

# PATIENTS TO PEERS: BARRIERS AND OPPORTUNITIES FOR DOCTORS WITH DISABILITIES

Alicia Ouellette\*

In May 2012, the National Disability Rights Network issued a report entitled *Devaluing People with Disabilities: Medical Procedures That Violate Civil Rights*.<sup>1</sup> The report is an indictment of a health care system that fails to recognize the value of life with disability, despite the importance of the health care system in the lives of people with disabilities. The report describes conversations between doctors and persons with disabilities and their families in which people with disabilities are “viewed as having little value as they are. They are considered not as fully human, endowed with inalienable rights of liberty, privacy and the right to be left alone—solely because they were born with a disability.”<sup>2</sup> The National Disability Rights Network is hardly the first group or individual to criticize American medicine for its treatment of persons with disabilities.<sup>3</sup> Disability scholars have documented a long history of medical mistreatment of and insensitivity toward people with disabilities at the hands of the medical establishment,<sup>4</sup> and individuals with disabilities have authored compel-

\* Professor of Law and Associate Dean, Albany Law School. Many thanks to Philip Zazove, Christopher Moreland, Demetrius Moutsiakis, and the members of the Drexel Law Faculty workshop for their thoughtful feedback on this paper. Thanks also to Sevil Nuredinoski for her research assistance.

<sup>1</sup> DAVID CARLSON, CINDY SMITH & NACHAMA WILKER, *DEVALUING PEOPLE WITH DISABILITIES: MEDICAL PROCEDURES THAT VIOLATE CIVIL RIGHTS* (2012), available at [http://www.ndrn.org/images/Documents/Resources/Publications/Reports/Devaluing\\_People\\_with\\_Disabilities.pdf](http://www.ndrn.org/images/Documents/Resources/Publications/Reports/Devaluing_People_with_Disabilities.pdf).

<sup>2</sup> *Id.* at 5.

<sup>3</sup> See, e.g., Paul K. Longmore, *Medical Decision Making and People with Disabilities: A Clash of Cultures*, in *WHY I BURNED MY BOOK: AND OTHER ESSAYS ON DISABILITY* 204, 204–11 (2003) (describing conflicts between disabled persons and their health care providers); Ford Vox, “*The Cyclops Child*”: *Inhumanity in a 1960 Hospital*, *ATLANTIC* (July 14, 2012, 9:28 AM), <http://www.theatlantic.com/health/archive/2012/07/the-cyclops-child-inhumanity-in-a-1960-hospital/259810/>; see also HARLAN LANE, *THE MASK OF BENEVOLENCE: DISABLING THE DEAF COMMUNITY* 212–13 (DawnSignPress new ed. 1999) (1992) (discussing the mistreatment of deaf patients in France); ROBERT WHITAKER, *MAD IN AMERICA: BAD SCIENCE, BAD MEDICINE, AND THE ENDURING MISTREATMENT OF THE MENTALLY ILL* 71–72 (Basic Books rev. ed. 2010) (2002); Diane Coleman & Stephen Drake, *Disability Discrimination*, *BIOETHICS F. BLOG* (July 11, 2012), <http://www.thehastingscenter.org/Bioethics/forum/Post.aspx?id=5913&blogid=140>; Stephen Drake, *The Doctor Said It Would Be Better If I Didn't Survive*, *NOT DEAD YET*, [http://www.notdeadyet.org/2012/03/stephens\\_story.html](http://www.notdeadyet.org/2012/03/stephens_story.html) (last visited May 7, 2013).

<sup>4</sup> See, e.g., *THE NEW DISABILITY HISTORY: AMERICAN PERSPECTIVES* (Paul K. Longmore & Lauri Umansky eds., 2001); JOSEPH P. SHAPIRO, *NO PITY: PEOPLE WITH DISABILITIES FORGING A NEW CIVIL RIGHTS MOVEMENT* (Three Rivers Press 1994) (1993); William J. Peace, *Comfort Care as Denial of Personhood*, 42 *HASTINGS CENTER REP.*, July–Aug. 2012, at 14;

ling narratives describing dehumanizing experiences in medical offices and hospitals.<sup>5</sup> Despite these criticisms and the advances made by the disability rights community—the emergence of disability studies as its own field<sup>6</sup> and the passage of civil rights statutes for persons with disabilities<sup>7</sup>—the American medical system continues to be an inhospitable place for many persons with disabilities.

It is not just as patients that people with disabilities face barriers within the medical system. More than twenty years after Congress passed the Americans with Disabilities Act (ADA) to end disability-based discrimination, many U.S. medical schools will not give a seat to applicants with certain sensory or mobility disabilities.<sup>8</sup> In some cases, the barriers to admission are explicit. They take the form of “Technical Standards”<sup>9</sup> that define baseline qualifications for applicants. These standards typically include the ability “to speak, to hear and to observe patients”<sup>10</sup> and make it clear that “[t]he use of a trained intermediary is

---

see also Carol J. Gill, *Becoming Visible: Personal Health Experiences of Women with Disabilities*, in *WOMEN WITH PHYSICAL DISABILITIES: ACHIEVING AND MAINTAINING HEALTH AND WELL-BEING* 5, 5–16 (Danuta M. Krotoski et al. eds., 1996).

<sup>5</sup> See, e.g., STARING BACK: THE DISABILITY EXPERIENCE FROM THE INSIDE OUT (Kenny Fries ed., 1997); KENNY FRIES, THE HISTORY OF MY SHOES AND THE EVOLUTION OF DARWIN’S THEORY (2007); HARRIET MCBRYDE JOHNSON, TOO LATE TO DIE YOUNG: NEARLY TRUE TALES FROM A LIFE (2005); Peace, *supra* note 4, at 14.

<sup>6</sup> For a good introduction, see generally HANDBOOK OF DISABILITY STUDIES (Gary L. Albrecht et al. eds., 2001); THE DISABILITY STUDIES READER (Lennard J. Davis ed., 3d ed. 2010).

<sup>7</sup> See, e.g., Rehabilitation Act of 1973, 29 U.S.C. § 794(a) (2012); Americans with Disabilities Act (ADA) of 1990, 42 U.S.C. §§ 12101–213 (2012).

<sup>8</sup> See Joel A. DeLisa & Peter Thomas, *Physicians with Disabilities and the Physician Workforce: A Need to Reassess Our Policies*, 84 AM. J. PHYSICAL MED. & REHABILITATION 5, 6 (2005); Sarah M. Eickmeyer et al., *North American Medical Schools’ Experience with and Approaches to the Needs of Students with Physical and Sensory Disabilities*, 87 ACAD. MED. 567, 567 (2012); Demetrius Moutsiakos & Thomas Polisoto, *Reassessing Physical Disability Among Graduating US Medical Students*, 89 AM. J. PHYSICAL MED. & REHABILITATION 923, 926 (2010); Michael J. Reichgott, *The Disabled Student as Undifferentiated Graduate: A Medical School Challenge*, 279 JAMA 79, 79 (1998) [hereinafter Reichgott, *The Disabled Student*]; Michael J. Reichgott, “Without Handicap”: *Issues of Medical Schools and Physically Disabled Students*, 71 ACAD. MED. 724, 726 (1996) [hereinafter Reichgott, *Without Handicap*] (describing the medical establishment as “intransigent in their unwillingness to consider the admission of physically disabled students”) (quoting Robert H. Meier, III, *Issues Concerning Medical School Admission for Students with Disabilities*, 72 AM. J. PHYSICAL MED. & REHABILITATION 341, 341–42 (1993)); Michael Schwartz, *Technical Standards for Admission to Medical School: Deaf Candidates Don’t Get No Respect*, 28 BUFF. PUB. INT. L.J. 31, 32, 51 (2009–2010) [hereinafter Schwartz, *Technical Standards*].

<sup>9</sup> See *infra* Part I for an explanation of the origin, development, and legal status of the technical standards.

<sup>10</sup> UNIVERSITY OF MICHIGAN MEDICAL SCHOOL TECHNICAL STANDARDS 1 (2011), available at <http://www.med.umich.edu/medstudents/policies/TechnicalStandards.pdf> [hereinafter UNIVERSITY OF MICHIGAN TECHNICAL STANDARDS]. The Standard on communication states:

Communication includes speech and writing. A candidate must be able to speak, to hear and to observe patients by sight in order to elicit information, describe changes in mood, activity and posture, and perceive nonverbal communications and be able to communicate effectively and sensitively with patients. The candidate must be able to demonstrate proficiency in the English language and communicate effectively and efficiently in oral and written form with all members of the health care team. The candidate must be proficient in keyboarding.

not acceptable.”<sup>11</sup> They also make clear that the ability to use one’s hands for fine motor tasks and the ability to perform gross motor tasks with coordination and equilibrium are prerequisites for admission.<sup>12</sup> In other words, deaf, blind, and physically impaired undergraduates need not apply to these medical schools. They are not welcome. They are, by definition, unqualified.

To be sure, there are blind,<sup>13</sup> deaf,<sup>14</sup> and other physically disa-

*Id.*

<sup>11</sup> *Id.* Specifically, the preamble to the Technical Standards states:

A candidate for the M.D. degree must possess abilities and skills which include those that are observational, communicational, motor, intellectual-conceptual (integrative and quantitative), behavioral and social. The use of a trained intermediary is not acceptable in many clinical situations in that it implies that a candidate’s judgment must be mediated by someone else’s power of selection and observation.

*Id.* Many other medical schools also preclude use of an intermediary (i.e., a sign language interpreter). *See, e.g., Technical Standards for Admission and Graduation*, GEO. U. SCH. MED., <http://som.georgetown.edu/about/prospectus/technicalstandards/> (last visited May 7, 2013) (“The employment of an intermediary potentially compromises a student’s judgment and their acquisition of powers of selection and observation, and is probably unacceptable.”).

<sup>12</sup> UNIVERSITY OF MICHIGAN TECHNICAL STANDARDS, *supra* note 10, at 1. Specifically, the University of Michigan Medical School’s Technical Standards state:

It is required that a candidate possess the motor skills necessary to directly perform palpation, percussion, auscultation and other diagnostic maneuvers, basic laboratory tests and diagnostic procedures. The candidate must be able to execute motor movements reasonably required to provide general and emergency medical care such as airway management, placement of intravenous catheters, cardiopulmonary resuscitation, application of pressure to control bleeding, suturing of wounds and the performance of simple obstetrical maneuvers. Such actions require coordination of both gross and fine muscular movements, equilibrium and functional use of the senses of touch and vision.

*Id.* *See also* UNIVERSITY OF PITTSBURGH SCHOOL OF MEDICINE TECHNICAL STANDARDS FOR THE DOCTOR OF MEDICINE DEGREE (2010), *available at* <http://www.medadmissions.pitt.edu/admissions-requirements/documents/technicalstandards-website12-15-2010.pdf>. Specifically, the Technical Standards of the University of Pittsburgh School of Medicine state:

Candidates should have sufficient motor function to elicit information from patients by palpation, auscultation, percussion, and other diagnostic maneuvers. A candidate should be able to do basic laboratory tests (urinalysis, CBC, etc.), carry out diagnostic procedures (proctoscopy, paracentesis, etc.) and read EKGs and x-rays. A candidate should be able to execute motor movements reasonably required to provide general care and emergency treatment to patients. Examples of emergency treatment reasonably required of physicians are cardiopulmonary resuscitation, the administration of intravenous medication, the application of pressure to stop bleeding, the opening of obstructed airways, the suturing of simple wounds, and the performance of simple obstetrical maneuvers. Such actions require coordination of both gross and fine muscular movements, equilibrium and functional use of the senses of touch and vision.

*Id.*

<sup>13</sup> For example, Tim Cordes graduated from the University of Wisconsin School of Medicine in 2005. *Blind Medical Student Earns M.D.*, NBCNEWS.COM (Apr. 5, 2005, 8:24 PM), [http://www.nbcnews.com/id/7318398/ns/health-health\\_care/t/blind-medical-student-earns-md/](http://www.nbcnews.com/id/7318398/ns/health-health_care/t/blind-medical-student-earns-md/). *See also* Ohio Civil Rights Comm’n v. Case W. Reserve Univ., 666 N.E.2d 1376, 1381 (Ohio 1996) (referencing “Dr. David W. Hartman, a psychiatrist who graduated from Temple University School of Medicine while totally blind in 1976”).

<sup>14</sup> For example, Carolyn Stern is a deaf doctor who works in Rochester, New York. Christina Cheakalos & Michelle York, *Hearing Heart*, PEOPLE, June 17, 2002, at 125, *available at* <http://www.people.com/people/article/0,,20137331,00.html>. Philip Zazove is a deaf family practitioner. *Dr. Philip Zazove—Doctor, Administrator, Candidate, and Deaf*, E-MICHIGAN DEAF AND HARD OF HEARING PEOPLE, [http://www.michdhh.org/profiles/zazove\\_phil.html](http://www.michdhh.org/profiles/zazove_phil.html) (last visited May 7, 2013). Sharon Meyers is also a deaf physician. Angela Brauer,

bled<sup>15</sup> doctors, but they are few and far between.<sup>16</sup> A handful of those disabled doctors found a medical school willing to waive Technical Standards and take a chance on a student who needed accommodations. For example, Philip Zazove, a deaf physician who serves as interim chair of the Department of Family Medicine at the University of Michigan,<sup>17</sup> was able to persuade Rutgers Medical School to admit him despite his hearing impairment.<sup>18</sup> Others found a medical school that has adopted Technical Standards that make room for applicants with disabilities, such as the University of Washington or the University of Rochester.<sup>19</sup> But more often than not, doctors with sensory, mobility, or other

---

*Deaf Doctor Gives Back to Community Volunteering During "Silent Coffee"*, KMTR.COM (Dec. 2, 2011, 5:47 PM), <http://www.kmtr.com/news/local/story/Deaf-doctor-gives-back-to-community-volunteering/ZPAB5Mu-y0Ox-WRD8YHQxQ.csp>.

<sup>15</sup> See, e.g., Aaron Broverman & Kent Cadogan Loftsgard, *Quad Doctors: In or Out?*, NEW MOBILITY (Oct. 2010), <http://www.newmobility.com/articleView.cfm?id=11728> (describing Dr. Sam Simms, an emergency room physician who was paralyzed in a car accident); Katherine Manders, Commentary, *Disabled Medicine*, 174 CANADIAN MED. ASS'N J. 1585, 1585 (2006) (describing the author as a medical student with physical disabilities); see also D. L. MOUTSIAKIS, *THE OTHER SHOE DROPPED: A JOURNEY TO HELL AND BACK AGAIN* 1, 45, 60 (2010) (describing the disabling bicycle accident suffered by the physician author while he was a medical student).

<sup>16</sup> DeLisa & Thomas, *supra* note 8, at 6 (noting that the percentage of physicians with disabilities in practice (two to ten percent) is far smaller than the percentage of the general population with disabilities (twenty percent)).

<sup>17</sup> Philip Zazove M.D., UOFMHEALTH.ORG, [http://www.uofmhealth.org/find+a\[hysician/1054](http://www.uofmhealth.org/find+a[hysician/1054) (last visited May 7, 2013).

<sup>18</sup> PHILIP ZAZOVE, *WHEN THE PHONE RINGS, MY BED SHAKES: MEMOIRS OF A DEAF DOCTOR* 91–92 (1993) (discussing the author's two-year effort to find a willing medical school).

<sup>19</sup> The University of Washington School of Medicine's Technical Standards stand out as especially disability friendly. They define the skill of communication without specifically requiring speech and hearing. The motor skills necessary for a place in medical school are defined in a way that would allow a wheelchair user or a person with contractures in a hand to apply, and the Standards allow for reasonable accommodations to execute the skills required. Specifically, they state:

Technical standards as distinguished from academic standards refer to those physical, cognitive and behavioral abilities required for satisfactory completion of all aspects of the curriculum, and the development of professional attributes required by the faculty of all students at graduation. The essential abilities required by the curriculum are in the following areas: motor, sensory, communication, intellectual (conceptual, integrative, and quantitative abilities for problem solving and diagnosis), and the behavioral and social aspects of the performance of a physician.

- The University of Washington School of Medicine curriculum requires essential abilities in information acquisition. The student must have the ability to master information presented in course work in the form of lectures, written material, and projected images.
- The student must have the cognitive abilities necessary to master relevant content in basic science and clinical courses at a level deemed appropriate by the faculty. These skills may be described as the ability to comprehend, memorize, analyze and synthesize material. He/she must be able to discern and comprehend dimensional and spatial relationships of structures, and be able to develop reasoning and decision making skills appropriate to the practice of medicine.
- The student must have the ability to take a medical history and perform a physical examination. Such tasks require the ability to communicate with the patient. The student must also be capable of perceiving the signs of disease as manifested through the physical examination. Such information is derived from images of the body surfaces, palpable changes in various organs, and auditory information (patient voice, heart tones, bowel and lung sounds).

physical disabilities developed their disability after being admitted to medical school, often post residency.<sup>20</sup> Had they been similarly impaired as applicants, it is likely these doctors would have had a very difficult time getting admitted to medical school.

The bar to admission to medical school means that as they train, medical professionals rarely encounter people with disabilities as peers. Rather, people with disabilities are subjects to be studied and patients needing treatment. The fact that some physicians with disabilities practice successfully raises questions about why some medical schools refuse to consider deaf, blind, or physically impaired candidates, and whether the barriers to medical school faced by people with disabilities should be removed. This Article exposes the explicit barriers to admission to the medical profession erected by medical schools in the United States, and argues that these barriers can and should be removed to ensure that the medical profession better serves people with disabilities when they are patients in the system. It is the first in a series of articles that will

- 
- The student must have the ability to discern skin, subcutaneous masses, muscles, joints, lymph nodes, and intra-abdominal organs (for example, liver and spleen). The student must be able to perceive the presence or absence of densities in the chest and masses in the abdomen.
  - The student must be able to communicate effectively with patients and family, physicians and other members of the health care team. The communication skills require the ability to assess all information including the recognition of the significance of non-verbal responses and immediate assessment of information provided to allow for appropriate, well-focused follow-up inquiry. The student must be capable of responsive, empathetic listening to establish rapport in a way that promotes openness on issues of concern and sensitivity to potential cultural differences.
  - The student must be able to process and communicate information on the patient's status with accuracy in a timely manner to physician colleagues and other members of the health care team. This information then needs to be communicated in a succinct yet comprehensive manner and in settings in which time available is limited. Written or dictated patient assessments, prescriptions, etc., must be complete and accurate. The appropriate communication may also rely on the student's ability to make a correct judgment in seeking supervision and consultation in a timely manner.
  - The student must be able to understand the basis and content of medical ethics. He/she must possess attributes which include compassion, empathy, altruism, integrity, responsibility and tolerance. He/she must have the emotional stability to function effectively under stress and to adapt to an environment which may change rapidly without warning and/or in unpredictable ways.

These essential functions of medical education identify the requirements for admission, retention and graduation of applicants and students respectively at the University of Washington School of Medicine. Graduates are expected to be qualified to enter the field of medicine. It is the responsibility of the student with disabilities to request those accommodations that he/she feels are reasonable and are needed to execute the essential requirements described.

*Expectations, Standards and Policies*, UW MED., <http://uwmedicine.washington.edu/education/MD-Program/admissions/pages/expectations-standards.aspx#technical> (last visited May 7, 2013); see also UNIVERSITY OF ROCHESTER SCHOOL OF MEDICINE AND DENTISTRY, STUDENT HANDBOOK 22–25 (2012), available at <http://www.urmc.rochester.edu/education/md/documents/student-handbook.pdf>.

<sup>20</sup> DeLisa & Thomas, *supra* note 8, at 6 (noting that the percentage of physicians with disabilities in practice (two to ten percent) is higher than the percentage of matriculants to medical school with disabilities (fewer than one percent), suggesting that “although getting into medical school is a hurdle for people with disabilities, . . . there is a stronger commitment to keep physicians in training or in practice”). See also MOUTSIAKIS, *supra* note 15 (an autobiography of a medical student who was in a disabling accident and is now a physician).

identify the barriers faced by people with sensory and motor impairments to entering the medical profession, and explore strategies for removing them.<sup>21</sup> Focusing on barriers to admission to medical school,<sup>22</sup> Part I of this Article examines the origins and justifications offered for the Technical Standards applicable to medical school applicants. Part II examines the failure of the ADA and other antidiscrimination statutes to open the doors to medical school for persons with disabilities. Part III argues that inclusion of persons with sensory and motor disabilities in medical schools—as students and teachers, not just as subjects and patients—is necessary not just as a matter of justice to applicants with disabilities, but also as an essential component of a medical system that respects persons with disabilities. Part IV introduces potential strategies for removing restrictive barriers. Later papers will examine additional barriers to the medical profession and offer a more thorough analysis of alternative legal arguments for breaking down restrictive Technical Standards and other barriers.

#### I. WHO BUILT THESE WALLS? THE ORIGIN OF ABLEIST ADMISSIONS STANDARDS IN MEDICAL EDUCATION

U.S. medical schools consider a number of factors when making admissions decisions. These include test scores, undergraduate records, life experience, and other academic criteria. Medical schools also employ Technical Standards for admission. Technical Standards are non-academic criteria

<sup>21</sup> People with cognitive, emotional, and mental disabilities also face barriers to entry to the medical profession. *See, e.g.*, *Brief v. Albert Einstein Coll. of Med.*, 423 F. App'x 88, 90–91 (2d Cir. 2011) (discussing a medical student who was denied accommodation for his attention deficit hyperactivity disorder (ADHD)); *Jakubowski v. Christ Hosp., Inc.*, 627 F.3d 195, 203 (6th Cir. 2010) (discussing a former medical resident who suffered from Asperger's Disorder and alleged he was terminated because of his Asperger's and that hospital failed to reasonably accommodate this disability). Disabilities can, for example, make it difficult to achieve adequate undergraduate GPAs or to pass the MCAT. *See, e.g.*, *Manickavasagar v. Va. Commonwealth Univ. Sch. of Med.*, 667 F. Supp. 2d 635, 638–39 (E.D. Va. 2009) (discussing medical school applicant with bipolar disorder who was rejected based on his undergraduate grade point average and MCAT score, and argued that his academic record was more significant than some students admitted into the program who were not disabled). Disabilities also cause some students difficulties that result in dismissal from medical school. *See, e.g.*, *Falcone v. Univ. of Minn.*, 388 F.3d 656, 660 (8th Cir. 2004) (discussing disabled student's dismissal from medical school and the student's claim that he would have become "otherwise qualified" to remain in medical school had he been provided more or better instructor feedback); *Baker v. Univ. of Tex. Health Sci. Ctr. Hous.*, No. H-08-1908, 2011 WL 1549263, at \*1 (S.D. Tex. Apr. 21, 2011) (discussing the dismissal of a medical student with Guillain-Barre Syndrome after she received poor reviews for her performance during rotations and the program director required her to complete a remediation plan, consisting of an additional three months of training, to complete the residency program). These difficulties are not trivial, and much of the discussion of sensory and physical disabilities presented in this Article is applicable to people with more hidden disabilities. This Article focuses on sensory and physical disabilities for two reasons—first, their presence is often an explicit disqualification from consideration for a seat at medical school; and second, as visible disabilities, they inevitably come to the attention of admissions professionals.

<sup>22</sup> People with disabilities face a different array of difficulties once they are admitted to medical school, and if they get through school, getting into and surviving residency. I will consider these issues in later papers.

deemed essential for participation in the educational program by individual medical schools. Technical Standards typically define five areas of abilities and skills deemed essential for graduating medical students: observation; communication skills; motor skills; intellectual-conceptual, integrative, and qualitative abilities; and behavioral and social attributes. In defining these five skill areas, many medical schools employ Technical Standards that require the ability to hear, to communicate orally, and to perform specific physical tasks, thereby making the presence of a sensory or motor disability in an applicant a disqualifier to admission to medical school (hereinafter “ableist Technical Standards”).<sup>23</sup> Not all schools employ ableist Technical Standards; others employ inclusive standards that focus on the ability to absorb knowledge and communicate—regardless of the means used to do those things.<sup>24</sup> The distinction makes all the difference. Standards that make oral and aural communication prerequisites to admission exclude deaf applicants. Those that focus on the ability to communicate give deaf applicants who communicate via sign language interpreters or technological devices the same chance as other applicants to obtain a seat in medical school.

The use of Technical Standards traces to a 1979 recommendation of the Association of American Medical Colleges (AAMC), an organization to which all medical colleges in the United States belong. In January of 1979, six years after Congress enacted Section 504 of the Rehabilitation Act, the AAMC adopted the *Report of the AAMC Special Advisory Panel on Technical Standards for Medical School Admission*.<sup>25</sup> The report encouraged medical schools

<sup>23</sup> See, e.g., *Technical Standards*, U.C., IRVINE—SCH. OF MED., [http://www.meded.uci.edu/admissions/technical\\_standards.asp](http://www.meded.uci.edu/admissions/technical_standards.asp) (last visited May 7, 2013) (requiring, among other things, that an applicant have “the functional use of visual, auditory, and somatic sensory functions” and “physical mobility, coordination of both gross and fine motor neuromuscular function and balance and equilibrium”); *Technical Standards for Admissions*, PERELMAN SCH. OF MED., U. OF PA. (Nov. 8, 2012), <http://www.med.upenn.edu/admiss/techstds.html> (requiring “functional use of the sense of vision, hearing, and equilibrium” and “coordination of both gross and fine muscular movement”); *University of Louisville School of Medicine Technical Standards for Admission, Continuation and Graduation*, U. OF LOUISVILLE (Nov. 30, 2007), <http://louisville.edu/medschool/admissions/medical-school-admissions-policies/technical-standards.html> (requiring that candidates “be able to clearly observe a wide variety of patients, both close at hand and at a distance, through visual, auditory, olfactory, and somatic senses[;] . . . utilize the entire range of human communication skills to gather and transmit as much information as possible in interactions with patients; therefore, candidates must possess and maintain the ability to communicate effectively in the English language, in both written and oral form[;]” and “possess adequate sensorimotor function and equilibrium to assume reasonable body postures when performing these skills and to perform them in a manner that does not compromise test accuracy, treatment effectiveness, or patient safety.”); see also *Ohio Civil Rights Comm’n v. Case W. Reserve Univ.*, 666 N.E.2d 1376, 1379–81 (Ohio 1996) (describing the Technical standards set by Case Western Reserve University to deny a blind applicant admission to medical school).

<sup>24</sup> See, e.g., *Requirements for Admission*, U. OF IOWA CARVER C. OF MED., <http://www.medicine.uiowa.edu/md/requirements/> (last visited May 7, 2013) (adopting standards that focus on the ability to absorb knowledge, observe, and communicate, rather than the functional ability to hear, speak, or perform manual tasks); see also Schwartz, *Technical Standards*, *supra* note 8, at 49–51 (comparing and contrasting ableist and inclusive technical standards).

<sup>25</sup> ASS’N OF AM. MED. COLLS., REPORT OF THE AAMC SPECIAL ADVISORY PANEL ON TECHNICAL STANDARDS FOR MEDICAL SCHOOL ADMISSION (1979) [hereinafter AAMC REPORT];

“to look beyond the stereotypes of handicapped individuals and to develop innovative and creative ways of opening the medical school curriculum to competitive, qualified handicapped individuals.”<sup>26</sup> Despite the call for inclusion, the report concluded that “there are certain minimum technical standards for physicians which must be examined and enforced in the admissions process.”<sup>27</sup> These standards include “the functional use of the senses of vision and hearing, . . . sufficient exteroceptive sense (touch, pain and temperature), . . . and sufficient motor function” to carry out activities such as venopuncture, lumbar puncture, and cardiopulmonary resuscitation.<sup>28</sup> The panel authoring the report recognized and accepted that adoption of Technical Standards would create barriers to medical school for disabled applicants. It explained,

It is inevitable that adherence to minimum requirements will disqualify some applicants including some who are handicapped. This does not imply, however, that a school has discriminated against these applicants. Since discrimination requires drawing a distinction without sufficient justification it follows that making discriminatory judgments on justified grounds is acceptable.<sup>29</sup>

The AAMC revisited the issue of Technical Standards in 1993 and in 2005.<sup>30</sup> The post-ADA reports encouraged schools to make reasonable accommodations for qualified students with disabilities but still stated that schools should adopt and apply Technical Standards for admission consistent with the school’s requirements for its medical students.<sup>31</sup> Because most medical schools continue to require specific physical abilities and motor skills of their students—lumbar punctures and palpation, for example—they continue to make sensory and motor impairments apparent disqualifiers for admission.<sup>32</sup>

The reason medical schools insist that all students must be able to perform specific skills—for example, a lumbar puncture is a requirement that disqualifies a person with contractures in her hands from admission to medical schools—is that modern medical education is designed to produce the “undifferentiated graduate.” That is, medical schools cling to the vision of medical education articulated in the 1950s in which the aim of medical education is “to give the student a comprehensive concept of man and his diseases and to inculcate those habits of mind which will enable him *to enter without handicap any one of the fields of medical practice and research.*”<sup>33</sup> “This new doctor would be an ‘undifferentiated graduate,’ or a doctor who would graduate medical

---

*see also* JENNIFER E. WATSON & SHANNON H. HUTCHENS, *MEDICAL STUDENTS WITH DISABILITIES: A GENERATION OF PRACTICE 3* (Daniel J. Wilkerson ed., 2005) (discussing the publication of the 1979 AAMC report).

<sup>26</sup> AAMC REPORT, *supra* note 25, at 6.

<sup>27</sup> *Id.* at 1.

<sup>28</sup> *Id.* at 5–6.

<sup>29</sup> *Id.* 6–7.

<sup>30</sup> *See* WATSON & HUTCHENS, *supra* note 25, at 3.

<sup>31</sup> *Id.* at 16, 20.

<sup>32</sup> *See* Eickmeyer et al., *supra* note 8, at 570.

<sup>33</sup> Schwartz, *Technical Standards*, *supra* note 8, at 38 (quoting Comm’n on Undergraduate Med. Educ., *Report to the American Surgical Association Committee on Undergraduate Medical Education*, 68 TRANSACTIONS AM. SEVENTEENTH MEETING SURGICAL ASS’N 523, 524 (1950)) (some emphasis added) (internal quotation marks omitted).

school with ‘general competence’<sup>34</sup> who would be fully qualified to pursue any of the medical specialties. In this age of specialization, physician extenders, and technology, the notion of the undifferentiated graduate has been questioned as unrealistic and quaint. One survey showed that 69.8% of the medical community

“disagreed with the concept of the undifferentiated graduate as one who possesses all of the technical skills required to enter any specialty.” As one respondent put it, “It is absurd to think that any physician today has a complete set of skills such that he or she can practice medicine independently of many individuals with other skills.”<sup>35</sup>

Yet the notion that the medical degree is a general degree indicating basic competency in all aspects of medicine is one that persists in medical education and drives the perpetuation of ableist Technical Standards. The next section discusses the (lack of) impact the ADA has had on the medical school admissions process.

## II. WHERE IS THE ADA? TECHNICAL STANDARDS AND TECHNICALITIES

Enacted in 1990 and strengthened by amendment in 2008, the Americans with Disabilities Act has worked in tandem with the Rehabilitation Act of 1973 to open the doors to educational institutions for thousands of individuals with disabilities. The Acts prohibit discrimination against people with disabilities. Specifically, Section 504 of the Rehabilitation Act provides, “No otherwise qualified individual . . . shall, solely by reason of her or his disability, be excluded from the participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance.”<sup>36</sup> The regulations accompanying Section 504 require educational institutions, including graduate and medical schools, to provide academic adjustments or accommodations for qualified students with disabilities to make sure that a school’s educational requirements “do not discriminate or have the effect of discriminating . . . against a qualified . . . student.”<sup>37</sup> The ADA extends the protections afforded individuals with disabilities under the Rehabilitation Act by including within its scope, among others, places of “public accommodation,” including private hospitals, universities, higher education

<sup>34</sup> *Id.*

<sup>35</sup> *Id.* at 62–63 (quoting Reed M. VanMatre et al., *Technical Standards for the Education of Physicians with Physical Disabilities: Perspectives of Medical Students, Residents, and Attending Physicians*, 83 AM. J. PHYSICAL MED. & REHABILITATION 54, 55–56 (2003)).

<sup>36</sup> 29 U.S.C. § 794(a) (2012); see also *Constantine v. Rectors & Visitors of George Mason Univ.*, 411 F.3d 474, 491 (4th Cir. 2005) (stating “any ‘program or activity’—including all the operations of a university or other postsecondary institution . . . that receives federal funding must not discriminate on the basis of disability”) (citing 29 U.S.C. § 794(b)(2)(A)).

<sup>37</sup> 34 C.F.R. § 104.44 (2012) (“A recipient to which this subpart applies shall make such modifications to its academic requirements as are necessary to ensure that such requirements do not discriminate or have the effect of discriminating, on the basis of handicap, against a qualified handicapped applicant or student. Academic requirements that the recipient can demonstrate are essential to the instruction being pursued by such student or to any directly related licensing requirement will not be regarded as discriminatory within the meaning of this section.”).

testing entities, and medical schools.<sup>38</sup> Like Section 504, the ADA prohibits institutions of higher education from denying admission to or discriminating against a qualified person on the basis of disability in admission or recruitment.<sup>39</sup> The ADA also requires that a covered entity make reasonable accommodations in order to afford an otherwise qualified applicant an equal opportunity to participate in the institution's programs.<sup>40</sup>

Despite their clear prohibition against disability-based discrimination by medical schools, Section 504 and the ADA have not proven to be effective tools in breaking down barriers to medical school admission for applicants with sensory or motor disabilities.<sup>41</sup> People with physical disabilities are vastly underrepresented in medical schools.<sup>42</sup> To be sure, the path to medical school is difficult for any student, and people with physical disabilities face barriers at every step of their educational journey, but the ADA has been effective in removing many of those barriers. For example, the number of students with disabilities earning a bachelor's degree has dramatically increased in the years since the ADA was enacted.<sup>43</sup> That change has not translated to medical schools. In fact, the proportion of graduating medical students with physical

---

<sup>38</sup> Title III of the ADA provides: "No individual shall be discriminated against on the basis of disability in the full and equal enjoyment of the goods, services, facilities, privileges, advantages, or accommodations of any place of public accommodation." 42 U.S.C. § 12182(a) (2012); *see also* *Kaltenberger v. Ohio Coll. of Podiatric Med.*, 162 F.3d 432, 433 (6th Cir. 1998) (applying Title III to a private podiatric college).

<sup>39</sup> *See, e.g., Kaltenberger*, 162 F.3d at 435–36; *Sandison v. Mich. High Sch. Athletic Ass'n*, 64 F.3d 1026, 1034 (6th Cir. 1995); *Wynne v. Tufts Univ. Sch. of Med.*, 976 F.2d 791, 795 (1st Cir. 1992); *Doherty v. S. Coll. of Optometry*, 862 F.2d 570, 573 (6th Cir. 1988); *Ohio Civil Rights Comm'n v. Case W. Reserve Univ.*, 666 N.E.2d 1376, 1383–84 (Ohio 1996).

<sup>40</sup> 42 U.S.C. § 12182(b)(2)(A)(ii). Title III of the ADA defines "discrimination" as including "a failure to make reasonable modifications" that are "necessary" to provide a disabled individual with such full and equal enjoyment, "unless the entity can demonstrate that making such modifications would fundamentally alter the nature of such goods, services, facilities, privileges, advantages, or accommodations." *Id.*; *see also* *Alexander v. Choate*, 469 U.S. 287, 299 n.19 (1985) ("[T]he ultimate question is the extent to which a grantee is required to make reasonable modifications in its programs for the needs of the handicapped."); *Bercovitch v. Baldwin Sch., Inc.*, 133 F.3d 141, 154 (1st Cir. 1998) ("[M]any of the issues that arise in the 'qualified' analysis, also arise in the context of the 'reasonable modifications' or 'undue burden' analysis. That is, if more than reasonable modifications are required of an institution in order to accommodate an individual, then that individual is not qualified for the program.").

<sup>41</sup> *Reichgott, Without Handicap*, *supra* note 8, at 724–26 (noting that "[t]he medical academic establishment has been intransigent in their unwillingness to consider the admission of physically disabled students") (quoting *Meier*, *supra* note 8, at 341–42) (internal quotation marks omitted).

<sup>42</sup> *Moutsiakis & Polisoto*, *supra* note 8, at 925 (finding that 0.15% of graduating medical students had physical disabilities); *see also* *Eickmeyer et al.*, *supra* note 8, at 567, 570 (reporting that "since 2001, 0.56% of medical students matriculating and 0.42% of those graduating have had a [physical disability]" in comparison with the 3.5% of the general population aged eighteen to twenty-four with similar disabilities).

<sup>43</sup> *See, e.g., Lex Frieden, People with Disabilities and Postsecondary Education—Position Paper*, NAT'L COUNCIL ON DISABILITY (Sept. 15, 2003), <http://www.ncd.gov/publications/2003/Sept152003> ("The number of high school graduates with disabilities matriculating in postsecondary education has risen from 3% in 1978 to 19% in 1996.") (citing *Jose Blackorby & Mary Wagner, Longitudinal Postschool Outcomes of Youth with Disabilities: Findings from the National Longitudinal Transition Study*, 62 EXCEPTIONAL CHILD. 399 (1996)).

disabilities has decreased since the passage of the ADA.<sup>44</sup> Technical Standards for admission to medical schools continue to present a potentially impenetrable barrier to admission for persons with sensory or motor disabilities.

Thus far, court challenges to Technical Standards have failed.<sup>45</sup> Put simply, the courts are loath to interfere with a school's admission standards or definition of its core educational program.<sup>46</sup> Once a school has defined an ability or skill as a fundamental requirement of its program, the courts have been essentially unwilling to require the school to waive the requirement for an applicant with a disability.<sup>47</sup> The reluctance to interfere with academic deci-

<sup>44</sup> Moutsiakis & Polisoto, *supra* note 8, at 924–25 (reporting that in comparison to the proportion of graduating medical students with physical disabilities (MSPD) between 1976 and 1980 (0.23%) and between 1987 and 1990 (0.19%), only 0.15% of graduating students had physical disabilities between 2002 and 2005). The same study showed that proportionately fewer graduating medical students had preexisting physical disabilities on admission than did students in a 1990 study. *Id.* at 923–25.

<sup>45</sup> *E.g.*, *Ohio Civil Rights Comm'n v. Case W. Reserve Univ.*, 666 N.E.2d 1376, 1383 (Ohio 1996) (upholding use of technical standards set by Case Western Reserve University to deny a blind applicant admission to medical school); *see also Betts v. Rector & Visitors of Univ. of Va.*, No. 97-1850, 1999 U.S. App. LEXIS 23105, at \*12–13 (4th Cir. Sept. 22, 1999); *Wong v. Regents of Univ. of Cal.*, 192 F.3d 807, 826 (9th Cir. 1999); *Zukle v. Regents of Univ. of Cal.*, 166 F.3d 1041, 1049–50 (9th Cir. 1999); *Kaltenberger v. Ohio Coll. of Podiatric Med.*, 162 F.3d 432, 437 (6th Cir. 1998); *McGuinness v. Univ. of N.M. Sch. of Med.*, 170 F.3d 974, 979–80 (10th Cir. 1998); *Wynne v. Tufts Univ. Sch. of Med.*, 976 F.2d 791, 796 (1st Cir. 1992); *Leacock v. Temple Univ. Sch. of Med.*, No. 97-7850, 1998 U.S. Dist. LEXIS 18871, at \*9–10 (E.D. Pa. Nov. 25, 1998); *Ellis v. Morehouse Sch. of Med.*, 925 F. Supp. 1529, 1549 (N.D. Ga. 1996); *Stafford v. Radford Cmty. Hosp., Inc.*, 908 F. Supp. 1369, 1372, 1376 (W.D. Va. 1995) (holding that a nurse who suffered a back injury resulting in her being unable to lift could not be accommodated by reassignment); *Zevator v. Methodist Hosp. of Hous., Tex.*, No. H-94-859, 1995 U.S. Dist. LEXIS 21870, at \*11, \*14 (S.D. Tex. Mar. 30, 1995) (finding that physical aspects of a nursing position could not be eliminated); *In re Bd. of Educ. of N.Y.*, No. 02-97-1125, 1997 NDLR (LRP) LEXIS 758, at \*7 (National Disability Law Reporter Oct. 15, 1997) (stating that a nursing student was not entitled to a waiver of lifting requirements because nurses must be able to lift and ambulate patients and to react immediately in emergency situations).

<sup>46</sup> *Kaltenberger*, 162 F.3d at 437 (noting that courts “should only reluctantly intervene in academic decisions”). With respect to admissions decisions by educational institutions, the courts are especially deferential to educational institutions. “[T]he determination to admit a student into a given academic program requires the expert evaluation of numerous factors that are not conducive to judicial decisionmaking.” *Betts*, 1999 U.S. App. LEXIS 23105, at \*13.

<sup>47</sup> *E.g.*, *Doe v. N.Y. Univ.*, 666 F.2d 761, 775 (2d Cir. 1981) (“[A]n institution is not required to disregard the disabilities of a handicapped applicant, provided the handicap is relevant to reasonable qualifications for acceptance, or to make substantial modifications in its reasonable standards or program to accommodate handicapped individuals but may take an applicant's handicap into consideration, along with all other relevant factors, in determining whether she is qualified for admission. The institution need not dispense with reasonable precautions or requirements which it would normally impose for safe participation by students, doctors and patients in its activities. Section 504 simply insures the institution's evenhanded treatment of a handicapped applicant who meets reasonable standards so that he or she will not be discriminated against solely because of the handicap. But if the handicap could reasonably be viewed as posing a substantial risk that the applicant would be unable to meet its reasonable standards, the institution is not obligated by the Act to alter, dilute or bend them to admit the handicapped applicant.”) (citations omitted). *But see Wynne v. Tufts Univ. Sch. of Med.*, 932 F.2d 19, 25–26 (1st Cir. 1991) (imposing “a real obligation on the academic institution to seek suitable means of reasonably accommodating a handicapped

sions is “especially” true “in the health care field [because] the conferral of a degree places the school’s imprimatur upon the student as qualified to pursue his chosen profession,”<sup>48</sup> a profession in which patient safety is paramount. As a result, once a medical school declares the ability to hear, to see, to perform specific manual tasks, or to maintain balance and equilibrium a requirement for admission, applicants cannot count on the law to require medical schools to accommodate them in the admissions process.

The deference given to institutions of higher education in defining their core educational programming dates back to a Supreme Court case decided in 1979 under the Rehabilitation Act. *Southeastern Community College v. Davis* involved a challenge by a prospective student to a nursing school that denied the applicant admission because she had a serious hearing impairment.<sup>49</sup> The Court held that the school did not discriminate against the applicant by refusing admission to its program.<sup>50</sup> The Court found that the applicant was not otherwise qualified for the program because she would have needed an individual instructor in order to participate in the clinical phase of the program without compromising patient safety.<sup>51</sup> If the applicant were unable to participate in clinical courses without close supervision, the nursing school could only allow her to take academic (as opposed to clinical) courses, meaning that she would not get the same training that the nursing school usually provides.<sup>52</sup> The Court held that such a fundamental alteration in the nature of a program is far more than what is required by Section 504: “It is undisputed that [the applicant] could not participate in [the school’s] nursing program unless the standards were substantially lowered. Section 504 imposes no requirement upon an educational institution to lower or to effect substantial modifications of standards to accommodate a handicapped person.”<sup>53</sup> Thus, *Davis* stands for the proposition that “[a]n otherwise qualified person is one who is able to meet all of a program’s requirements in spite of his handicap.”<sup>54</sup>

The *Davis* standard was softened somewhat by the Supreme Court in *Alexander v. Choate*.<sup>55</sup> In *Alexander*, the Court said of *Davis*:

The balance struck in *Davis* requires that an otherwise qualified handicapped individual must be provided with meaningful access to the benefit that the grantee offers. The benefit itself, of course, cannot be defined in a way that effectively denies otherwise qualified handicapped individuals the meaningful access to which they are entitled; to assure meaningful access, reasonable accommodations in the grantee’s program or benefit may have to be made.<sup>56</sup>

---

person and to submit a factual record indicating that it conscientiously carried out this statutory obligation”).

<sup>48</sup> *Kaltenberger*, 162 F.3d at 437 (quoting *Doherty v. S. Coll. of Optometry*, 862 F.2d 570, 576 (6th Cir. 1988)) (internal quotation marks omitted).

<sup>49</sup> *Se. Cmty. Coll. v. Davis*, 442 U.S. 397, 400–02 (1979).

<sup>50</sup> *Id.* at 414.

<sup>51</sup> *Id.* at 409.

<sup>52</sup> *Id.* at 401–02.

<sup>53</sup> *Id.* at 413.

<sup>54</sup> *Id.* at 406.

<sup>55</sup> *Alexander v. Choate*, 469 U.S. 287 (1985).

<sup>56</sup> *Id.* at 301.

In other words, “in determining whether an individual meets the ‘otherwise qualified’ requirement of [the disability statutes], it is necessary to look at more than the individual’s ability to meet a program’s *present* requirements.”<sup>57</sup> The question is whether on the facts presented in the individual case some “reasonable accommodation” is available that would allow the “otherwise qualified” individual to participate.<sup>58</sup>

Despite *Alexander*,<sup>59</sup> courts have reaffirmed the principle that schools need not modify their academic standards because of a student’s disabilities.<sup>60</sup> In a 2004 case, for example, the Eighth Circuit considered the case of a medical student who entered medical school with a learning disability and subsequently failed out.<sup>61</sup> After he failed out, he sued the school claiming that the university had failed to provide accommodations he needed to succeed, and that the university dismissed him based solely on his disability.<sup>62</sup> The Court found that the university’s decision to dismiss the student was not based on the student’s disabilities but on the student’s poor performance.<sup>63</sup> In rejecting the student’s arguments, the court reiterated that the law “does not require an educational institution to lower its standards for a professional degree, for example, by eliminating or substantially modifying its clinical training requirements. ‘An otherwise qualified person is one who is able to meet all of a program’s requirements in spite of his handicap.’ ”<sup>64</sup>

The rule that schools are not required to make fundamental alterations to their programs to accommodate students with disabilities applies equally to medical school admissions decisions and underlies holdings that students with physical disabilities are not “otherwise qualified” when they cannot meet a school’s Technical Standards.<sup>65</sup> For example, in rejecting a blind student’s challenge to a decision by Case Western Reserve University denying her admission to medical school, the Supreme Court of Ohio found that the trial court had “abused its discretion in finding that . . . [the applicant] could com-

---

<sup>57</sup> *Wynne v. Tufts Univ. Sch. of Med.*, 932 F.2d 19, 24 (1st Cir. 1991).

<sup>58</sup> *Sch. Bd. of Nassau Cnty. v. Arline*, 480 U.S. 273, 277 (1987) (concluding that an individualized factual inquiry was necessary to determine if an individual is “otherwise qualified” under section 504).

<sup>59</sup> *Alexander*, 469 U.S. at 300 (explaining that “*Davis* . . . struck a balance between the statutory rights of the handicapped to be integrated into society and the legitimate interests of federal grantees in preserving the integrity of their programs: while a grantee need not be required to make ‘fundamental’ or ‘substantial’ modifications to [a program], it may be required to make ‘reasonable’ ones”).

<sup>60</sup> *E.g.*, *Strathie v. Dep’t of Transp.*, 716 F.2d 227, 231 (3d Cir. 1983) (stating “[a] handicapped individual who cannot meet all of a program’s requirements is not otherwise qualified if there is a factual basis in the record reasonably demonstrating that accommodating that individual would require either a modification of the essential nature of the program, or impose an undue burden on the recipient of federal funds”).

<sup>61</sup> *Falcone v. Univ. of Minn.*, 388 F.3d 656, 657 (8th Cir. 2004).

<sup>62</sup> *Id.* at 659.

<sup>63</sup> *Id.* at 660.

<sup>64</sup> *Id.* at 659 (quoting *Se. Cmty. Coll. v. Davis*, 442 U.S. 397, 406 (1979)); *see also* *Manickavasagar v. Va. Commonwealth Univ. Sch. of Med.*, 667 F. Supp. 2d 635, 644 (E.D. Va. 2009).

<sup>65</sup> *E.g.*, *Ohio Civil Rights Comm’n v. Case W. Reserve Univ.*, 666 N.E.2d 1376, 1384 (Ohio 1996).

plete the medical program at CWRU with reasonable accommodation.”<sup>66</sup> The four-judge majority rejected as nonprobative evidence that Temple University had successfully accommodated a blind medical student, evidence the lower court found persuasive on the availability of reasonable accommodations.<sup>67</sup> Referencing the AAMC Technical Standards, the court explained that “a waiver of the medical school’s requirements such as starting an I.V. or reading an X-ray, or the use of an intermediary to perform these functions would fundamentally alter the nature of the program.”<sup>68</sup> Thus, the court concluded that “[o]nce CWRU confirmed the complete absence of an ability to observe, CWRU could deny [the applicant’s] application based upon a bona fide standard for admission to the medical school.”<sup>69</sup>

The validity of the Ohio Supreme Court’s decision is debatable. Three judges dissented. The dissenters blasted the majority for relying “on the blanket exclusion standard of the Association of American Medical Colleges,”<sup>70</sup> and “[u]nintentionally . . . elevat[ing] the status of the AAMC guidelines to the level of a federal regulation.”<sup>71</sup> In her dissent, Justice Resnick further faulted the majority for its dismissal of ninety-four transcribed pages of testimony by a blind psychiatrist that a blind medical student could perform the requirements of medical school with reasonable accommodation, such as those provided to him by Temple University.<sup>72</sup> Given the Supreme Court’s admonition in *Alexander* that the ADA requires an individualized inquiry into the availability of reasonable accommodations and the mounting evidence that medical schools find ways to accommodate enrolled students who develop disabilities during the course of study, the dissenters appear to have the better argument.

Nonetheless, the *Davis* rule, as applied by the majority of the Ohio Supreme Court, that medical schools need not waive Technical Standards to accommodate physically impaired applicants, has staying power. A 2005 report by the AAMC advises that “[a]n educational institution is not required to modify its admission standards for applicants with disabilities. An applicant with a disability may lawfully be denied admission to the program if the applicant is unable to meet the program’s admission requirements.”<sup>73</sup> Thus, medical schools with Technical Standards that include the ability to see, to hear, and to perform particular motor tasks have institutional and legal support for deeming applicants with physical disabilities unqualified for admission even if the AAMC has otherwise promoted inclusion of people with disabilities in medical school.<sup>74</sup> As a result, applicants with physical and sensory disabilities appear to

<sup>66</sup> *Id.* at 1386.

<sup>67</sup> *Id.* at 1385.

<sup>68</sup> *Id.* at 1387.

<sup>69</sup> *Id.* at 1388.

<sup>70</sup> *Id.* (Douglas, J., dissenting); *see also id.* at 1391 (“[B]lanket requirements are not *ipso facto* bona fide.”) (Resnick, J., dissenting).

<sup>71</sup> *Id.* at 1392 (Resnick, J., dissenting).

<sup>72</sup> *Id.*

<sup>73</sup> WATSON & HUTCHENS, *supra* note 25, at 16.

<sup>74</sup> The same report, and another published in 2010 entitled *Medical Students with Disabilities: Resources to Enhance Accessibility*, encourage medical schools to go beyond what is legally required to accommodate students with physical disabilities. *Id.*; ASS’N OF AM. MED. COLLS., MEDICAL STUDENTS WITH DISABILITIES: RESOURCES TO ENHANCE ACCESSIBILITY

have limited choices—find a medical school with disability-friendly Technical Standards, or try to convince a school with traditional Technical Standards based on skills and abilities to go beyond what the law requires. They might also have a third option: bring a renewed legal challenge to ableist Technical Standards based on the recently reinvigorated ADA. Before exploring how such a challenge could be fashioned, however, it is important to explain why ableist Technical Standards should be refashioned to require independent assessment of an individual's capacity to complete medical school with reasonable accommodations, especially including current technologies and physician extenders that render previously core skills dispensable in modern practice.<sup>75</sup>

### III. WHY IT MATTERS: PERMANENT PATIENTS, A BROKEN EAR WITH A CHILD ATTACHED, AND “NOT REAL WOMEN”<sup>76</sup>

In the case discussed in the previous section involving Case Western Reserve University, there was testimony that a physician-member of the admissions committee “thought it ridiculous that a blind person could complete medical school.”<sup>77</sup> Although there is evidence that blind students can and have completed medical school and residency,<sup>78</sup> the question remains whether more medical schools should take the steps necessary, including revising ableist Technical Standards, to recruit and retain medical students with disabilities. My answer is a resounding yes, subject, of course, to careful consideration for patient safety. It almost goes without saying that denying an individual admission to a graduate education program because of a physical impairment is unjust to the individual who has completed the rigorous academic requirements for admission. Indeed the federal disability statutes were recently strengthened to provide “‘a clear and comprehensive national mandate for the elimination of discrimination’ [against individuals with disabilities].”<sup>79</sup> But the problem is broader in scope than individual justice for an applicant with disabilities. The exclusion of persons with disabilities from the medical profession affects the entire health care system in the same way that the historical exclusion of women and racial minorities affected the system. Having spent the past decade engaged in research about the experience of persons with physical disabilities in the health care system, I am convinced that including persons with physical impairments as medical professionals will help improve the health status and

---

22–24 (John A. Hosterman et al. eds., 2010). Some medical schools appear to be doing so. See Eickmeyer et al., *supra* note 8, at 569 (reporting 86 hearing impaired, 64 ambulation impaired, and 60 vision impaired students had matriculated in U.S. medical schools).

<sup>75</sup> See Schwartz, *Technical Standards*, *supra* note 8, at 69–70.

<sup>76</sup> Gill, *supra* note 4, at 6.

<sup>77</sup> Ohio Civil Rights Comm'n v. Case W. Reserve Univ., No. 66721, 1994 Ohio App. LEXIS 5803, at \*11 (Ohio Ct. App. Dec. 22, 1994).

<sup>78</sup> In *Ohio Civil Rights Commission*, a blind psychiatrist explained the accommodations Temple University made that allowed him to successfully complete medical school. *Id.* at \*9–\*10. One judge described them as minimal: “The accommodations made by Temple to enable Dr. Hartman to matriculate through the medical school program were insignificant. Through the use of raised-line drawings, models, instructive descriptions, tape-recorded books, personal tutoring, and the assistance of graduate students, Dr. Hartman was able to successfully complete every course.” *Id.* at \*10.

<sup>79</sup> ADA Amendments Act of 2008, Pub. L. No. 110-325, § 2(b)(1), 122 Stat. 3553, 3554.

health care experience of all people with disabilities. This section argues in favor of changing medical school admission standards to recruit and retain students with sensory and motor disabilities as an essential part of a larger effort to address past and present disparities in the health care received by people with disabilities, to mitigate attitudinal barriers to care, and to create a more culturally competent physician workforce. The following section addresses concerns about patient safety in relation to doctors with disabilities, and strategies for making change.

#### A. *Health Disparities and Barriers to Health Care*

Disability discrimination in medicine is not new. In fact, the historic mistreatment, segregation, and cruelty inflicted upon people with disabilities by the American medical establishment is well documented.<sup>80</sup> People with disabilities have been forced into institutionalization,<sup>81</sup> subjected to coerced medical experimentation,<sup>82</sup> refused available lifesaving treatments,<sup>83</sup> and systematically sterilized without their consent.<sup>84</sup> Although such wide-scale atrocities may be a thing of the past, people with disabilities continue to face serious inequities in the U.S. health care system.<sup>85</sup>

---

<sup>80</sup> See, e.g., Brad Byrom, *A Pupil and a Patient*, in *THE NEW DISABILITY HISTORY: AMERICAN PERSPECTIVES*, *supra* note 4, at 133, 136 (describing the establishment of hospital-school specifically tailored and named for the “Ruptured and Crippled”); see also PAUL A. LOMBARDO, *THREE GENERATIONS, NO IMBECILES: EUGENICS, THE SUPREME COURT, AND Buck v. Bell* 45 (2008); Anita Silvers, *Formal Justice*, in *DISABILITY, DIFFERENCE, DISCRIMINATION: PERSPECTIVES ON JUSTICE IN BIOETHICS AND PUBLIC POLICY* 13, 42 (1998).

<sup>81</sup> Richard K. Scotch, *American Disability Policy in the Twentieth Century*, in *THE NEW DISABILITY HISTORY: AMERICAN PERSPECTIVES*, *supra* note 4, at 375, 377–78.

<sup>82</sup> JAMES H. JONES, *BAD BLOOD: THE TUSKEGEE SYPHILIS EXPERIMENT 1* (new and expanded ed. 1993); Henry K. Beecher, *Experimentation in Man*, 169 *JAMA* 461, 469–70 (1959); Henry K. Beecher, *Ethics and Clinical Research*, 274 *NEW ENG. J. MED.* 1354, 1354–60 (1966).

<sup>83</sup> E.g., Dennis F. Cantrell, *Bowen v. American Hospital Association: Federal Regulation Is Powerless to Save Baby Doe*, 19 *IND. L. REV.* 1199, 1199 (1986); see also *Weber v. Stony Brook Hosp.*, 95 A.D.2d 587, 587–88 (N.Y. App. Div. 1983).

<sup>84</sup> PHILIP R. REILLY, *THE SURGICAL SOLUTION: A HISTORY OF INVOLUNTARY STERILIZATION IN THE UNITED STATES* 30–40 (1991); Michael G. Silver, Note, *Eugenics and Compulsory Sterilization Laws: Providing Redress for the Victims of a Shameful Era in United States History*, 72 *GEO. WASH. L. REV.* 862, 867 (2004).

<sup>85</sup> See, e.g., Letter of Transmittal from John R. Vaughn, Chairperson of the National Council on Disability, to the president of the United States, in *NAT’L COUNCIL ON DISABILITY, THE CURRENT STATE OF HEALTH CARE FOR PEOPLE WITH DISABILITIES* 1, 1 (2009), available at [http://www.ncd.gov/rawmedia\\_repository/j0d7c848f\\_3d97\\_43b3\\_bea5\\_36e1d97f973d?document.pdf](http://www.ncd.gov/rawmedia_repository/j0d7c848f_3d97_43b3_bea5_36e1d97f973d?document.pdf); Elizabeth Pendo, *Disability, Equipment Barriers, and Women’s Health: Using the ADA to Provide Meaningful Access*, 2 *ST. LOUIS U. J. HEALTH L. & POL’Y* 15, 18 (2008); Karen Hwang et al., *Access and Coordination of Health Care Service for People with Disabilities*, 20 *J. DISABILITY POL’Y STUD.* 28, 29–30 (2009) (collecting results of population-based surveys); see also U.S. DEP’T OF HEALTH & HUMAN SERVS., *THE SURGEON GENERAL’S CALL TO ACTION TO IMPROVE THE HEALTH AND WELLNESS OF PERSONS WITH DISABILITIES* 17 (2005), available at <http://www.surgeongeneral.gov/library/calls/disabilities/calltoaction.pdf>; Ctr. for Research on Women with Disabilities, *Health Disparities Between Women with Physical Disabilities and Women in the General Population*, *BAYLOR C. MED.* (May 2005), [www.bcm.edu/crowd/?PMID=1331](http://www.bcm.edu/crowd/?PMID=1331) (discussing the first national sur-

Recent reports demonstrate that people with disabilities “experience significant health disparities and barriers to health care”; encounter a lack of coverage for necessary services, medications, equipment, and technologies; and are not included in the federally funded health disparities research.<sup>86</sup> Despite laws requiring accessible health care, people with mobility disabilities continue to have difficulty finding medical offices and hospitals equipped with accessible examination tables, scales, and x-ray machines.<sup>87</sup> As a result, they are less likely to receive preventative services such as screening for prostate, breast, and cervical cancer.<sup>88</sup> People with disabilities are also less likely to receive screening for cardiovascular disease.<sup>89</sup> They have poorer health outcomes and experience more preventable emergency room visits than their able-bodied counterparts.<sup>90</sup>

The problem of inaccessible medical equipment has not gone unnoticed by lawmakers. As the ADA did not solve the problem as intended, the Department of Justice issued a 2010 guidance document about accessibility to health care that mentioned equipment.<sup>91</sup> In 2012, the DOJ issued a notice of proposed rulemaking “to ensure that medical diagnostic equipment, including examination tables, examination chairs, weight scales, mammography equipment, and other imaging equipment used by health care providers for diagnostic purposes are accessible to and usable by individuals with disabilities.”<sup>92</sup> Congress also included incentives in the Affordable Care Act for accessibility.<sup>93</sup> These laws may eventually eliminate equipment barriers, but they will not eliminate the insensitivity to disability-related needs that allowed medical providers to invest in equipment unusable by their physically impaired patients.

### B. Disability-Related Alienation and Attitudinal Barriers

An additional problem facing people with disabilities in the health care setting—a problem that is potentially a factor contributing to the poor health outcomes and disparities in treatment—is perceived and actual discriminatory or biased attitudes of physicians concerning the value of the lives of their disabled patients. Although many people with disabilities have excellent relationships with their physicians, others experience a sense of alienation,

---

vey of women with disabilities on their experiences with women’s health care conducted in the years immediately following passage of the ADA).

<sup>86</sup> Vaughn, *supra* note 85, at 1; *see also* Hwang et al., *supra* note 85, at 29–30 (discussing barriers to effective care).

<sup>87</sup> Elizabeth Pendo, *Shifting the Conversation: Disability, Disparities and Health Care Reform*, 6 FLA. INT’L U. L. REV. 87, 92 (2010) (noting that “twenty years after passage of the [ADA], many people with mobility impairments cannot get on examination tables and chairs, cannot be weighed, and cannot use x-ray and other imaging equipment”).

<sup>88</sup> NAT’L COUNCIL ON DISABILITY, *supra* note 85, at 92.

<sup>89</sup> Hwang et al., *supra* note 85, at 29.

<sup>90</sup> *Id.* at 28.

<sup>91</sup> DEP’T OF JUSTICE & U.S. DEP’T OF HEALTH & HUMAN SERVS., ACCESS TO MEDICAL CARE FOR INDIVIDUALS WITH MOBILITY DISABILITIES pt. 4, at 8–19 (2010), available at [http://www.ada.gov/medcare\\_mobility\\_ta/medcare\\_ta.pdf](http://www.ada.gov/medcare_mobility_ta/medcare_ta.pdf).

<sup>92</sup> Medical Diagnostic Equipment Accessibility Standards, 77 Fed. Reg. 6916, 6916 (proposed Feb. 9, 2012) (to be codified at 36 C.F.R. pt. 1195).

<sup>93</sup> Pendo, *supra* note 87, at 96.

subordination, and even fear in the health care system. For example, disability scholar William Peace believes that “most people with a disability fear even the most routine hospitalization. We do not fear any of the commonplace indignities those without a disability worry about when hospitalized. Our fear is primal—will our lives be considered devoid of value?”<sup>94</sup> The fear is rooted in history. Disability scholar Joseph Shapiro explains:

Throughout U.S. history, doctors have routinely starved or ended the lives of infants born with Down syndrome or various birth defects, although those children were in no danger of dying. The practice was given national exposure in 1983, when the Reagan Administration opposed the parents of “Baby Jane Doe,” a Long Island infant born with spina bifida. The baby’s mother and father chose to withhold medical treatment, agreeing with their doctors that it was more humane for the severely disabled child to die. . . . In 1973, two doctors, writing in the *New England Journal of Medicine*, revealed that forty-three infants with various disabilities had been allowed to die in the special care nursery of the Yale-New Haven Hospital “rather than face lives devoid of meaningful humanhood.” A California state court in 1979 ruled in favor of the parents of Philip Becker, a thirteen-year-old with Down syndrome, who wanted to withhold life-saving heart surgery, arguing that his life was not worth living.<sup>95</sup>

Disability experts maintain that these practices reflect discriminatory attitudes that permeate medical culture. For example, in a brief to the Supreme Court filed in a challenge to the Baby Doe regulations, the Association of Retarded Citizens argued that the “difference in the treatment of handicapped and non-handicapped children directly reflects the physician’s judgment that the life of the handicapped infant is of significantly less value than is the life of the non-handicapped infant.”<sup>96</sup>

Disability experts also contest the ways in which doctors sometimes treat people with disabilities as disabled first, persons second. For example, Claire Ramsey contends that doctors see a deaf child as “a broken ear with a child attached.”<sup>97</sup> Others explain that women with mobility disabilities are desexualized:

[W]omen with disabilities are stripped of our roles. We are not expected to be workers, romantic partners, caregivers, or mothers. Socially, we are in limbo—not quite children, but not adults; not men, but not real women either. It is difficult to get your bearings and struggle out from under that kind of unremitting yet subtle oppression, because it steals from you the very sense of self you need in order to fight.<sup>98</sup>

The limited view physicians have of women with mobility impairments has a direct impact on care. Doctors are far less likely to ask women with mobility and other physical impairments routine questions about reproductive

<sup>94</sup> William J. Peace, *Disability Discrimination: The Author Responds*, Comment to *Bioethics Forum*, HASTINGS CENTER (July 27, 2012), <http://www.thehastingscenter.org/Bioethicsforum/Post.aspx?id=5935&blogid=140#ixzz22VbDNxiW>.

<sup>95</sup> SHAPIRO, *supra* note 4, at 273–74.

<sup>96</sup> Brief of Amici Curiae the Ass’n for Retarded Citizens of the United States et al. in Support of Petitioner, *Bowen v. Am. Hosp. Ass’n*, 476 U.S. 610 (1985) (No. 84-1529), 1985 WL 669102, at \*7.

<sup>97</sup> Claire L. Ramsey, *Ethics and Culture in the Deaf Community Response to Cochlear Implants*, 21 SEMINARS IN HEARING 75, 78 (2000).

<sup>98</sup> Gill, *supra* note 4, at 6.

health than they are other women,<sup>99</sup> and explicit requests for routine reproductive health services like pap smears and mammograms are sometimes denied. For example, a woman with post-polio syndrome who uses a power wheel chair reported:

My primary physician and several specialists I respect all practice at a major university medical center fairly close to my home. Recently, though, when I requested a gynecology referral there, I was told that I would not be seen unless I could bring my own assistants to help me get on the examining table. This is a huge world-renowned hospital. This is the era of [the] ADA. Still I am treated as though I don't belong with the other women who seek services in OB/GYN unless I can make my disability issues go away. This news makes me weary. I know it means once again that I can't simply pursue what I need as an ordinary citizen. I can't be just a woman who needs a pelvic exam; I must be a trailblazer.<sup>100</sup>

These negative experiences and stereotypes discourage people with disabilities from seeking health care and may help explain disability-related health disparities. In any case, that people with disabilities feel devalued in the health care setting reflects an unacceptable lack of understanding and absence of training in disability competence issues for health care practitioners.<sup>101</sup>

### C. *Inclusiveness in Medical Education, Training, and Practice Will Make a Difference*

Increased training in disability competence for health care providers is a first and necessary step to redress the negative attitudes and false stereotypes encountered by people with disabilities in the health care setting.<sup>102</sup> It is not enough, however. So long as people with physical impairments are outsiders—permanent patients and persons to be studied—negative attitudes and false stereotypes are likely to continue. One way to counter bias against outsiders is to make them insiders. As the rich body of literature on the value of diversity in the educational setting shows, it is only by encountering and interacting as peers with individuals of different backgrounds that students transcend their

---

<sup>99</sup> See *id.* at 8–9; Barbara Faye Waxman, *Up Against Eugenics: Disabled Women's Challenge to Receive Reproductive Health Services*, 12 *SEXUALITY & DISABILITY* 155, 155 (1994).

<sup>100</sup> Pendo, *supra* note 85, at 16; June Isaacson Kailes, *The Patient's Perspective on Access to Medical Equipment*, in *MEDICAL INSTRUMENTATION: ACCESSIBILITY AND USABILITY CONSIDERATIONS* 3, 5 (Jack M. Winters & Molly Follette Story eds., 2007).

<sup>101</sup> The lack of disability training in disability competence issues for health care practitioners was documented in the report, *The Current State of Health Care for People with Disabilities*. See NAT'L COUNCIL ON DISABILITY, *supra* note 85, at 304.

<sup>102</sup> An effective example of training in disability competence can be found at Rochester's Strong Hospital, where there is a large deaf community and several deaf physicians. See *Deaf Strong Hospital*, NAT'L CENTER FOR DEAF HEALTH RES. (May 23, 2011), <http://www.urmc.rochester.edu/ncdhr/training/hospital.cfm>.

preconceptions about others.<sup>103</sup> That has certainly been my experience working alongside my colleagues with disabilities.<sup>104</sup>

Former president of the AAMC Jordan Cohen recognized the importance of diversifying the health care workforce to reflect the diverse society health care workers will serve in an influential 2002 article.<sup>105</sup> Cohen identified four practical benefits of bringing the traditionally underrepresented into the classroom: “(1) advancing cultural competency, (2) increasing access to high-quality health care services, (3) strengthening the medical research agenda, and (4) ensuring optimal management of the health care system.”<sup>106</sup> Although his paper did not name disability as diversity criteria,<sup>107</sup> these practical benefits apply at least as forcefully to persons with disabilities as they do to members of racial and ethnic minorities.

To provide optimal care . . . , all health care professionals must become culturally competent practitioners. Future physicians . . . can acquire the necessary attributes . . . only by being educated in the company of a broadly diverse student body and in learning environments that reflect the diverse society they will be called upon to serve.”<sup>108</sup>

Diversifying the medical profession to include more doctors with disabilities will help create a more empathetic workforce. For example, a doctor with mobility disabilities would likely note immediately the problems presented by inaccessible exam tables in patient rooms. Deaf doctors who use sign language

---

<sup>103</sup> E.g., Barbara A. Noah, *A Prescription for Racial Equality in Medicine*, 40 CONN. L. REV. 675, 675 (2008); Thomas E. Perez, *Enhancing Access to Health Care and Eliminating Racial and Ethnic Disparities in Health Status: A Compelling Case for Health Professions Schools to Implement Race-Conscious Admissions Policies*, 9 J. HEALTH CARE L. & POL’Y 77, 86 (2006); Michael A. Schwartz, *Deaf Patients, Doctors, and the Law: Compelling a Conversation About Communication*, 35 FLA. ST. U. L. REV. 947, 953 n.23 (2008).

<sup>104</sup> Such was also the case for bioethicist Erik Parens, who described the ways in which working with the disabled has changed his perspective:

I am not proud to confess that when I first heard people with disabilities say [that disabling features are a central part of their identity], I practiced some armchair psychoanalysis: “Yes, yes, that’s very nice. You say that the problem is social responses to your disability, not your disability. But let’s be honest; you’re in denial.” The more I heard [about] people [who] say that the most difficult thing about having a disability was the way temporarily able-bodied people like me treated them, however, the more I began to take them at their word. I became convinced that if, after a process of truly informed decision-making, someone with a disability refuses the use of medical means to improve her social experience, then there is no good alternative to respecting her decision, no matter how surprising I might find it.

Erik Parens, *Respecting Children with Disabilities—and Their Parents*, 39 HASTINGS CENTER REP. 22, 22 (2009).

<sup>105</sup> Jordan J. Cohen et al., *The Case for Diversity in the Health Care Workforce*, 21 HEALTH AFF. 90 (2002).

<sup>106</sup> *Id.* at 91.

<sup>107</sup> Cohen later called for increasing the number of students with physical disabilities in the physician workforce.

<sup>108</sup> Cohen et al., *supra* note 105, at 100.

report better understanding of and communication with deaf patients.<sup>109</sup> In a sense, the empathy point parallels the arguments made in favor of opening medical schools to women and racial minorities.<sup>110</sup> Women doctors better understand what women need and feel.<sup>111</sup> Minority doctors may better understand what it means to be a minority in a health care system rife with racial disparities.<sup>112</sup> Bringing underrepresented people into a profession traditionally reserved for people of privilege, thus, may affect care of similarly situated underprivileged patients.

The case is even more compelling with disability. Unlike race and gender, disability itself may be the reason a person seeks medical treatment. It is the disability that makes a person the subject of study, the person needing care, the patient. The same is not true of race or gender.

Although disability does not equal bad health (a person with deafness, blindness, or paralysis can be perfectly healthy), the presence of a disability may well be relevant to the purpose of a medical visit, which makes the need for cultural competence and empathy even higher than in the context of race and gender. For that reason, a profession that includes human variation in the form of disability is better equipped to serve a human population that includes people with disabilities.

#### IV. AVENUES TO ENTRY, PATIENT SAFETY, AND OTHER CONCERNS

Opening the door to medical schools for qualified applicants with physical disabilities presents several challenges. First is patient safety—one of the very concerns that gave rise to ableist Technical Standards in the first place. Sensitivity to patient safety is paramount. But inclusiveness in medical education need not compromise patient safety. Bringing people with physical impairments into the medical profession requires careful consideration of individual limitations and thoughtful assessment of what constitutes reasonable accommodations. Assessing individual limitations and reasonable accommodations in light of patient safety are not easy tasks, but years of experience with medical students and physicians with disabilities provide significant guidance.

Based on these years of experience with medical students and doctors with disabilities, the AAMC published guidelines for enhancing accessibility in 2010.<sup>113</sup> The guidelines provide specific strategies for accommodating specific disabilities in the academic and clinical settings. The guidelines emphasize the role of new technologies as opposed to live patients for teaching technical skills

---

<sup>109</sup> See, e.g., Lisa Hoang et al., *Assessing Deaf Cultural Competency of Physicians and Medical Students*, 26 J. CANCER EDUC. 175, 175–76 (2011).

<sup>110</sup> See Noah, *supra* note 103, at 678; Perez, *supra* note 103, at 86.

<sup>111</sup> See Fiona Brooks, *Do Women Want Women Health Workers? Women's Views of the Primary Health Care Service*, 23 J. ADVANCED NURSING 1207, 1209 (1996); Pauline W. Chen, *Do Women Make Better Doctors?*, N.Y. TIMES (May 6, 2010), <http://www.nytimes.com/2010/05/06/health/06chen.html>.

<sup>112</sup> See Noah, *supra* note 103, at 678.

<sup>113</sup> ASS'N OF AM. MED. COLLS., *supra* note 74.

such as intubation and suturing.<sup>114</sup> In fact, computerized medical mannequins are available to teach medical students everything from laparoscopy to neonatal care. These technologies allow all medical students to learn and practice skills without compromising patient safety. The AAMC suggests their use as a means of accommodating medical students with physical disabilities.

The AAMC guidelines also recognize that some specialties must be off limits to individuals with certain impairments. A person with contractures in her hands and arms could not be a surgeon, for example. But she could be a radiologist or a psychiatrist. These limitations suggest the need for specialized tracks and reconsideration of the notion of the undifferentiated graduate.<sup>115</sup> To this, there will be resistance from traditionalists in medical education. Specialization is a fact of life in modern medicine, however, and rebuilding the curriculum for accessibility is as essential to inclusiveness as creating curb cuts and installing elevators and wheelchair ramps in modern buildings.

Indeed, incorporating such changes will require pressure. Ideally, that pressure will come from within the medical academy. The recent publications by the AAMC, and changes by the medical school accrediting body,<sup>116</sup> suggest a positive trend. These reports, rules, and the decades of experience by medical schools that have gone beyond the legal minimum to graduate successful students with physical disabilities may also provide fodder for court-ordered change. That is, medical school applicants might well be able to make a legal case against application of ableist Technical Standards based on mounting evidence that people with similar disabilities can and have completed a course of medical education when schools accommodate their needs. Empirical work in this area is needed. The available evidence indicates that medical schools graduate more medical students with sensory and motor disabilities than they admit, suggesting that they make accommodations for students who develop specific disabilities after they have started their course of study. Data showing how often and how exactly the schools accommodate such students would be useful for testing the assertion that ablest Technical Standards define essential program requirements. Evidence that medical schools regularly accommodate existing students who develop disabilities while enrolled undermine arguments that technological and other accommodations during the admissions process are unreasonable and reveal ableist Technical Standards as pretextual. Thus, a direct challenge to *Davis*, as it has been interpreted to allow for blanket exclusions, seems viable.

Whether through litigation or voluntary action, medical schools and the medical profession will better serve all patients when more people with disabilities are part of the profession. Working alongside people with disabilities as

---

<sup>114</sup> See *id.* For examples of mannequins used in medical education, see the products at GAUMARD, <http://www.gaumard.com/> (last visited May 7, 2013).

<sup>115</sup> Others have also suggested this. *E.g.*, Schwartz, *Technical Standards*, *supra* note 8, at 59.

<sup>116</sup> See, *e.g.*, FUNCTIONS AND STRUCTURE OF A MEDICAL SCHOOL: STANDARDS FOR ACCREDITATION OF MEDICAL EDUCATION PROGRAMS LEADING TO THE M.D. DEGREE 5 (Liaison Comm. on Med. Educ. ed., 2012); DIVERSITY POLICY AND PROGRAMS 1 (Ass'n of Am. Med. Colls. ed., 2012).

Spring 2013]

*PATIENTS TO PEERS*

667

peers will help a new generation of physicians to better serve a population that includes patients with disabilities.