/pdfs/elibrary/carnegie_flexner_report.pdf).

34 The Flexner Model has been criticized for its impact on access to medical education by minority students and its related impact on access to health care for minorities Anna Flagg, *The Black Mortality Gap and a Document Written in 1910*, N.Y. TIMES (Aug. 30, 2021) <https://www.nytimes.com/2021/08/30/upshot/black-health-mortality-gap.html>. That discussion is beyond the scope of this article, although some of the same criticisms about the impact of the Flexner model on minority students can be applied to potential medical students with disabilities.

type program, which would be followed by two years of clinical education where students would apply what they had learned in the previous two years.<sup>35</sup> Notable is that these two types of experiences would often mean different types of accommodations for various disabilities.<sup>36</sup>

This four-year model was adopted by most medical schools between 1910 and 2010,<sup>37</sup> although some medical schools allowed the first two years to become three-year programs earlier than 2010.<sup>38</sup> Under the Flexner model, after the first two (or three years) of taking academic-type courses, students would begin to integrate their education and basic knowledge into clinical experience. Notably, the academic evaluation and the licensure evaluation are interwoven throughout the medical school experience. At the end of these two (or three) years of academic work, students take what is known as the Step 1 exam. This is a comprehensive knowledge-based exam (multiple choice questions) designed to assess understanding of the basic information learned during the first two years. It is the first step in the licensure process. It is intended to evaluate basic scientific knowledge. The test is created and administered by the National Board of Medical Examiners (NBME).<sup>39</sup> The score for that test not only assesses whether the student has achieved the requisite basic knowledge, it is also a significant factor in the application for highly competitive residency programs.<sup>40</sup>

Students then enter the next two-year phase where they apply the basic knowledge in clinical settings to patients.<sup>41</sup> The first year of this stage (the third year of medical school) generally consists of several “clinical rotations” or “clerkships.” These are done at teaching hospitals connected to the medical school. Although there is no mandatory national standard, generally, there are several “required” rotations that are considered to be the “core” disciplines of medical practice. These are family medicine, internal medicine, obstetrics and gynecology, pediatrics, psychiatry, and surgery. Evaluation for each rotation is done through what is known as a “Shelf Exam,” which simulates licensing exams administered by the NBME. Many rotations also incorporate oral evaluations with supervising faculty physicians. Notable is the fact that the evaluations consist of both “traditional”

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35 At this stage, the delivery of the education and the evaluation of performance by students becomes quite complex and often team based, making it challenging to place specific accountability for certain assessments on the institution and faculty and staff making decisions about performance.

36 Molly Cooke, et. al, *A Summary of Educating Physicians: A Call for Reform of Medical School and Residency* (Feb. 3, 2020, 1:53 PM), [http://archive.carnegiefoundation.org/pdfs/elibrary/summary\\_educating\\_physicians.html](http://archive.carnegiefoundation.org/pdfs/elibrary/summary_educating_physicians.html).

37 *What to Expect in Medical School*, ASS'N OF AM. MED. COLLS., <https://students-residents.aamc.org/choosing-medical-career/article/what-expect-medical-school/> (last visited Apr. 4, 2020) (describing what is learned, how it is evaluated, interaction with patients, and specialization by the AAMC).

38 *Id.*

39 See <https://www.nbme.org/> (last visited July 30, 2021).

40 Buja, *supra* note 10. Failure is a significant factor in any residency program. Failing to meet requirements the first time could lead to failure to match at all, even if the student passed the second time.

41 Although legal education also increasingly incorporates the expectation that students engage in experiential education, many of the experiences in law school are based on simulations and not live client representation.

testing procedures and more subjective individual evaluations, usually by more than one supervising clinical faculty member.<sup>42</sup>

At the end of the first year of clinical education (the third year of medical school), students generally move on to a series of both elective and selected clinical educational programs. Required courses at this level often include ambulatory medicine, critical care, emergency care, and subinternships, although most fourth-year rotations are elective. Again, this aspect of the program contemplates actual patient contact under the supervision of the teaching faculty and evaluation by them. During the time when it was required, students prepared for their Step 2 exam during this time, and have flexibility to schedule residency interviews. Step 2, also referred to as “Step 2 Clinical Knowledge,” was the required second step for licensure. This test measures clinical knowledge.<sup>43</sup>

At the end of the second or third year of medical school, some students decide to move to a slightly different track, at least temporarily, to obtain a dual degree (MD-MPH).<sup>44</sup> This program might include either additional clinical work and/or other educational programming.

In the second half of the fourth year, medical students engage in what is known as the “matching process” where they seek to be accepted into a residency program at a specific teaching hospital. It is during the residency stage that the student must complete the Step 3 exam as the final requirement for licensure. It generally must be completed during the first or second year of residency. Many medical trainees choose to complete a fellowship program after completing residency in order to receive subspecialty training. Accreditation of residency and fellowship programs is determined by the Accreditation Council for Graduate Medical Education (ACGME).<sup>45</sup>

Residency and fellowship programs incorporate aspects of both educational and employment experiences, and as such, disability discrimination laws applicable to these different aspects are relevant. The trainee is in a hybrid-type situation because the trainee is now being compensated for work but is being evaluated as a student by clinical teaching faculty. Unlike employment in other settings, however, the student/employee has no leverage or choice related to conditions of employment.<sup>46</sup> The ability of the trainee to decide that the conditions are not satisfactory and seek another residency or fellowship are significantly constrained.<sup>47</sup>

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42 The involvement and interest of the teaching faculty is a topic worthy of much greater focus, but it should be noted at this point that because medical school expects that teaching faculty themselves provide clinical services and/or engage in research (both of which can provide financial benefits to the medical school), those individuals who are teaching do not necessarily have a focus on pedagogy, including knowledge about formative assessment. While there are many gifted medical educators, the model of medical education does not necessarily ensure high teaching quality.

43 See text accompanying note 84, *infra*, regarding the 2021 decision to eliminate Step 2 exams.

44 Some medical schools offer a Howard Hughes–sponsored PhD degree to complement the MD degree.

45 See <https://www.acgme.org/> (last visited Sept. 22, 2021).

46 There are some states in which trainees have some union bargaining rights, but that is not the general situation.

47 Residents and fellows switch training programs occasionally. However, to do so, a resident

## 2. Reform in Medical Education

The previous section describes the 1910 Flexner model traditional program. In 2010, the Carnegie Foundation released a report calling for reform of medical school and residency.<sup>48</sup> The basic finding of the report on “Educating Physicians: A Call for Reform of Medical School and Residency”<sup>49</sup> was that medical students needed more patient contact at earlier stages of their education in order to integrate formal knowledge learned in the classroom setting.<sup>50</sup> The American Medical Association (AMA)<sup>51</sup> response came in 2013, when it created the “Accelerating Change in Medical Education Initiative.”<sup>52</sup> One of the priorities of the revision was educating students on health systems through earlier clinical experiences with patients.<sup>53</sup>

Some of the adopters of these programs incorporate initiatives that focus on providing service to underserved populations, seek to provide service in underserved types of practice (such as family practice), and include components of cultural competence in recognition of expectations in those underserved areas. Others prioritize areas of high need (such as emergency care).<sup>54</sup> Still others incorporate

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or fellow must find an alternative program willing to take them. They would not have to go through the match again.

48 *Educating Physicians: A Call for Reform of Medical Schools and Residency*, [http://archive.carnegiefoundation.org/pdfs/elibrary/summary\\_educating\\_physicians.html](http://archive.carnegiefoundation.org/pdfs/elibrary/summary_educating_physicians.html) (summary).

49 *Id.* This report was based on a study at eleven medical schools in the United States. AMA Consortium Medical Schools, *Accelerating Change in Medical Education: AMA Reimagining Residency initiative*, AMA, <https://www.ama-assn.org/education/accelerating-change-medical-education/ama-reimagining-residency-initiative> (last visited Aug. 18, 2021).

50 *Id.* This approach is similar to the move within legal education to infuse more practical skills (experiential education) into the entirety of the program.

51 The AMA is responsible for accreditation of medical schools; see <https://www.ama-assn.org/>.

52 *Accelerating Change in Medical Education: Member Schools in the Consortium*, AMA (Jan. 30, 2020, 9:17 AM), <https://www.ama-assn.org/education/accelerating-change-medical-education/member-schools-consortium>. The AMA provided grants to eleven medical schools to fund the changes and began the Accelerating Medical Education Consortium (the Consortium). *Id.* In 2016, twenty-one more medical schools were added to the Consortium and now includes at least one-fifth of all allopathic and osteopathic medical schools.

53 AMA, *CREATING A COMMUNITY OF INNOVATION 12* (2017), <https://www.the-hospitalist.org/hospitalist/article/206173/leadership-training/changing-landscape-medical-education> (last visited December 2, 2021).

54 The University of California Davis program implemented a three-year accelerated program for those who know they want to enter primary care. In that program, students begin clinical work the first week of class. *Id.* The University of California, San Francisco, includes a placement in “clinical microsystems” in students first and second year, in which they are part of the patient’s clinical care team. *Id.* at 8. One particularly innovative program is at Florida International University Herbert Wertheim College of Medicine. The program is called NeighborhoodHELP, and it “focuses on the social and behavioral determinants of health to provide a longitudinal, interprofessional community-based experience for medical students.” *Id.* at 9. The learning goals for this program include cultural competence, interviewing skills, and understanding social and behavioral aspects of health. *Id.* This program has begun to incorporate mobile health centers to provide health screenings and other services to household members. *Id.* The University of South Carolina (Greenville) has implemented a program that trains students to become emergency medical technicians within the first seven weeks of enrollment. These students work a twelve-hour shift each month within the county’s ambulance services. They learn the critical skills of taking a patient history and assessing vital signs, and they receive valuable patient interaction in early years. *Id.*



more learning about team building, and others ensure that cultural competency issues are incorporated.<sup>55</sup> There have also been some variations in the traditional timing of education, allowing for both shorter and longer time frames.<sup>56</sup> Use of technology in providing treatment has been the subject of discussion.<sup>57</sup> The experiences of 2020 during the COVID emergency care crisis highlighted the importance of physicians on the front lines and also concerns about deficiencies in the number of physicians.<sup>58</sup>

Implementation of the changed approach occurred through grant programs to members of the Accelerating Change in Medical Education Consortium (the Consortium).<sup>59</sup> Since their founding in 2013, one of the priorities of the Consortium has been educating medical students on “health systems,” which includes earlier clinical experiences and access to patients.<sup>60</sup>

A number of commentaries have addressed the changing programs.<sup>61</sup> All of

55 *Teamwork: The Heart of Healthcare*, ASS'N OF AM. MED. COLLS. (Sept. 27, 2016), <https://www.aamc.org/news-insights/teamwork-heart-health-care>; Office of Diversity Programs, *Cultural Awareness*, WASH. UNIV. SCH. OF MED. IN ST. LOUIS, <https://mddiversity.wustl.edu/cultural-awareness/> (last visited Aug. 18, 2021).

56 Kristen Moon, *From Freshman to Resident: BS/MD Programs You Can Complete in Only 6 Years*, FORBES (June 18, 2018, 4:52 PM), <https://www.forbes.com/sites/noodleeducation/2018/06/18/3-bsmd-programs-only-6-years/?sh=3e56c78b6c59>; Stacy Weiner, *Med School in 3 Years: Is This the Future of Medical Education?*, ASS'N OF AM. MED. COLLS. (Mar. 29, 2019), <https://www.aamc.org/news-insights/med-school-3-years-future-medical-education>.

57 Eui-Ryoung Han et al., *Medical Education Trends for Future Physicians in the Era of Advanced Technology and Artificial Intelligence: An Integrative Review*, 19 BMC MED. EDUC. 460 (2019), <https://bmcmededuc.biomedcentral.com/articles/10.1186/s12909-019-1891-5#citeas>.

58 Michael Dill, *We Already Needed More Doctors and Then COVID-19 Hit*, ASS'N OF AM. MED. COLLS. (June 17, 2021), <https://www.aamc.org/news-insights/we-already-needed-more-doctors-then-covid-19-hit>.

59 *Id.* These went from eleven in 2013 to twenty-one in 2016 to currently being applied at one-fifth of all allopathic and osteopathic medical schools. *Id.*

60 AMA, *supra* note 53, at 12. One of the Consortium schools, The University of California, Davis, School of Medicine created a three-year accelerated track for primary medicine. Students who are accepted to the program begin school six weeks earlier than other students and receive training to help them prepare to do clinical work. In their first week of medical school, students are placed within a local clinic or other patient-care setting and begin working with a clinician to provide patient care. Students must be accepted into this program before beginning medical school and must therefore know they are interested in primary care. University of California, San Francisco, School of Medicine has also incorporated early patient care into its curriculum. In students' first and second years, they are placed within “clinical microsystems” where they become part of a patient's clinical care team. Once they demonstrate their ability to address the needs of both the patient and their care delivery team, they begin directly caring for the patient and learning patient skills. Florida International University Herbert Wertheim College of Medicine initiated a program called NeighborhoodHELP. In their first year, each student is assigned an interprofessional team consisting of nursing, social work, and/or physician assistant students. These teams are assigned to households within underserved communities. See <https://medicine.fiu.edu/about/community-engagement/green-family-foundation-neighborhoodhelp/> (last visited December 1, 2021).

61 Brian Kwan et al., *The Changing Landscape of Medical Education*, HOSPITALIST (Aug. 9, 2019), <https://www.the-hospitalist.org/hospitalist/article/206173/leadership-training/changing-landscape-medical-education>; Timothy M. Smith, *Not Your Grandfather's Med School: Changes Trending in Med Ed*, ASS'N OF AM. MED. COLLS. (Feb. 7, 2017), <https://www.ama-assn.org/education/accelerating-change-medical-education/not-your-grandfather-s-med-school-changes-trending> (referencing the

this is set against the backdrop of the awareness that the medical services delivery model, which is driven by health insurance, hospital certificates of need, how teaching hospitals and medical students are critical to many types of health care service and research, and other external factors. The attention given to health care delivery and its financing during the COVID crisis highlighted many of the overarching deficiencies in the U.S. health care delivery system.

It is against this backdrop that medical education of individuals with disabilities arises. Medical education is long and difficult, both for the student and for the institution. For that reason, it is not surprising that many judicial decisions have addressed disputes that have arisen in this context. It can be challenging to provide insights from past judicial disputes involving medical students with disabilities when the content and evaluation of performance is in a state of flux. Some themes have arisen, however, from many of these cases that highlight medical student issues to consider regardless of what medical education model is in place.

These themes from judicial disputes will be discussed more fully below, but at this point, the following topics should frame the consideration of this issue. They are essential functions and criteria for admission and continued education at all points; the content of the curriculum and how it is presented and by whom (e.g., basic knowledge and/or practical skills); the means of evaluation and who is doing the evaluation; the procedures for requesting accommodations at various points and the individuals involved in that process; the policies, practices, and procedures for challenging determinations that a student's performance has been deficient and who is involved in that process; and the transparency and proactive approach to all of the above.

## ***B. Medical School Application Process and Enrollment***

In order to evaluate issues for applicants and students with disabilities, it is necessary to set out the application and enrollment process.<sup>62</sup>

### *1. Common Application*

The American Association of Medical Colleges (AAMC)<sup>63</sup> maintains a common application for member medical schools.<sup>64</sup> The common application does not ask

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American Medical Association Council on Long Range Planning and Medical Education 2016–17. The new curriculum would incorporate “values based care, patient safety, quality improvement, team work and team science, leadership, population health, socio-ecological determinants of health, and health care policy and economics.” The report also addresses attention to work-life balance issues including attention to mental health among students and trainees—“earlier exposure to patient care, growing focus on the science of the health systems, more team-based learning opportunities, shorter times to completion, and greater emphasis on new technology.” Kevin Truong, *What Needs to Change in Medical Education to Prepare Clinicians of the Future*, MED. CITY NEWS (Oct. 10, 2018, 11:47 PM), <https://medcitynews.com/2018/10/what-needs-to-change-in-medical-education-to-prepare-clinicians-of-the-future/>; Buja, *supra* note 10.

62 Kathryn Meador, Brandeis Law School graduate class of 2021, provided extensive research and content for this section.

63 ASS'N OF AM. MED. COLLS., <https://www.aamc.org/> (last visited June 26, 2021).

64 Aspiring Docs, *Applying to Medical School*, ASS'N OF AM. MED. COLLS., <https://students-residents>.

applicants about disability.<sup>65</sup> The only thing the application asks about from the student's background is where they grew up, if they believe the area was medically underserved, and questions about the student's socioeconomic status during their childhood. The application asks about misdemeanor and felony convictions. The application also asks whether the student would like to be considered a "disadvantaged applicant so that medical schools can consider social, economic, or educational factors." The factors that the AAMC suggests the applicant should consider when determining whether they will self-report as "disadvantaged" include living in a household receiving government aid and if their area was medically underserved.

In addition, each medical school has a school-specific application. These ask questions about why the applicant is interested in that particular school, what they would contribute to the school, and how their goals and experiences align with the school's mission.<sup>66</sup>

## 2. *Physical Requirements for Prospective Students (Technical and Academic Standards)*

Students are not generally required to undergo a physical exam before entering medical school. The Liaison Committee on Medical Education (LCME), however, has accreditation standards requiring that medical schools set "technical standards."<sup>67</sup> Technical standards are defined as "[a] statement by a medical school of the: 1) essential academic and non-academic abilities, attributes, and characteristics in the areas of intellectual-conceptual, integrative, and quantitative abilities; 2) observational skills; 3) physical abilities; 4) motor functioning; 5) emotional stability; 6) behavioral and social skills; and 7) ethics and professionalism that a medical school applicant or enrolled medical student must possess or be able to acquire, with or without reasonable accommodation, in order to be admitted to, be retained in, and graduate from that school's medical educational program."<sup>68</sup> While medical schools are allowed to set their own technical standards, most follow the same basic format and contain the same standards. Many have identical wording.<sup>69</sup> Examples from Harvard Medical School and the University of Kentucky Medical School illustrate how some of these standards are implemented.

The standards fall under the categories of observation, communication, sensory and motor coordination or function, intellectual-conceptual integrative and quantitative abilities, and behavior attributes. Students must be able to observe medical

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[aamc.org/applying-medical-school/article/applying-medical-school/](https://www.aamc.org/applying-medical-school/article/applying-medical-school/) (last visited Feb. 26, 2020).

65 To do so would be an impermissible preadmissions inquiry.

66 Aspiring Docs, *Applying to Medical School*, ASS'N OF AM. MED. COLLS, <https://students-residents.aamc.org/applying-medical-school/article/applying-medical-school/> (last visited Feb. 26, 2020).

67 See LCME, Standards for Accreditation of Medical Education Programs Leading to the MD Degree, Standard 10.5, at 16 (2019). [https://medicine.vtc.vt.edu/content/dam/medicine\\_vtc\\_vt.edu/about/accreditation/2018-19\\_Functions-and-Structure.pdf](https://medicine.vtc.vt.edu/content/dam/medicine_vtc_vt.edu/about/accreditation/2018-19_Functions-and-Structure.pdf) (last visited December 29, 2021). See also <https://www.aamc.org/services/first-for-financial-aid-officers/lcme-accreditation>.

68 LCME, Standards for Accreditation of Medical Education Programs Leading to the MD Degree, (published March 2020).

69 For example, the University of Kentucky Medical School and Harvard are quite similar and are the basis for the observations in this section.

demonstrations and have the ability to obtain a medical history and perform physical examinations.<sup>70</sup>

Harvard Medical School specifies that observation includes the ability to observe patients accurately from both a distance and nearby.<sup>71</sup> Harvard also states that “observation necessitates the functional use of the sense of vision and somatic sensation” but is merely “enhanced by the functional use of the sense of smell.”<sup>72</sup>

Students are generally expected to be able to communicate with both patients and other health care team members effectively through written and oral communication. Students must also be able to observe and effectively communicate changes in mood, activity, and posture, and must also be able to pick up on nonverbal cues.<sup>73</sup>

Students should also have sufficient motor functions to “elicit information from patients by palpation, auscultation, percussion, and other diagnostic maneuvers.”<sup>74</sup> They must also be able to “execute motor movements reasonable required to provide general care and emergency treatment to patients.”<sup>75</sup> Some schools also specify that students should be able to do basic laboratory tests.

Schools generally also require students to possess sufficient cognitive abilities to engage in problem solving. This expectation includes the ability to assimilate, interpret, and apply detailed and complex information.<sup>76</sup>

Harvard Medical School states that students must possess the “emotional health” required to fully utilize their intellectual abilities and develop effective relationships with patients. Harvard also requires students to be able to handle physically taxing workloads and work effectively under stress. Both schools emphasize the ability to be sensitive to patients. The University of Kentucky states that “personal qualities of empathy, integrity, honesty, concern for others, good interpersonal skills, interest, and motivation are required.”<sup>77</sup>

Harvard also includes a statement about medical students with disabilities and the ADA. The AAMC statement on the ADA and medical students with disabilities, which was released in 1993, is quoted in their application materials. Harvard requires all students to possess the requisite physical, mental, and emotional capabilities to undertake the curriculum in a “reasonably independent”

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70 *Technical Standards*, UNIV. OF KY. SCH. OF MED., <https://meded.med.uky.edu/medical-education-technical-standards> (last visited Mar. 1, 2020).

71 *Technical Standards*, HARV. MED. SCH., <https://meded.hms.harvard.edu/admissions-technical-standards> (last visited Mar. 1, 2020).

72 *Id.*

73 *Id.*

74 *Id.* University of Kentucky has identical wording.

75 *Id.*

76 *Technical Standards*, Univ. of Ky. Sch. of Med., <https://meded.med.uky.edu/medical-education-technical-standards> (last visited Mar. 1, 2020). University of Kentucky specifies that students must possess good judgment and the ability to communicate the limits of their knowledge to others when appropriate.

77 *Id.*

manner and without the need for reliance on intermediaries.<sup>78</sup> Harvard further specifies that it can provide accommodations for students who are affected by disabilities, including impaired mobility, chronic illness, dyslexia, and other learning disabilities.<sup>79</sup>

### 3. *Licensing Exams*

The licensing exams are administered by the United States Medical Licensing Examination (USMLE).<sup>80</sup> While these steps were mentioned previously, a review is provided here. The exam consists of three parts taken at various points in medical school and after residency.

The first exam is Step 1. Step 1 is typically administered after the second year of medical school. Step 1 is a purely multiple-choice exam that tests knowledge of pathology, physiology, pharmacology, biochemistry and nutrition, microbiology, immunology, anatomy, behavioral sciences, and genetics. The questions also test patient diagnosis, communication skills, and practice-based learning. In May 2020, the exam increased the number of questions that test communication and interpersonal skills from two percent to five percent to six percent to nine percent.<sup>81</sup> USMLE recently announced that it is also changing the score-reporting format from a numbered score to pass/fail.<sup>82</sup> This policy was enacted to “strengthen the integrity of the USMLE and address concerns about Step 1 scores impacting student well-being and medical education.”<sup>83</sup>

Step 2, before it was canceled, tested clinical knowledge and clinical skills. This step was cancelled in 2020 and then discontinued permanently in 2021.<sup>84</sup>

Step 3 is the final examination, which leads to licensing.<sup>85</sup> Step 3 is a two-day multiple-choice exam that tests the ability to apply medical knowledge and understand clinical science in order to practice medicine unsupervised. The test includes substantive questions that also test patient diagnosis and management. Communication and professionalism make up between seven percent and nine percent of the questions.

78 *Technical Standards*, Harv. Med. Sch., <https://meded.hms.harvard.edu/admissions-technical-standards> (last visited Mar. 1, 2020).

79 *Id.*

80 *Step 1*, U.S. Licensing Examination, <https://www.usmle.org/step-1/#overview> (last visited Mar. 1, 2020).

81 *Id.*

82 *Announcements*, U.S. Licensing Examination, <https://www.usmle.org/announcements/> (last visited Mar. 1, 2020).

83 *Id.* There are some concerns that changing this to pass/fail may have some unintended consequences in ensuring greater rigor in the program and evaluation for residency selection.

84 See <https://www.aamc.org/news-insights/what-elimination-major-medical-licensing-exam-step-2-cs-means-students-and-schools> (last visited Sept. 22, 2021).

85 *Step 3*, U.S. Licensing Examination, <https://www.usmle.org/step-3/#outlines> (last visited Mar. 1, 2020). The ability to practice medicine without direct supervision is determined by the residency program director. It is not a function of the USMLE or the NBME.

#### 4. *Physician Licensing and Transferability*

Physicians must be licensed in each state in which they practice. Licenses are not transferable among states. Each state has its own medical licensing board that develops criteria for licensing similar to state bar associations. When physicians are applying for their first state license, they must provide the licensing office with proof that they successfully completed all three step exams. The licensing offices also independently verify that the individual requesting the license completed medical school and the required residency programs. The licensing office also considers exam scores, references, other state licenses, and hospital privileges. A full and unrestricted license is required in order to receive privileges and malpractice insurance.<sup>86</sup> Physicians must also periodically renew their license and participate in continuing medical education.<sup>87</sup> Most states require annual renewal of licenses. The practice of licensing focuses on completed education and criminal background checks and disciplinary and grievance actions.<sup>88</sup>

#### 5. *Privileges and Transferability*

Privileges are the authorization of a hospital for an individual to practice medicine within a specific scope of practice based on the person's credentials and performance. Individual hospital boards are responsible for setting guidelines and requirements for privileges within that particular hospital. Privileges are not transferable; an individual must apply for and receive privileges from each hospital or hospital system where they wish to practice. There are different types of privileges. These include active and courtesy. Active privileges generally mean that the person is eligible to be appointed to the medical staff and may admit patients to the hospital. Courtesy privileges allow the individual to admit patients occasionally or act in a consulting role.

Before doctors receive privileges, they must first go through credentialing. Credentialing is the process where the hospital reviews an individual's education, training, experience, *current competence*, certifications, licenses, and malpractice liability certificates. The person must also sometimes provide references; submit letters of recommendation; and/or submit case reports, including number and types of cases handled and treatment outcome. After the hospital board reviews the person's credentials, it may then consider the person's application for privileges.<sup>89</sup> Physicians who develop disabilities during the course of their career may have difficulties obtaining new privileges or may receive limited privileges as a result of their disability.

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86 *Navigating State Medical Licensure*, AMA, <https://www.ama-assn.org/residents-students/career-planning-resource/navigating-state-medical-licensure> (last visited Mar. 1, 2020).

87 Most states require annual renewal of licenses. Kentucky practice is similar to most states. Its licensing agency is made up of physicians, medical school deans, three Citizens at Large (who are all attorneys), and a Department of Public Health. Continuing education is required. 201 KAR 9:021, (2018), <https://apps.legislature.ky.gov/law/kar/201/009/021.pdf>.

88 201 KAR 9:081, (2016), <https://apps.legislature.ky.gov/law/kar/201/009/081.pdf>.

89 *Hospital Credentialing and Privileges FAQs*, Am. Acad. of Fam. Physicians, <https://www.aafp.org/practice-management/administration/privileging/credentialing-privileging-faqs.html#privileging> (last visited Mar. 1, 2020).

## 6. Accreditation Standards and Position Statements

As noted above, in order to be licensed or granted privileges, the individual must meet the requirements of a range of accrediting and oversight agencies. The following generally describes the role that each of them has with respect to this process.

The LCME<sup>90</sup> provides accreditation standards for medical schools in the United States and Canada. There are currently twelve standards that address institutional leadership, faculty, curriculum, standards for admission into medical school, and student health services.<sup>91</sup> Standard 10 on student qualifications for admission includes the requirement that medical schools publish their technical standards.

The LCME states that its purpose is to provide an optional, peer-reviewed process that ensures medical programs meet established standards. This includes the ability of the institution to produce competent graduates who are ready for entry into the next step of their medical education.<sup>92</sup>

The ACGME<sup>93</sup> accredits residency and fellowship programs. The ACGME accredits institutions that sponsor training programs, gives recognition of program formats, and allocates resources to initiatives that address important issues in graduate medical education. The ACGME publishes Common Program Requirements for residencies, which establishes standards in oversight, personnel, student appointments, evaluations, and work environment.<sup>94</sup> Student physical and/or mental ability is not addressed in the Common Program Requirements.

Although not accrediting organizations, there are two groups that should be mentioned because they provide guidance on issues relevant to this discussion. The Association of American Medical Colleges (AAMC)<sup>95</sup> is a leading nonprofit organization dedicated to “advancing medical education to meet society’s evolving needs; making patient care safer, more affordable, and more equitable; and sustaining the discovery of scientific advances.” The AAMC provides data and reports for policy considerations and professional development.

The AMA<sup>96</sup> is a group of doctors and health professionals that provides research

90 See LCME, Standards for Accreditation of Medical Education Programs Leading to the MD Degree, (published March 2020).

91 LCME, Standards for Accreditation of Medical Education Programs Leading to the MD Degree 16 (2019). [https://medicine.vtc.vt.edu/content/dam/medicine\\_vtc\\_vt\\_edu/about/accreditation/2018-19\\_Functions-and-Structure.pdf](https://medicine.vtc.vt.edu/content/dam/medicine_vtc_vt_edu/about/accreditation/2018-19_Functions-and-Structure.pdf) (last visited December 29, 2021).

92 *Scope and Purpose of Accreditation*, LCME, <https://lcme.org/about/> (last visited Mar. 1, 2020).

93 *What We Do*, Accreditation Council for Graduate Med. Educ., <https://www.acgme.org/What-We-Do/Overview> (last visited Mar 1, 2020). Milestones are now used and are a more accurate assessment of a resident’s progress.

94 *Common Program Requirements (Residency)*, Accreditation Council for Graduate Med. Educ., <https://www.acgme.org/Portals/0/PFAssets/ProgramRequirements/CPRResidency2019.pdf> (last visited Mar. 1, 2020).

95 *What We Do*, Ass’n of Am. Med. Colls., <https://www.aamc.org/what-we-do> (last visited Mar. 1, 2020).

96 *About*, AMA, <https://www.ama-assn.org/about> (last visited Mar. 1, 2020).

and data for medical professionals. The AMA states that it is “a powerful ally in patient care, giving strength to physician voices in courts and legislative bodies across the nation.” It is “dedicated to driving medicine toward a more equitable future, removing obstacles that interfere with patient care and confronting the nation’s greatest public health crises.”

7. *Academic and Clinical Education and the Impact of the Evolving Flexner Model on the Application and Enrollment Process in Light of Disability Issues*

As the preceding sections note, students today are aware before they apply and are admitted what the essential requirements are for medical education. While it may not have been the case before disability discrimination laws took effect or became included as part of the process, section 504 of the Rehabilitation Act of 1973 requires virtually all medical schools to incorporate into their programming how to ensure that the school not discriminate on the basis of disability, including providing reasonable accommodations.

While medical schools were initially slow to respond to these changed expectations, by 1990 when the ADA was enacted, medical schools had incorporated into their policies an awareness of the need to ensure that medical students met the essential functions of the program and provided for that by proactively alerting them to these requirements.

What medical schools seem to be less adept at, however, is planning for and thinking through the accommodation issues that are needed for students with various disabilities throughout medical education. That is probably why the litigation described below has occurred and why more attention should be paid to this issue.

Under the Flexner model of traditional classroom learning in the first two years, accommodations, such as additional time for exams, readers, and other support services, can often address the disabilities of some students. For example, giving extra time for exams for students with learning disabilities, providing readers and signers for those with visual and hearing impairments, and ensuring accessible classrooms for wheelchair users is possible for a traditional academic course. It is at the clinical stage, where the student must meet specific physical and technical requirements that have now been set after 1973, where often the challenges begin. This becomes even more complex once students enter the residency portion of education. This is apparent from the case litigation descriptions below.

There have been criticisms of the standards as presenting barriers to individuals with disabilities.<sup>97</sup> Some of the criticisms have argued that there should be differentiated standards that allow credentialing based on abilities, not disabilities.<sup>98</sup> In light of

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97 Sarah H. Ailey & Beth Marks, *Technical Standards for Nursing Education in the 21st Century*, 42 *Rehab. Nursing* 245 (2017), <https://pubmed.ncbi.nlm.nih.gov/27197703/>; *Accreditation Standards for Nursing Education Programs*, Nat’l League of Nurses, Comm’n for Nursing Educ. Accreditation (Feb. 2016), <http://www.nln.org/docs/default-source/accreditation-services/cnea-standards-final-february-201613f2bf5c78366c709642ff00005f0421.pdf?sfvrsn=12>.

98 Beth Marks & Sarah Ailey, *White Paper on Inclusion of Students with Disabilities in*



the fact that the courts have been quite reluctant to accept those arguments and defer to educational agencies that set standards, addressing those arguments is not part of this article.

## V. Legal Framework

### A. *Statutory and Regulatory Requirements and Agency Guidance*

The application of federal disability discrimination law to health care professional programs begins in 1973 with amendments to the Vocational Rehabilitation Act. Those amendments prohibit programs receiving federal financial assistance from discriminating on the basis of handicap/disability. While most medical schools receive federal funding and are therefore subject to these mandates, it was the 1990 ADA that provided additional coverage. The ADA provided expanded coverage of disability discrimination law to programs that do not receive federal funding, most importantly accreditation bodies, licensing agencies, and administrators of various standardized examinations for admission to medical school and throughout the medical school process. The following provides a basic framework for how these major statutes applied to health care professional programs.

#### 1. *Section 504 of the Rehabilitation Act*

In 1973, Congress considered the reauthorization of the Vocational Rehabilitation Act, and in doing so, added provisions that mandated that programs receiving federal financial assistance must not discriminate on the basis of disability.<sup>99</sup> While much of the private sector (most employers and places of public accommodation) was not covered by this statute, the two most significant programs that did receive federal financial assistance were educational programs (both private and public) and many health care service providers who received Medicare/Medicaid funding. Because of that, much of the early judicial interpretation of how section 504 of the Rehabilitation Act and its implementing regulations were to be applied arose in the context of higher education and/or health care providers.<sup>100</sup>

The basic provision of section 504 of the Rehabilitation Act<sup>101</sup> was that individuals with disabilities (originally the term was handicap) were protected from discrimination on the basis of the disability. The individual had to be otherwise

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Nursing Education Programs for the California Committee on Employment of People with Disabilities (CCEPD), Am. Ass'n of Colls. of Nursing, <https://www.aacnnursing.org/Portals/42/AcademicNursing/Tool%20Kits/Student-Disabilities-White-Paper.pdf> (last visited Aug. 20, 2021). This is a very interesting advocacy article that evaluates these issues.

99 Laura Rothstein, *Higher Education and Disability Discrimination: A Fifty Year Retrospective*, 36 J.C. & U.L. 842, 847 (2010), <https://www.stetson.edu/law/conferences/highered/archive/media/Higher%20Education%20and%20Disability%20Discrimination-%20A%2050%20Year%20Retrospective.pdf>.

100 Laura Rothstein & Julia Irzyk, *Disabilities and the Law* (4th ed. 2021)).

101 Rehabilitation Act of 1973, Pub. L. No. 93-112, § 504, 87 Stat. 355 (codified as amended at 29 U.S.C. § 794).

qualified and the program also had to provide reasonable accommodations.<sup>102</sup> Individuals with disabilities were those who had a substantial limitation to one or more major life activities, who had a record of such an impairment, or who were regarded as having such an impairment. The implementing regulations, which were not promulgated until 1978,<sup>103</sup> provide greater specificity for different programming areas. There was very little litigation interpreting this statute for several years. The provisions applied to a range of activities for those covered entities, including employment, admissions, access to services, and other programming.

## 2. *Americans with Disabilities Act*

Advocates for disability rights realized the limitations of a nondiscrimination statute only applicable to recipients of federal financial assistance.<sup>104</sup> It was not until 1990, however, that they were able to succeed in convincing Congress to pass the ADA.<sup>105</sup> Section 504 of the Rehabilitation Act was fairly minimalist in detailing its requirements in the statutory language. The ADA was able to build on not only the regulations and federal agency guidance<sup>106</sup> that had been promulgated under section 504, but the extensive case law that had developed. Much of that guidance language was incorporated into its provisions that provided much greater statutory language than section 504. The ADA provided additional clarifying language about the terms and definitions and how the protections of the ADA applied to most employers (Title I),<sup>107</sup> to state and local governmental programs (Title II),<sup>108</sup> and twelve categories of private providers of programs available to the public (Title III).<sup>109</sup> The vast majority of these covered entities had not been subject to section 504. While most medical schools had been subject to section 504, the coverage of the employment sector under Title I of the ADA and state licensing agencies under Title II provided related benefits for individuals with disabilities attending medical schools in terms of protections.

The basic nondiscrimination mandate of the ADA was similar to section 504. Individuals with disabilities (defined virtually identically to the Rehabilitation Act)<sup>110</sup> were protected from discrimination. They were also entitled to reasonable

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102 *Id.*

103 Rothstein, *supra* note 99, at 849.

104 Two other provisions applied to federal contracts (section 503 of the Rehabilitation Act of 1973) and federal agencies (section 501 of the Rehabilitation Act of 1973), but these additional areas of protection did little to expand coverage to most of the private sector.

105 For the story behind the passage of the ADA, see LENNARD J. DAVID, *ENABLING ACT: THE HIDDEN STORY OF HOW THE AMERICANS WITH DISABILITIES ACT GAVE THE LARGEST US MINORITY ITS RIGHTS* (2015).

106 Although agency guidance does not have the force of regulations, it is often followed by the entities subject to the federal mandates, and courts are generally deferential to agency guidance.

107 Americans with Disabilities Act of 1990, Pub. L. No. 101-336, §§ 101-108, 104 Stat. 327 (codified as amended at 42 U.S.C. § 12101).

108 *Id.* §§ 201-205.

109 *Id.* §§ 301-310.

110 Rehabilitation Act of 1973, Pub. L. No. 93-112, § 504, 87 Stat. 355 (codified as amended at 29 U.S.C. § 794).

accommodations and modifications to the programs. The individuals receiving protection were required to be able to carry out the essential requirements of the program, with or without reasonable accommodations.<sup>111</sup> The statutes are intended to be interpreted consistently, and this means that case law from either statute is generally applicable to interpretation of both.

Cases brought under the ADA began to give much greater focus to the definition of “disability” than had been the case under section 504. The pre-ADA section 504 cases focused more on whether the individual was qualified and whether requested accommodations or modifications were reasonable.<sup>112</sup> Most of the early section 504 restrictive definition cases arose in the context of employment, but some were addressed in higher education settings, particularly related to individuals with learning disabilities.<sup>113</sup>

Ultimately Supreme Court decisions in 1999 and 2002<sup>114</sup> narrowed the definition of disability (notably in employment cases) so significantly that advocates came together to pass major amendments to the ADA in 2008. The amendments clarified that a broad definition of disability was intended. The amendments also provided statutory clarification about what would constitute major life activities and documentation that could be required to prove that an individual was a person with a disability.<sup>115</sup> The cases discussed below from the higher education and/or health care context are only a small number of the judicial decisions interpreting section 504 and the ADA.<sup>116</sup>

## ***B. Judicial Interpretation***

### *1. Consistent Themes*

The judicial analysis from the cases involving admission and readmission into health care professional programs<sup>117</sup> generally demonstrate several consistent themes.<sup>118</sup> Noteworthy is the fact that very few of the cases focus on whether the

111 42 U.S.C. § 12101(8).

112 For a comparison about how conditions might be treated differently before and after the amendments, see LAURA ROTHSTEIN & ANN C. MCGINLEY, *DISABILITY LAW: CASES, MATERIALS, PROBLEMS* (6th ed. 2017) pages 59-60.

113 See ROTHSTEIN & IRZYK, *supra* note 100, § 3:22.

114 See *Sutton v. United Airlines*, 527 U.S. 471 (1999); *Albertson’s, Inc. v. Kirkingburg*, 527 U.S. 555 (1999); *Murphy v. United Parcel Serv., Inc.*, 527 U.S. 516 (1999); *Bartlett v. N.Y. State Bd. of Law Examr’s* 527 U.S. 1031 (1999).

115 42 U.S.C. § 12102 et seq.

116 For additional cases, see ROTHSTEIN & IRZYK, *supra* note 100, at chs. 3, 5, and 10.

117 This is also true for cases involving determining that a licensed professional is no longer qualified.

118 See also Leslie Francis & Anita Silvers, *The Health Care Work Force: How to Understand Accommodations*, 9 St. Louis U.J. Health Law & Pol’y 57, at 76–87 (2015), <https://scholarship.law.slu.edu/cgi/viewcontent.cgi?article=1073&context=jhlp>, an excellent overview of the issue of health care workers with disabilities (including a discussion of accommodations in the educational setting).

individual meets the definition of having a disability.<sup>119</sup> These themes include a focus on what it means for the individual to be “otherwise qualified,” generally expecting an individualized assessment. In addressing the issue of reasonable accommodations in an educational setting, the burden is on the institution to establish that *relevant officials* engaged in an evaluation that showed consideration of “alternative means, their feasibility, cost and effect on the academic program, and came to a *rationally justifiable conclusion* that the *available alternatives* would result *either in lowering academic standards or requiring substantial program alteration.*”<sup>120</sup>

There has long been a significant level of judicial deference to educational institutions with respect to the content of the program, and such deference is also given to health care institutions concerning issues of patient safety. The courts, however, do not automatically defer to such programs regarding whether certain accommodations could be made. The burden is on the institution to demonstrate what are essential functions and why a requested reasonable accommodation would be unduly burdensome or would fundamentally alter the program. The courts are consistent in expecting an interactive process in resolving accommodation issues, so deference is not generally given where that did not occur.

Courts are consistent about allowing academic programs to require certain grade point and academic performance standards. Some cases, however, highlight that where the program did not provide reasonable accommodations to a known disability that might have affected the performance, a remedy (such as readmission with accommodations) could be ordered. In all cases, however, the court holds that the individual would be required to meet the academic and performance standards for completing the program.

Courts are uniform in not requiring professional health educational programs themselves to change to a limited competency program. The fact that a doctor or nurse might be able to perform many (or even most) of the functions of a licensed professional does not change the expectation that during the educational preparation leading to the license, the individual still had to learn and perform in

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119 It was not until the enactment of the ADA in 1990, and its widespread application to employment settings that defendants began responding to discrimination claims by filing a motion to dismiss because the person was not covered by section 504 or the ADA. When the Supreme Court responded to these cases narrowing the definition of coverage in 1999 and 2002, Congress amended both statutes to clarify not only that a broad interpretation was intended, but also clarifying within the statutory language what documentation would be required and specifying major life activities. Having those clarifications within the statutory language (not just in regulations and judicial holdings is important because it makes these interpretations far more sustainable. It is much more difficult to amend a statute than to revise a regulation or regulatory guidance). *See also* Nicole Porter, *The Difficulty Accommodating Health Care Workers*, 9 ST. LOUIS J. HEALTH L. & POL'Y 1 (2015) (noting physical requirements and attendance standards for health care workers); E. Pierce Blue, *Job Functions, Standards, and Accommodations Under the ADA: Recent EEOC Decisions*, 9 ST. LOUIS U.J. HEALTH L. & POL'Y 19 (2015), [https://www.slu.edu/law/academics/journals/health-law-policy/pdfs/issues/v9-i1/blue\\_article.pdf](https://www.slu.edu/law/academics/journals/health-law-policy/pdfs/issues/v9-i1/blue_article.pdf) (discussing framing standards as essential functions in the employment setting, and also noting physical requirements and attendance standards for health care workers); Samuel R. Bagenstos, *Technical Standards and Lawsuits Involving Accommodations for Health Profession Students*, 18 AMA J. ETHICS 1010 (2016).

120 See *Wynne v. Tufts Univ. Sch. of Med.*, 932 F.2d 19 (497 (1st Cir. 1991). This case is discussed more fully *infra* in section V(B)(2)(b).

all areas that are evaluated for licensing. There remains a debate about whether these programs *should* change their requirements, but that discussion is a policy question that does not change the legal analysis of what section 504 and the ADA require.

Courts across the board in virtually every disability discrimination case hold that complainants do not get a “second chance,” after performance deficiency, to raise the issue of disability when the disability had not been identified nor any accommodations requested before the unacceptable performance occurred.<sup>121</sup> The courts require that an individual make “known” the disability (and provide appropriate documentation of the disability) when seeking accommodations or claiming that discrimination was based on the disability.

Another theme that is notably consistent is that in the vast majority of cases, the outcome favors the defendant. Although plaintiffs rarely win the cases, many of the decisions provide an important framework for institutions to develop revised policies and practices. Some of the decisions discussed in this article highlight the deficiencies in the procedures or standards implemented by the programs.

Of relevance to any type of discrimination case is whether the claimant must prove that the discrimination was intentional or whether disparate impact/effect is sufficient. This issue has been addressed by the Supreme Court in a number of contexts. Of most relevance to this discussion is how it was analyzed in the context of disability discrimination. In *Alexander v. Choate*,<sup>122</sup> the Supreme Court considered the state of Tennessee’s Medicaid reimbursement policies. It was argued that limiting the number of days of coverage for Medicaid was discriminatory because it had a disparate impact on people with disabilities. The judicial guidance highlighted the fact that disability discrimination is almost never due to malice or ill will and that individuals are not generally going to be required to show intentional discrimination to prevail. The Court cautioned, however, that not all disparate impact cases are actionable and deferred to the balance struck in 1979 in the *Southeastern Community College v. Davis*<sup>123</sup> standard that requires meaningful access.<sup>124</sup>

Finally, while almost all of the cases result in a holding that the educational program did not violate section 504 or the ADA, the disputes often lasted years (sometimes as much as a decade) to resolve. The cost to the health care professional education institutions, even when they win, can be quite high in terms of attorneys’ fees and costs, time and energy spent by administrators in responding to litigation, and in some cases lost reputation or the appearance of lost reputation. Rather than rely on the likelihood of winning, institutions would benefit from giving careful thought at the outset, before disputes turn into litigation, into ensuring that their policies, practices, and procedures are proactive and anticipate the kinds of issues raised in the cases discussed in this article.

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121 While as a policy matter an institution may choose to give a second chance, courts have almost never required an institution to do so.

122 469 U.S. 287 (1985).

123 442 U.S. 397 (1979).

124 See *infra* Section V(B)(2)(a).

2. *Basic Framework for Admissions, Conditional Admission, and Readmission Judicial Opinions*

One focus of this article is on the initial admissions process<sup>125</sup> and its relationship to licensing. The question is whether the consideration of a disability at the admissions stage should be allowed in light of the possibility or probability that the student would not be likely to succeed in the clinical portions of the program or to be licensed because of performance requirements that are not evaluated until after the first two years of the academic program. It also addresses cases where a student who was admitted was later found to not be otherwise qualified and denied readmission because of that. Also relevant are the cases where a student completed one level of medical education but is denied entry into the next level (such as a medical residency program). Although rare, there may be instances where a student who is not impaired at the time of admission, becomes impaired through an illness or accident. This raises questions about whether that impairment might impact the ability to complete the educational program or to be licensed.

In some of the readmission case decisions, there are factors that might have been addressed at the point of the initial admission decision. A few of these cases highlight the fact that the expenditure of substantial resources and lost opportunities for the individual might have been avoided by a careful and appropriate consideration of at least some impairment issues at the admission stage. A better alternative, in some situations, to simply denying admission would be for the medical school to be more proactive in planning for and implementing appropriate reasonable accommodations early in the process, thus avoiding at least some instances where the individual is later dismissed for performance deficiencies related to the impairment.

There are numerous judicial decisions involving admission of individuals with a range of disabilities that are relevant to this discussion. Some of those decisions directly consider the licensing issue, while others deem the student not qualified regardless of licensing. Other cases providing insights are where a student has been dismissed and seeks readmission. Some of these decisions highlight the issue about whether the student might have been identified as not "otherwise qualified" at the outset during the admission process. Related to those decisions are cases where a student has been "conditionally" admitted, but then does not meet the conditions, and a disability is a factor in that deficiency.

The following analysis sets out the current general state of judicial consideration on these issues. The first Supreme Court case to address any issue under section 504 of the Rehabilitation Act involved admission of an individual with a severe hearing impairment to a nursing school program. Although the decision was in 1979, it still provides valuable and relevant framing for how the issue of admission

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125 There are not many admission cases, perhaps in part because programs do not accept every student who applies, and it is often not apparent what the reasons were for not accepting an applicant in a competitive process. It is somewhat rare for a rejected initial applicant to know that the reason for the rejection was based on the impairment. One of the few cases to highlight the competitive process is *Manickavasagar v. Va. Commonwealth Univ. Sch. of Med.*, 667 F. Supp. 2d 635 (E.D. Va. 2009) *discussed infra*, Section VII(F)(1).

of an individual with a disability into a health care professional program would be judicially considered.

**a. *Southeastern Community College v. Davis* (1979)—Otherwise Qualified.**

While there are dozens of judicial decisions involving individuals with disabilities in health care educational programs or in the profession, the two key cases that are the basic starting place are a Supreme Court decision and a federal circuit court opinion that has been given great weight in subsequent judicial decisions. The first focuses primarily on the definition of “otherwise qualified” (while considering the issue of accommodations), and the second focuses primarily on the issue of what constitutes a “reasonable accommodation” in the context of determining whether an individual is otherwise qualified to continue. The two cases together highlight how these two issues are often intertwined.

The story behind the *Southeastern Community College v. Davis*,<sup>126</sup> decision was detailed in a 2008 book chapter by this author.<sup>127</sup> Frances Davis had completed a Licensed Practical Nursing program and was licensed by the State of North Carolina. She then sought admission to Southeastern Community College’s registered nursing program and was accepted into the program for a preliminary year with the notation on her acceptance that progress would be evaluated at the end of the first year. If progress was satisfactory, she could complete the next two years of the program (the Associate Degree Nursing Program) to receive the degree, a credential that was required for licensing as an RN in North Carolina. The first year of the program was primarily academic content (similar to most medical school programs today). Ms. Davis was advised at the initial admission that at the end of the year, her admission to the Associate Degree program would be based on her academic status and a physical examination. She performed adequately in the academic work, and it was during the interview that her difficulty in communication due to her hearing deficiencies was identified. The community college engaged in a thoughtful process. It referred her for a hearing evaluation, which resulted in a determination that even with a hearing aid, she would still require lip reading skills to understand speech. Before denying the admission, Southeastern sought an opinion from the North Carolina Board of Nursing about whether Ms. Davis could be licensed to practice or whether safety concerns prevent such licensing. It was based on the Board assessment that the accommodations that might be provided during the program could result in her not receiving the “full learning to meet the objectives of [the] nursing programs.” The opinion noted patient care situations where she might be unable to respond to “patient needs that might be critical in life and death situations.”<sup>128</sup>

After the denial, Ms. Davis sought and received consideration of a review of the decision by the college president’s office. The president consulted a committee

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126 442 U.S. 397 (1979) (holding that at least some minimal hearing level is an essential requirement for a registered nurse).

127 Laura Rothstein, *The Story of Southeastern Community College v. Davis: The Prequel to the Television Series “ER”* in EDUCATION LAW STORIES ch. 7, pages 197-220 (2008).

128 *Id.* at 201.

of staff members who reviewed and confirmed the concerns, and the denial was upheld. Ms. Davis sought redress in federal courts, and the case was ultimately decided by the Supreme Court. It took five years between her denial and the Supreme Court decision.

At all judicial levels, the courts focused on the definition of the term “otherwise qualified” under the Rehabilitation Act.<sup>129</sup> The Supreme Court considered federal agency guidance that had been promulgated during the pendency of the lower court decisions, and found that she was not “otherwise qualified.” This determination was based on the fact that she could not participate in the clinical aspects of the coursework, and not requiring those would be a fundamental alteration to the program. The Court did state (noting the requirement that such assessments be “individualized”) that technological advances should be considered in future cases where they did not result in undue financial or administrative burden, in determining whether someone could complete the clinical aspects of the program. The fact that the educational program was tailored to relate to the expectations of licensure was taken into account. The argument that licensure in another jurisdiction might be possible, so the college should admit her, was specifically dismissed.<sup>130</sup>

The Court specifically stated that “Section 504 ... does not compel educational institutions to disregard the disabilities of ... individuals or to make substantial modifications in their programs to allow disabled persons to participate.”<sup>131</sup> In so holding, the Court specifically quoted the regulations that provide that “a ‘[q]ualified handicapped person’ is, ‘[w]ith respect to postsecondary and vocational educational services, a handicapped person who meets the academic and technical standards requisite to admission or participation in the [school’s] educational program or activity.’”<sup>132</sup> The Court further referenced the explanatory note within the regulations that provides the following: “The term ‘technical standards’ refers to *all* nonacademic admissions criteria that are essential to participation in the program in question.”<sup>133</sup> Rejected was the plaintiff’s argument that section 504 requires that the program should “dispense with the need for effective communication” (which was required in its degree, in addition to being a registered nurse, as the ability to understand speech without reliance on lip reading, as necessary for patient safety during the clinical aspects of the program).<sup>134</sup>

This case is the guiding framework for subsequent judicial decisions in similar cases. Initially, there were few such cases, probably primarily because until the

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129 This would be a virtually identical analysis had the ADA been in effect and also a basis for judicial consideration.

130 This is the reverse of the decision in *Palmer College of Chiropractic v. Davenport Civil Rights Commission*, 850 N.W.2d 326 (Iowa 2014) (holding that potential licensing in one state was relevant to whether a student should be admitted to a program of the same college in a different state. See Section VII(A)(3) *infra*).

131 *Se. Cmty. Coll.*, 42 U.S. at 405.

132 *Id.* at 406.

133 *Id.* (emphasis supplied by the Court).

134 *Id.* at 400.



mandates of the 1975 special education law<sup>135</sup> had been in place for a few years, and section 504 had been implemented in colleges, there were few individuals in a position to seek admission to health care programs. In addition, litigation can take years to reach judicial closure.

**b. *Wynne v. Tufts University School of Medicine* (1991)—Reasonable Accommodation Process.**

The other key case that provides an essential framework for decisions involving qualification for health care professional programs is *Wynne v. Tufts University School of Medicine*.<sup>136</sup> While the decision is not a Supreme Court opinion, the reasoning provides such a sound and well-reasoned framework for evaluating the issue of accommodations in higher education settings that it has been adopted by numerous courts in all jurisdictions. The fact that it involves a medical school setting makes it even more relevant for the discussions in this article.

The case involved a medical school student who became aware that he had difficulty with multiple choice exams after failures on multiple choice exams in his first year (which ended in 1984). After a conditional readmission,<sup>137</sup> he was evaluated by a neuropsychologist who diagnosed that he had a condition that affected his ability to answer multiple choice exams. Noteworthy is the fact that a diagnosis of a learning disability or other protected disability was never made, although the case proceeds as though it were stipulated that he was covered under section 504. During his conditional readmission process, he was provided a number of accommodations and supports, including counseling, tutors, note takers, and taped lectures, and being allowed to retake exams that he previously failed. Due to failures on two of the required exams, he was dismissed from the medical school. Wynne's complaint with the Department of Education and subsequent lawsuit claimed that section 504 had been violated because he had not been granted the requested accommodation of being tested on material in something other than a multiple-choice format. The denial of the request was based on the determination by the school that the multiple-choice test purpose was to measure the ability not just to memorize complicated material, but also to "understand and assimilate it." Further the decision noted the necessity that "practicing physicians keep abreast of the latest developments in written medical journals."<sup>138</sup> This might call for reading and assimilating computer-generated data and other complex written materials. Making choices under stressful situations could require "a quick reading, understanding and interpretation of hospital charts, medical reference materials, and other written resources. A degree from Tufts University ... certifies ... that its holder is able to read and interpret such complicated written medical data quickly

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135 The Education for All Handicapped Children Act, Pub. L. No. 94-142, 89 Stat. 773 (1975).

136 932 F.2d 19 (1st Cir. 1991).

137 It is quite likely that legally Tufts would not have been required to readmit him. The school had no notice of a disability that might make him eligible for accommodations. This raises the issue of what a school "can" do but is not legally required to do, and ultimately whether it "should" do it if not required.

138 *Wynne*, 932 F.2d at 27.

and accurately."<sup>139</sup> It was further stated that "it was the judgment of the medical educators who set Tufts 'academic standards' that the above described demands 'are best tested...by written, multiple choice examinations.'"<sup>140</sup>

The court, while recognizing that judicial deference is generally given to the school, faulted the medical school for not engaging in the appropriate process for giving that deference. The court noted that the decision did not mention whether possible alternatives were considered. It was not clear who the decision makers were. The decision was viewed as "conclusory" and might be viewed as a decision that was based on the convenience of the faculty and administration. The court remanded with the guidance (which is quoted frequently by subsequent court decisions) that follows:

If the institution submits *undisputed facts* demonstrating that the *relevant officials* within the institution *considered alternative means, their feasibility, cost and effect on the academic program*, and came to a *rationaly justifiable conclusion* that the available alternatives would result either in *lowering academic standards or requiring substantial program alteration*, the court could rule as a matter of law that the institution had met its duty of seeking reasonable accommodation.<sup>141</sup> (emphasis added)

The medical school subsequently engaged in the requisite thoughtful process. The circuit court then reconsidered the case and found that Tufts decision not to allow a different testing format placed it in compliance with section 504 expectations.<sup>142</sup> While this was a framework for decisions about reasonable accommodations, it provides an equally sound framework for demonstrating that initial admission criteria was appropriately grounded.

The 1992 circuit court opinion in *Wynne* provides an "eloquent"<sup>143</sup> analysis that the medical school did an appropriately careful evaluation of why the multiple-choice test was necessary for at least the particular course in question. It also noted that the appropriate "hierarchy" was involved in that assessment.

The *Wynne* case facts arose in 1984, and the final decision was not reached until 1992 (eight years later). This case is one of several examples of extremely lengthy resolution of decisions in which the university almost always ultimately prevails but only after it had expended substantial resources. This is also an example of a situation where an institution probably did much more than was required at the outset (given that a disability had never been documented) and might well have not allowed a conditional admission. Once it did so, however, the door was open to questions about reasonable accommodation. The 1992 opinion also notes

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139 *Id.*

140 *Id.*

141 *Id.* at 26.

142 The medical school showed that the alternative proposed would be a substantial program alteration. *Wynne v. Tufts Univ. Sch. of Med.*, 976 F.3d 791 (1st Cir. 1992).

143 Judge Selya, who wrote the opinion, is known for his writing style. Also joining the opinion in this case was Justice (then Judge) Stephen Breyer.

that the fact that other medical schools have granted a similar request does not determine whether Tufts is required to do.

### c. Subsequent Decisions.

The early cases interpreting section 504 in health care professional contexts are interesting because they include a range of impairments—from sensory to mental health—and can provide a window into how courts were addressing denials of admission based on disability as well as how courts address issues of qualification in situations where readmission is sought after performance deficiencies and in cases where a student seeks to advance to a higher level of programming or specialty. All of these cases can shed light on whether an individual is likely to be qualified for licensure or certification and can factor into the decision to admit, readmit, or advance a student with a disability in a health care professional setting.

One of the early decisions on admissions was also a Supreme Court decision, but the decision did not directly address whether the individual was otherwise qualified. In *County of Los Angeles v. Kling*,<sup>144</sup> the Court did not reach the issue of whether an applicant to the Los Angeles County Medical Center School of Nursing was otherwise qualified. Instead, the Court found that the applicant with Crohn's disease was not disabled under Ssection 504. While the Supreme Court dismissed the case based on its determination that she did not have a disability covered by section 504, the lower court opinion provides the specific facts that the plaintiff was rejected because of the school's assumption that her health condition would result in excessive absenteeism.<sup>145</sup>

The nursing school had not engaged in an individualized assessment of how her condition might affect performance when it learned, after her admission and during a medical examination of admitted applicants, that she had Crohn's disease. While the program had concerns about the potential hospitalization, the plaintiff indicated that this might not be a concern because she could schedule hospitalizations to minimize interference with required school programs. The nursing school apparently did not want to explore that further. The circuit court granted a preliminary injunction, but ultimately the issue of accommodation was not explored further when the Supreme Court in a very short opinion decided that Crohn's disease is not a disability.<sup>146</sup>

There are few other cases in the higher education admission context in which the court finds the individual not to be disabled within the statutory protection.<sup>147</sup> There may be a number of reasons that early higher education litigation did not reach the issue of whether the person was denied, when courts addressing employment settings were dismissing cases frequently based on the person not being disabled

144 474 U.S. 936 (1985).

145 *Kling v. Cnty. of L.A.*, 633 F.2d 876 (9th Cir. 1980, *on appeal* 769 F.2d 532 (9th Cir. 1985)).

146 The 2008 amendments to the ADA would probably mean that courts today would find her to be a protected individual, and if so, the lower courts would be expected to engage in much greater exploration of whether the health condition could be reasonably accommodated. There is, however, less clarity about how that would be determined at the initial admission stage.

147 See ROTHSTEIN & IRZYK, *supra* note 100, at § 3:2.

within the statutory definition. One reason may be that the courts were often able to determine that there was not impermissible discrimination regardless of whether the person was covered under the statute, so they did not need to reach that issue.

## VI. Judicial Interpretations (by Type of Impairment)

In 2016, the *Journal of College and University Law* published an excellent article by Ellen Babbitt and Barbara Lee on “Accommodating Students with Disabilities in Clinical and Professional Programs: New Challenges and New Strategies.”<sup>148</sup> In the article, the authors establish a framework for providing disability accommodations in medical schools and other professional programs that have clinical aspects to their programs. The article indicates a number of specific recommendations.

The discussion below, while tracking many of the same statutory and judicial interpretations,<sup>149</sup> and building on the framework for medical schools, provides a detailed examination of the most challenging cases. The review tries to identify key institutional policies, practices, and procedures that, if they had been implemented differently, might have avoided protracted and costly litigation.

The following discussion provides an overview of how courts addressed health care professional program admission and subsequent qualification. The case discussions are organized by type of impairment. Providers of health care professional services are generally required to have competencies that include knowledge, cognitive abilities, and technical skills, as noted previously in this article.<sup>150</sup> In addition, the ability to interact with patients and other staff members is often critical to competent practice. The type of impairment may be significant for health care professionals in meeting the technical and academic standards. The possibility of reasonable accommodations or modifications to compensate for deficiencies is essential to examine to determine competency, keeping in mind that changes in technology may affect the ability to compensate. For example, is it critical that a particular health care professional be able to “hear” a heartbeat through a stethoscope, or might adapted instruments give the heartbeat visually on the instrument? These types of questions suggest that those setting technical standards and criteria in terms of assessing what is required do more than they are currently doing at some institutions. These questions also require institutional administrators who set and implement policies, practices, and procedures for evaluating performance to examine these issues carefully. Without such an examination, health care professional programs can find themselves in lengthy legal disputes. Although the institutions generally succeed in litigation that ultimately results in a finding of nondiscrimination, significant resources are often expended in resolving those cases.

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148 Ellen Babbitt & Barbara A. Lee, *Accommodating Students with Disabilities in Clinical and Professional Programs: New Challenges and New Strategies*, 42 J.C. & U.L. 119 (2016).

149 The Babbitt/Lee article includes a number of Office for Civil Rights (OCR) opinions from the Department of Education in addition to case discussion. These are not included in this author’s discussion.

150 See Section VI(F) *infra*.

### A. *Visual Impairments*

Decisions involving visual impairments and health care professional program admission<sup>151</sup> highlight the need for greater clarification about what is permissible in the admissions process. These cases seem to reach inconsistent outcomes, leaving programs in jurisdictions not subject to these holdings unsure about what is mandated or required. In some of the cases, the court denies a motion for summary judgment, indicating that there were issues in dispute that required greater consideration. Such holdings highlight the value of having thoughtful procedures within the institution in handling these cases.

#### 1. *Doherty v. Southern College of Optometry (Clinical Stage)*

In *Doherty v. Southern College of Optometry*,<sup>152</sup> an optometry student with retinitis pigmentosa was found not to be qualified to continue in the program because he was unable to operate certain equipment necessary for the practice of optometry. This case is instructive because, although Doherty was admitted (with considerable concerns and only after three applications),<sup>153</sup> it was at the clinical stage when he was required to perform on certain instruments that it was determined that he was not otherwise qualified to continue. Although his academic performance was competent, it was determined that he would never be able to “practice optometry as a ‘normal’ clinical practitioner.”<sup>154</sup> Because he was unable to demonstrate mechanical proficiency on some of the instruments in the pathology lab (and there were concerns about patient safety in how some might be used), he was denied completion of the program with a degree. The program determined that the ability to use the instruments was both essential to the educational program and also to the practice. Noteworthy is the fact that the instrument usage had only been required for a few years, so previously certified optometrists would not have been trained on them. There was testimony in the case that many of those who had received their degrees before these instruments were included in the educational program never used the instruments in their practice. The court noted that while there is evidence that some educational programs waive the training on certain instruments, that was not relevant to the decision in this case. The lower court’s analysis of deference to be paid in these cases applied the reasoning in *Davis*.<sup>155</sup> It provides the interesting example that the refusal to waive a physical education requirement for a history degree is very different from modifying a requirement that relates to patient safety.

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151 Employment cases can also be relevant for determining a number of issues relevant to the educational aspects of the program. *See, e.g.*, *Babb v. Maryville Anesthesiologists, P.C.*, 361 F. Supp. 3d 762 (E.D. Tenn. 2019). (termination of nurse with retinal degeneration legitimately based on safety concerns because of errors that gave clinic reason to believe that nurse lacked clinical judgment).

152 862 F.2d 570 (6th Cir. 1988).

153 *Doherty v. S. Coll. of Optometry*, 659 F. Supp. 662 (W.D. Tenn. 1987).

154 *Id.* at 666.

155 *Id.* at 672.

2. *Ohio Civil Rights Commission v. Case Western Reserve University (Admission)*

In *Ohio Civil Rights Commission v. Case Western Reserve University*,<sup>156</sup> the Supreme Court of Ohio, addressed whether Ohio state law (which was virtually identical to section 504 and the ADA)<sup>157</sup> was violated when the Case Western Medical School denied admission to a totally blind applicant on the basis that she was not otherwise qualified to complete the program. The court struck down the Ohio Civil Rights Commission's decision that found that Ohio law had been violated by the denial. In doing so, the court provided analysis that incorporates both the *Davis* and the *Doherty* reasoning.<sup>158</sup>

The case opinion comments on the fact that a blind applicant had been admitted to medical school at Temple University.<sup>159</sup> The plaintiff had offered that fact as proof that it was not a fundamental alteration of a medical school program to admit someone who was blind. The court rejected that argument and provided relevant guidance for future cases. The court noted that Dr. Hartman's admission had been twenty years previous to the facts of this case, and that the medical school had not admitted the student because it believed it was required to, but because it decided to go beyond what might be legally required. It added one more student to the class and voluntarily absorbed the costs of the accommodations.

In its opinion, the court offered this guiding language.

The goal of medical schools is not to produce specialized degrees, but rather general degrees in medicine which signify that the holder is a physician prepared for further training in any area of medicine. As such graduates must have the knowledge and skills to function in a broad variety of clinical situations and to render a wide spectrum of patient care. All students, regardless of whether they intend to practice in psychiatry or radiology, are expected to complete a variety of course requirements including rotations in pediatrics, gynecology and surgery.<sup>160</sup>

In reaching its decision, the court relied on the expertise of the AAMC<sup>161</sup> and medical educators who testified that the use of intermediaries to develop skills of medical diagnostic judgment would interfere with the student's exercise of independent judgment, which is crucial to developing diagnostic skills.<sup>162</sup>

Noteworthy in this case is the holding that in cases such as this, an individualized inquiry is not expected. The court finds that it is permissible to have a standard

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156 76 Ohio St. 3d 168, 666 N.E.2d 1376 (1996).

157 *Id.* at 181. The court specifically relied on section 504 interpretations in its analysis. *Id.*

158 *Id.* at 191 ("An educational institution is not required to [eliminate] a course requirement which is reasonably necessary to the proper use of the degree conferred at the end of study.").

159 *Id.* at 188.

160 *Id.* at 191.

161 ASS'N OF AM. MED. COLLS., <https://www.aamc.org/> (last visited June 26, 2021).

162 *Case W. Reserve Univ.*, 76 Ohio St. 3d at 192.

that denies admission where a standard excludes all individuals in a particular group such as all blind applicants.

3. *Palmer College of Chiropractic v. Davenport Civil Rights Commission (Conditional Admission)*

The outcome in *Ohio Civil Rights Commission v. Case Western Reserve University* can be contrasted with the Iowa State Supreme Court's decision in *Palmer College of Chiropractic v. Davenport Civil Rights Commission*,<sup>163</sup> In the *Palmer* case the court found that the denial of a blind student to a chiropractic program violated a state law (which was similar to federal disability discrimination law). The court in its opinion stressed the importance of an individualized assessment (in contrast to the Ohio case), in reaching its conclusion. Although the court noted that deference should be paid to an institution, it nonetheless found that the institution was in violation of disability discrimination law when it denied admission to Mr. Palmer.

Aaron Cannon initially applied to the chiropractic college at its Iowa location (the college had other locations in Florida and California) in 2004 for its bachelor of science program (the program also had a doctor of chiropractic programs) and informed the school early in the admission process of his blindness. His intent was to complete both the undergraduate and graduate programs. The school had adopted technical standards in 2002 and referred Mr. Cannon to its disability student coordinator to assess the impact of Mr. Cannon's blindness in meeting the technical standards.

Although concerns were raised at the point of undergraduate admission about whether he would be able to perform the requisite skills to complete the graduate degree, he was conditionally admitted to the graduate program contingent on success in the undergraduate program. Mr. Cannon notified the school early in the undergraduate process about how various accommodations had enabled him to engage in academic programming, and after two trimesters, he had a 3.44 grade point (on a 4.00 scale) and sought confirmation about his admission to the graduate program. At that point the disability steering committee began to discuss further education with him and expressed doubts about his ability to complete the graduate program, and the interactive discussion about his proposed modifications still left the school in doubt about whether the point at which courses such as radiology would be required would be a "stoppage" point. Although Mr. Cannon was willing to face that obstacle later, the school was concerned that he would not be able to complete the work, and discussions of whether the technical standards and the related accreditation standards resulted in their decision that such waiver was not negotiable.

Factors relevant to the decision of the Iowa Civil Rights Commission and the Iowa Supreme Court were that there had been previous graduates who were blind, and accommodations granted through that process had not resulted in loss of accreditation (at least in California). Both of these entities found the

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163 850 N.W.2d 326 (Iowa 2014). The initial admission was in 2004, and ten years passed before the final judicial resolution.

denial of admission and proposed accommodations to violate state and federal discrimination law. In contrast, the district court gave deference to the college claim that the accommodations would be a fundamental alteration of the program.

The Supreme Court's analysis focuses on the issue of fundamental alteration (notably not addressing the undue burden issue because it was not raised below). The court took into account the decisions in *Davis*<sup>164</sup> and *Case Western*<sup>165</sup> and *Wynne*<sup>166</sup> in noting that a rigorous analysis was required before granting deference to the educational institution. In the court's view, *Palmer* (in contrast to the other settings) had not engaged in this requisite assessment.<sup>167</sup> The school had not engaged in the detailed, individualized inquiry expected before deferring to the institution. A lengthy dissent disagrees and provides specifics about how the school had engaged in such an individualized careful assessment of Mr. Cannon. The dissent also rejected the majority reliance on the fact that Mr. Cannon would have to be admitted in California by noting a specific California statute that provides for waiver of certain coursework.

Both the majority and dissent in *Palmer* provide lengthy and detailed analysis of the opinions and conclusions. If the *Palmer* majority opinion were to be adopted in other cases, there would be no instance in which a school could decide not to admit a blind student on the basis of a determination that such a student could not complete essential requirements, even taking into account accommodations.

The *Palmer* majority notes, in passing, the fact that during the interactive<sup>168</sup> process about whether Cannon should be allowed to continue, the school raised its concern about the "time, effort, and money Cannon had already expended and would continue to expend despite the indications that he would not be able to complete the program." The majority also notes, but does not discuss, the fact that the issue of undue burden was not raised in the proceedings,<sup>169</sup> so the issue was not addressed. The issue of cost, however, should be more intentionally addressed in these cases. That would be cost to both the individual and the institution, and the concern should be not only financial cost, but also administrative cost to the institution and costs of lost opportunities to an individual who might be allowed to continue in an educational program, when the institution providing that program believes the student will never be able to use that program to engage in a professional practice. The ten years between initial admission and final judicial resolution imposed substantial costs to both parties.

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164 Se. Comty. Coll. v. Davis, 442 U.S. 397 (1979).

165 Ohio Civ. Rights Comm. v. Case W. Reserve Univ., 76 Ohio St. 3d 168.

166 Wynne v. Tufts Univ. Sch. of Med., 932 F.2d 19 (1st Cir. 1991).

167 Palmer Coll. of Chiropractic, 850 N.W.2d at 337.

168 *Id.* at 331.

169 *Id.* at 336.



4. *Stopka v. Medical University of South Carolina (During Academic Portion of Medical School; Admission to Residency)*

The case of *Stopka v. Medical University of South Carolina*,<sup>170</sup> is instructive because it involves a medical resident who became disabled after he had already begun medical school. The student began medical school in 1997 and, at the end of his first year, suffered a fall that resulted in a closed head injury that resulted in visual perception impairments and substantially slower reading rate. He returned to medical school, but with a reduced class load and clinical load, and additional time for exams and coursework. He graduated in 2003, taking six years not the usual four years.

At the point he sought a residency appointment, the concerns about his competency reached a critical point. He began a pediatric residency, informing the host school of his limitations. Residency is a hybrid employment/educational experience, and thus he signed an “employment” contract as part of it. He received no accommodations initially. His rotations through various programs (neonatal intensive care, emergency, hematology, and oncology) resulted in marginal and unsatisfactory performance assessments. At this point he received a reduced clinical load, but he still took much more time than others to read information. Patient visits took much longer than those conducted by his peers. Assistive devices for reading were not totally adequate and were problematic for reading handwritten notes. He was unable to quickly synthesize complex or large amounts of information. After further performance deficiencies, he was dismissed in January 2004. He had been enrolled for seven years before it was determined that he was not otherwise qualified, even with accommodations.

He challenged the dismissal on the basis that the school had failed to provide accommodations to his disability as required by the ADA. The court found that he was not qualified because he did not possess the essential skills for patient care. The court rejected the argument that not every resident already possesses the skills because the purpose of the residency is to gain the skills. The court noted the extensive accommodations that had been given during the six years of medical school after the injury occurred, but these had not been able to offset the deficiencies of memory, decision making, and speed. His proposal that a handheld scanning device could read aloud texts and notes was deemed not reasonable because many notes are handwritten by many different people, and such an accommodation would not address the concern about speed. The dismissal was permissible and did not violate the university’s procedures for such a dismissal.

This case highlights the issue about whether the medical school *should* have provided the accommodations it did during medical school, if it were likely that he would not be able to succeed in a residency. The court never addresses whether the school *must* have provided the accommodations it did when they reinstated him or whether the school might have been able to justify that he was no longer otherwise qualified at that point. While a medical school *can* provide accommodations, even

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170 2007 WL 2022188 (D.S.C. 2007 July 11, 2007) (medical resident with cognitive and visual deficiencies from closed head injury not qualified; could not carry out essential function of caring for patients; accommodations could not compensate).

if not legally required to do so, the unresolved question is whether it wise to do so in all cases. The cost to the student and the institution of six years of medical school that would not in all likelihood lead to licensure as a physician raises this question. The question then becomes what might have been a better course of action in 1998 to avoid this outcome.

5. *Cunningham v. University of New Mexico Board of Regents (During Medical School)*

The decision in *Cunningham v. University of New Mexico Board of Regents*,<sup>171</sup> provides marginal precedential guidance for decision makers because the court did not really reach the issue of accommodations or otherwise qualified. It determined instead that because the medical student bringing the claim had not provided sufficient documentation to prove that his Scotopic Sensitivity Syndrome was substantially limiting, the case should be dismissed. The facts involved a medical student admitted in 2005, whose condition caused headaches and high blood pressure due to prolonged reading, which resulted in his request for a medical leave. Although he had been diagnosed with a reading disability in grade school, he had learned to compensate for it and was a superior student who throughout his entire grade school, high school, and college experience was able to complete extensive reading assignments without accommodation.

Upon his return in 2007, he was advised that he had to retake the first-year courses. His requested accommodations for his now diagnosed condition were denied. He passed his coursework without accommodation. When he was to take the First Step of the United States Medical Licensing Exam, he again requested accommodations and was denied. After failing the test, he requested accommodations to take it a second time. He asked the University of New Mexico Disability Committee for assistance in obtaining accommodations, but they did not provide the requested assistance. When he failed the exam (without accommodations) the second time, he was placed on academic leave, and at that point he brought suit against the University and the NBME. The court found that because he was able to mitigate his disability in the past by using colored glasses and taking medication, he was not disabled within the statutory definition. It thus dismissed his ADA/Rehabilitation Act claims, and the dismissal was affirmed by the Tenth Circuit in 2013. From his initial enrollment to the circuit court decision, eight years passed.

The outcome in this case might be different if the same facts were involved today. The primary reason is that during the time of this litigation, a number of cases involving the "mitigating measures" standard were being considered.<sup>172</sup> Congress ultimately amended the ADA in 2008 to clarify that such measures should not be taken into account in determining whether someone has a disability. It is much more likely that the plaintiff would have been considered to be a person with a disability. What is unknown is whether the accommodations he requested

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171 779 F. Supp. 2d 1273 (D.N.M. 2011), *aff'd*, 531 F. App'x 909 (10th Cir. 2013).

172 Before the ADA amendments, courts had ruled that the analysis of whether or not an individual was disabled should include whether accommodations were able to mitigate the effect of the disability such that the individual no longer met the definition of "disabled."

would be viewed as “reasonable” under today’s judicial interpretation standards. The facts of the case also highlight the interrelationship of the university and the licensing agency. Mr. Cunningham had requested assistance of the medical school on obtaining accommodations with the licensing agency, and that request was not granted. What is unclear given the facts in the case is what assistance from the medical school would be in his case, since it had denied his requested accommodations itself. It also highlights the extensive time and resource issues of resolving these issues.

## B. Hearing Impairments

There have been several judicial decisions where the issue of hearing impairments and accommodations and related issues have been addressed in the context of both nursing programs and medical school.<sup>173</sup> Significant to these cases is the fact that the first federal court judicial guidance on disability issues in health care professional programs arose out of a nursing program and a student with a severe hearing deficit.<sup>174</sup> As noted by the Supreme Court in 1979, changes in technology should be considered in making determinations about accommodations, and hearing is an area where there have been substantial changes in technology. Such changes include CART<sup>175</sup> technology and adapted stethoscopes. The issue often becomes not whether the individual can “hear” but whether the individual can receive the necessary information in a timely manner depending on the setting.<sup>176</sup> Courts consistently consider issues of patient safety in these settings.

### 1. *Argenyi v. Creighton University (During Medical School)*

One of the major cases on this issue is *Argenyi v. Creighton University*,<sup>177</sup> which addressed the accommodation requests by a medical student with a significant hearing loss. Mr. Argenyi did not use sign language, but rather relied on cued

173 See ROTHSTEIN & IRZYK, *supra* note 100, at § 10:7. (Sensory Impairments—Hearing and Vision); Christopher J. Moreland et al., *Deafness among Physicians and Trainees*, ACAD. MED. (Feb. 2013), [https://journals.lww.com/academicmedicine/Fulltext/2013/02000/Deafness\\_Among\\_Physicians\\_and\\_Trainees\\_A.27.aspx](https://journals.lww.com/academicmedicine/Fulltext/2013/02000/Deafness_Among_Physicians_and_Trainees_A.27.aspx). The following are judicial decisions in the employment setting that might be relevant as well. *Searls v. Johns Hopkins Hosp.*, 158 F. Supp. 3d 427, 32 A.D. Cas. (BNA) 885 (D. Md. 2016) (undue financial hardship should consider overall budget, not amount budgeted for accommodations; case involved cost of interpreter service for a deaf nurse (\$120,000)); *Osborne v. Baxter Healthcare Corp.*, 798 F.3d 1260, 31 A.D. Cas. (BNA) 1770 (10th Cir. 2015) (deaf applicant for position of plasma center technician did not have to show under direct threat standard that requested accommodation would eliminate every de minimis health or safety risk hypothesized by employer).

174 See the discussion of Southeast Community College, *infra*, Section V(B)(2)(a).

175 CART stands for Communication Access Realtime Translation. See <https://www.nad.org/resources/technology/captioning-for-access/communication-access-realtime-translation/>.

176 Adapted stethoscopes and other technology that provide the heart rate visually are examples.

177 2011 WL 4431177 (D. Neb. Sept. 22, 2011), *rev'd on other grounds*, 703 F.3d 441 (8th Cir. 2013) (medical student with significant hearing loss requested communications access real time transcription, and interpreters as accommodation; preliminary order remanding, recognizing fact issues about whether request was reasonable).

speech.<sup>178</sup> He began medical school in 2009 and sought to use CART technology, cued speech, and an FM system, an accommodation he had received in undergraduate school. The school provided the FM system for lectures, small groups, and labs. The CART accommodation request, however, was denied. Shortly after beginning, Mr. Argenyi recognized the inadequacy of the accommodation and again requested captioning technology. The school instead provided enhanced notetaking. Mr. Argenyi paid for captioning and additional services himself at a cost of over \$53,000 in addition to his tuition. He renewed his request for his second year of medical school and was again denied. Again, he paid for the service himself at a cost of \$61,000. The second year of medical school included clinical courses, which involved interaction and communication with patients. The university negotiated an initial agreement to provide the captioning services in clinical courses, but when these settlement talks broke down, he passed his clinical work and courses without the services. At that point, he took a leave of absence and brought suit under section 504 and the ADA.

The district court in 2011 granted summary judgment to the university, finding that the university had provided effective communication and apparently some findings that the documentation to support the requested accommodations was inadequate because it relied on “unsupported self-serving allegations.”<sup>179</sup> The appellate court addressed the issue of whether the university had provided necessary accommodations and whether the accommodations it had provided ensured “meaningful access.”<sup>180</sup> That requirement expects that an individual will be given equal opportunity to gain the same benefits as peers who are not disabled. The court found that applying that standard to this case, the university would be expected to consider how its programs are available to medical students who do not have disabilities and to take reasonable steps to provide him with a like experience.<sup>181</sup> The court found that there was evidence to demonstrate that he had been denied this and remanded for further findings in the case.

On remand,<sup>182</sup> the court found that it was discriminatory to not provide the services and required the service prospectively for his last two years of medical school. Because intentional discrimination could not be found, Michael Argenyi was not awarded reimbursement of the \$133,595 he had expended for the CART services for his first two years. The court did find that the university had not met its burden of showing undue financial burden, making this one of the few decisions where this issue is addressed. Because Argenyi was considered to be the prevailing party, however, he was awarded almost \$500,000 in attorneys’ fees and costs.<sup>183</sup>

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178 2011 WL 4431177. at \*1.

179 2011 WL 4431177. at \*10.

180 *Argenyi v. Creighton Univ.*, 703 F.3d 441, 445-46 (8th Cir. 2013).

181 *Id.* at 449.

182 *Argenyi v. Creighton Univ.*, 2013 WL 4434424 (D. Neb. August 14, 2013); 2014 WL 1838980 (D. Neb. May 8, 2014).

183 *Deaf Nebraska Student Awarded Legal Fees*, KETV NEWSWATCH (May 9, 2014), <https://www.ketv.com/article/deaf-nebraska-med-student-awarded-legal-fees/7646174#>. The initial enrollment was 2009 and the final judicial resolution was in 2014, a period of five years.

While this is a relatively “speedy” judicial resolution, at least as to the issue of the standard to be applied, it again demonstrates the time and cost of litigation. What is not decided in this case is whether Argenyi’s hearing deficit would ultimately prevent him from being licensed or admitted to a residency, and if so, whether the medical school could have considered that in its initial admission decision.

### 2. *Featherstone v. Pacific Northwest University of Health Sciences (During Medical School)*

The case of *Featherstone v. Pacific Northwest University of Health Sciences*<sup>184</sup> involved issues that arose during medical school although they were raised at the admission stage. In 2012, Zachary Featherstone applied for admission to the osteopathic medicine program at Pacific Northwest University of Health Sciences, and during the admissions interviews he used an interpreter for his hearing impairment. Upon acceptance for admission, he requested captioning for lectures and an interpreter for more interactive sessions such as labs and clinics. The university worked with the state vocational rehabilitation programs in considering his requests, and indicated that it would take more time to make the arrangements and asked if he would defer admission for a year, which he agreed to. The University withdrew its admission decision, claiming concerns about patient safety and the ability to complete his performance evaluation within the time requirements. Cost was apparently not an issue because the state office of vocational rehabilitation had indicated its willingness to pay if the University could not. The court found that the university’s concerns were speculative and unfounded. Featherstone had requested a preliminary injunction after the university’s claims that his requests for accommodations would be a fundamental alteration. No request for additional timing for exams had been made. The claims about fundamental alteration were speculative. Interesting in this case was the concern about the limited availability of interpreter services in Yakima, Washington. The court addressed that concern by finding that those concerns were unfounded, and evidence indicated that such services could be made available. Similarly, the court found the concerns about patient safety to be unfounded.

What is not addressed by this court is what would happen if a clinical rotation (such as surgery) raised an issue of patient safety that could not be accommodated.<sup>185</sup> That issue remains unresolved. The same concern might be raised at the point of entry into a residency.

### 3. *Guidance from Other Professional Program Settings*

Whether hearing is an essential function (or the ability to communicate in an alternate format) might depend on which health care professional program is involved and also on the level of the program. For example, quick response by a nurse

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184 2014 WL 3640803 (E.D. Wash. July 22, 2014). He completed the program.

185 Jake New, *Fighting Their Way into Medical School*, INSIDE HIGHER EDUC. (July 28, 2014), <https://www.insidehighered.com/news/2014/07/28/judge-orders-medical-college-accommodate-deaf-student> (reporting on an order to admit Zachary Featherstone to the osteopathy program at Pacific University after acceptance was withdrawn during the process of working out accommodations for his hearing impairment).

to auditory information in an emergency room setting is more essential than for a physician who diagnoses cancer using visual information. As noted throughout, however, many professional programs have training that requires demonstration of essential functions regardless of specialization or later employment.<sup>186</sup>

The case of *Alexander v. State University of New York at Buffalo*,<sup>187</sup> involved a student in a nursing program who relied on lip reading rather than signing and who had worn hearing aids since she was four years old. The case is interesting from the perspective of its detailed description of the communications (and possible miscommunications) before the student started the program about what the accommodations would be. The services at issue included CART technology, preferential seating, note takers, extended time and separate rooms for exams, and an FM system for hearing aids. The student was accepted in December 2008, and in June 2009, the first request to the school about accommodations was communicated to the school. The ensuing discussions during the summer raised questions about what had been promised, and when several of the requested accommodations were not in place when Sara Alexander began the program, she withdrew before the end of the first semester and enrolled in other programs where the requested accommodations were provided and where she was succeeding. The only reported decision came four years after her initial enrollment, and was a denial of the school's motion for summary judgment.

The case is instructive to educational programs in a number of ways. It highlights the importance of an early interactive process for addressing accommodation issues. However, although the process was initiated by the student (there was substantial involvement of the mother)<sup>188</sup> it was not initiated until June, and some of the accommodations seemed to have taken longer to implement than expected, so they were not in place at the beginning, often a crucial part of a course. There was also some disagreement about what had been promised (which would require further resolution), and this highlights the value of clear and specific written follow-up to discussions. This was critical in this case because of the note-taking concern. The case also involves a practice that is somewhat questionable in terms of implementation, which is to give a student a note to give to a faculty member regarding accommodations (such as preferential seating).

In this case, there are questions about faculty member compliance, obligation of the institution to ensure compliance, and the impact on her learning as a result. The court generally addresses that issue in its discussion of whether intentional

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186 See, e.g., *Osborne v. Baxter Healthcare Corp.*, 798 F.3d 1260 (10th Cir. 2015) (deaf applicant for position of plasma center technician did not have to show under direct threat standard that requested accommodation would eliminate every de minimis health or safety risk hypothesized by employer); *Alexander v. State Univ. of N.Y. at Buffalo*, 932 F. Supp. 2d 437 (W.D.N.Y. 2013) (nursing student with severe hearing impairment sought various accommodations and claimed university was deliberately indifferent to her; denial of summary judgment); *Wells v. Lester E. Cox Med. Ctrs.*, 379 S.W.3d 919 (Mo. Ct. App. S.D. 2012) (no evidence that providing sign language interpreter to student in nursing program would fundamentally alter the program or pose a threat to safety).

187 932 F. Supp. 2d 437 (W.D.N.Y. 2013).

188 The fact that the plaintiff was a high school senior when the process began explains the substantial involvement of the parent.

discrimination had occurred (necessary for some monetary remedies) in noting that “deliberate indifference” facts might meet that requirement.<sup>189</sup> The court noted that more than mere bureaucratic negligence is required; if the institution knows of a need and fails to adequately respond, the standard might be met.

While no clear judicial standard or regulation as to what an institution must do to ensure faculty compliance exists on such an issue, it is one that merits closer examination by policy makers and administrators, especially in light of the potential liability of the institution. The case notes, but does not resolve, whether the institution knew of concerns about professors who did not ensure preferential seating and whether the institution should have taken actions to ensure compliance. This type of faculty obligation and related supervisory responsibility is likely to become an increasing concern in all higher education settings where faculty involvement in accommodations is involved. Some medical schools are not organized or financed in a way that emphasizes pedagogy, with faculty members at such institutions expected to give greater priority to revenue-generating clinical services or research. As a result, the conceptualization, coordination, and presentation of classroom instruction can suffer.

So, while the decision does not specify whether the requested accommodations were reasonable, it does give a signal to institutions about taking care in ensuring that their policies, processes, and procedures are adequate to avoiding liability ultimately, and even if there is no liability, avoiding unnecessary litigation.

### C. *Mobility Impairments*

Medical school and other health care professional programs require a range of physical capabilities,<sup>190</sup> many of which are incorporated into the clinical work and some of which are inquired about when students are asked to sign an acknowledgment of specific technical abilities when they enter the program. These can and often do include a range of physical functions that can require physical dexterity, strength, and stamina (depending on the particular program).

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189 *Alexander*, 932 F. Supp. 2d at 445.

190 In *Widomski v. State University of New York (SUNY) at Orange*, 933 F. Supp. 2d 534 (S.D.N.Y. 2013), *aff'd*, 748 F.3d 471 (2d Cir. 2014) the court did not determine whether impermissible discrimination had occurred. The reason was that it found that the condition was not a disability. The court granted the university’s motion for summary judgment in a claim by student that he was perceived as disabled because of hand shaking that occurred during the phlebotomy clinical program. Because his hand shaking only affected one particular job, he was not disabled. It is possible that even if the applicant would have been found to be protected under the statute, that the court might have found him not to be otherwise qualified because the course affected by his hand shaking was required for graduation. In *Russell v. Salve Regina College*, 890 F.2d 484, 57 Ed. Law Rep. 382 (1st Cir. 1989), *rev’d on other grounds*, 499 U.S. 225 (1991) the court provided only nominal guidance on disability discrimination issues. The case was decided before the courts had clarified that federal financial assistance need not be directly for the program in which the individual was involved for section 504 of the Rehabilitation Act to apply. But the fact pattern is interesting for consideration if the situation arose today. The impact of a nursing student’s weight was a stated reason for her dismissal from a private program. The school initially tried to get her to agree to lose weight (she weighed over three hundred pounds), and when she did not, she was dismissed based on a breach of contract basis. There have been numerous more recent decisions involving physical qualifications of nurses (with varying outcomes). The question to be considered is whether a health care professional program can consider obesity (or its impact) at the initial admissions stage. Could Salve Regina College deny admission to Ms. Russell at the outset?

1. *Pushkin v. Regent of the University of Colorado (Denial of Residency)*

One of the few cases in which the result was in favor of the residency applicant with a disability is the 1981 decision in *Pushkin v. Regents of the University of Colorado*,<sup>191</sup> a case involving an individual with multiple sclerosis who was denied admission to the psychiatric residency program directly related to his impairment. Dr. Pushkin was a wheelchair user, and his rejection was a result of the interview process in which the committee members expressed concern about “their concern for psychologic reactions of the patient and in turn the doctor, as a result of his being in a wheelchair.”<sup>192</sup> These observations were found not to be “predicated on any known deficiency of Dr. Pushkin himself.”<sup>193</sup> The basis for rejection was solely because of the disability, although after the decision, there was an attempt to justify the decision after the fact based on other nonqualifying factors.<sup>194</sup> Both the trial court and the appellate court determined that Dr. Pushkin was qualified (he met the academic standards) and he had provided a letter from his residency program in psychiatry. The articulated reasons for rejection were determined to have been based on incorrect assumptions or inadequate factual grounds.<sup>195</sup> Noteworthy is the fact that this is one of the earliest judicial decisions addressing the issue of disability in the context of medical school admission, and as noted above, it is one of the few cases in which a plaintiff has been successful in such a case.

2. *McCully v. University of Kansas School of Medicine (Conditional Admission)*

The facts in *McCully v. University of Kansas School of Medicine*<sup>196</sup> involved the admission of Emily McCully had a spinal cord injury before she was admitted to medical school, and upon responding to the postadmission information about the ability to meet specified technical standards and her responses to the inquiry about needed accommodations, the admission was withdrawn. Her responses were based on consultation with her physician. Specifically, her physician recommended that a staff person be provided to “assist with lifting and positioning patients, stabilizing elderly patients, and performing basic life support.” The decision was based on consultation with the clinical faculty members who considered the specific recommendations in light of requirements for the program. She then brought suit under the ADA and section 504, and the district court granted the university’s motion for summary judgment.

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191 658 F.2d 1372 (10th Cir. 1981).

192 *Id.* at 1386. The interview notes showed that the opinion and judgment of all of the interviewers was “inextricably involved with [his] handicap.” *Id.*

193 *Id.*

194 *Id.*

195 *Id.* at 1383. Pushkin’s rejection was discussed “only in terms of the handicap,” and he was given no “no other reason[s]” for his rejection. *Id.* at 1382. Additionally, “[t]he interview sheets which refer to assumed disabilities occasioned by his multiple sclerosis ... and additional testimony which shows after the fact articulation of concern about his alleged emotional instability which was not manifested in the interview sheets or in Dr. Carter’s conversations with Dr. and Mrs. Pushkin.” *Id.*

196 591 F. App’x 648 (10th Cir. 2014). Medical School withdrew admission to individual who had a spinal cord injury. *Id.*



The circuit court upheld the lower court and noted that while the applicant did not plan to practice in an area that would require these specific skills, the school's decision that the accommodations for the education program would be a fundamental alteration of the program (the required Motor Technical Standards), because she would be an observer, rather than a participant in the training. It recognized the legality of a medical school only providing an undifferentiated medical curriculum, and references that the United States Medical Licensure Examination require these skills.

Noteworthy, related to the possible remedy had she been successful, the court found that the medical school had engaged in an "interactive" process and was not indifferent. Thus, even had it been determined that the accommodations should be granted, compensatory damages would not be awarded because such an award requires a finding of intentional discrimination (deliberate indifference). The final decision was reached in a relatively short period of time (two years from denial of admission), and it provides an example of a more proactive approach to assessing the ability to meet requirements at the admission stage.

### 3. *Nathanson v. Medical College of Pennsylvania (Withdrawal After Enrollment)*

One of the early cases involving medical school and students with mobility impairments is *Nathanson v. Medical College of Pennsylvania*.<sup>197</sup> The medical school was aware of concerns about Nathanson's back and neck injuries during the admissions interview process. Her major concern was being able to sit in the seats provided for exams. In undergraduate school, she had been allowed to take exams at a table. She indicated, however, that she did not think she would need any special seating during the admissions process. After one year (1985–86), she withdrew from medical school because of her difficulties in sitting. It was not clear whether she had made specific requests for accommodations for seating or whether the school should have been on notice of her needs based on the initial interview. She did not have a "visible" impairment. She had requested closer parking and a straight back chair, but it is unclear whether these requests were specifically as accommodations to a disability.

The reported decision does not reach final resolution but does note issues to be resolved regarding whether the medical school could have/should have engaged in any inquiries and what inquiries would be permissible. It is noteworthy that the facts in this case occurred in 1985, at a very early stage of the development of policies, practices, and procedures for higher education pursuant to section 504 compliance. The case facts to be resolved highlight the value of engaging in an interactive process, which had not received much judicial attention at that point.

Of particular interest for future consideration, however, is that this is one of the few cases in health care professional programming that gives any attention to the cost of an accommodation, which incorporates the undue burden defense. The court incorporates regulatory guidance from employment, which sets out the factors to be considered in determining whether closer parking and a straight back

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197 926 F.2d 1368 (3d Cir. 1991).

chair would be unduly burdensome to provide. These factors are overall size of program (referencing number of *employees*), number and type of facilities, size of the budget, type of operation (including structure of *workforce*), and nature and cost of accommodations.

Not addressed in this opinion would be whether a medical school would be required to provide specialized equipment. The regulatory guidance in higher education does not require the provision of personal devices.<sup>198</sup> For example, a university would not be required to provide a specialized wheelchair or other equipment for her personal use that would extend beyond her educational program, but it may well be expected to provide equipment at the education site as an accommodation.

#### 4. Cases Resolved Without Litigation

The other major admissions decisions involving mobility impairments and health care professional programs receiving high-profile attention were not litigated. Nevertheless, they provide interesting and useful insights.

The case receiving the greatest media attention highlights a success story. James Post had been injured in a diving accident at age fourteen, and was quadriplegic when he applied to several medical schools. He was denied admission by ten medical schools although he had exemplary academic credentials. Albert Einstein Medical School in Philadelphia granted admission on the condition that he pay for his own physician's assistant, which he did at considerable cost. A tort settlement from his injury provided the funding for these costs. In addition, his wife provided substantial assistance.<sup>199</sup> After graduation, he practiced in the field of nephrology (kidney specialty), which requires diagnostic skills, at which he excels.

There are several success stories about physicians and medical students with mobility impairments.<sup>200</sup> The media accounts are persuasive in demonstrating that a greater openness to intermediaries and assistants and technological developments

198 45 C.F.R. § 84.12 (1990).

199 *Quadriplegic Aims to Become a Doctor*, N.Y. TIMES (Nov. 27, 1992); *Quadriplegic Student Is Set to Graduate from Medical School*, L.A. TIMES (June 5, 1997), <https://www.latimes.com/archives/la-xpm-1997-06-05-mn-347-story.html>; Jon O'Connell, *Quadriplegic Doctor Lives a Fulfilled Life*, TIMES LEADER (Apr. 19, 2014), <https://spinalcordinjuryzone.com/news/12592/quadriplegic-doctor-lives-fulfilled-life>; Joe Ungaro, *Quadriplegic Student Finishes Long Journey by Getting M.D.*, ASSOCIATED PRESS (June 5, 1997), <https://apnews.com/e38b2270df62fdf1606e06b45ef6ffb6>.

200 Joe Ungaro, *Quadriplegic Student Completes Long Journey by Getting M.D.*, ASSOCIATED PRESS (June 5, 1997), <https://apnews.com/e38b2270df62fdf1606e06b45ef6ffb6>; Cindy Dampier, *Chris Connolly is a Brilliant Medical Student. He's Also a Quadriplegic—And the Person Who May Change the Way We Think about Doctors*, CHI. TRIB. (Sept. 18, 2018, 5:00 AM), <https://www.chicagotribune.com/lifestyles/ct-life-quadriplegic-med-student-connolly-0917-story.html>; Kevin Joy, 'A Seat at the Table': Why U-M's Medical School Wants More Students with Disabilities, UNIV. OF MICH. HEALTH LAB (Oct. 10, 2017, 7:00 AM), <https://labblog.uofmhealth.org/med-u/a-seat-at-table-why-u-ms-medical-school-wants-more-students-disabilities>. See also Tim Gilmer, *Disabled Doctors: Healing the Medical Model?*, NEW MOBILITY (Mar. 1, 2019), <https://newmobility.com/disabled-doctors/> (includes stories about a number of physicians who became mobility impaired during medical school or afterward; discusses the technical standards and how they have evolved).

can provide the accommodations that lead to these success stories. Not discussed in these stories, however, is the cost of such accommodations. Because courts rarely address cost as a defense, it is difficult to assess how a court would respond to a medical school that found that undue financial burden prevented providing certain accommodations (a legitimate defense if well founded).

These success stories all seem to be about individuals who demonstrated exceptional academic and other aptitudes by individuals who were highly motivated and who had additional personal support or a mentor or advocate at the medical school. It is less clear whether litigation would have required the medical schools to enroll and accommodate these students. While the medical school *can* provide accommodations that it might not legally be obligated to, the issue to be considered is whether that is something the medical school *should* do. Given the cost of attending medical school for both the individual and the institution, there are questions about the obligations of the school to advise entering students (or continuing students) that certain program completion requirements might not be able to be achieved, even with accommodations.

#### ***D. Health Impairments***

The technical requirements for admission to medical school often include reference to abilities that would be relevant for an individual with a health condition. Such reference is often much less specific than indicating criteria for other physical characteristics such as sensory concerns or mobility concerns. These requirements are more indirect by making reference to long hours and presence being required during the educational process. Expectations of stamina and attendance are raised in these decisions. There are other health impairments, however, that do not necessarily affect performance but that may create a risk to patients. The decisions relating to these conditions is discussed in this section.

##### *1. Crohn's Disease*

###### **a. *County of Los Angeles v. Kling (Admission).***

One of the early decisions on admissions was also a Supreme Court decision but did not directly address whether the individual was otherwise qualified. In *County of Los Angeles v. Kling*,<sup>201</sup> the Court did not reach the issue of whether an applicant to the Los Angeles County Medical Center School of Nursing was otherwise qualified. Instead, the Court found that the applicant with Crohn's disease was not disabled under **Section 504**. While the Supreme Court dismissed the case based on its determination that she did not have a disability covered by section 504, the lower court opinion provides the specific facts that the plaintiff was rejected because of the school's assumption that her health condition would result in excessive absenteeism.<sup>202</sup> The nursing school had not

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201 474 U.S. 936 (1985). This case is discussed as a foundational decision in an earlier section. See *infra* VI(D)(1)(a).

202 *Kling v. Cnty. of L.A.*, 633 F.2d 876 (9th Cir. 1980, *on appeal* 769 F.2d 532 (9th Cir. 1985)).

engaged in an individualized assessment, when it learned after her admission and during a medical examination of admitted applicants, that she had Crohn's disease. While the program had concerns about the potential hospitalization, the plaintiff indicated that this might not be a concern because she could schedule hospitalizations to minimize interference with required school programs. The nursing school apparently did not want to explore that further. The circuit court granted a preliminary injunction, but ultimately the issue<sup>203</sup> of accommodation was not explored further when the Supreme Court in a very short opinion decided that Crohn's disease is not a disability.<sup>204</sup> The 2008 amendments to the ADA would probably mean that courts today would find her to be a protected individual, and if so, the lower courts would engage in much greater exploration of whether the health condition could be reasonably accommodated. There is, however, less clarity about how that would be determined at the initial admission stage.

**b. *Redding v. Nova Southeastern University, Inc. (Enrollment During Clinical Rotations).***

Three decades after the "nondecision" in *Kling*, the issue of Crohn's disease in the context of medical school was again addressed, this time not avoiding the issue of qualification because the individual was found to be disabled within the statute. The case of *Redding v. Nova Southeastern University, Inc.*,<sup>205</sup> begins with the student's initial enrollment in 2009 in the osteopathic medical school program. The court seemingly assumed in its decision that Meredith Redding's Crohn's disease was a disability.<sup>206</sup> The lengthy trial court decision resulted in several findings and holdings. These included that her absences and unprofessional conduct were the basis for failing clinical rotations that ultimately resulted in her dismissal, and no ADA or Rehabilitation Act violations occurred regarding the dismissal.

Her accommodation issues before the clinical rotations, however, raised issues left open because she could obtain damages under the Rehabilitation Act if the failure to accommodate at that point was intentional (defined as including deliberate indifference to statutory rights).<sup>207</sup> Further resolution were issues about whether she had appropriately requested accommodations and whether the accommodations sought would have been reasonable.<sup>208</sup> A confusing record of

203 See *Kling*, 464 U.S. 936 .

204 *Id.* (overruling 769 F.2d 532 (9th Cir. 1985)).

205 165 F. Supp. 3d 1274 (S.D. Fla. 2016).

206 The fact that the facts arose after the 2008 ADA amendments that broadened the definition of disability may account for that issue not being addressed, particularly in light of the fact that her disease resulted in hospitalizations that would probably have demonstrated that the impairment was substantially limiting. The court notes in a footnote (footnote 3) that the institution raised a question about the hospitalization that seemed to question whether she was entitled to protection, but the court resolves this in her favor.

207 *Redding*, 165 F. Supp. 3d at 1296.

208 The Student Handbook requires that students address accommodation requests to the outside entity where the rotation was to occur. *Id.* at 1285. The court does not address whether this is a valid practice or procedure or whether the educational institution should/must bear any responsibility in facilitating such accommodation arrangements. This is an issue largely left unaddressed in judicial

communications between the student and the school raises not only legal issues, but highlights the value of having clear policies and practices regarding requests for accommodations, who has the authority to grant them, and what process is to be followed in various situations.

While ordinarily, it would have taken two years to complete the academic portion of the program, Meredith Redding took four years because of missed exams and disputes over makeup exams and her health situation. It is not clear how tuition was charged during this dispute. Her dismissal occurred after the academic program and was based on noncompliance with the attendance policy, a situation for which she had apparently not requested accommodations. Thus, it may be that she would ultimately have been dismissed, even if the academic years had included the provision of accommodations related to her makeup exam requests.<sup>209</sup>

There is no further official record of disposition of the case on the issue of damages. Nonetheless the decision highlights several issues of relevance to this article in light of the seven years it took for judicial resolution that ultimately found her not to be qualified to continue, when the absences were almost certainly related to her disability. The first issue is the muddled communications between the student and the institution at the outset regarding her requests for accommodations. Ms. Redding did not raise any accommodation issues during her first year, but in the first semester of her second year, she had several hospitalizations that resulted in her missing several exams. The published make-up exam policy, while allowing instructor discretion regarding format, is confusing about timing, but of greatest significance is the apparent practice of making make-up exams more difficult and being given exams in a short answer or essay format instead of multiple-choice format as was the case for the original exam. The timing of course blocks within a semester would require her to take make-up exams at the same time she was beginning a new block of coursework. The process for her to seek a disability-based accommodation to this schedule required her to contact the university's ADA coordinator, who was to tell her who to contact within the medical school.

The opinion includes a lengthy summary of the various contacts between Redding and various administrators, but it seems to indicate confusion about whether there was a clear communication to her about specifically how to request a disability accommodation. It was not until 2012 that there seems to have been a clear invitation to her to request accommodations under the university policies and procedures. There is a dispute about whether her contacts with the Dean of Students allowed her to know how to request an accommodation. While programs are not required to give second chances to students whose disabilities were not made known, the facts raise questions about whether the university had a process that made it clear how students were to do that and what type of documentation

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decisions involving higher education programs where outside placements are incorporated into the educational experience.

209 The court opinion provides information that the practice of giving makeup exams was to make them intentionally more difficult. The court did not address whether this itself was a violation, and it would perhaps have been an issue to be resolved in further litigation.

would be required to obtain certain accommodations. In its discussion of denying summary judgment on the failure to accommodate issue under section 504, the court recounts the confusing policies regarding who to contact within the university and the factual dispute about whether she had made contacts and was rebuffed, and how the documentation provided by the physician was considered in the decision to grant her accommodations (extra time for exams and bathroom breaks) that were not really responsive to her requests for make-up classes. The unresolved issues raise factual disputes about whether, if she had received the requested accommodations, she would have taken four years to complete a two-year program, which resulted in her payment of additional tuition costs. Regardless of what damages are or were ultimately ordered or agreed to in settlement, it would seem that having a clear policy, practice, and procedure for obtaining accommodations in higher education is likely to resolve an issue without years of costly litigation.

Finally, and related to the issue of clear procedures is whether an “invitation” by Nova to all incoming students who might want to seek accommodations might have resulted in a better outcome. A student who has a condition, such as Crohn’s disease, who knows it might impact attendance, might be able to ascertain and clarify policies such as make-up exams earlier than the point at which it became an issue.

## 2. *Sleep Disorders and Seizure Related Conditions*

In addition to the decisions discussed below, there are a few decisions involving employment that might also provide guidance.<sup>210</sup> They reinforce the concerns about patient safety.

### a. **Rodrigo v. Carle Foundation Hospital (*Residency and Clinical Rotation*).**

There are numerous health related conditions that can affect the ability to pass examinations required for completion of medical school work, including during the residency aspects of the program. Seizure disorders and sleep disorders are

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210 Stern v. St. Anthony’s Health Ctr., 788 F.3d 276, 31 A.D. Cas. (BNA) 1149 (7th Cir. 2015) (not reasonable to require shift changes essential to supervisory job for chief psychologist with memory and cognitive functions deficiencies because these were not marginal functions, although health center did not engage in interactive process that would not have changed the outcome); Olsen v. Capital Region Med. Ctr., 2012 WL 1232271 (W.D. Mo. April 12, 2012), *aff’d*, 713 F.3d 1149 (8th Cir. 2013) (mammography technologist with epilepsy not otherwise qualified; safety issue); Roberts v. Bayhealth Med. Ctr., Inc., 2015 WL 5031961 (D. Del. August 25, 2015) (denying summary judgment to hospital; part-time nurse with disability resulting from brain tumor sought to maintain previously provided eight-hour daytime shifts that had been changed to twelve-hour shifts; dispute about whether those shifts were essential functions); Badri v. Huron Hosp., 691 F. Supp. 2d 744 (N.D. Ohio 2010) (surgeon with sleep problems not disabled; case challenged revocation of medical privileges); Moran v. Chassin, 638 N.Y.S.2d 835 (3d Dep’t 1996) (physician with epilepsy).

examples.<sup>211</sup> In *Rodrigo v. Carle Foundation Hospital*,<sup>212</sup> it was apparently not until the student entered the clinical/preresidency program after successfully completing the first two years of medical school that his sleep disorder raised a consideration for accommodation of being allowed to retake the Step 3 exam a third time. He had not requested accommodation nor provided documentation on the disorder prior to the time he took the exam a second time and failed. He was given leave time before the third attempt, but failed again, and was advised that he would be terminated from the program. At this point the issue of whether his “disability” should be the basis for allowing another chance was raised. The district court granted the university’s motion for summary judgment.

On appeal, the circuit court upheld the lower court, finding that it was reasonable to require him to pass the Step 3 exam before continuing, and therefore he was not “otherwise qualified.” The court does not directly address whether his claim that he did not seek accommodations earlier was based on concerns about confidentiality. The general standard was applied that accommodations are only required for “known” disabilities.

The circuit court’s decision was reached eight years after he began his residency, and by then, there had been an investment by both the student and the school of two years in medical school, and two years of residency training. Would there have been a way to address the potential impact of this disorder at the point of admission? Would that have been permissible? If an institution defines the requisite standards at the outset, there would seemingly be a burden on the applicant to determine whether a disability might affect the ability to meet those standards. The technical standards adopted at most medical schools often reference within Cognitive Skills the expectation of engaging problem solving within a timely fashion. Under the category of Behavioral Attributes, Social Skills, and Professional Expectations, the expectation of being able to “effectively handle and manage heavy workloads and to function effectively under stress” is often stated. These are attributes that have been addressed in the context of physician employment. An individual with a previously identified sleep disorder might want to inquire as to accommodations that might be available at the outset of medical school to avoid the investment of time and money if accommodations could not ensure success.

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211 See, e.g., *Morgan v. Nova Se. Univ., Inc.*, 2007 WL 2320589 (S.D. Fla. August 10, 2007) (finding that a medical student with epilepsy controlled by medication was not disabled). The student had requested an accommodation of a flexible schedule to allow for doctor appointments, and the court did not reach the issue of whether that was reasonable, and instead determined that he was not disabled. That decision was before the 2008 expanded definition, and today the court would be more likely to focus on whether the accommodation was reasonable and would be likely to find that he was disabled within the ADA).

212 56 Nat’l Disability L. Rep. (LRP) ¶ 104 (7th Cir. 2018) (medical student with sleep disorder was unable to pass exams required to advance; passing exam was legitimate requirement to advance and complete residency program).

**b. *Abdullah v. State* (Residency).**

Another case raising concerns about sleep issues is *Abdullah v. State*,<sup>213</sup> which was also raised in the context of the residency portion of the program. This highlights that conditions such as this may not require accommodations during the first two years of medical school when the focus is primarily on academic classes rather than clinical training. This is somewhat different in that the student did his preliminary medical education in Syria, graduating in 1999. The ADA and section 504 would not have been relevant for his medical school training.

The dismissal from residency programs was based on concerns about his professionalism, and he presented a number of theories challenging that dismissal, none of which were successful. One of the defenses was that his behavior related to sleep deprivation, and he was perceived as disabled because of that. The court rejected that argument and did not allow the disability discrimination claims to go forward.<sup>214</sup> Based on the other issues discussed in the opinion, it is probable that even if he was covered as disabled, his behavior<sup>215</sup> would have been found to render him not otherwise qualified.<sup>216</sup>

The district court's grant of summary judgment for the university was affirmed.

**3. *Contagious and Infectious Diseases***

Cases involving health care providers with contagious and infectious disease rarely arise in the context of the educational health care program. There are, however, several that have been addressed in the context of posteducation settings.<sup>217</sup> The cases focus primarily on concerns relating to direct threat to patients, and include

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213 771 N.W.2d 246 (N. D. 2009) (upholding dismissal of physician from residency program; dismissal based on professional concerns not because his bouts with sleep deprivation were regarded as a disability).

214 *Id.* at 258.

215 The behavior of concern included a home visit to a patient, and misrepresentations about his employment and academic history.

216 *Abdulla*, 771 N.W.2d at 251.

217 *Bradley v. University of Texas M.D. Anderson Cancer Center*, 3 F.3d 922 (5th Cir. 1993) (HIV positive surgical technician found to pose direct threat to patients, which could not be accommodated in that position); *Estate of Mauro By and Through Mauro v. Borgess Med. Ctr.*, 137 F.3d 398 (6th Cir. 1998) (surgical technician with HIV posed direct threat); *Waddell v. Valley Forge Dental Assocs., Inc.*, 276 F.3d 1275 (11th Cir. 2001) (dental hygienist's HIV status posed significant health risk to patients, which could not be eliminated by reasonable accommodation); *Sternberg v. N.Y. City Health and Hospitals Corp.*, 191 F. Supp. 3d 303 (S.D.N.Y. 2016) (dentist with hepatitis C viral load above guideline levels was qualified to perform essential functions of his work); *Robles v. Texas Tech Univ. Health Scis. Ctr.*, 131 F. Supp. 3d 616 (W.D. Tex. 2015) (legitimate reason to discipline and terminate employee with HIV; employee was a patient specialist and coder; employer's treatment had nothing to do with condition). *See also Tarver v. Okla.*, 2011 WL 3626690 (N.D. Okla. 2011) (nurse requesting light duty as accommodation to stroke; hepatitis C; ability to return to work not clear, could depend on receiving reasonable accommodations); *Gowesky v. Singing River Hosp. Sys.*, 321 F.3d 503, 13 A.D. Cas. (BNA) 1711 (5th Cir. 2003) (emergency room physician who had undergone successful treatment for hepatitis C infection failed to establish that she was "regarded as disabled").



HIV positive status as well as Hepatitis C and other conditions.<sup>218</sup> The technical standards for medical schools do not seem to directly address this kind of issue.

**a. Doe v. University of Maryland Medical System Corp. (Residency).**

One of the few cases to address this issue involved a student whose HIV positive status resulted from a needle stick when he was a neurosurgery resident during his third year of his residency training (which meant that he had also completed four years of medical school). In *Doe v. University of Maryland Medical System Corp.*,<sup>219</sup> the infection occurred in 1992, which was early in the understanding and awareness of HIV transmission issues, and was also at a point in time when treatment for HIV was in the early stages. This meant that both the risk of transmission from provider to patient in various settings was clearly known. The outcomes of infection created high concerns about direct threat and the consequences.

When it was known that the resident was HIV positive, an assessment was made by a panel of experts on blood borne pathogens. The panel recommended that he be allowed to continue in the neurosurgery residency but not allowed to carry out procedures that require use of exposed wire. The panel also recommended other practices but did not recommend that he should be removed from the surgical residency. The senior administrators gave these recommendations careful consideration and engaged in further study,<sup>220</sup> and rejected the recommendation. Instead, they suspended him from any surgical residencies but offered him residencies that did not involve surgery. He declined that offered accommodation and brought suit under the ADA and section 504 seeking equitable relief and damages.<sup>221</sup>

The court's decision recognized the Centers for Disease Control (CDC) position regarding the small risk but noted that the CDC provided that certain surgical procedures were exposure prone, and his continuation in the surgical residency would involve those procedures. This was the basis of the termination of his surgical residency. The court noted that the decision was based on thorough deliberation of reasonable medical judgment of public health officials.

218 The issue of COVID is beyond the scope of this article, but it is an issue for consideration in determining whether an individual seeking an exemption from COVID vaccination, based on various reasons, is nonetheless not otherwise qualified because of the risk to patients and others in a health care setting.

219 50 F.3d 1261 (4th Cir. 1995).

220 This would seem to pass the *Wynne* test, which calls for appropriate personnel to make such a careful assessment. See discussion of *Wynne*, *supra* (V)(B)(2)(b).

221 Notably the court does not dispute that his HIV status is a disability, which was not always the case before the 2008 amendments. The broadened definition makes it extremely unlikely that the coverage would be an issue of dispute today, but there is at least one decision where that was the case. See, e.g., *Alexiadis v. N.Y. Coll. of Health Pros.*, 891 F. Supp. 2d 418 (E.D.N.Y. 2012) (allowing claim to go forward regarding whether HIV positive status was a disability when a college student who was HIV positive was arrested for stealing a bag of hand sanitizer and dismissed from college).

**b. *Roggenbach v. Touro College of Osteopathic Medicine (During Enrollment)*.**

In the case of *Roggenbach v. Touro College of Osteopathic Medicine*,<sup>222</sup> the court found that a student in the osteopathy program was dismissed because of his conduct violations, not because of his HIV status. Significant to the decision is that the program did not know of his HIV status when it began disciplinary measures for tardiness, missing exams, absences, fabricating emails, and other conduct violations. The student had begun the program in 2008, and the misconduct occurred throughout his enrollment. In the fall of his third year, disciplinary proceedings based on his misconduct leading to his dismissal began. The court deferred to the college regarding academic requirements and upheld the dismissal. The school did not know of his HIV status before the disciplinary action began, and court found that it was the basis of the dismissal. From the first enrollment to court decision was six years.

*4. Pregnancy-Related Conditions*

While pregnancy itself is not a disability, the 2008 amendments clarify that pregnancy-related conditions might be a disability in some circumstances. While pregnancy-related conditions occur in the context of employment generally, there is little guidance for cases in the health care professional education courses. One of the few decisions is *Khan v. Midwestern University*.<sup>223</sup> The case involved a student in an osteopathy program who had struggled academically from the outset but who had been given a second chance to complete required coursework. She succeeded on the repeated failed courses but failed new courses during the second year, at which point she was pregnant. After her dismissal based on the second chance failures, she brought suit claiming that her pregnancy-related impairments should have been accommodated.

The appellate court affirmed the lower court's grant of summary judgment for the school, holding that ADA/504 violations had not occurred. The analysis referenced the fact that by the time one of the professors was aware of her condition, she had already failed the courses. She was not otherwise qualified to continue. She was required to make her case to continue after her first set of failures. Her husband's illness was a factor in giving her a second chance. She did not succeed in the semester that followed, failing three courses. At the beginning of the spring 2013 semester, she had become pregnant and requested accommodations for depression and anxiety related to her pregnancy.<sup>224</sup> She received some,<sup>225</sup> but not all

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222 7 F. Supp. 3d 338 (S.D.N.Y. 2014).

223 879 F.3d 838 (7th Cir. 2018), *amended on denial of reh'g*, Feb. 26, 2018.

224 It was not addressed, but it is not certain that she would be found to be disabled within the statutory definition, unless these conditions were substantial limitations. *Id.* at 844–45. The court did not need to decide that issue because the case was decided on the basis that she was not otherwise qualified. Also noted in the opinion is the fact that she had a two-hour round-trip journey to school each day, which exacerbated her pregnancy-related conditions, and which caused her to be late for one of the exams. She was not allowed to reschedule that exam and failed it.

225 The school provided some tutoring and some rescheduling.

of the requested accommodations.<sup>226</sup> In its decision, the court noted the deference to academic decision making that is given to educational programs, and accepted the assessment of the school (through its policy related to accumulated course failures) that she was not otherwise qualified. It noted that in its discretion she had been given a second chance, although the school was not required to do so, and that she did not succeed and was therefore no longer otherwise qualified.

She began her coursework in 2010, was finally dismissed in spring 2013 (three years after beginning the program), and the final court decision was 2018, eight years after she began.

#### 5. *Chemical Sensitivities*

A common sensitivity in the health care profession is a latex allergy, which can be significant because of the use of latex gloves. Health care programs can also expose those providing health care services to many other chemicals. There is very little litigation involving educational programs. There are, however, a few decisions in the context of the nursing profession.<sup>227</sup>

#### 6. *Other*

In *Wagel v. George Washington University*,<sup>228</sup> the court addressed a claim by a resident in a psychiatric medical school program for failure to provide reasonable accommodations for her kidney cancer. The claim was that when Family and Medical Leave Act leave was requested, it should have put the program on notice that she was requesting ADA accommodations. The appellate court upheld the district court's grant of summary judgment for the university. The decision also addressed the legitimate nondiscriminatory reasons for the adverse actions taken toward this individual based on significant performance concerns.

#### E. *Learning and Cognitive Disabilities*

The technical standards for most medical schools include requirements that relate to **Communication Skills**. This standard expects effective oral and written communication with all members of a health care team and with patients in order to gather information. The technical standards also include **Intellectual–Conceptual Skills**. These require effective interpretation, assimilation and understanding of complex material in individual, small group, and lecture formats. These requirements expect the ability to synthesize information effectively in person and remotely, and interpretation of casual communications to reach accurate and

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226 The school did not provide a quiet room, extended time during exams, or extended time between exams.

227 See, e.g., *Dickerson v. Peake*, 2011 WL 1258138 (M.D. Ga. 2011), *aff'd*, 489 F. App'x 358 (11th Cir. 2012) (holding that the claimant has the burden to identify accommodation and demonstrating that it allows performance of essential functions). The case involved a nurse with multiple chemical sensitivities who could not be accommodated by providing work environment that had rigid limited exposure to certain compounds, odors, and molds.

228 957 F.3d 1364 (D.C. Cir. 2020). The Family and Medical Leave Act, 29 USC 2601-2654.

fact-based conclusions. **Cognitive Skills** require the ability to measure, calculate, analyze, integrate, and synthesize information, and the ability to comprehend three-dimensional relationships and spatial relationships of structures. These are necessary for the problem-solving skill that is expected of physicians. Notably, these skills must be able to be performed in a timely fashion, which introduces the issue of speed, which can be a challenge for individuals with some types of learning disabilities.

The judicial decisions involving learning and cognitive disabilities are similar in certain ways to some of those involving mental health impairments because of the types of skills and qualifications involved. Another similarity is that in many of the cases, the concerns or deficiencies are not apparent at the time of initial enrollment but become apparent once the program has begun. The concerns and deficiencies often become apparent as a consequence of the heavy and challenging academic and clinical programs (which are often time pressured) and/or the stress inherent with a professional program that prepares students to treat and serve patients and to work with other staff members.

First, it is necessary to provide a brief overview of what is included within the learning disability context and how such conditions are covered by the ADA and section 504, both before and after the 2008 amendments. The basic definition of disability has not changed since 1973. It requires a substantial limitation to one or more major life activities, a record of such an impairment, or being regarded as having such an impairment.<sup>229</sup> The student must still be otherwise qualified and able to carry out the essential requirements of the program with or without reasonable accommodation.<sup>230</sup> Before the 2008 amendments, many judicial opinions in numerous higher education settings addressed the issues of major life activities, how to determine if one is substantially limited (by inconsistently deciding about whether this was compared to the general population or another group), and whether mitigating measures (self-compensation) should be considered. The pre-2008 cases often found that a student's learning disability did not meet the definition of a protected disability under the ADA and section 504 due to a narrow interpretation.

The 2008 amendments and related regulatory guidance changed that to some degree.<sup>231</sup> The clarification that major life activities included "learning, concentrating, thinking, communicating, and working"<sup>232</sup> may mean that an individual is more likely to meet the definition but does not necessarily mean that the individual is otherwise qualified. Appropriate documentation of the condition is still required, and although the requirements of documentation of the disability have also been revised over time, some individuals with learning disabilities

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229 Rehabilitation Act of 1973, Pub. L. No. 93-112, § 702(9), 87 Stat. 355 (codified as amended at 29 U.S.C. § 705(9); Americans with Disabilities Act of 1990, Pub. L. No. 101-336, § 3(2), 104 Stat. 327 (codified as amended at 42 U.S.C. § 12101).

230 Americans with Disabilities Act of 1990, Pub. L. No. 101-336, § 2(2), 104 Stat. 327 (codified as amended at 42 U.S.C. § 2(2)).

231 See ROTHSTEIN & IRZYK, *supra* note 100, at § 3:22.

232 42 U.S.C. § 12012(1).

continue to find limited redress under the ADA/504 when there are deficiencies in their performance.

There are approximately fifty reported decisions that involve students with learning disabilities in health care professional programs. Many of these cases involve a combination of learning and other disabilities (sometimes mental health impairments related to anxiety and similar conditions). In some cases, a student might raise both mental health and a learning disability as justification for the conduct. In some situations, the student has been found *not* to have a protected disability.<sup>233</sup> In other cases, the courts found that the student had not made *known* the disability before the academic failure.<sup>234</sup> In still others, the condition was not allowed to excuse other types of misconduct or lack of professionalism.<sup>235</sup> In still other decisions, the courts have found that the student had not met the academic requirements.<sup>236</sup>

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233 See, e.g., *Doherty v. Nat'l Bd. of Med. Exam'rs*, 60 Nat'l Disability L. Rep. (LRP) ¶ 62 (5th Cir. 2019) (unpublished) (holding that that claimant's learning disability was not a protected disability under the ADA and that the additional time to take the Step 2 licensing exam need not be provided).

234 See, e.g., *Jin Choi v. Univ. of Tex. Health Sci. Ctr. at San Antonio*, 633 F. App'x. 214 (5th Cir. 2015) (holding that dental student with ADD who was dismissed after failures in clinical courses did not provide timely notice and request for accommodation, and the university was not in a position where it should have known of the condition); *Shaikh v. Lincoln Mem'l Univ.*, 46 F. Supp. 3d 775 (E.D. Tenn. 2014), *aff'd*, 608 F. App'x 349 (6th Cir. 2015) (holding that osteopathic medical school student with ADD and dyslexia had been provided with numerous accommodations and had been dismissed for academic deficiencies; request for deceleration of program occurred after dismissal); *Buescher v. Baldwin Wallace Univ.*, 86 F. Supp. 3d 789 (N.D. Ohio 2015) (holding that a nursing program student had not requested accommodations for a learning disability); *Shamonsky v. Saint Luke's Sch. of Nursing*, 2008 WL 724615 (E.D. Pa. March 17, 2008) (holding that the school was not aware of nursing student's learning disability which was diagnosed after dismissal for poor academic performance); *Leacock v. Temple University Sch. of Medicine*, 1998 WL 1119866 (E.D. Pa. Nov. 25, 1998) (holding that a medical student did not make known need for accommodations during the first year or before dismissal).

235 *J. Endres v. Ne. Ohio Med. Univ.*, 2019 WL 4125263 (6th Cir. May 2, 2019) (providing preliminary rulings in case involving medical student with ADHD and his dismissal and whether it was based on discipline or disability); *Pahlavan v. Drexel Univ. Coll. of Med.*, 2020 WL 674475 (E.D. Pa. Feb. 10, 2020) (student with ADHD dismissed because of lack of success in clinical rotations; had been given accommodations during first two academic years and more during clinical rotations); *Chenari v. George Washington Univ.*, 847 F.3d 740 (D.C. Cir. 2017) (affirming summary judgment to medical school that dismissed student with ADHD for honor code violation, taking additional time for exam which had not been requested); *Driscoll v. Bryant Univ.*, 393 F. Supp. 3d 153 (D.R.I. 2019) (finding no violation of ADA/504 where student with ADHD in physician's assistant program that required intensively rigorous exam schedule was "held back" after failing to meet grade point average and required to retake courses; recognizing judicial deference to educational institutions on matters of academic judgment; finding that student had been provided with reasonable accommodations and that some requests were communicated after academic deficiencies); *Shah v. Univ. of Tex. Sw. Med. Sch.*, 54 F. Supp. 3d 681 (N.D. Tex. 2014) (granting university's motion to dismiss claim by medical student with ADHD, finding that dismissal was based on lack of professionalism, not on the basis of a disability); *Schwarz v. Loyola Univ. Med. Ctr.*, 2012 WL 2115478 (N.D. Ill. June 11, 2012) (granting summary judgment against physician with ADD who was not otherwise qualified to perform essential functions of surgical resident; inappropriate and unprofessional behavior was a concern).

236 *McGuinness v. Univ. of N.M. Sch. of Med.*, 170 F.3d 974 (10th Cir. 1998) (finding that a medical student with test anxiety in math and chemistry did not meet requirements and that a passing grade not a reasonable accommodation). It should be noted that test anxiety is generally not found to be a disability. See also *Johnson v. Washington Cnty. Career Ctr.*, 982 F. Supp. 2d 779 (S.D.

Judicial disputes involving learning disabilities generally do not arise in the context of initial admission, but rather in performance after admission. Notably, while accommodations for learning disabilities often involve additional time for tests taken in academic courses and in the step exams during medical school, the clinical rotations after the first two years may be the first time the accommodation and qualification issues become significant.<sup>237</sup>

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Ohio 2013) (allowing case to proceed when a student in surgical technology training with dyslexic learning disability who requested numerous accommodations at the outset, disputed that reasonable accommodations were provided, and that resulted in not meeting the performance requirement and recognizing that the program's requirements were related to accreditation requirements; student began in 2008); *Ellis v. Morehouse Sch. of Med.*, 925 F. Supp. 1529, 1535 (N.D. Ga. 1996) (upholding dismissal of medical school student who had been granted decelerated program and extra time on exams after he struggled from outset and provided documentation of his reading disabilities; began in 1988; unprofessional behavior also an issue; during Medicine clerkship in third year he had behavior deficiencies resulting in low grades; during surgery rotation his performance which included poor judgment and inability to process and integrate knowledge raised concerns about patient safety; concerns about ability to achieve "diagnostic formulations in a timely way" and that there was no accommodation that would enable him to carry out the essential functions; lengthy opinion analyzing fundamental requirements and that no accommodation would be available to offset inability to process complex material). The decision in *Singh v. George Washington University School of Medicine and Health Sciences*, 597 F. Supp. 2d 89 (D.D.C. 2009), *aff'd*, 667 F.3d 1 (D.C. Cir. 2011) is particularly useful because it addresses several issues. It holds that test taking is not a major life activity, cautions that the institution should consider the documentation of a disability before making a final decision to dismiss, but also notes that the academic difficulties resulted from factors other than the impairment such as undue pressure, inability to concentrate, and excessive involvement in extracurricular activities. She began medical school in 2003. The decisions recount her academic strengths, but difficulties with multiple choice tests, and failures to follow up with counseling center and to reduce activities. She was in the decelerated program. The relevant major life activity was learning, and she had a strong record of academic success, including in timed settings and reading. The court noted that the dismissal occurred after receiving documentation of a disability before the dismissal but before considering it. The court stated the following: "A well-regarded institution of higher education, such as George Washington University, should be committed to the success of all of its students, and surely that entails a sincere evaluation of their abilities and needs before issuing a decision to dismiss them." 597 F. Supp. 2d at 98.

237 The decision in *Pahlavan v. Drexel University College of Medicine*, 2020 WL 674475 (E.D. Pa. Feb. 10, 2020) is instructive. It also provides a window into the amount of time it can take to resolve these cases. The student began medical school in 2008, and the federal district court grant of summary judgment for the university occurred twelve years later. In the interim, the student was given accommodations during both his academic first two years and during his clinical rotations, given a leave of absence, and opportunity for readmission. The decision highlights a situation where concerns about performance were apparent from the beginning. After his first semester, he requested and received additional exam time based on a psychiatric assessment and recommendation regarding his ADHD. The psychiatrist who evaluated him for these accommodations also provided treatment and diagnosed him as having general anxiety disorder. Academic performance deficiencies were apparent as early as the end of his first year, although he had received exam accommodations. Although offered, the student declined academic support services, personal support services, and the option of having two years to complete the second year of the academic program. He did, however, successfully pass the required exams that he had previously failed. He did pass (with extended time for preparation) the Step 1 exam required before entering clinical rotations. He demonstrated deficiencies in some of the clinical rotations, including failures on Shelf exams and on clinical competence. He was given support at the end of the first year of clinical rotation. During his second year of clinical rotations, he was referred for neuropsychological evaluation (and reviewed during the course of the year), and by February of 2012 his performance was reviewed by the Clinical Promotions Committee, which dismissed him. His appeal of the dismissal resulted in a conditional grant to continue. The conditions included a leave of absence, which was to include intensive counseling and requiring him to repeat clinical rotations. In preparation for his return after the year's leave, he was given a fitness for duty

The key case, of course, related to learning disabilities and health care professional programs is the decision of *Wynne v. Tufts University School of Medicine*.<sup>238</sup> This is discussed in more detail earlier in this article.<sup>239</sup> It provides the framework of the process by which a medical school (or other health care program) should assess whether an accommodation is an undue burden or fundamental alteration. A concern that the *Wynne* decision (and many of the others) highlights is that while some learning disabilities can be accommodated during the first two years, the disability may not be able to be accommodated thereafter. This raises the question about what notice should be provided to the student with a learning disability at the point of initial enrollment that the disability may ultimately result in the student not being able to be accommodated.

One way to address this may be conditional admission programs. This was an issue in *Betts v. Rector and Visitors of University of Virginia*.<sup>240</sup> The 2000 lower court decision describes a program of conditional admissions for students who are economically disadvantaged or from minority backgrounds. Admitted in 1994, the student did not meet the conditions to continue but was given another year and additional support to meet the requirements. In the interim, he was diagnosed as having a learning disability and given additional time on some exams, which resulted in strong grades, but his grades in other courses where he was not given additional time apparently pulled his semester GPA to a level where his cumulative performance still did not meet the required standards. His dismissal after two years of effort resulted in his lawsuit seeking damages and injunctive relief. Six years transpired between initial admission and the court's granting of summary judgment to the institution. It is noteworthy that the time frame of the court's decision that he did not have a learning disability was before the 2008 ADA amendments providing clarification, and other federal guidance on documentation had been issued. While the court found that the student's learning disability was not a covered disability under the ADA, the school had provided accommodations of additional time once documentation had been provided regarding his condition.

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evaluation, which was the basis for the faculty member who reviewed this to express concerns about his fitness, but she cleared him to return. She raised concerns but thought he should be given one final chance. The readmission was conditioned on several very specific accommodations, some additional to his previous ones. These included mentoring, clinical placements in the Philadelphia area to allow for ongoing psychological treatment, and academic accommodations such as additional time and accessible materials when he repeated his rotations. Upon repeating the rotations, thought organization and integrating information continued to be problematic. Although there was some improvement, he did not pass some of the mandatory coursework, which was a requirement to continue. In his appeal of grades, although faculty evaluators declined to change their evaluations and noted that they had not considered disabilities or accommodations, they were not required or expected to do so because he had not raised the issue in his letters to them. The dean's appeal review upheld the recommendations of the faculty evaluators and also did not address directly disability issues, although noting that the student had been given many opportunities for improvement.

238 932 F.2d 19497 (1st Cir. 1991).

239 See *supra* V(B)(2)(b).

240 191 F.3d 447 (4th Cir. 1999) (unpublished) (holding that a denial of admission to a student with a learning disability who did not achieve the required GPA in special admission program did not violate ADA or section 504). The court on remand considered the issue of whether the student was even disabled under the statute. *Betts v. Rector and Visitors of Univ. of Va.* 113 F. Supp. 2d 970 (W.D. Va. 2000).

Lessons can be drawn from this conditional admissions program, incorporating the changed analysis of definitional coverage after the 2008 amendments. While conditional admissions programs should be encouraged, a more proactive approach today would be to both invite students upon admission to identify learning disabilities for accommodation consideration and to assess whether such accommodations are likely to be allowed on an ongoing basis by the step exams throughout the medical school process.

Lessons might also be drawn from the cases involving decelerated programs that are available in some medical schools. Several of the decisions include provision of such opportunities where a medical school allows a student to take more than the usual two years for the academic program. Often these cases involve learning disabilities or mental impairments. While the accommodations of additional time for exams or reduced course loads may work in an academic setting, in many of these cases, the institutions find difficulties (and the courts recognize the legitimacy of these challenges) in allowing additional time in medical settings.<sup>241</sup>

A case that highlights the high stakes regarding accommodations in these settings is *Soignier v. American Board of Plastic Surgery*.<sup>242</sup> This case involves an individual claiming that the board examining entity had not provided reasonable accommodations. The timing of this case highlights the challenges. This individual had apparently completed medical school, his clinical rotations, and the step exams without accommodations for his attention deficit disorder (ADD), dyslexia, and learning disabilities. When he failed his oral certification exam for plastic surgery (having passed the written exam),<sup>243</sup> however, he could not take it another time, and he appealed for failure to accommodate. He had been provided some, but not all, of the accommodations he requested. The board licensing was not essential to practice, but the court noted the following:

[His] diligence in seeking professional certification is understandable; besides the professional prestige associated with board certification, many health maintenance and preferred provider associations refuse to contract with non-board certified plastic surgeons. Over half of [his] potential patients are associated with either an HMO or a PPO.<sup>244</sup>

So, while this individual can practice medicine generally and even plastic surgery, he is limited by what he can do as a result of the licensing exam. What is not apparent from the opinion is whether he had sought accommodations at any

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241 See, e.g., *Soignier v. Am. Bd. of Plastic Surgery*, 92 F.3d 547 (7th Cir. 1996) (dismissing on a statute of limitations basis a case by a plastic surgeon claiming failure to accommodate his learning disabilities on his licensing board exam); *Singh v. George Washington Univ. Sch. of Med. and Health Scis.*, 667 F.3d 1 (D.C. Cir. 2011).

242 92 F.3d 547 (7th Cir. 1996). See also *Ramsay v. Nat'l Bd. of Med. Exam'rs*, 968 F.3d 251 (3d Cir. 2020) (granting preliminary injunction when extra time for national board exam was requested for dyslexia and ADHD).

243 He first took the exam in 1982, and his fifth attempt was in 1992. After five failures, he would be required to take an additional year of training before reapplying to take the oral exam.

244 *Id.* at 549.



earlier point in his medical education. It is notable that this was an oral exam, and it might be difficult to assess at an earlier point in his medical training whether this is something that might present challenges to him.

There have been several decisions involving the limited number of times one can take various step exams or licensing exams.<sup>245</sup> Some cases involve requests for changes in the clinical rotations or additional time between clinical rotations in order to pass the step exams.<sup>246</sup>

Two major cases arose in the same jurisdiction, both requiring several years to resolve and both involving numerous “second chances” after deficient performance. These cases both involved the same medical school system, and both involved students with learning disabilities.

In *Zukle v. Regents of University of California*,<sup>247</sup> the student began medical school at UC Davis in fall 1991, her difficulties began very early. In spring 1992, she was placed on academic probation, but she could have been dismissed. In fall 1992, she was referred for a learning disability evaluation by university, resulting in the recommendation of various accommodations for her reading difficulties (comprehension and speed concerns). These were provided beginning fall 1993. She had gone two years without accommodations. Noteworthy is the difference in performance when testing was timed (2% reading comprehension) and untimed (83%). This disparity should result in an examination of the importance of speed in reading in such a program. In 1994, the student took the Step 1 in 1994 and failed. She was in the midst of her OB/Gyn clerkship when she learned of the failure. As a result, she took a review course and requested that she be able to retake her OB/Gyn clerkship later. This request was initially granted, but then denied. She passed Step 1 on the second try, but received unsatisfactory grades on the OB/Gyn clerkship and later the Medicine rotation. This became a cycle of having to study for exams and retake past failed exams at the same time as she was taking new rotations. The process for obtaining accommodations during medical school was not clear. She was dismissed in spring 1995. She appealed through an internal process, but lost at every level. In January 1996 (after having been in medical school for four years), she brought suit seeking damages and reinstatement.

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245 In *Lipton v. New York University College of Dentistry*, 865 F. Supp. 2d 403 (S.D.N.Y. 2012), *aff'd*, 507 F. App'x 10 (2d Cir. 2013) (unpublished) the court upheld the the dental school in its denial of permission to take national exam an unlimited number of times without paying rematriculation fee or being allowed to take exam more than four times. The student with a reading disorder had been granted additional time on exams. The court thought the school's refusal to create an exception to graduation requirements was entitled to great deference. See also *Awodiya v. Ross Univ. Sch. of Med.*, 391 F. Supp. 3d 1098 (S.D. Fla. 2019) (granting motion to dismiss claim that medical school in Dominica had not provided testing accommodations; Title III and Rehabilitation Act did not apply to extraterritorial programs). This case involved a student who had failed the NCBE Basic Science Comp test five times. The school required that it be passed by the end of the fifth semester. He was not granted his request for additional time on the exam. Because the case is dismissed based on the nonapplication of the ADA and section 504 to this school, the court did not discuss the accommodation request issue in detail.

246 Compare *Zukle v. Regents of Univ. of Cal.*, 166 F.3d 1041 (9th Cir. 1999) with *Wong v. Regents of Univ. of Cal.*, 192 F.3d 807 (9th Cir. 1999), *as amended*, Nov. 19, 1999.

247 166 F.3d 1041.

The judicial review of the decision noted that “speed” of reaction time is “essential.”<sup>248</sup> The court adopted an approach of deference to academic decision making.<sup>249</sup> The court discussed her request to rearrange her clerkships (noting that she had been given extra time on exams, and included commentary that the clerkship experience is intended to simulate practice including long hours. The court noted that she had failed clinical portion of exam, although she had passed the exam in Medicine. She had been allowed decelerated schedule, but not been allowed to take eight weeks off between clerkships. Ultimately, however, the court found that even if she had been granted the requested clerkship rescheduling, she still had significant academic deficiencies. She was denied the remedies she sought.

This decision can be compared with *Wong v. Regents of University of California*,<sup>250</sup> in which the court reversed and remanded the lower court grant of summary judgment to the medical school. The lower court had upheld the dismissal from medical school of an individual with a learning disability. In this case the student began medical school in fall 1989 with an excellent undergraduate record. He performed acceptably in his first two years, and passed the Step 1 exam. During his third year, he learned he had failed his surgery clerkship. He was placed on academic probation while continuing his medicine clerkship. He was granted support, but took time off for his father’s illness. There were issues of competent performance in some areas, with mixed evaluations about his knowledge, but concerns about his difficulty with putting things together and effective communication of thoughts, organizational skills, and setting priorities. He was subsequently given several years of accommodation for personal issues and academics, but a learning disability was not identified until his third or fourth year when he sought evaluation from the Disability Resource Center (DRC). This occurred in 1994 with the DRC finding that he had receptive deficiencies and recommended that he receive various accommodations. The medical school administrator recommended that he would need extra time and suggested extra time to read between clerkships and recommended that a school resource team be set up, but that was never done. By December 1997, he still requested additional reading time, but he was dismissed based on academic performance deficiencies<sup>251</sup> This occurred eight years after he had started medical school.

The court’s decision in the case in which the student challenged the 1997 dismissal discussed deference to academic decision making. The court noted that the detailed *Wynne* test had not been met in this case. The decision to dismiss was based primarily on recommendations by the Associate Dean of Student Affairs, with the court noting a “conspicuous failure to carry out the obligation to ‘conscientiously’ ... explore possible accommodations.” The Associate Dean had indicated that additional time

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248 *Id.* at 1044.

249 *Id.* at 1048.

250 192 F.3d 807 (9<sup>th</sup> Cir. 1999) and later decision 379 F.3d 1097 (9<sup>th</sup> Cir. 2004). For commentary on this decision, see W. Thomas Smith & William L. Allen, *Implications of the 2008 Amendments to the Americans with Disabilities Act for Medical Education*, 10 ACAD. MED. 1097 (2011); DYLAN GALLAGHER, *Wong v. University of California: The ADA, Learning Disabled Students and the Spirit of Icarus*, 16 GEO. MASON U. C.R. L.J. 153 (2005–06).

251 The decision includes a long detailed discussion of the various rotations.

for reading between rotations might be reasonable. The university position was that this altered the curriculum.

The court distinguishes *Zukle* (where the court deferred to the university's decision about accommodations) because the circumstances were different. The court noted the need for individualized assessment in these cases. The issue in *Wong* seems to be about processing under stress, rather than a speed issue, as was the situation in *Zukle*. The court noted a pattern of strong performance when accommodations had been granted but not when they had not. Thus, the university's actions did not pass the *Wynne* test. While the court noted that a jury *might* have found that extra time was fundamental alteration, the university had failed to demonstrate the individualized assessment.

After remand, the case again reached the Ninth Circuit,<sup>252</sup> which found that because he could function with accommodations, he was not disabled within the ADA, so he was not entitled to accommodations. The court focused on the finding that he was not substantially limited in the major life activity of learning, applying the Supreme Court reasoning from the 1999 cases,<sup>253</sup> which was addressed in the 2008 ADA amendments. If this fact setting arose today, although the student would probably be protected as "disabled" within the statute, the court might well have still determined that even with accommodations, he was not otherwise qualified because of the essential nature of reading at a rapid rate in a medical professional setting.<sup>254</sup>

The process by which the accommodation requests were handled, however, highlights the importance of having transparent, manageable, and procedurally defensible policies and procedures in place from the outset of a medical student's admission and throughout the education of that student.

Other decisions involve whether accommodations on the medical board exams themselves should have been granted.<sup>255</sup> These decisions highlight the

252 379 F.3d 1099 (9<sup>th</sup> Cir. 2004).

253 See *supra* cases cited in note 114. In particular, one case is relevant. *Bartlett v. N.Y. State Bd. of L. Exam'rs*, 527 U.S. 1031 (1999). The Supreme Court remanded a case involving whether an individual with a learning disability seeking accommodations on the New York bar examination was covered under the ADA because of her reading disability. The analysis that the lower court made of that issue is similar in many respects to the *Wong* court's analysis, but the 2008 amendments made that analysis no longer the test to be applied.

254 For commentary on this decision, see Smith & Allen, *supra* note 249.; GALLAGHER, *supra* note 249.

255 One of the earliest decisions in the context of medical education was decided before the 2008 ADA amendments, which broadened the definition of disability. It is probable, however, that in this case, the decision would have been the same. In *Price v. National Board of Medical Examiners*, 966 F. Supp. 419 (S.D. W. Va. 1997) the court found that the student was not disabled within the ADA and the denial of accommodations for Step One exams was not a violation of the ADA. It is noteworthy that the student had received accommodations for ADHD on the MCAT exam. The court looked at the comparison to the average person in the population, not the average medical student. The application of the amended ADA definition to an individual seeking accommodations on board exams is found several years later in the decision in *Shaywitz v. American Board of Psychiatry and Neurology*, 848 F. Supp. 2d 460 (S.D.N.Y. 2012). The issue of whether he was disabled was not the primary focus of the opinion. It focused more on the expectation of providing notice and documentation in order to receive accommodations. The decision is one of the few that addresses accommodations

interrelationship between medical school and the various step exams and licensing exams themselves.<sup>256</sup>

### *F. Mental Health Conditions*

The cases related to mental health are the most challenging in terms of complexity and procedures for medical school professional education. It is not surprising, therefore, that these are often the cases that take the longest to resolve. The previous section on Learning and Cognitive Disabilities, Section VI(E), also involves challenging issues, and it is not uncommon that these issues arise in combination with mental health concerns.

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on a specialized board exam. The facts are somewhat different from many of the other decisions in that the student was highly successful in both academic and clinical settings, and had receiving accommodations for his dyslexia throughout most of elementary school, college, standardized admission testing, and apparently in medical school (which he began in 1994 and completed in 1998). It was not until he tried to obtain the psychiatry certification from the American Board of Psychiatry and Neurology that he faced a barrier in receiving requested accommodations for the assessments. These Board assessments include three different settings—a written exam and two oral exams (one an essay or audiovisual exam and the second a live-patient exam to assess clinical skills. There were stated time limitations and sequencing requirements for these assessments, and these had changed in 2007/2008, applicable depending on when individuals had completed their residency. The Board's motion for summary judgment was granted because the individual had not provided the required documentation in a timely manner. The individual seemed to argue that he should be granted the certification in spite of not having a passing score but because of his past record of performance overall. The claims seem to be that the factors required by the documentation were "unreliable" and "subjective." *Id.* at 465. The claim does not address why; although documentation had been provided for earlier accommodation requests (which had been granted), it was not provided for this last stage. The holding basically finds that because the individual had not made known the need for reasonable accommodations during the clearly described process, there was no ADA discrimination. In this case, the fact that he had made known the disability and provided the documentation at earlier stages, made it difficult to justify why he had ignored the expectation and requirements for such notice and documentation at the later stage. The decision indirectly highlights that different types of exams might require different types of accommodations. The change in the requirement eliminated the Part II exam for students completing their residency after a certain point in time but retained it for those who completed it before (which was this applicant). The result is somewhat odd because it seems to hold this individual to a standard that is no longer in effect and applies the requirements to demonstrate success in meeting that standard to the procedures in place at that time.

256 The decision in *Kotz v. Florida*, 33 F. Supp. 2d 1019 (M.D. Fla. 1998) is interesting in many respects. The court declined to decide the merits of the case, applying procedural analysis for federal courts deciding such matters. It is one of the few decisions to not address the merits where similar facts were involved. The case involved an individual who had received accommodations for ADD and dyslexia at various points during her medical education based on the documentation she had provided. It was only at the Step Three exam point (given at the end of a year of residency), when she was denied requested accommodations unless she paid for and submitted additional documentation. Although she had not requested accommodations for the Step One exam and during her four years of medical education exams, she did not request accommodations for Step Two. She was allowed the accommodations without the requested documentation, but the license was withheld pending her submission of the documentation. The decision is useful in its description of the stages of medical education and in its comparison of medical education and licensure to legal education and bar admission. She began medical school in 1992, and the only concerns about her fitness to be licensed occurred at the Step Three phase when the NCBE also asked her to provide information about how with her condition she was fit to practice the entire scope of medical practice and would not be a risk to patients. *Id.* at 1021. It highlights the importance of determining at the outset of medical education whether and how issues of fitness and accommodation will be addressed at various stages of education and licensure.

The technical standards that most medical schools apply refer to qualifications that relate to mental health. In the section on **Communications Skills**, there is often reference to capacity to speak, to hear, and to observe patients in order to elicit information, to describe changes in mood activity and posture, and observe nonverbal communications. A candidate must be able to communicate effectively and sensitively with patients. Communication includes not only speech but reading and writing. The candidate must be able to communicate effectively and efficiently in oral and written form with all members of the health care team.<sup>257</sup> Within **Behavioral and Social Attributes** are additional somewhat subjective qualities. These include “good judgment, the prompt completion of all responsibilities attendant to the diagnosis and care of patients, ... the ability to handle and manage heavy workloads and to function effectively under stress.”<sup>258</sup>

Mental health conditions include a range of conditions from depression (mild to severe), bipolar disorder, anxiety, compulsive behavior impairments, posttraumatic stress disorder, and other stress-related syndromes. In some cases, there are coexisting impairments such as learning disabilities, autism/Aspergers spectrum conditions, ADHD, and ADD.<sup>259</sup> Unlike some of the other impairments discussed in this article, it is not unusual for individuals not to realize that they have a mental impairment, and as a result, they do not request accommodations before there has been a performance or conduct deficiency.<sup>260</sup> The impact of mental health conditions can have a number of negative effects on medical education, particularly the clinical aspects of the program. It can affect attendance, attentiveness, interaction with patients, concentration, honesty, and judgment.

There are a number of judicial decisions that address cases involving mental health impairments in this context, and many of these cases take several years to resolve and involve complex and challenging fact situations. Decisions from employment situations can provide valuable reference regarding what it means

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257 <https://meded.hms.harvard.edu/admissions-technical-standards> (last visited December 29, 2021).

258 *Id.*

259 The impact of learning disabilities and related syndromes is discussed more fully in the previous section VI(E). *See also* Herzog v. Loyola Colle. in Md., Inc., 2009 WL 3271246 (D. Md. Oct. 9, 2009) (clinical psychology student with ADHD had good grades, but was dismissed due to behavior issues during a mandatory internship).

260 Research indicates that the onset of bipolar disorder may often occur in young adulthood (around age twenty-five), which is often the age during which medical students and residents are in the educational program. Philipp S. Ritter et al., *Disturbed Sleep as Risk Factor for the Subsequent Onset of Bipolar Disorder—Data from a 10-Year Prospective-Longitudinal Study among Adolescents and Young Adults*, 68 J. PSYCH. RSCH. 76 (2015), <https://www.sciencedirect.com/science/article/abs/pii/S0022395615001764> (re: disturbed sleep as a triggering factor). In addition, there is evidence that sleep deprivation may be a triggering factor, and the stress of clinical rotations in medical educational programs may well be related to this. *Id.*

to be otherwise qualified for medical professions.<sup>261</sup> Important to student, employment, and licensing settings is that qualification is not based on diagnosis and treatment, but rather on behavior and conduct, although a diagnostic evaluation might be appropriate for predicting future misconduct or threat.

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261 See, e.g., *Stevens v. Rite Aid Corp.*, 851 F.3d 224 (2d Cir. 2017), *cert. denied*, 138 S. Ct. 359 (2017) (employer may change job description to add new essential function; pharmacist with needle phobia no longer qualified when new job description required pharmacists to provide immunizations); *Guice-Mills v. Derwinski*, 967 F.2d 794 (2d Cir. 1992) (nurse with depression that interfered with ability to arrive at work on time); *Rivera v. Smith*, 2009 WL 124968 (S.D.N.Y. Jan. 20 2009), *aff'd*, 375 F. App'x 117 (2d Cir. 2010), *petition for cert. filed* Jan. 18, 2011 (no violation of Title I for employer to require medical testing regarding fitness for duty where physician had continued to contact nurse after a romantic relationship and she complained to hospital about harassment and stalking; safety of employees and patients basis for testing; physician not discriminated against on basis of perceived mental illness or disability); *Harris v. Reston Hosp. Ctr., LLC*, 2012 WL 1080990 (E.D. Va. March 26, 2012), *aff'd*, 523 F. App'x 938 (4th Cir. 2013) (registered nurse who attempted suicide not otherwise qualified); *Lewin v. Med. Coll. of Hampton Rds.*, 910 F. Supp. 1161 (E.D. Va. 1996), *aff'd*, 131 F.3d 135 (4th Cir. 1997) (physician with epilepsy and emotional disorder had license revoked because of professional misconduct); *Doe v. Region 13 Mental Health-Mental Retardation Comm'n*, 704 F.2d 1402 (5th Cir. 1983) (psychiatric worker with suicidal tendencies presented risk to other patients if she committed suicide); *Kroll v. White Lake Ambulance Auth.*, 27 A.D. Cas. (BNA) 1720, 2013 WL 2253757 (W.D. Mich. May 22, 2013), *rev'd and remanded*, 763 F.3d 619 (6th Cir. 2014); *Jakubowski v. Christ Hosp.*, 2009 WL 2407766 (S.D. Ohio Aug. 3, 2009), *aff'd*, 627 F.3d 195 (6th Cir. 2010) (medical resident with Aspergers was direct threat to patient care); *Alexander v. Margolis*, 98 F.3d 1341 (6th Cir. 1996) (physician whose license was revoked claimed ADA violation for reinstatement of license, claiming psychological disability was reason for misconduct of distribution controlled substances); *Bodenstab v. Cnty. of Cook*, 539 F. Supp. 2d 1009 (N.D. Ill. 2008), *aff'd*, 569 F.3d 651 (7th Cir. 2009) (hospital's discharge of anesthesiologist based on supported concerns about direct threat not a violation of ADA; individual did not have a disability within the definition); *Goomar By and Through Goomar v. Centennial Life Ins. Co.*, 76 F.3d 1059 (9th Cir. 1996) (claim that psychological disability caused behavior of making sexual advances and molesting a woman during an exam); *Guttman v. Khalsa*, 669 F.3d 1101 (10th Cir. 2012) (state medical licensing board immune from Title II claims in case involving license revocation; physician had history of depression and posttraumatic stress disorder); *Melville v. Third Way Ctr., Inc.* 59 Nat'l Disability L. Rep. (LRP) ¶ 139 (D. Colo. 2019) (therapist with history of mental illness and suicidal ideation working at center for at-risk young people, terminated not because she requested Family and Medical Leave Act (FMLA) leave, but because work was terminated for other reasons); *Needham v. McDonald*, 33 A.D. Cas. (BNA) 1318, 2017 WL 5171197 (N.D. Ill. Nov. 8, 2017) (nurse with depression expressed suicidal intentions; triable issues on whether she was otherwise qualified); *Rifai v. CMS Med. Care Corp.*, 2017 WL 4179748 (E.D. Pa. Sept. 21, 2017) (doctor's Title I ADA claim that termination was based on perception of disability; court granted employer summary judgment; condition was transitory and minor; termination based on code of conduct regarding threatened workplace violence; no evidence that perceived mental impairment lasted more than six months); *Antoon v. Woman's Hosp. Found.*, 2012 WL 1094715 (M.D. La. March 30, 2012) (employee a direct threat; ultrasound technologist); *Holland v. Shinseki*, 2012 WL 162333 (N.D. Tex. 2012) (nurse with depression and acute stress disorder not entitled to job reassignment to position of her choice); *Kailikole v. Palomar Cmty. Coll. Dist.*, 384 F. Supp. 3d 1185 (S.D. Cal. 2019) (denying dismissal of claim by employee with anxiety condition who claimed adverse employment actions were based on her disability); *Kenney v. Peake*, 812 F. Supp. 2d 34 (D. Mass. 2011) (inability to work not related to nurse's severe anxiety and depression; lost nursing license due to incarceration); *Hetz v. Aurora Med. Ctr of Manitowoc Cnty.*, 2007 WL 1753428 (E.D. Wis. June 18, 2007) (Title III applies to hospital privileges; claim by physician with bipolar disorder and sleep apnea); *Kirbens v. Wyo. State Bd. of Med.*, 992 P.2d 1056 (Wyo. 1999) (revocation of license of physician with bipolar disorder not ADA violation; individual posed safety risk; had performed unnecessary or inappropriate surgeries).

See also *Rivero v. Bd. of Regents* (10th Cir. 2020) (affirming grant of summary judgment to hospital in case involving psychiatric evaluations of surgeon, which was soon withdrawn without any change in the present terms of employment, did not create a job environment that a reasonable person would consider intolerable and could not be the basis of a constructive discharge).

### 1. Admissions to Medical School Cases

It is rare that a situation would occur where a student is specifically rejected for admission based on mental health status.<sup>262</sup> After the Virginia Tech shootings and the aftermath, it is understandable that higher education institutions are concerned about mental health of individuals within the community. Such a concern is particularly understandable in the context of a health care professional program, where good mental health may be critical to competency. During 2019 some institutions adopted admissions procedures that gave a red flag to give closer scrutiny whenever an applicant self-identified, through a personal statement or other means, that there might be a reason for concern. Because that practice was so controversial, it seems to have been discontinued.<sup>263</sup>

The admission process is a key point in time for identifying the need for accommodations for a mental health impairment that might relate to whether that the individual is otherwise qualified or may require reasonable accommodations or modification to the program. It is clear that it is impermissible to ask in an admissions application about disabilities, including mental health disabilities. Programs may, however, make appropriate disability-related inquiries *after* the student has been accepted for admission.

While the practice of advising applicants of the technical standards might result in an applicant volunteering information related to a mental health concern, it is more likely that an admitted student might raise concerns after admission and before beginning the coursework. Admitted students are generally required to sign a statement that they can meet the technical standards. For a range of reasons, however, an individual may be in denial or may not be self-aware (or may even not yet have the trigger that brings on a mental illness), and the individual would sign the statement that they are able to meet the stated technical standards.

One of the few cases involving the disqualification of an admitted student based on mental health arose in the context of the practice of requiring admitted medical students to undergo physical examinations. That was the general practice before section 504 and the ADA, but today medical schools have changed that practice to the current practice of requiring signing off on the technical standards after admission. In *Doe v. N.Y. University*,<sup>264</sup> a student admitted to medical school was identified as having concerning behavior as a result of the postadmission physical exam. The decision recounts the fact that Jane Doe had represented

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262 The initial criticism of one institution for its process of special review of applicants who self-identified with mental health concerns may have signaled that this is not a wise practice, however well intentioned. See, e.g., Scott Jaschik, *Red Flags for Applicants with Mental Health Issues*, INSIDE HIGHER EDUC (Apr. 29, 2019), <https://www.insidehighered.com/admissions/article/2019/04/29/new-college-florida-criticized-over-its-approach-applicants-mental>. While not tested in courts, there may be concerns about the legality of such practices. *College Found Guilty of Admissions Discrimination in Mental Health*, NET ASSETS (Aug. 28, 2019, 11:15 AM), <https://www.netassets.org/blogs/net-assets/2019/08/28/mental-health-discrimination-ruling>.

263 While that is an extreme example of an inappropriate process that might run afoul of ADA section 504 if tested in court, there are a few cases in which the existence of a mental health concern occurred at a very early stage of a medical school admission process.

264 666 F.3d 761 (2d Cir. 1981).

on her application that she had no “emotional problems.”<sup>265</sup> It is questionable whether such a question would be permissible today, but she originally enrolled in medical school in fall 1975, at which time the regulations pursuant to the 1973 Rehabilitation Act (section 504) had not been promulgated. During the fall semester, her mandatory physical exam<sup>266</sup> and subsequent acquisition of psychiatric history resulted in her agreement to withdraw,<sup>267</sup> with no guarantee of reinstatement, but with the understanding that she might request it. While there may have been improvement in her psychiatric condition, when she applied for reinstatement, the request was not granted. The decision was based on the consideration of her offered evidence of improvement and the judgment of other faculty members.

During the attempt to resolve the dispute, the parties agreed to an examination of the facts by a clinical psychiatry faculty member, who determined that while there were some positive signs, medical school requires “successful interaction with people”<sup>268</sup> and she recommended that Jane Doe not be readmitted. This predictor of success was challenged through litigation (seeking injunctive relief that was not granted) and through the Office for Civil Rights complaint proceedings that were not resolved quickly. During the pendency of these pursuits, she was employed at the Department of Health Education and Welfare (now Department of Education and Department of Health and Human Services) and received strong, positive evaluations, and used these to again seek reinstatement, which was again declined.<sup>269</sup> When she agreed to an examination by the district court, the findings indicated that “she remained at high risk of personality disorganization if exposed to situations of stress such as would occur on return to medical school.”<sup>270</sup> Based on that opinion and other information, the school denied her reinstatement. The district court granted her a preliminary injunction for reinstatement, finding that the evidence was that Jane Doe was likely to prevail on the merits and that she did not present a sufficient danger. The judge indicated that any destructive acts would likely be toward other students or authority figures but not to other patients, although conceding that she might be a danger to patients.<sup>271</sup>

On appeal, the court reversed the order and noted the deference to be given to the program in this case. The court validated the interest of the educational program to take into account “ability to function as a student and *doctor*, to get along with other persons, and to withstand the stress of the kind likely to be encountered in medical school and *practice*.”<sup>272</sup> Noteworthy is the inclusion of

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265 *Id.* at 765. Jane Doe was a gifted student academically but had a substantial record of serious psychiatric and mental disorders, which manifested as both self-destructive acts and attacks on others.

266 The physical exam indicated scars from cutting that had occurred as a result of the self-destructive acts she had committed over several years.

267 The opinion recounts a long and detailed series of self-destructive acts and serious behaviors that raised the concerns that lead to the withdrawal.

268 *Doe*, 666 F.3d at 770.

269 *Id.*

270 *Id.* at 772.

271 *Id.* at 773.

272 *Id.* at 777 (emphasis added).



language recognizing that medical school is not just about knowledge, but also about the application of that knowledge in practice. The appellate court applied a standard regarding risk, requiring that she not pose a significant risk of recurrence of her self-destructive and antisocial behavior. In applying that standard, the court found that the evidence supported such a finding.<sup>273</sup> The decision was based on substantial evidence provided by experts with excellent reputations. While finding that there may be some evidence that could be provided that would make a summary judgment premature, the motion for preliminary injunction was denied, but the case was left open. The language in that portion of the opinion does not seem promising for ultimate success by Jane Doe.

The *Doe v. N.Y. University* case is a very early decision, one of the very first, but it provides a number of signals for these types of cases. First, these evaluations are very difficult. Mental illness can be difficult to diagnose, and future risks are hard to determine. However, where there is substantial evidence of such risks, and the assessment is thoughtful and individualized, deference to the institution is likely to be granted.<sup>274</sup> Patient safety is a critical factor. And the relationship of medical education and practice is relevant to consider. This early decision signaled the types of assessments subsequent courts would make in other cases involving individuals with mental health impairments.<sup>275</sup>

Issues at the admissions stage were again addressed several years later in *Manickavasagar v. Virginia Commonwealth University School of Medicine*.<sup>276</sup> In that case the medical school applicant had applied three times (beginning in 2001) and been rejected. It was not until his fourth application that he indicated that he had a diagnosis of bipolar disorder, apparently as a means of justifying why he had requested accommodations for past academic deficiencies and performance that had apparently been a primary basis for his previous rejections. At that point, he was granted an interview. This was the first time he had reached the interview level. The interviews raised concerns about his weak academic performance, and his interviewers gave him low rankings. They did not reference his bipolar disorder but noted other weaknesses. After the rejection based on those interviews, he requested accommodations of reconsideration and other considerations, some of which might take into account his mental illness. The claims referenced the belief that the decision was based on “antiquated attitudes and unfounded societal and institutional barriers.”<sup>277</sup>

The court noted that he had received an accommodation by being granted an interview based on his “identified” disability.<sup>278</sup> The court granted the school’s motion to dismiss.

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273 *Id.* at 777–78.

274 Babbitt and Lee, *supra*, note 147.

275 Note also that from her original enrollment (1975) it took six years for the appellate court to rule.

276 667 F. Supp. 2d 635 (E.D. Va. 2009).

277 *Id.* at 641.

278 *Id.* at 647.

## 2. *Postadmission Conduct or Events Resulting in Dismissal*

A number of judicial decisions have addressed fact situations involving medical or other health care professional school students<sup>279</sup> where the student has requested an accommodation after admission or where deficiencies or performance concerns have resulted in a mental health disability becoming an issue.

The fact patterns for each case are important to consider because of the individualized nature of these situations, but some general guidance can be found in these decisions. First, is that while the institutions generally succeed in the cases, the judicial resolution can take years, at great cost to all concerned. The fact that these students press on for so long probably reflects the high stakes, and highlights the value of identifying policies, practices, and procedures that might have (at least in some cases) prevented such prolonged dispute resolution.

### a. **Academic Performance Deficiencies.**

There are several cases involving dismissal from the program based on academic performance deficiencies. Many of the cases intertwine “academic” performance and “clinical performance success” because both are evaluated for grades that allow a student to continue in the program. In some of these cases, the student seeks the accommodation of readmission, based on the argument that accommodations that were not in place could have improved the outcome. As noted previously, however, courts are fairly consistent in holding that an institution does not violate disability discrimination law where the disability is not made “known” to the institution. Some of the cases highlight the importance of a process that clarifies to the student how to make known a disability and need for accommodations, rather than the student assuming imputed knowledge.

- (i) *El Kouni v. Trustees of Boston University (Dismissal)*. One of the earliest judicial opinions to address this issue was the 2001 decision in *el Kouni v. Trustees of Boston University*.<sup>280</sup> Initially, this student (who had bipolar disorder and clinical anxiety and depression diagnosed in 1993) was admitted and enrolled in a joint MD/PhD program in 1993.<sup>281</sup> Because

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279 *Mbawe v. Ferris State Univ.*, 366 F. Supp. 3d 942 (W.D. Mich. 2018), *aff'd*, 751 F. App'x 832 (6th Cir. 2018), *cert. denied*, 139 S. Ct. 2022 (2019) (unpublished) (affirming state university's decision regarding pharmacy student with mental health issues because he did not possess mental health to fully utilize his abilities, and licensing was lost because of involuntary commitment); *Horton v. Methodist Univ., Inc.*, 2019 WL 320572 (E.D.N.C. Jan. 23, 2019) (student with anxiety in graduate physician assistant program; student did not request accommodations before failing courses; student had numerous struggles but did not seek specific accommodations for them); *Yennard v. Boces*, 241 F. Supp. 3d 346 (N.D.N.Y. 2017) (former nursing student with bipolar disorder raised plausible claim of 504 discrimination against county vocational school); *Yennard v. Boces*, 353 F. Supp. 3d 194 (N.D.N.Y. 2019) (nursing student with bipolar disorder not able to meet essential requirements for program even with reasonable accommodation; clinical deficiencies were repeated; discharge from program not discriminatory); *Mbawe*, 366 F. Supp. 3d 942 (pharmacy student with mental health problems was dismissed after involuntary commitment for mental health treatment; student was not otherwise qualified based on technical standards established for pharmacy internships).

280 169 F. Supp. 2d 1 (D. Mass. 2001).

281 MD-PhDDualDegree Training, <https://students-residents.aamc.org/md-phd-dual-degree->

of his persistent offensive and disruptive behavior during lectures, he was dismissed from the MD program in 1994 and ultimately dismissed from the PhD program in 2000 (six years later). He also had academic deficiencies during this time period. He had not initially requested any accommodations in spite of his problems with scientific aptitude affecting his ability to do laboratory experiments. In 1997, he notified the school of his mental health concerns, and he was given extra time on exams as an accommodation. Such a condition can affect thought processes and result in cognitive blunting. His performance deficiencies resulted in his dismissal. From his initial admission in 1993 until the judicial resolution in which he sought damages and injunctive relief, both of which were denied, took eight years. The court found that his dismissal was based not only on his academic performance, but also his persistent offensive and disruptive behavior during lectures.

As noted previously, an institution is only obligated to provide reasonable accommodations to a known disability. It is important for the individual with a disability to make that known if accommodations are needed before a deficiency in performance or behavior occurs. Courts are very consistent about not requiring an institution to give a second chance. This can be problematic in situations where an individual may not be self-aware of a mental health impairment. It can also be problematic where the individual mistakenly believes that the institution is or should be aware of the condition and should have acted accordingly in providing accommodations.

- (ii) *Slaughter v. Des Moines University College of Osteopathic Medicine (Depression)*. In *Slaughter v. Des Moines University College of Osteopathic Medicine*,<sup>282</sup> the court affirmed the lower court decision that the medical school did not violate the ADA in responding to a medical student's performance and depression. The record in the case indicates that those in a position to consider a reasonable accommodation, had it been requested, did not have the requisite knowledge. While she had been counseled by the school psychologist, the student specifically did not waive allowing the psychologist to disclose her condition to anyone at the institution. The court held that knowledge of the condition by the school psychologist should not be imputed to the institution. In addition, it found that no accommodations would have allowed the student to meet academic standards. Notable is that administrators were aware of her academic struggles and did suggest an extended program, which she declined. Other academic support was provided, but no specific disability accommodations were requested or explored. When she was dismissed, she raised the issue of her depression during the appeals process, but the dismissal was upheld. In the opinion, the court noted that in response to discussion of expectations for interactive communication regarding accommodations, the school had "consistently communicated and sought methods to improve her academic

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[training/md-phd-dual-degree-training](#) (last visited Sept. 8, 2021).

282 925 N.W.2d 793 (Iowa 2019).

performance.”<sup>283</sup> The court also discussed the assistance provided both before and after the disclosure, and that it was relevant to consider assistance provided before the disclosure in determining whether the school had provided reasonable accommodations.<sup>284</sup> The court found that even if the school should have been more interactive, she had not provided sufficient evidence that any possible accommodation would have allowed her to perform at the required level.

The case decision highlights the value of having a clear process for specifically requesting accommodations because of a disability that is protected under the ADA/504. Discussions with the school psychologist are protected by privilege. The court discussed the reasons for such a privilege, primarily that confidentiality was expected, but did not address the post-Virginia Tech exceptions when a student’s status may present legitimate concerns about a direct threat of danger to self or others. This was not such a situation. She should not have expected that her treating psychologist would disclose her status and possible accommodations to anyone else within the institution.

Discussions with administrators and faculty members may well not be specific enough for this to trigger a request for a reasonable accommodation. Although faculty members and student service administrators generally want to be helpful to student success, nonspecific conversations by a student may not raise whether a reasonable accommodation should be requested through a specific procedure within the institution. In this case, the possibility of medical leave was never requested or considered.

The court recounts the numerous areas of assistance that were provided before the end of the semester when she provided the diagnosis. It notes that she did not inform academic “decision makers” of her depression (in this instance she was aware, but in other situations an individual may not have been diagnosed) until after she had failed academically. While the school psychologist’s knowledge would limit institutional knowledge, she had communications with others within the institution that at least made them aware of her concerns. These communications included the Academic Progress Committee (APC) (its chair and its faculty members), who encouraged her to seek assistance from several parties (her course instructor, her faculty advisor, the Center for Academic Success and Enrichment (CASE), and the counseling center). At this point she was never specifically informed that she might be eligible for reasonable accommodations for a disability. Her communications with CASE provided generalized information about wanting study strategies. She did not tell them of her depression; she believed she had told some staff members and her tutor about her depression. She did not disclose her depression directly to her faculty advisor (with whom she had communications throughout the semester). After her academic failures and meeting with the APC in December, she did not inform them of her depression, but rather generally described trouble sleeping. It was this committee that suggested

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283 *Id.* at 800.

284 The court referenced a similar situation in *Dean v. University of Buffalo School of Medicine & Biomedical Sciences*, 804 F.3d 178, 190–91 (2d Cir. 2015).

the Extended Pathways Program, which would allow her five years to complete the program. When she discussed this with her faculty advisor, she disclosed her depression for the first time as an explanation about why that program would not be advisable for her. At no point did any of her contacts indicate the possibility of a medical leave or any specific process for requesting reasonable accommodations for a disability.

When she was placed on academic probation and met with the Associate Dean for Academic Curriculum to discuss study strategies, the depression was not made known. Noteworthy (as discussed in the dissent) is the fact that had that administrator known of that diagnosis, it “would have changed the nature of the conversation.” He indicated that had he known, he would have advised seeking accommodations or a leave of absence.

This raises the value of ensuring that faculty and staff members who have direct contact with students regarding their performance know how a student can request a reasonable accommodation and have that process known. While more attention has been given to this issue regarding awareness of students whose behavior may be threatening, the benefits of having a faculty member or staff member refer a student who shows signs of stress or depression to the appropriate administrator are perhaps less likely to be put into practice.

The dissent in this decision provided some valuable perspectives about medical students with depression. It also highlights the possible distinction between what an institution *must* do and what it *should* do. The dissent argues that the institution did not do what it was legally required to do. At the beginning of the dissent, the opinion provided extensive reference information about the prevalence of depression in medical school and the need for medical schools to respond appropriately. The opinion acknowledged the challenge of dealing with this issue to achieve legal compliance. The three-judge dissent found that the court should not have granted summary judgment and that more should have been required before a determination that the school had adequately engaged in the required interactive process.<sup>285</sup>

The dissent disputed the majority opinion regarding whether the interactive process should have been triggered at an earlier point to provide reasonable accommodations. The dissent pointed to specific email language sent on December 17 to Slaughter’s faculty advisor, and the chair of the Academic Progress Committee, which should have put the school on notice. The dissent further opined that offering “standard” assistance available to any student (in this case a five-year course program, tutoring, etc.) is not sufficient where the institution should be aware that something more or different is needed. The dissent notes that “magic words” should not be required. The opinion also provides an excellent discussion of what an institution should do.<sup>286</sup>

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285 Noteworthy is the fact that the dissent specifically references that the Iowa statute, although virtually identical to the federal disability discrimination statute might require more, given its stated purposes, and should not be bound by precedents under federal law.

286 *Slaughter*, 925 N.W.2d at 800.

The details of the student contacts with various parties at the institution highlight the challenge of not what *must* be done, but what *should* be done. While a student handbook should specify how to seek accommodations for a disability, it is arguable that key administrators should be proactive (and trained when to be proactive) about advising students of accommodation issues. While more information is available on campuses today to inform all educational personnel (faculty and staff members) about signals and signs of distress, and to whom to refer students, this is a difficult area. The student who is not dangerous or disruptive, but “only” depressed, may not receive the needed attention without such training and sensitivity. While it may not be reasonable to expect that all faculty members have such training and awareness, key student contact administrators should. Less clear is who those key personnel are. In this case, there was a faculty advisor, a progress committee, an academic support program, a counseling program, and ultimately the Associate Dean (who perhaps had oversight over all of these areas). Particularly challenging for a stigmatizing condition is the expectation that a student should know what and to whom to disclose in order to ensure success in a program.

- (iii) *Toma v. University of Hawaii (Depression)*. While having some similar issues to the *Slaughter* decision, the case of *Toma v. University of Hawaii*,<sup>287</sup> also involved a student with depression whose academic performance declined, and there were questions about what the medical school should have done to address the student’s depression. He did not request any assistance, although he developed symptoms early in his first semester in 2005. By 2007, his condition required psychiatric care. But it was not until 2009, when he was to take the step licensing exams, that he made a request for some modification, specifically postponing the exam. Like the *Slaughter* case, several individuals within the medical school were involved in working through this issue. These included the Student Standing and Promotion Committee (SSPC), which denied his request to delay the July 2009 exam, which he failed. The failure triggered a major depressive episode. The Director of Student Affairs became involved and required his appearance before the SSPC again. At that point he communicated to the Director about his depression and disability. She did not, however, refer him to the disability services office but did allow two postponements of meetings with the committee. What followed was a series of interactions regarding delayed exams.<sup>288</sup> Like the *Slaughter* fact situation, this case raises the challenges of to whom a request for accommodation *must* be made and how specific it must be. With multiple administrators and committee responsibilities, that information can be challenging for any student with a disability, particularly one with a mental health impairment where stress is a triggering factor and that is often a stigmatizing condition. Unlike *Slaughter*, this court focused to some degree on whether his condition actually was a disability protected under the ADA. This is important because depression can be episodic (in which case it may not be an ADA

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287 304 F. Supp. 3d 956 (D. Haw. 2018).

288 *Id.* at 958–59.

disability), or it may not be severe. Without a clear process for requesting ADA accommodations, an individual would not even know what documentation might be required to receive various accommodations.

What the *Toma* decision has in common with many of the decisions involving mental health disabilities is the length of time it took to resolve. He started medical school in 2005; his condition resulted in a final dismissal in 2011. He did not bring an action until four years later (raising a potential statute of limitations issue), and this opinion was rendered in 2018 (thirteen years after his initial enrollment), and it remains not finally resolved.<sup>289</sup> The case seems to have some of the same contextual concerns about how clearly it was made known to a student how to obtain accommodations for disabilities and what would be required to receive those, as compared to modifications and arrangements that might be available to any student with special circumstances.

- (iv) *Duncan v. University of Texas Health Science Center at Houston (Depression)*. The *Toma* decision tangentially referred to the issue of whether his condition was a disability, and most cases do not focus on that issue. One of those that has focused on the definition of disability is *Duncan v. University of Texas Health Science Center at Houston*,<sup>290</sup> which involved a student with depression whose final dismissal occurred before 2008, before Congress had amended the ADA definition to a broader definition. His condition was major depression that was addressed by mitigating measures.<sup>291</sup> The decision highlights that some mental health conditions might not be substantial enough to provide coverage to the student. The application of coverage is likely to be quite broad today because, even if the impairment is not substantially limiting, there may well be situations where the individual is “regarded as” having an impairment if there is information that provides the basis for adverse action (including failure to accommodate).

Regardless of his status as protected as having a disability, the court found that performance deficiencies that resulted in dismissal occurred before he gave any notice of having a disability. He entered in August 2004 and immediately began having conduct issues (that he later claimed were related to his dismissal). The court noted the written admissions criteria and technical standards in place at the time of his admission, which included reference to taxing workloads and functioning under stress. Interpersonal skills are also referenced. His performance and behavior concerns occurred very soon after admission and continued until his dismissal in 2006, but he was allowed to be reenter in 2007. His behavior resulted in three appearances before the Student Evaluation and Promotion Committee, and on his third appearance he was permanently dismissed in 2008. In his discrimination case, he claimed that mitigating measures for his mental health would have made him qualified, the court turns that around to find that these mitigating measures (which he knew about) would result in his not having

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289 Statute of limitations issues affected much of the case.

290 469 F. App'x 364 (5th Cir. 2012).

291 *Id.* at 369.

a disability. This was the Catch-22 that gave rise to the ADA amendment, but this student would not benefit from the amendment because the misconduct preceded 2008, when the definition removing consideration of mitigating measures was changed. The case, nonetheless, provides an additional framework to consider how a better or more clear policy or practice might have resulted in a better outcome. It is not known from the opinion whether the medical school had policies, practices, and procedures in place that would have encouraged students with disabilities to seek accommodations. From the additional admission to the court dispensation, it was a period of eight years.

- (v) *Peters v. University of Cincinnati (Depression)*. As noted above, mental health impairments may not be known to the individual or perhaps not the need for a reasonable accommodation. In *Peters v. University of Cincinnati College of Medicine*,<sup>292</sup> the medical student struggled from the outset, but received help, including a tutor. She sought help from a psychologist who determined that she had clinical depression and battered woman syndrome. The medication she was given, however, did not seem to assist with her academic difficulties, and during a consideration regarding dismissal from medical school, further assessment resulted in a determination that she had ADD and seasonal affective disorder. Upon appeal, she was allowed to conditionally reenroll, but she continued to struggle. Although the second year was completed successfully, she again had problems during her third year. Subsequent events indicated a challenging diagnosis of conditions and appropriate medication to stabilize her to allow her to perform. She may have been misdiagnosed initially, which could have had an impact on her performance. Upon assessment of her being allowed to continue, the dean followed the finding of the committee. The committee found that her ups and downs of following the medical regimen, made it unlikely that she could be a successful physician. There was lack of clarity regarding whether if the correct diagnosis had occurred initially, the correct diagnosis and appropriate treatment at an earlier stage would have allowed her performance to be acceptable.

She sought relief in court, and the court denied the university's motion for summary judgment. In allowing the case to proceed, the court noted concerns that the dean had not fully considered all relevant information regarding her disability and possible accommodations. Furthermore, the dean had allowed other students to continue in similar situations. There was evidence that she was perceived as having a mental impairment, when her condition may have been ADD. She did not win the case at this point, but the university would have to demonstrate that the dismissal was not based on a pattern of psychiatric difficulties. A question that is relevant going forward is to what degree it was permissible for the dean to focus on whether she could be a physician rather than whether she could complete the academic program. A number of events during her enrollment raise issues about whether the policies, practices, and procedures were appropriate and would ensure an interactive process regarding accommodations.



- (vi) *Sherman v. Black (Depression)*. The decision in *Sherman v. Black*<sup>293</sup> provides another fact pattern where a student's academic failure seemed to have been affected by his depression. He began medical school in 1999, but it was not until the end of his third year that he was advised by the Dean of Students (pursuant to the recommendation of the Faculty Grades Committee) of the recommendation that he take a leave of absence and that his third year be repeated upon his return, during which time he would be placed on probation. The letter noted that his anxiety was affecting his ability to master the material. The student declined the leave, and his repeated third year resulted in his dismissal. He sought to have the appeal hearing regarding his dismissal postponed because of his depression, but when the Committee met, it upheld the dismissal, which was further approved by the Dean. That fall (2003), he brought legal action through the Office for Civil Rights (OCR) process claiming that the school had failed to provide accommodations related to his psychiatric disability for coursework between 2000 and 2003. The OCR investigation was closed based on a finding that the student had not provided documentation to justify the accommodations he was requesting. In 2006, he brought suit in court to compel OCR to engage in further review. This was unsuccessful, and in 2009, ten years after he began medical school, the district court's adverse ruling was upheld. The case, like others, highlights the issue of the obligation of the individual to give notice to a medical school regarding accommodations.
- (vii) *Doe v. Board of Regents of the University of Nebraska (Depression)*. A more recent case in which the court affirmed the lower court's grant of summary judgment for the medical school is *Doe v. Board of Regents of University of Nebraska*.<sup>294</sup> The medical student brought a failure to accommodate case based on his recurrent depressive disorder. The student began in 2003 and immediately had academic deficiencies based on his performance. Although the student had notice of the process to request accommodations in orientation materials and the student handbook, he never specifically requested an accommodation or provided documentation of his depression. The facts in the case recount a long series of both academic and unprofessional performance concerns that the student was warned about. He never raised the issue of depression in order to receive accommodations. The court noted<sup>295</sup> that the institution would not be on notice of a disability just because the individual had raised depression during various communications. The student had many opportunities and should have known how to request accommodations. Had he done so, he might have been required to provide appropriate documentation, but because he did not make the request, the issue of whether he was disabled under ADA / 504 was never addressed. The student was dismissed in 2006, three years after initial admission, and after a long and varied series of

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293 510 F. Supp. 2d 193 (E.D.N.Y. 2007), *aff'd*, 315 F. App'x 347 (2d Cir. 2009).

294 287 Neb. 990, 846 N.W.2d 126 (2014).

295 *Id* at 1017.

concerns. In 2014, eleven years after he started, the case was decided. This case is a good example of how the medical school did have the procedures in place and known to students. There is no obligation of administrators to be proactive and inquire further when a student notes depression as a basis for deficiencies.

Most of the cases described in this section involved requests for a second chance, the opportunity to retake courses, or to have an additional probationary period. On rare occasions, a complaining party seeks to have grades changed. Reasonable accommodations have never been found to include giving passing grades. Retaking a course or exam might be reasonable, but simply giving a passing grade has never been required.<sup>296</sup>

### **b. Behavior and Conduct Performance Deficiencies.**

Virtually all medical schools include in their technical standards that there is an expectation of critical behavioral attributes, social skills, and professional expectations. These tend to be evaluated more during the clinical rotations, but sometimes concerns are raised even during the first two years of medical school. Such standards expect respect, adaptability, and the ability to manage heavy workloads and function effectively under stress.

Some of the judicial decisions relating to behavior and conduct issues are related to the clinical performance. Other decisions are separate but related.<sup>297</sup> Courts consistently do not require excuse of such conduct,<sup>298</sup> even if related to a mental health issue.

- (i) *Zimmeck v. Marshall University Board of Governors (Depression)*. One of the cases resulted in an unpublished opinion in 2015. It is a case that began in 2009, when the student initially enrolled. The court in *Zimmeck v. Marshall University Board of Governors*,<sup>299</sup> issued a summary judgment to the university. The student had been removed from the program because of her lack of professionalism, which included being consistently late and

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296 *McGuinness v. Regents of Univ. of N.M.*, 183 F.3d 1172 (10th Cir. 1999) (not reasonable accommodation to give passing grade to medical student with test anxiety). See blog for Lessons Learned, by William Goren (Sept. 19, 2012), <http://www.williamgoren.com/blog/2012/09/19/removing-student-disabled-disability-terminating-from-program-higher-education/>. See also Paul D. Grossman & Edward J. Smith, *NASPA Research and Policy Institute Issue Brief: Five Things Student Affairs Professionals Should Know About Disability*, NASPA FOUND. (June 2015), [https://www.naspa.org/images/uploads/main/5Things\\_ADA\\_Download.pdf](https://www.naspa.org/images/uploads/main/5Things_ADA_Download.pdf); Ryan Ballard & Chris Henry, *Mediation and Mental Health Claims Under the ADA*, 44 CAPITAL UNIV. L. REV. 31, 52–54 (2015) (referencing Job Accommodation Network and accommodations for mental health impairments).

297 See also *Doe*, 287 Neb. 990, 846 N.W.2d 126, discussed *supra* in Section VI(F)(2)(a)(vii)—regarding both academic and professionalism issues. In *Doe*, the student played internet poker during a labor and delivery and took care of personal matters during academic times.

298 See, e.g., *Bharadwaj v. Mid Dak. Clinic*, 954 F.3d 1130 (8th Cir. 2019) (affirming dismissal of doctor because he could not get along with others, not because he was regarded as having a mental impairment).

299 106 F. Supp. 3d 776 (S.D. W. Va. 2015), *aff'd*, 632 F. App'x 117, 328 Ed. Law Rep. 76 (4th Cir. 2015) (unpublished).

disruptive and failing to take an exam. Her conduct issues were observed during her first semester of medical school. She was informed that she did not meet standards for professionalism. In the meeting to discuss this, she noted that she felt isolated, and when asked by the associate dean if she was receiving treatment for depression, she said she did not think she was depressed. This case suggests that, when developing policies, practices and procedures, the policies should include a requirement that agents of the medical school, such as admissions staff, when conducting the interactive process, ensure that students understand the consequences of not requesting accommodation for a disability when there are deficiencies in the student's performance.

In this case, after this notification, the student received evaluations indicating she did meet the standards of professionalism and had improved her communication with faculty members for the subsequent semester, but in June 2011, she did not meet standards and failed to sit for a required exam. By her third year she had received treatment and medication during the preceding summer. At this point she received an evaluation noting that she would be evaluated at the end of the third year. The notice specified the conduct of concern, which included that she was "tardy, dressed inappropriately, made unsettling comments to patients, failed to follow directions, interrupted her teachers, and ran through the hallways."<sup>300</sup> When she was emailed about the need to discuss this behavior, she responded, "I quit." This was taken to be a suicide note, but she continued with permission, and received an additional warning during that semester and was dismissed.<sup>301</sup> At this point, she tapered off medication and at a readmission proceeding, she indicated this was because the side effects of the medication caused the behavior. She had never raised that before the readmission proceeding.

The court's decision notes that professionalism is an essential aspect of the program,<sup>302</sup> as noted in the handbook and student standards and goals. She had seen the standards and had signed acknowledgments of seeing them. The court stated that there is no duty to provide accommodation until the student asks.<sup>303</sup> The court found that the argument that the school "should have known" was not persuasive. The court further found that misconduct, even if related to disability, is not a disability. This is another lengthy process (six years) from entry to final judicial determination.

- (ii) *Shurb v. University of Texas Health Science Center at Houston-School of Medicine (Anxiety and Depression)*. In *Shurb v. University of Texas Health Science Center at Houston-School of Medicine*,<sup>304</sup> the court granted a summary judgment for the university in a case involving a medical student who was suspended after a series of events that involved both academic and

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300 *Id.* at 778.

301 *Id.* at 779.

302 *Id.* at 781.

303 *Id.* at 782, citing the *Halpern* decision, which involved similar facts.

304 63 F. Supp. 3d 700 (S.D. Tex. 2014).

behavior-related issues and concerns about direct threat to self or others. The case involves a complex set of facts related to his condition and numerous university representatives (with varying obligations and responsibilities) involved in the decision making. In essence, the student was academically withdrawn from medical school after concerns were raised regarding his anxiety and depression during his first year. This began in fall 2009. When university officials were notified,<sup>305</sup> they advised the student to take the Alternate Pathway Program, which extended the first year into a two-year program. He agreed to that, but his problems continued. He sought and obtained accommodations, including Power Point slides from some, but not all, professors. These apparently were granted on an individual basis, not as part of an ADA accommodation process.<sup>306</sup> The student's contacts with the dean about accommodations were eventually directed to the Office of Student Affairs. That office did not facilitate granting the requested Power Points from professors.<sup>307</sup> The student subsequently suffered from migraines and as a result took a medical leave, at the recommendation of the Assistant Dean of Student Affairs and Assistance.<sup>308</sup> His return to class in fall 2011 was initially conditioned on a letter of fitness to return from his treating psychiatrists. Apparently, the letter was provided, and he returned, but shortly thereafter, he had some significant episodes that resulted in a hospitalization during which a psychiatrist (not his treating physician) raised concerns about attempted suicide.

When he asked to return to class after this incident, there was a dispute about whether he provided the requested documentation to return to class, and he was escorted from classes by a Student Affairs staff member, and met by the Associate Dean for Students, the Director of Admissions and Student Affairs, and the Assistant Dean for Admissions and Student Affairs.<sup>309</sup> A few days later, the student and his mother met with the three administrators about the situation, and when the student attempted to record the meeting, it was terminated because legal counsel was not present. The next day, the student and his mother met with the university counsel. The court opinion notes that the student claimed that university counsel was surprised by what had been requested. University counsel, however, requested some, but not all, of the information requested by the three student service administrators (apparently the release of medical records). The student, however, did not provide any of the requested information, believing it was

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305 It is not clear from the opinion which officials were notified.

306 This highlights the challenge of having individual professors giving assistance. This is not surprising where it is not requested as an ADA accommodation, but could be problematic if this were part of a university process of providing accommodations.

307 It is not clear whether this office was nonresponsive or denied the request.

308 This does not indicate whether ADA accommodations were discussed or the process to obtain them.

309 These administrators told him that he could not return without the following documents and actions: (1) full medical records from hospitalization and urgent care center; (2) attend scheduled appointments with treating physicians, and provide certification from his psychiatrist that he was not a danger to himself or others and was fit to return to class; and (3) authorizations to obtain medical information.

impermissible. Subsequently, when the administrators believed that the needed information had not been provided, they notified the university counsel that the student would be withdrawn. During the following year, he was also asked to return a \$5,000 grant that had been given to him.

A little more than one year after these events (fall 2011), the student brought suit claiming ADA/504 violations. In 2014, the motion was granted, five years after his initial enrollment. The court found that the actions were based on a determination that he was not a protected individual with a disability,<sup>310</sup> that he was not otherwise qualified because he had not provided documents required for return,<sup>311</sup> and that his removal was based on his performance deficiencies, not his disability and only after “numerous attempts to reasonably accommodate plaintiff’s disability.”<sup>312</sup> It is unclear whether the university was treating this situation as a disability accommodation process or simply as an attempt to work with a student regarding health problems.

The court also addressed the failure to accommodate claim, first noting that once an individual requests a reasonable accommodation (and the burden is on that individual to make the request), there is an obligation to engage in an interactive process.<sup>313</sup> With respect to the request for Power Points, the court notes that an individual does not have a right to a preferred accommodation. The court notes many instances when accommodations were provided, but these did not improve his academic performance and did not alleviate the university’s concerns about his continued self-harming activities and potential for harm to others. The court determined that the activities of the university did not indicate a failure to accommodate.

(iii) *Halpern v. Wake Forest University Health Sciences (Anxiety Disorder)*. The decision in *Halpern v. Wake Forest University Health Sciences*,<sup>314</sup> involved a pattern similar to the *Shurb* case. The student’s enrollment in medical school lasted from 2004 to 2009. Although he had ADHD and an anxiety disorder, which had been diagnosed and treated in college and for which he had received accommodations,<sup>315</sup> he did not disclose that, nor request accommodations upon enrolling in medical school. He was diagnosed as having an anxiety disorder in the spring of his second year of medical school. The behaviors that began immediately included inappropriate interactions with the Academic Computing staff to which he was very abusive, missing classes, lying about the reasons for his conduct and being late for class.<sup>316</sup> Only after several years of engaging in unprofessional acts,

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310 The record did not demonstrate documentation supporting that his visual learning concerns were a disability.

311 The court does not address whether it was permissible to request these documents.

312 *Shurb v. University of Texas Health Science Center at Houston-School of Medicine*, 63 F. Supp. 3d 700, 708 (S.D. Tex. 2014).

313 *Id.*

314 669 F.3d 454 (4th Cir. 2012).

315 *Id.* at 457.

316 His justification was side effects of the ADHD medication.

including abusive treatment of staff and multiple unexcused absences, did he raise his condition as a justification for an accommodation. He was allowed a delay in the Step 1 exam at the end of the second year. Although he had both behavior and academic deficiencies during his first two years, it was not until the clinical rotations that he made known the disability. He requested test accommodations during the surgery rotation but did not provide the documentation required to evaluate the request in a timely manner. After his continued pattern of performance deficiencies, he was dismissed in 2007.<sup>317</sup> The record notes that he did not accept constructive criticism.

In his appeal of the dismissal to the dean of the medical school, he proposed the accommodation of allowing psychiatric treatment, participating in a program for distressed physicians, and continuing on strict probation. The denial of the appeal was based on the determination that this pattern of behavior made it appear that he would continue to resort to unprofessional behavior. It seemed that while he might be able to control conduct toward doctors, he had difficulties with staff.<sup>318</sup> The importance of the team approach in patient treatment was relevant to the decision.

The student challenged the denial in court, which took until 2012 for final decision. The court stipulated that his condition was a disability, but ADHD might not be a disability in all cases. The court held, however, that the proposed accommodation was not reasonable. The court deferred to the dean's assessment that the student's proposed remediation plan was indefinite in time and was unlikely to be successful. Of greatest significance is the fact that he did not request accommodations before the misconduct.<sup>319</sup> The court also noted that the school had engaged in an interactive process. The case follows a pattern of several similar cases where the removal does not occur until the clinical rotations began, and the resolution of the case took several years.

(iv) *el Kouni v. Trustees of Boston University (Anxiety, Depression, Bipolar Disorder)*. In *el Kouni v. Trustees of Boston University*,<sup>320</sup> the student initially enrolled in an MD/PhD program in 1993. This decision was referenced previously in the context of dismissal due to academic performance.<sup>321</sup> It should be noted, however, that he was also dismissed from the MD program in 1994 based on his persistent offensive and disruptive behavior during lectures. He was later dismissed from the PhD program in 2000, six years later. Although he had been diagnosed with clinical anxiety and depression in 1993 and with bipolar disorder in 1997, it was not until 1997 that he requested accommodations. The accommodation requests were related to his academic work. Such accommodations, however, would not address the disruptive behavior concerns that were also a basis for his dismissal.

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317 Halpern, 669 F.3d at 459.

318 *Id.* at 460.

319 *Id.* at 466.

320 169 F. Supp. 2d 1 (D. Mass. 2001).

321 See Section VI(F)(2)(a)(i).

- (v) *Amir v. St. Louis University (Obsessive Compulsive Disorder)*. In *Amir v. St. Louis University*<sup>322</sup> the resolution was eight years from entry to judicial decision for the university, but the facts included some issues that are important to consider for the university's development of policies, practices, and procedures that appropriately respond to students whose serious mental health conditions raise concerns about being qualified. The student with obsessive-compulsive disorder (OCD) (who entered medical school in 1991 at age twenty) demonstrated rude and arrogant behaviors toward staff, even before classes began. This conduct resulted in a meeting with the dean who advised him that he might want to consider a profession that did not require compassion, but the admission was not revoked. Given the experience of this setting, this might be a point at which a proactive and interactive approach regarding disability issues could give earlier attention to possible accommodations.

The student's OCD disorder was not diagnosed until his third-year rotations. During the first years, however, he had academic failures in some coursework and also some behavior issues.<sup>323</sup> After the academic problems, he was offered an extended curriculum, which he declined. After a second semester of failed exams, he was again offered an extended curriculum or a leave of absence. At this point, he accepted the leave. When he returned, his performance was weak but adequate. It was during his third-year clinical rotations that he had significant deficiencies in behavior that affected his evaluations. When he was diagnosed at that point with severe obsessive-compulsive behavior, he told his supervising faculty members and hoped that would be a factor for consideration in his performance. The faculty members did not adjust expectations based on this, and other professors were made aware of the condition.

At this point it was suggested that he receive treatment and hospitalization, which he initially declined, but later he voluntarily admitted himself for treatment. The university had notice of this. When he sought to return to the psychiatry rotation after this treatment, the reentry was denied because of the length of time he was absent.<sup>324</sup> When he was later allowed to retake the psychiatry rotation (after receiving passing grades in three other rotations and passing after remediation in the fourth), he did not pass the psychiatry rotation. In the interim, the evaluation policy had changed but only in the psychiatry rotation. The court noted this but found he was nonetheless not qualified, although allowing a retaliation claim to proceed based on the medical school's response to his requests.

While there were sufficient deficiencies in the record for the court to uphold the dismissal on the basis that he was not otherwise qualified,<sup>325</sup> there were concerns

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322 184 F.3d 1017 (8th Cir. 1999).

323 *Id.* at 1022. The court noted some misrepresentations in selling tickets to a Cardinals game that did not result in adverse action, although they were in the record.

324 *Id.* It is not clear whether he was given notice at any point how long he would be permitted to be absent from the program.

325 The court found that either the academic or the performance deficiencies would have justified the dismissal.

that allowed the case to go forward on retaliation claims, which might ultimately result in a finding of damages.<sup>326</sup> This is an example of a case where a university may win the case in terms of the dismissal of the student, but still be found to have retaliated and thus be obligated to pay damages, highlighting the value of developing policies, practices, and procedures to avoid such potential liability.

The court noted that none of the student's proposed accommodations for the psychiatry rotation were reasonable.<sup>327</sup> These included attending a different institution (which was never allowed for students with academic difficulties). Consistent with all other judicial decisions, his proposal that he be given a passing grade was not reasonable because it interferes with academic discretion. Of most significance, however, was his request to continue his psychiatry rotation under a different faculty member. While the facts indicate that this might have been a good idea, perhaps to avoid any appearance of bias, it was not a reasonable accommodation.

It is noteworthy that these facts occurred before the ADA amendments to the definition of disability in 2008. The court found that his OCD was a disability,<sup>328</sup> but it may be that more documentation of the condition might be required, although his hospitalization may weigh in favor of the substantial limitation.

Nonetheless, he was also initially found to be qualified for admission. The case provides a setting to examine whether a more proactive approach to accommodating him at an earlier point would have resulted in his ability to succeed.

### c. Cases Involving the Timing of Clinical Rotations.

A few cases deal with the timing of clinical rotations and passing various exams within set time frames. In these cases, the student may be seeking accommodation in timing due to the mental health concerns. Although the individual is a student at a medical school, it is the NBME that administers the step tests, so the lawsuit is sometimes brought against that organization, in addition to the medical school.

- (i) *Powell v. National Board of Medical Examiners* (*Learning Disability, Stress, Anxiety*). In *Powell v. National Board of Medical Examiners*,<sup>329</sup> the timing of tests was at issue, and the case demonstrates the interrelationship of board exams and medical education. The student began medical school at the University of Connecticut in 1992 but struggled from the outset. While the primary impairment is a learning disability issue, there are elements of mental health (stress and anxiety) intertwined.

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326 *Amir*, 184 F.3d at 1026.

327 *Id.* at 1029.

328 His condition resulted in his not being able to eat or drink without vomiting, inability to get along with others, and affected his ability to concentrate and learn. *Id.* at 1027. The 2008 amendment guidance specifically notes that the inability to get along with others is not a major life activity. The other areas might be sufficient to establish a substantial limitation to other major life activities. It is possible that documentation of his condition today would require more.

329 364 F.3d 85 (2d Cir. 2004), *corrected*, 511 F.3d 238 (2d Cir. 2004).



The Step 1 exam, required for passage in order to advance after two years, is administered by the NBME, but the medical school has discretion to allow a student to retake the exam. Passing the test can be a condition of continuing into the third year. Not only did this individual have deficiencies in course work, but she also failed the Step 1 exam. She was informed by the medical school that she would have to remediate these deficiencies to continue. The medical school provided substantial assistance during the two years in which she sought to do so.<sup>330</sup> Although the student failed the Step 1 exam again, she was allowed conditional admission into the third year, based on her passing the course. During that year, the school provided substantial assistance, but she still failed two times. She was informed that she would be dismissed, but the final decision was to be deferred until after her litigation against the NBME for failure to accommodate was resolved. She did not prevail in the litigation, and was dismissed.

The litigation against the NBME followed her 1997 referral to the medical school's neuropsychologist (paid for by the school), who recommended additional time due to the diagnosis of ADD and a learning disability, and noting that anxiety and depression might be a factor in her academic problems. The NBME did not accept the documentation provided to them as demonstrating that she had a protected disability. These events occurred before the 2008 ADA Amendments Act that clarified to some extent the definition and guidance that addressed what documentation should be required. If this set of facts occurred today, the judicial outcome might have been different, but the opinion highlights the concerns about documentation to justify the requested accommodation.<sup>331</sup> When she was finally dismissed as a result of the failure to pass the exam, she brought suit in 1999 (seven years after her initial admission) against both the NBMC and the medical school.

The district court granted the motion for summary judgment by both defendants, and the appellate court addressed the issue, affirming the motion. In reaching the decision, the court focused on whether she was otherwise qualified. Oddly, the court highlighted facts that raise questions about whether she was qualified to have been admitted to medical school in the first place. She had a weak undergraduate record and MCAT scores. In spite of her weak record, she was admitted, and when she struggled, she was provided substantial assistance, but to no avail.<sup>332</sup> The school was not obligated to provide her requested accommodation of being allowed to continue in medical school without passing the Step 1 exam.<sup>333</sup> The NBME had not acted discriminatorily when it determined that the documentation she provided did not establish a disability or that the accommodation of additional time was required. The court further indicated that even if she had prevailed, money damages are only available where there has been

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330 Assistance included "free tutoring services, overlooking an honor code violation ..., expressing concern over the level of stress, and allowing her the opportunity to remediate certain subjects multiple times." *Powell*, 364 F.3d at 82.

331 *Id.* at 84.

332 *Id.* at 87–88.

333 *Id.* at 88.

intentional discrimination, which includes “deliberate indifference.”<sup>334</sup> In 2004, over a decade after her 1992 admission to medical school, the final judicial decision was rendered, again raising the question about whether something might have been done at an earlier stage to avoid the protracted resolution that was costly to all parties.

- (ii) *Datto v. Harrison (Stress)*. An extremely complex set of facts gave rise to the preliminary order in *Datto v. Harrison*.<sup>335</sup> The student was admitted to a joint MD/PhD program and enrolled in 1998, after resolving his expectation of scholarship support.<sup>336</sup> His first two years were quite successful, and he began his PhD work. It was at this point that problems occurred. A series of events, including closure of the program connected to his research, and several faculty members leaving, and other events resulted in his returning to the medical school aspect of the program. Although he again excelled academically, his thesis defense did not go well.<sup>337</sup> He sought additional scholarship support to complete the thesis,<sup>338</sup> but this request was denied. This lack of funding triggered stress for which he received treatment from the medical school’s psychiatrist who prescribed medications. These medications caused significant side effects, which may have affected his performance in the clinical aspects of the program as well as affecting his cognitive abilities. These performance deficiencies resulted in his being placed on a mandatory leave of absence.

In meeting with the Committee on Student Promotions, he told them that his tremors and shaking were side effects of the medication. He did not tell them that his cognitive problems were related. He had been told by the treating psychiatrist that these problems were caused by his bipolar disorder and ADHD.<sup>339</sup> During his penultimate rotation in rheumatology, events occurred regarding communication with a patient that resulted in an adverse performance outcome.<sup>340</sup> This adverse grade resulted in his dismissal from medical school, which he unsuccessfully appealed, the resolution being in July 2005, seven years after initial enrollment. His subsequent litigation claiming ADA/504 violations when he was not provided with accommodations raise questions about when the school was on notice of a request to accommodate. The case reports have not yet addressed those issues. The 2009 judicial decision was remanded for further deliberations, so by then

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334 *Id.* at 89.

335 664 F. Supp. 2d 472 (E.D. Pa. 2009).

336 There was disagreement about whether he had been promised the support, but ultimately the medical school committed to providing him full support for the seven years. This support adversely affected funds available to other students, and the student alleged that this caused ill will toward him by school officials.

337 The student raised concerns about not having received the expected support from his advisor or the thesis committee.

338 The student had expressed concerns over the workload to the Dean of Student Affairs.

339 Perhaps the student was concerned about the stigmatizing impact of having such information would have in his record. Noted in the opinion is that the student requested that the Dean’s letter remove reference to his anxiety. This request was refused.

340 The facts involved in this are quite complex.

it had been eleven years from entry to only a preliminary resolution. The court order recognized the possibility of individual liability for retaliation claims. This murky fact pattern raises a number of questions about timing and other issues. Notable is the more than adequate academic performance initially and that stress seemed to be a factor in subsequent deficiencies. Whether the medical school had any accommodation obligations related to that stress (depending on whether there was notice of a disability and request for accommodations) remains unresolved.

(iii) *Doe v. Samuel Merritt University (Anxiety Disorder)*. While it is not certain that all cases of anxiety disorder (including test anxiety) will mean that a student has a disability protected by the ADA/504, in some cases the court will recognize that without detailed discussion. In *Doe v. Samuel Merritt University*,<sup>341</sup> a student in podiatry school with anxiety disorder raised questions about whether test taking was a major life activity and whether limiting the number of times the student could take the licensing exam should be given deference. The student began medical school in 2009 (notably after the date that the ADA definition of coverage had been amended), and was diagnosed with generalized anxiety disorder and agoraphobia in the spring of her second year of medical school (2011). She received additional time for her exams that semester. While this improved her grades in her courses, she was required to pass the Step 1 exam within three attempts, and when she failed to do so, she was dismissed during the summer of 2011. At that point she requested the accommodation of being allowed to take the test an unlimited number of times. She did take the test a fourth time and failed. Her attempt to take the test again was not allowed because she was no longer enrolled. She brought suit in December 2012 as a result.

The motion for a preliminary injunction in the suit was denied. In the opinion, the court addresses the likelihood of success on the merits. This discussion of whether she had a disability specifically noted the changes from the 2008 amendments that provided for a broader definition.<sup>342</sup> This is one of the few opinions in the medical school context to give attention to the definition for anxiety-related disorders. The court specifically provided, while noting the precedent of cases decided before the amendments, that test taking might be a major life activity and that she was substantially limited in that regard. While learning is a major life activity, she did not provide adequate evidence of being substantially limited. Interestingly, because it connects to the practice, she argued that the test is required for her to work as a podiatrist, so she was also limited in working, which is a major life activity. The court did not accept that argument.<sup>343</sup> The fact that she was provided accommodations would indicate that the school “regards her” as having an impairment, but that was not the basis for the denial of the modification of the three-time rule.<sup>344</sup>

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341 921 F. Supp. 2d 958 (N.D. Cal. 2013).

342 *Id.* at 965–66.

343 *Id.* at 967–68.

344 *Id.* at 568. The rule was established in 2008. *Id.*

The court's discussion of deference to the institutional policy of limiting the number of times is particularly interesting. The passage of the policy by the Dean's Council was not based on a finding that additional times to pass would fundamentally or substantially alter the standards.<sup>345</sup> In addressing the balance of hardships, the court recognizes legitimate concerns if she is allowed to be enrolled in the clinical courses but that if the institution waived the requirement that she must be enrolled to take the test, pending the resolution of the application of the three-strikes rule itself, that would resolve the preliminary injunction order. Thus, the preliminary injunction allowing her to take the test is granted, which seems to de facto, at least in this case, mean that she would not need to be enrolled.

(iv) *Dean v. University of Buffalo School of Medical & Biomedical Sciences (Depression)*. Another case affecting the timing of the Step 1 exam is *Dean v. University of Buffalo School of Medical & Biomedical Sciences*.<sup>346</sup> A medical student sought additional leave to deal with his depression. He had completed his first two years of medical school (2004–06), but had failed the Step 1 exam the first time. Although given a leave of absence from medical school before retaking the exam, he was subsequently granted additional leaves. He was informed, before he took the test a second time, that a failure would automatically result in his suspension from medical school, pursuant to the handbook policy. His request for an extension from the February to the May test administration was denied. Although his request noted his "depression, stress, and anxiety," he did not request a medical leave. This raises an interesting question about whether he was requesting a reasonable accommodation pursuant to an ADA recognized disability. The court noted that "sometime *after* failing the Step One Exam for the second time," the student *became* disabled.<sup>347</sup> The university's psychologist diagnosed him with situational depression due to his symptoms and recommended a leave of absence, and the student's request for a three-month leave was granted in order for his new medication to become effective. When he realized that he needed more time for the treatment to be effective, he requested an additional month, but this request was denied. Notably, he was not requesting an exception to the number of times the test could be taken, but instead an extension in the medical school's leave of absence time limitation rules.

This denial was followed by an OCR complaint and a court complaint seeking reinstatement and damages. The district court granted the school's motion for summary judgment. On appeal, the court discussed the interrelationship of the student's request based on the need for the medication to take effect and the need for additional time to prepare for the exam. The court found that there was sufficient evidence that the amount of time allowed was not a reasonable accommodation under the circumstances and consistent with the school's policy of allowing a set period to prepare for each exam. The court further set out burdens of proof

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345 *Id.* at 969.

346 804 F.3d 178 (2d Cir. 2015).

347 *Id.* at 183 (emphasis added).

and persuasion, and while finding that the student initially has those burdens, they were met in this case. The school did not counter the request with evidence that the request would impose an undue burden or fundamental alteration. The district court's grant of summary judgment to the school on the ADA/504 claims was overruled and remanded for further proceedings.<sup>348</sup> Thus, from the initial enrollment in 2004 to the ruling in 2015 (which is not a final resolution), over a decade had expired.

- (v) *Bhatt v. University of Vermont (Obsessive Behavior/Tourette's Syndrome)*. Dishonest behavior will almost never be excused regardless of whether an underlying mental health condition was a factor in the behavior. In *Bhatt v. University of Vermont*,<sup>349</sup> a decision that took thirteen years from initial enrollment to resolve, the court held that a medical student's falsifying the evaluations (on more than one occasion) did not have to be excused because of the student's Tourette's Syndrome obsessive behavior. His dismissal was upheld. The decision noted that the stress of medical school, particularly the clinical rotations, may have triggered his conditions. Also noted and significant was the fact that the student did not make known the condition or request any accommodations for it until after the disciplinary actions had occurred. After his dismissal, and subsequent treatment, he sought reinstatement. He continued his medical degree by transferring to another medical school, whose degree was not recognized in every state and which limited where he could practice medicine. Because of this, he brought suit against the University of Vermont in November 2004, seeking equitable relief of reinstatement and granting the degree, based on Vermont's discrimination statute that is virtually the same as the ADA.

The lower court granted the university's motion for summary judgment. The state supreme court, in upholding the lower court, applied standards consistent with most other decisions. These included deference to academic decision making, significant priority for patient safety in these decisions, and caution in applying employment discrimination case precedent to education settings.<sup>350</sup> Significant factors in the court's decision included that the conduct involved was egregious, that the student had not made known the condition until after the adverse action, and that the situation taken as a whole was relevant.<sup>351</sup> He did not even raise the disability during the dismissal proceedings, only after an adverse result. The court even noted that it is possible that this individual would not even be found to have a disability.

### 3. Admission into Residency Programs

There are a few cases in which admission into residency programs has raised disability discrimination issues. Residency admission generally occurs during

348 *Id.* at 191.

349 184 Vt. 195, 958 A.2d 637 (2008).

350 *Id.* at 201–02.

351 In this case, the student had already been given a second chance.

the fourth year of medical school. By that point, the medical school has a record of academic and technical performance. That information may be a factor for individuals when they seek the residency “match.” It is at this stage that the medical student enters into an employment/student relationship, so cases from employment law might provide additional guidance.

The most significant case was discussed previously in the context of mobility impairments. It also involved concern about the applicant’s psychological health, perhaps more than his mobility limitations, that was the basis for the initial denial. In *Pushkin v. Regents of the University of Colorado*,<sup>352</sup> an individual with multiple sclerosis was denied admission to the psychiatric residency program based on the interviewer’s “concern for psychologic reactions of the patient and in turn the doctor, as a result of his being in a wheelchair.”<sup>353</sup> As noted earlier,<sup>354</sup> the articulated reasons for rejection were determined to have been based on incorrect assumptions or inadequate factual grounds.<sup>355</sup> It should also be noted that in virtually every discrimination context, it is impermissible to use “coworker or customer preference” as a defense to discriminatory action. The possibility of negative reactions from patients (as compared to something that would be a direct threat to patients) should never be the reason for such a decision.

Several years later, a court again addressed a case involving a residency program. In this instance it involved a decision not to readmit a student for admission to a residency program. In *Kaminsky v. Saint Louis University School of Medicine*,<sup>356</sup> a student was denied readmission based on the individual’s conduct. The Eighth Circuit affirmed a lower court decision that found that it was not unreasonable to rely on a state website listing indicating medical license suspension in making its decision not to hire (or readmit) the individual into a residency program. The medical school did not have to readmit the student with psychosis into the residency program, where his conduct was unprofessional and illegal, even if it related to his disability. The conduct in question included self-prescribing medication, which resulted in the loss of his medical license.

The case is somewhat unusual in that it involves a transfer from one institution to another. Kaminsky had completed his medical/osteopathy degree (apparently without incident) at the University of Missouri at Kansas City in 1998. He was initially admitted into the residency program for pathology at Wake Forest, but after two years, he sought to transfer to Saint Louis University, which initially granted the transfer. Shortly thereafter, a series of events occurred including unprofessional behavior and learning that his medical license had been revoked because of self-prescribing medication. As a result, his residency was terminated in fall 2002. When he later sought reinstatement, he was denied that in 2004—

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352 658 F.3d 1372 (10th Cir. 1981).

353 The interview notes showed that the opinion and judgment of all of the interviewers was “inextricably involved with [his] handicap.” *Id.* at 1386 (quoting the trial court).

354 See discussion in Section VI(C)(1).

355 *Pushkin* 658 F.3d at 1383.

356 2006 WL 2376232 (E.D. Mo. 2006), *aff’d*, 226 F. App’x 646 (8th Cir. 2007).

05, and his subsequent court challenges based on disability discrimination law were unsuccessful. His denials were based on conduct and behavior, not on his disability status.

### *G. Alcohol and Substance Use and Abuse*

There are few, if any, cases involving issues of alcohol and substance use and abuse in the context of adverse action during medical school. There are, however, numerous decisions in health care professions themselves involving this issue.<sup>357</sup> This is an issue particularly within health care professions because of the stress of the work in combination with the access to controlled substances. It is quite

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357 See, e.g., *Altman v. N.Y. City Health and Hosps. Corp.*, 100 F.3d 1054 (2d Cir. 1996) (head of internal medicine department could be required to be supervised after several incidents and relapses); *McDaniel v. Miss. Baptist*, 74 F.3d 1238 (5th Cir. 1995) (no longer engaging in drug use means being in recovery long enough to have become stable); *Bekker v. Humana Health Plan, Inc.*, 229 F.3d 662 (7th Cir. 2000) (physician unsuccessful in claim of discrimination on basis of perceived disability of alcoholism); *Dovenmuehler v. St. Cloud Hosp.*, 509 F.3d 435 (8th Cir. 2007) (nurse with history of illegal activity related to drug dependency; not reasonable for recovery plan to require supervision when handling narcotics; unduly burdensome; related to monitoring illegal activity); *Hartley v. Boeing Co.*, 59 Nat'l Disability L. Rep. (LRP) ¶ 91 (E.D. Pa. 2019) (emergency medical technician job offer contingent on passing drug screen; later requirement of medical test issue about requirement of a health screening not required of all similarly situated employees; questions about whether this was an impermissible health test remained); *McNulty v. Cnty. of Warren, N.Y.*, 59 Nat'l Disability L. Rep. (LRP) ¶ 8 (N.D.N.Y. 2019) (preliminary rulings in claim by county nurse who took FMLA leave for treatment for alcoholism was supervised in a discriminatory manner based on her alcoholism not on performance); *Sper v. Judson Care Ctr., Inc.*, 29 F. Supp. 3d 1102 (S.D. Ohio 2014) (registered nurse terminated for her failure to comply with narcotics distribution procedures not because of her disability); *Wells v. Cincinnati Children's Hosp. Med. Ctr.*, 860 F. Supp. 2d 469 (S.D. Ohio 2012) (fitness for duty issue for nurse potentially regarded as disabled for concerns about use of controlled substance); *Talmadge v. Stamford Hosp.*, 2013 WL 2405199 (D. Conn. May 31, 2013) (nurse with past opioid dependence did not present evidence of being qualified to return to work in operating room after participating in rehabilitation program); *Skidmore v. Virtua Health Inc.*, 2012 WL 2369357 (D.N.J. June 21, 2012) (registered nurse with alcoholism terminated because of nonattendance allowed to bring state disability law claim although FMLA claim was dismissed); *Love v. Baptist Mem'l Hosp.—N. Miss., Inc.*, 2012 WL 4465569 (N.D. Miss. Sept. 25, 2012) (registered nurse with knee injury who fell asleep at work contended that hospital regarded her as drug addicted; she was entitled to reasonable accommodation, not accommodation of her choice; hospital had provided a transitional employment plan for the knee injury); *Scott v. Presbyterian Hosp.*, 2012 WL 4846753 (W.D.N.C. Oct. 11, 2012) (registered nurse with lupus, ADD, and other medical conditions who also had a history of drug abuse for which she had treatment; denial of summary judgment in ADA claim after she was terminated for charting errors that had been attributed to her drug addiction; "regarded" as issue allowed to go forward); *Horne v. Clinch Valley Med. Ctr., Inc.*, 2012 WL 4863791 (W.D. Va. Oct. 12, 2012) (registered nurse who was insulin-dependent was terminated; issue of whether the reason was a pretext could go forward); *Fedorov v. Bd. of Regents for Univ. of Ga.*, 194 F. Supp. 2d 1378 (S.D. Ga. 2002) (dental student with drug addiction not qualified because he was a current drug user and remained a threat to patients); *Judice v. Hosp. Serv. Dist. No. 1*, 919 F. Supp. 978 (E.D. La. 1996) (neurosurgeon with severe alcoholism symptoms could be required to be evaluated by addictionologist before reinstatement); *Wallace v. Veterans Admin.*, 683 F. Supp. 758 (D. Kan. 1988) (nurse with alcoholism and history of drug addiction qualified except for administration of narcotics because she had substantial ICU experience, had been drug free for nine months, and had completed rehabilitation); *Cavins v. S & B Health Care, Inc.*, 39 N.E.3d 1287 (Ohio Ct. App. 2d Dist. Montgomery Cnty. 2015) (registered nurse who was terminated for use of prescription pain medication was regarded as disabled; lack of sufficient evidence that it would be undue hardship to allow employee to work while taking medication).

possible that alcohol and substance use and abuse might have affected performance during medical school, but these situations do not seem to be raised as a factor in excusing performance in the medical school setting. It is possible, although not directly addressed in the decisions, that side effects of medications (not abuse or misuse) relate to performance of students with mental health impairments.

At this point it should be noted that a person with a disability includes a definitional reference to the use of illegal drugs.<sup>358</sup> The term

“individual with a disability” does not include an individual who is currently engaging in the illegal use of drugs, when the covered entity acts on the basis of such use. Further rules of construction provide that one is still protected if the person:

- (1) has successfully completed a supervised drug rehabilitation program and is no longer engaging in the illegal use of drugs, or has otherwise been rehabilitated successfully and is no longer engaging in such use;
- (2) is participating in a supervised rehabilitation program and is no longer engaging in such use; or
- (3) is erroneously regarded as engaging in such use, but is not engaging in such use;

except that it shall not be a violation of this Act for a covered entity to adopt or administer reasonable policies or procedures, including, but not limited to drug testing, designed to ensure that an individual described in paragraph (1) or (2) is no longer engaging in the illegal use of drugs; however, nothing in this section shall be construed to encourage, prohibit, restrict, or authorize the conducting of testing for the illegal use of drugs.<sup>359</sup>

## VII. Overarching Themes to Consider in Evaluating Policies, Practices, and Procedures for Treatment of Applicants and Students with Disabilities in the Medical Education Process

The 2016 article by Ellen Babbitt and Barbara Lee<sup>360</sup> provides a framework for providing disability accommodations in medical schools and other professional programs that have clinical aspects to their programs. The article includes a number of specific recommendations, which provide a valuable framework for both the admission of medical students and the accommodation of students during medical school (particularly in clinical placements). These recommendations are based on a review of judicial decisions up to that point. The focus is primarily on issues arising at the admissions stage and the clinical placement stage. The following strategies and standards<sup>361</sup> are noted as a framework, and they are a critical starting point:

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358 42 U.S.C. § 12210.

359 42 U.S.C. § 12210(b).

360 Babbitt & Lee, *supra* note 147.

361 42 J. C. & U.L. at 142-149.



1. Adoption of technical standards for all clinical programs;
2. Periodic review and updating of technical standards;
3. Consistent and nondiscriminatory application of standards during admissions process;
4. Additional discussion of technical standards at the point student begins clinical rounds;
5. Individualized and rigorous review of requests for accommodations;
6. Consistent and effective documentation of interactive processes and accommodation plans;
7. Effective and clear appeal process(es);
8. Education of admissions staff, faculty, and administrators of clinical programs;
9. Attention to confidentiality and proper communication within the program and institution;
10. Coordination with clinical sites;
11. Appropriate policies regarding information provided to site personnel; and
12. Consistency of technical standards, procedures, and policies as between different clinical programs.

A second study from 2018 provides even greater specificity about steps for various parties in medical schools to take to ensure greater inclusion of individuals with disabilities. The 2018 document<sup>362</sup> provides a number of very specific recommendations for applicants, admissions office staff, student affairs staff and orientation planners, learners, and faculty.<sup>363</sup> Institutional and academic barriers identified in the executive summary are the following:

- Uninformed disability service providers
- Lack of clear policies and procedures
- Lack of access to knowledge about nuanced clinical accommodations and assistive technology
- Lack of access to other meaningful accommodations

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362 LISA M. MEEKS & NEERA R. JAIN, ACCESSIBILITY, INCLUSION, AND ACTION IN MEDICAL EDUCATION: LIVED EXPERIENCES OF LEARNERS AND PHYSICIANS WITH DISABILITIES, (2018), <https://sds.ucsf.edu/sites/g/files/tkssra2986/f/aamc-ucsf-disability-special-report-accessible.pdf>. The 2018 report is aspirational in arguing for a more proactive approach to inclusion and advocating some steps that may be beyond the requirements of current disability discrimination law.

363 *Id.* at 60–64.

- Failure to publicize technical standards and to provide information on accessing accommodations
- Technical standards that do not reflect current technology and other developments in medical practice
- Lack of access to health care and wellness supports

Structural arrangements specified by the report in order to make arrangements more conducive to students with disabilities are

- Access to appropriate accommodations
- Ease in accessing accommodations
- Knowledge of clinical accommodations and medical education among disability service providers
- Personal networks and student organizations

Additional guidance is provided about culture and climate, including a “top-down commitment to diversity.”<sup>364</sup> Although providing some specific steps to accomplishing some of the goals, the report does not designate *who* should initiate and monitor such steps. These steps include

- Designating and providing resources for disability service providers who are knowledgeable about medical education
- Publicizing clear, accessible policies and processes
- Providing access to appropriate accommodations
- Reviewing and revising technical standards in light of current promising practices
- Normalizing help-seeking behaviors and facilitating access to wellness services

And this is followed by specific considerations for fostering an inclusive and welcoming culture. These are

- Regularly assessing institutional policies, processes, services and physical space
- Providing ongoing professional development for faculty and staff
- Integrating best practices in disability inclusion, as well as accessible and respectful language, into curricula and pedagogy
- Integrating disability into diversity and inclusion initiatives

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364 *Id.* at 59.

- Making information about disability services and accommodations easily accessible
- Reviewing recruitment and hiring practices
- Taking a universal design approach to both physical space and learner activities and experiences

For many of these steps, there should be a designation of who is to do the task. In many cases the designated person should be the dean of the medical school.<sup>365</sup> This does not mean that the dean is the individual who must actually develop the policies and practices, but it is the dean who should ensure that *somebody* does it. And it is the dean who sets a tone that faculty and staff should work across various often siloed offices and units of the medical school and university on these issues. Job descriptions, staff and faculty evaluations, rewards and incentives are opportunities for where a dean should use power, influence, or decision-making responsibility.

University counsel can play a leveraging role in making certain that decanal prioritization by ensuring that the university president, provost, and board are aware of the high cost of unnecessary dispute resolution, and encouraging that the appointment, retention, and evaluation of medical school deans takes into account the ability to create and implement and monitor policies, practices, and procedures described in both the 2016 article by Babbitt and Lee and in the 2018 report by Meeks and Jain. The 2018 report recognizes the importance of “Top Down” commitment (noting the powerful role of making policy). What can be added to both documents is the designation of responsibility for those in a position of top leadership (university presidents, provosts, vice presidents, and medical school deans) to see that these strategies and goals are established and implemented and updated. For example, when deans are filling key staff positions within the medical school, job descriptions for those who are medical school admissions officers, disability service providers, and student service providers should require the ability to work across departments and knowledge of disability issues.

The Babbitt and Lee article examines medical school and other clinical professional education cases to reach the conclusion that specific steps are necessary to avoid unnecessary dispute. What the five additional years of case decisions highlight, however, is the importance of additional attention to including some specific task assignments and communication flow to the framework. Neither the 2016 nor the 2018 detailed publications provide specificity of the role of the dean in setting policy.

A major goal of my article is to get the attention of university counsel, medical school risk management administrators, and medical school deans (and presidents of universities that have medical school programs) who have the power and

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365 I base this belief on my five years of experience as a law school dean (2000–05), my six years as an associate dean (1986–1993; 1999–2000), and my many years of service on law school admissions committees and student readmission and support committees. I have also observed the various ways these roles can be most effective through leadership at the top from my several years of experience in the accreditation and membership process for the American Bar Association Section of Legal Education and Admission to the Bar and the Association of American Law Schools. In that service, I reviewed the leadership structure and effectiveness of dozens of law schools.

position to ensure the implementation of the excellent recommendations of these two reports. The reason those in these roles should want to do that is not just because it is the right thing to do, but also because it is likely to provide much more effective resolution of issues in terms of time, resources, and attention for not only the medical school, but also the individuals with disabilities themselves. Even though medical schools will “win” most of the cases, the years of litigation can often be avoided by better implementation of the practices proposed by the 2016 and 2018 publications. This avoids not only the financial costs to all parties, but also can prevent the reputation of the medical school from being damaged.

A few themes from both publications are worth highlighting because in reviewing the extensive litigation of these issues, it seems that breakdowns in accommodating medical students with disabilities often occur because of these barriers. One barrier is the way that medical school administrators and faculty members often do not work across departments. It is important that the admissions administrator communicates to applicants the technical requirements expected for both the academic and clinical portions of the program and also for expectations for licensure and step exams. After admission, these administrators should reach out to all admitted applicants, inviting them to identify accommodations that might be needed. This avoids requiring applicants to self-identify before acceptance. The admissions officer can then share that information with the administrators and faculty members responsible for the enrollment of the student, and coordinate with the campus disability services office about documentation that will be required for some accommodations. Those in these three roles must communicate and coordinate to ensure clear and transparent processes for the accepted students.

The nature of academic work and clinical work, and how faculty members are responsible for evaluating that work and moving students to the next stage of achieving a medical degree require that administrators and faculty members do not work in isolation from each other. As appropriate, faculty members need to be advised about accommodation issues and where and how to seek technical assistance on how to accommodate various disabilities. Faculty members are often not well informed about disability accommodation issues, including confidentiality and privacy related to those issues. An examination of some of the disputes above illustrates how this can be problematic leading to prolonged litigation.

Finally, the spreading of responsibility and lack of clear lines of responsibility and decision making account for at least some of the unnecessarily prolonged litigation. Some cases have factual settings where it was unclear if the student’s inadequate performance was just one aspect of the program, in all of the program, etc., making it confusing to the student to know where and how to appeal or otherwise address the deficiency.

While a detailed comparison of the disputes involving students with disabilities in legal education and medical education is beyond the scope of this article, a general overview might provide some guidance on why there are far fewer lengthy judicial disputes involving law school when compared to medical school.<sup>366</sup>

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<sup>366</sup> While the stakes are higher in medical school in some respects, and the clinical education beginning in the third year of medical school may explain some of the difference, it may also be

There appears to be much less litigation involving legal education. That may be because the stakes are higher in medical education. Patient lives may literally be on the line when medical students are involved in patient care. It may also be because those in legal education are attuned to process and procedure. It may also be that law schools have been more directly aware of litigation because of the inherent nature of law schools. It is also probably in part because medical education directly infuses clinical aspects into its program and almost everyone who goes to medical school will “practice medicine” and want certification. Law graduates are much more diffuse in their career paths. The difference in the amount and length of dispute resolution through the courts may be, however, at least in part, due to the factors noted in the details of the cases described above.

### VIII. Summary and Conclusions

This article primarily addresses issues of individuals with disabilities in medical school. While that is the health care professional program with the highest stakes, most of the same guidance would be relevant to other health care professional training and how admissions and enrollment relate to licensure. This includes nursing, dentistry, chiropractic studies, and optometry. Some of the guidance may also be relevant for paraprofessional programs, including physician assistant, nurse practitioner, and physical and occupational therapy programs. University counsel and top administrators in these programs should consider the analysis and recommendations that might be relevant to those programs.

The article provides a detailed description of medical school education today and its relationship to licensure and to the accrediting and other regulating agencies that affect the admission, enrollment, and employment of medical students with disabilities. A detailed review of the litigation that has resulted from settings in which individuals in medical school settings with a range of disabilities highlights the importance of prioritizing an examination at many medical schools about how policies, practices, and procedures are established and implemented. Many of the cases, particularly those in settings involving mental health issues, result in litigation that may take a decade to resolve, usually in favor of the institution, but with high costs for all parties.

The article builds on previous assessments of the issue and focuses attention on the importance of having top leadership ensure that the specific strategies and frameworks are actually implemented.<sup>367</sup> Not only will such efforts be likely to

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because law schools and leadership within legal education have focused attention on proactively addressing these issues far longer than medical schools. Laura Rothstein, *Forty Years of Disability Policy in Legal Education and the Legal Profession: What Has Changed and What Are the New Issues?* 22 AM. U. GENDER, SOC. POL'Y & L. 519 (2014). A rough comparison of litigation involving legal and medical education programs indicates less than a dozen cases against law schools compared to approximately fifty involving medical schools. There are 155 medical schools and 37 schools of osteopathy, with about 45,000 enrolled each year. There are 205 ABA accredited law schools, with about 40–45,000 law students enrolled each year.

367 Laura Rothstein, *Southeastern Community College v. Davis*, in EDUCATION STORIES ch. 7 (pages 197-220) (Michael Olivas & Ronna Schneider eds., 2007); Laura Rothstein, *Impaired Physicians and the ADA*, 313 JAMA 2219 (2009), <http://jama.jamanetwork.com/article.aspx?articleid=2319174> (with Mark Rothstein); Laura Rothstein, *Licensing and Physician Mental Health: Problems & Possibilities*, (with Hendin et.al), 93 J. MED. LICENSURE & DISCIPLINE No. 2 (2007); Laura Rothstein, *Health Care Professionals*

save time, money, and good will, but these efforts are the right thing to do.

This article encourages university counsel and top administrators to do more to implement programming at medical schools to ensure fair and transparent admission, enrollment, and transition to licensing. Other national and state organizations (accreditation agencies through their technical standards and licensing agencies through their approval requirements) should take account of this and communicate with the medical school leadership on implementing and communicating appropriate policies.

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*with Mental and Physical Impairments: Developments in Disability Discrimination Law*, 41 ST. LOUIS U. L. REV. 973 (1997) (Symposium Issue). Publications by others on these issues that were important foundational research for this article include Babbitt and Lee, *supra* note 147; Lisa M. Meeks & Neera R. Jain, *Accessibility, Inclusion, and Action in Medical Education*, ASS'N OF AM. MED. COLLS. (Mar. 2018), <https://sds.ucsf.edu/sites/g/files/tkssra2986/f/aamc-ucsf-disability-special-report-accessible.pdf>; Philip Zazove et al., 91 U.S. Medical Schools' Compliance with the Americans with Disabilities Act: Findings from a National Study, 91 ACAD. MED. ( 979) (2016), (concluding that the technical standards of most medical schools do not support providing reasonable accommodations for students with disabilities); *The ADA at 25: Disability Rights and the Health Care Workforce*: Symposium Issue, 9 ST. LOUIS U. J. HEALTH L. & POL'Y (2015) (articles in the issue include Nicole Buonocore Porter, *The Difficulty Accommodating Health Care Workers* (1–18); Pierce Blue, *Job Functions, Standards and Accommodations Under the ADA: Recent EEOC Decisions* (19–34); Mark C. Weber, *Numerical Goals for Employment of People with Disabilities by Federal Agencies and Contractors* (35–46); Leslie Francis & Anita Silvers, *The Health Care Workforce: How to Understand Accommodations* (57–88); Mary Crossley, *Disability Cultural Competence in The Medical Profession* (89–110)); Thomas W. Koenig et al., *Core Personal Competencies Important to Entering Students' Success in Medical School: What Are They and How Could They Be Assessed Early in the Admission Process*" 88 ACAD. MED. 603 (2013); Lucian L. Leape & John A. Fromson, *Problems Doctors: Is There a System-Level Solution?* 144 ANNALS INTERNAL MED. 107 (2006) (addresses physician performance failures and need for better performance measures and substantial expansion of external programs for assessment and remediation by hospitals; calls on Federation of State Medical Boards, the American Board of Medical Specialties, and the Joint Commission on Accreditation of Healthcare Organizations to collaborate); ASS'N OF AM. MED. COLLS. MEDICAL STUDENTS WITH DISABILITIES: A GENERATION OF PRACTICE (2005); Claudia Center et al., *Confronting Depression and Suicide in Physicians: A Consensus Statement*, 289 JAMA 3161 (2003) (concluding that the low priority given to physician mental health is a barrier to their seeking help; recommending transforming professional attitudes and changing institutional policies); Annie Steinberg et al., *Reasonable Accommodations for Medical Faculty with Disabilities*, 288 JAMA 3147 (2002); Questions and Answers about Health Care Workers and the Americans with Disabilities Act, [http://www.eeoc.gov/facts/health\\_care\\_workers.html](http://www.eeoc.gov/facts/health_care_workers.html) (Mar. 2015).