The Implications of the ADA Amendments Act of 2008 for Residency Training Program Administration

Alexandra Regenbogen, BA, and Patricia R. Recupero, JD, MD

The Americans with Disabilities Act (ADA) is rarely invoked by medical residents in training. Dr. Martin Jakubowski, a family medicine resident with Asperger's disorder, was dismissed for communicating poorly with patients, peers, and supervisors and for issuing dangerous medical orders. In an attempt to become reinstated, he sued under the ADA (*Jakubowski v. The Christ Hospital*), arguing that the program had failed to make reasonable accommodation for his disability. The Sixth Circuit Court of Appeals ruled in favor of the hospital, finding that although the doctor was disabled under the ADA, he had failed to demonstrate that he was otherwise qualified for the position. This article comments on the ADA Amendments Act of 2008, the Equal Employment Opportunity Commission (EEOC) guidelines from 2011 and their application to medical residency training, and the Accreditation Council for Graduate Medical Education (ACGME) core competencies as essential job functions.

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The Americans with Disabilities Act (ADA)[1] is federal legislation designed to protect the civil rights of disabled persons in the workplace and in places of public accommodation. Signed into law in 1990, the ADA was subsequently amended in 2008 to broaden its coverage of disabled persons, including individuals with mental health difficulties.[2] It is likely that mental health professionals (MHPs) will be increasingly called on for ADA evaluations and as consultants or expert witnesses on behalf of employees, employers, or administrative bodies.[3,4] This discussion will begin with the description of a case (*Jakubowski v. The Christ Hospital*)[5] against an educational institution for allegedly violating the ADA. Historically, allegations that medical residents have been subject to disability discrimination have been rare,[6] but new legislation and regulatory guidelines may prompt an increase in such claims. This article addresses changes introduced by the ADA Amendments Act of 2008 and their implications for employees and employers, with particular attention to problems arising in medical residency. Through analyzing the case, we hope to shed light on the mechanics and essentials of a thorough ADA evaluation as applied to a resident in training.

Ms. Regenbogen is a fourth-year medical student and Dr. Recupero is Clinical Professor of Psychiatry, Warren Alpert Medical School, Brown University, Providence, RI. Dr. Recupero is also President/CEO of Butler Hospital, Providence, RI. Address correspondence to: Patricia R. Recupero, JD, MD, Butler Hospital, 345 Blackstone Boulevard, Providence, RI 02906. E-mail: patricia_recupero@brown.edu.

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Jakubowski v. The Christ Hospital

In 2007, Martin Jakubowski, a former family medicine resident at The Christ Hospital in Cincinnati, Ohio, filed suit against the hospital and its residency director, arguing that his termination from the program was the result of discrimination on the basis of his disability, Asperger's disorder.[5]

Dr. Jakubowski began his residency at the hospital in July 2007 (Ref. 5, pp 197–198). After graduating from the University of Medical Sciences in Poznan, Poland, and failing to obtain a residency through the match process, he later found a position at St. Elizabeth's Hospital in Youngstown, Ohio, through an alternative process, the scramble, whereby candidates pursue remaining training opportunities. In the first half of his residency at St. Elizabeth's, Dr. Jakubowski was placed in a remedial program, and by the end of his first year, he was denied renewal of

his contract. Understanding that he needed to improve his clinical skills, Dr. Jakubowski enrolled in a program for supervised clinical training at New York Medical College, before attempting the match a second time. Again, he was unable to attain a residency position through the match and had to scramble for his position at Christ Hospital (Ref. 5, p 197).

Despite scoring in the 90th percentile for medical knowledge, Dr. Jakubowski continued to struggle early in his residency at the hospital (Ref. 5, p 198). He was noted by many attendings to have striking deficits in social competence with both faculty and patients, and to struggle with navigating the health care system. He was documented as failing to relay trustworthy information to other medical professionals, to organize his thoughts and treatment plans adequately, to complete procedures correctly, and to keep up a pace on par with his peers. Attendings were also concerned about his having "given dangerous orders that would have harmed patients if not caught by other physicians" (Ref. 5, p 198).

In light of Dr. Jakubowski's difficulties, the residency director suspected that he might have Asperger's disorder and recommended psychological evaluation in early August 2007 (Ref. 5, p 198). As the month progressed, however, his performance continued to be poor enough that on August 25, before the program was aware of his official diagnosis, the director informed him that his residency would be terminated at the end of September (Ref. 5, p 198). On the same day, Dr. Jakubowski met with the director and several attendings to inform them that his psychological evaluation revealed that he had Asperger's disorder.

Under the ADA, an employer's failure to provide reasonable accommodation to an otherwise qualified employee with a disability may constitute actionable discrimination. With the aid of a lawyer, Dr. Jakubowski proposed a set of accommodations. He argued that if the faculty members approached his diagnosis with "knowledge and understanding," they could be cognizant of the "symptoms and triggers of Asperger's," and that in this context, he would be able to improve his communication skills (Ref. 5, p 198). The parties reconvened to discuss his proposal but ultimately decided that the program lacked adequate resources to comply with it. The director offered instead to assist him in finding a residency position in pathology, a field the director believed placed fewer demands on interpersonal communication skills.

Unsatisfied, Dr. Jakubowski appealed his termination to the Graduate Medical Education Committee, but in December 2007, the committee upheld the termination (Ref. 5, p 199). Dr. Jakubowski then filed suit, alleging that the hospital's failure to accommodate his Asperger's disorder constituted a violation of the ADA. The hospital moved for and was granted summary judgment by the district court. Dr. Jakubowski appealed the decision, arguing that the district court incorrectly judged him "not otherwise qualified" for the position and that the program had failed to engage in a good-faith interactive process to provide reasonable accommodations (Ref. 5, pp 200–201). Citing an earlier case,[7] the Sixth Circuit Court of Appeals evaluated Dr. Jakubowski's case in light of the following: "To recover on a claim of discrimination under the Act, a plaintiff must show that: 1) he is an individual with a disability; 2) he is 'otherwise qualified' to perform the job requirements, with or without reasonable accommodation; and 3) he was discharged solely by reason of his handicap" (Ref. 5, p 201, citing Ref. 7, p 1178).

The ADA in Employment

A brief overview of the ADA in the employment context will help to understand the court's analysis of Dr. Jakubowski's case. The ADA defines disability as "(A) a physical or mental impairment that substantially limits one or more of the major life activities of [the] individual; (B) a record of such an impairment; or (C) being regarded as having such an impairment" (Ref. 1, § 3, pp 329–30). Title I of the act prohibits discrimination on the basis of such a disability in almost every aspect of employment, including residency training.

The ADA covers several forms of discrimination. These include disparate treatment, in which an employee is treated different from his coworkers due to his disability; disparate impact, in which a policy disproportionately affects disabled workers; and failure to provide reasonable accommodations.[8] Plaintiffs would also be covered by the ADA for "disability harassment or a hostile work environment," as well as "reprisal for protected conduct," (e.g., termination as a repercussion for filing an ADA complaint).[4]

Beginning in 1999, the Supreme Court began to curtail the scope of protection under the ADA. In three seminal cases (*Sutton v. United Air Lines, Inc.*[9];

Murphy v. United Parcel Service, Inc.[10]; and *Albertson's, Inc. v. Kirkingburg*[11]), the court held that an employee would not be disabled under the ADA if a medication were to control his symptoms such that he was no longer substantially limited in performing a major life activity (MLA). These terms came under even closer scrutiny in 2002, when in *Toyota Motor Manufacturing, Kentucky Inc. v. Williams* the Supreme Court ruled that MLAs are "activities . . . of central importance to most people's daily lives" and that a substantial limitation must "prevent" or "severely restrict" one's performance of an MLA (Ref. 12, p 198).

The culmination of these rulings led to decisions predicated on whether the plaintiff could demonstrate that he was disabled, rather than on whether any discrimination occurred.[13,14] By the middle of the first decade, nearly all ADA employment claims brought before courts were dismissed.[15,16] Physicians had to document sufficient impairment while leaving the claimant the ability to perform all essential job functions.[17]

The ADA Amendments Act of 2008 and EEOC Guidance 2011

The ADA Amendments Act of 2008 (ADAAA) was signed into law on September 25, 2008, after civil rights advocates and others worked to develop legislation that favored a less restrictive interpretation of the ADA.[14,18] The ADAAA emphasizes that "the definition of disability shall be construed in favor of broad coverage" (Ref. 2, § 4, p 3555). This rule of construction specifically rejects the Supreme Court's rulings in *Sutton*[9] and *Toyota*.[12]

The Equal Employment Opportunity Commission (EEOC) plays an important role in the interpretation, regulation, and enforcement of the ADA.[3] As directed by the ADAAA, the EEOC released new regulations in 2011 that clarify the implementation of the ADAAA in employment.[13] The EEOC defines impairment as a physiological disorder or condition affecting one or more body systems or "any mental or psychological disorder, such as . . . emotional or mental illness, and specific learning disabilities" (Ref. 19, § 1630.2(h)(2)). An impairment rises to the level of a disability on a case-by-case basis if it substantially limits an individual's ability to perform an MLA relative to the general population.[19]

The term substantially limits was redefined such that an impairment need not be severely or significantly restrictive to constitute a substantial limitation.[14,19] The extent of limitation can be gauged by the impairment's nature and severity, duration or expected duration, and long-term impact on the individual.[19] These metrics are evaluated independent of beneficial effects of "medications . . . ; reasonable accommodations . . . ; or learned behavioral or adaptive neurological modifications" (Ref. 2, § 3(E), p 3556).

Furthermore, under the ADAAA, an MLA no longer must be of central importance in one's day-to-day life,[15] but may include: "caring for oneself, . . . sleeping, . . . thinking, communicating, and working . . ." and "major bodily functions" (Ref. 2, § 4(a), p 3555). This definition clarifies the applicability of the ADA to persons with psychiatric conditions that affect one of these MLAs, as well as for those with conditions whose treatment produces side effects that limit an MLA. Before the ADAAA, the question of whether communicating and interacting with others constituted MLAs was controversial; some courts had been reluctant to recognize such abilities as MLAs.[20]

As Scott noted, "[T]he implications of the ADAAA are clear: more individuals will be eligible for disability consideration under the ADA and more psychiatrists will be needed to evaluate these increased ADA disability claims" (Ref. 21, pp 98–9). Before the ADAAA, a plaintiff like Dr. Jakubowski may have had difficulty in convincing a court that he was disabled and therefore entitled to ADA protection. Now, however, MHPs can expect to see more cases like that of Dr. Jakubowski, in which the central question is not whether the employee is disabled under the ADA but whether he can perform essential job functions and what reasonable accommodations may be appropriate.[22]

Reasonable Accommodation and Qualification for the Position

Under the ADA, the disabled employee has the responsibility for disclosing the need for reasonable accommodation.[23] If the employer has no knowledge of the employee's disability, then termination or discipline based on the employee's misconduct or poor work is not typically held to violate the ADA.[3]

Having established that he is disabled under the ADA, the employee next must show that he is otherwise qualified for the position.[22] To be qualified one must have "the requisite skill, experience, education

and other job-related requirements of the . . . position" such that "with or without reasonable accommodation, [one] can perform the essential functions" of the job (Ref. 19; 29 C.F.R. § 1630.2(m), p 17002). That is, the employee must be able to complete "the fundamental job duties," excluding "marginal functions of the position" (Ref. 19, 29 C.F.R. § 1630.2(n)(1)).

To be otherwise qualified, an employee must not pose a direct threat in the workplace.[3] If an employee's condition is remedied by medication that eliminates his potential harm to himself or to others in the workplace, he cannot be considered a threat. Conversely, if an employee's medication causes somnolence or other side effects such that his ability to perform the job safely is impaired, then he may be said to pose a direct threat.

Having been informed that an employee has a disability and may need accommodation in the workplace, the employer has a duty to provide such reasonable accommodations. The employer is entitled to request supporting documentation that conceptualizes the best ways to overcome the worker's limitations but, barring undue hardship, must engage in good faith in an interactive process with the employee to identify reasonable accommodations.[22,23] The EEOC suggests possible accommodations, such as time off, modified work schedules, room modifications, increased supervision and guidance, provision of a job coach, and job restructuring.[24] The employer, however, is not obligated to restructure essential job functions or transfer major job responsibilities to a different worker.[3,23,25]

The ADA and Medical Residency

Medical students in the United States graduate from medical school and enroll in medical residency as a postgraduate level of training. Supervised by fully licensed physician attendings, medical residents learn experientially by assuming full responsibility for the care of patients but typically may not acquire an unrestricted license until successful completion of supervised training. Residency training is predicated on the notion that physicians will become increasingly competent, independent practitioners by means of graded and progressive responsibility.[26] Medical residents fulfill a dual role: they are simultaneously understood to be learners operating within the health care delivery system and to be paid employees of the program site.[27]

Residency programs are regulated by the Accreditation Council for Graduate Medical Education (ACGME), a private nonprofit council whose mission is to ensure quality health care delivery by "advancing the quality of resident physicians' education through exemplary accreditation."[28] For accreditation, the ACGME requires many structural components. The program must achieve adequate administrative supervision, employ a variety of participating clinical sites, devote a certain number of hours to resident teaching, protect residents' work hours, and so on.[28] The ACGME also requires a structured evaluation of residents around core competencies, metrics befitting the skill set of a new, independent clinician. These core competencies may be considered some of the essential job functions of a medical resident for purposes of an ADA evaluation.

The ACGME Core Competencies

There are six core competencies on which all residents (including those in family medicine) are evaluated. They are: patient care, medical knowledge, practice-based learning and improvement, interpersonal and communication skills, professionalism, and systems-based practice.[29] In addition to these six core competencies, individual specialties may have additional competencies, as determined by Residency Review Committees specific to each specialty. A discussion of each competency, including considerations specific to Dr. Jakubowski's intended specialty of family medicine will follow.

Patient care competency requires the ability to provide "compassionate, appropriate and effective" treatments for health problems (Ref. 29, § IV.A.5.a, p 28). Residents are expected to be facile with a family-oriented framework by "taking into account social, behavioral, economic, cultural and biologic dimensions" so as to "demonstrate cultural competence" (Ref. 26, § IV.A.5.a.(2).(b).(ii), p 18). They must develop skills for basic procedures, admissions, discharges and order writing so as to be able to take on "progressive responsibility for increased patient visit volume and efficiency" (Ref. 26, § IV.A.5.a.(2).(c).(iii).(b), p 20).

Medical knowledge for family medicine is gauged by the residents' application of their skills to various subspecialties, including maternal and neonatal care, child and adolescent care, and adult and geriatric care.[26] Residents must work within the various de-

mands of patient care in both longitudinal clinical settings and inpatient wards.[26]

Practice-based learning and improvement focuses on the ability to engage in constant "self evaluation and lifelong learning" (Ref. 29, § IV.A.5.c, p 30), so as to be able to "identify strengths, deficiencies and limits in one's knowledge and expertise," "set learning and improvement goals," and "incorporate evaluation feedback into daily practice" (Ref. 26, § IV.A.5.c, p 35).

Interpersonal and communication skills constitute a core competency that charges residents with collaborating with patients, their families, and other health professionals, across a broad range of socioeconomic and cultural backgrounds (Ref. 29, § IV.A.5.d, pp 34–5). This competency also includes working effectively as a "member or leader of a health care team," as well as acting in a consultative role (Ref. 29, § IV.A.5.d, p 34). "Comprehensive, timely and legible medical records" are also evaluated in the context of interpersonal and communication skills (Ref. 29, § IV.A.5.d.(5), p 24).

Professionalism entails "a commitment to carrying out professional responsibilities and an adherence to ethical principles" (Ref. 29, § IV.A.5.e, p 36). Residents must demonstrate accountability to their "patients, society and the profession," by acting with "compassion, integrity and respect for others" (Ref. 29, § IV.A.5.e, p 36).

Finally, competency in systems-based practice is demonstrated by success in navigating the health care system, including "[coordinating] patient care," "[working] in interprofessional teams," and developing sound differential diagnoses and treatment plans that are conveyed effectively to other team members and consultants (Ref. 26, § IV.A.5.f, pp 36–8).

Residents are evaluated on their achievement of the core competencies in two different ways. Through formative evaluations, supervisors provide objective measures of performance in each core competency; these progressive performance reports are documented and discussed with residents semiannually for feedback and learning (Ref. 29, § V.A.1). Summative evaluations are required for "high-stakes" decision making, such as graduation, transfer or termination (Ref. 29, § V.A.2). The summative evaluation is written and discussed with the resident for review. Should trainees be noted to have deficiencies in their core competencies and be recommended for remediation or termination, they are entitled to due process for appealing the adverse action.[26,30,31]

Dr. Jakubowski and the Core Competencies

There was no dispute regarding Dr. Jakubowski's qualifying as a disabled individual according to the ADA (Ref. 5, p 201). He demonstrated limitations substantial enough that within one month of his residency at the hospital he was recommended for psychological testing specifically to evaluate whether he had Asperger's disorder (Ref. 5, p 198). Throughout the record, it is clear that Dr. Jakubowski's ability to communicate and interact with others was severely compromised. To establish his eligibility as an "otherwise qualified individual," however, Dr. Jakubowski had to demonstrate that he was capable of performing the essential job functions of a family medical resident with or without reasonable accommodation.

Dr. Jakubowski's poor performance without accommodations is well documented. He clearly failed to uphold five of the six ACGME core competencies for family medicine:

> His deficits in interpersonal and communication skills are indisputable. Attending physicians in his first residency at St. Elizabeth's, in his extra year at New York Medical College, and at his second residency at Christ Hospital all commented on Dr. Jakubowski's communication impairment, noting that he did not "properly relay instructions between health care professionals," communicated poorly with nurses, and had "difficulty answering, and communicating, on the phone" (Ref. 5, p 198).
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> Dr. Jakubowski's competency in patient care was jeopardized by his documented "difficulty relating to colleagues and gathering information from a patient and integrating it" (Ref. 5, p 199).
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> His systems-based practice competency was questionable at best, given comments that he had trouble coordinating treatment with other clinicians and functioning as a member of a treatment team (Ref. 5, p 199).
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> Dr. Jakubowski failed to demonstrate competency in practice-based learning and improvement in light of identified weaknesses in "self awareness, social competence, and relationship

management" (Ref. 5, p 198), as well as supervisors' characterizations of his behavior as "clueless" and lacking insight, attention, and organization (Ref. 5, p 199). The vagueness and superficial nature of his proposed accommodations also speak to a diminished capacity for self-reflection and goal setting.

Finally, Dr. Jakubowski's professionalism was in question, given his propensity to "present untruths" and "[say] yes to things [he] has not done" (Ref. 5, p 199). Furthermore, he also did not disclose his previous failure at St. Elizabeth's, which raises concerns about his integrity (Ref. 5, p 201).

Perhaps most important, he was noted on more than one occasion to have committed errors that could have severely harmed patients. The hospital therefore had little difficulty in demonstrating that he posed a direct threat to patients.

These complaints were each lodged within one or two months of the beginning of Dr. Jakubowski's residency training, and, given the ACGME's emphasis on "graded and progressive responsibility" under the "guidance and supervision of faculty members" (Ref. 26, Int.A., p 1), one might argue that he was merely a beginning trainee in need of further support, which seems questionable grounds for dismissal. However, the longitudinal nature of his subpar evaluations and the consistency with which he received them across various institutions suggest that his difficulties speak to a deep deficit beyond the struggles of the average trainee. Furthermore, he was not a beginning resident, given that he had the advantages of a full prior year of training.

Reasonable Accommodations?

Finding that Dr. Jakubowski was unable to fulfill his essential job functions without accommodations and very likely constituted a direct threat to patient safety, the court turned to the viability of his proposed accommodations to overcome his professional deficits. In his meeting with the program directors, his original proposal for accommodations was vague and did not specify how or why increased "knowledge and understanding" among coworkers and supervisors would remedy his poor performance (Ref. 5, p 202). In discovery, his expert witness revealed that the hospital had previously accommodated a struggling resident by assigning him increased supervision, increasing his time designated for studying, and providing a personal tutor for remediating his medical knowledge (Ref. 5, p 199). However, such accommodations address cognitive deficits that could be remedied through tutoring and studying. His deficits were primarily behavioral. Notably, he had already received remedial training and supervision before beginning his residency at Christ Hospital, and despite this, he continued to have significant problems and poor evaluations.

The hospital deemed that Dr. Jakubowski's requested accommodations were not reasonable. They cited "undue hardship" (Ref. 5, p 200), claiming that the program lacked the necessary resources to divert toward his training (Ref. 5, p 203). Because residents are both learners and employees, these accommodations focused too heavily on his learning and not on his ability to be a productive employee and competent clinician. Furthermore, residency training programs owe a duty to society and perform a gatekeeping function, ensuring that program resources are directed toward the professional development of capable physicians who will safely perform the essential job functions. Allowing a resident who poses a threat to patients to progress through training can cause the program or supervisor to be held liable for harm later caused by the resident.[32]

The court's decision to defer to Dr. Jakubowski's supervisors regarding his eligibility for continued progress in a family medicine residency is supported by previous court rulings after *Board of Curators of University of Missouri v. Horowitz*,[33] in which the U.S. Supreme Court indicated that in academic matters the court defers to the judgment of educators. The Court in *Horowitz* declined to impose a judicial review process on academic decisions (Ref. 33, p 90).

Furthermore, while Dr. Jakubowski's proposed accommodations may have addressed his poor medical decision-making and knowledge, they did not adequately address his deficits in communication, capacity for self-reflection, insight, ability to integrate information and successfully navigate the health care system, and, by extension, ability to ensure adequate safety. Because even with the proposed accommodations he would pose a direct threat to patients, the court also found that the hospital rightly concluded that there were no reasonable accommodations for his continued employment in their family medicine residency program.

Although not required to do so, the training director offered to accommodate Dr. Jakubowski by assisting him in transferring to a pathology residency. Pathology is a field geared toward diagnosis through close inspection of tissues, cells and body fluids. Much of the work is focused around specimen analysis in a laboratory rather than on patient wards. It therefore requires medical knowledge but not necessarily skill in interpersonal communication. These factors taken together have led to a common but superficial reputation of pathology as a field suited for physicians who are interested in science rather than patients. Given Dr. Jakubowski's communication deficits, one can understand the hospital's thought that he might find a home in pathology.

On closer inspection, however, one might wonder just how reasonable and effective this proposed accommodation truly was. Pathology, like family medicine, is an accredited residency program overseen by the ACGME. The substance of the ACGME's common core competencies remains the same across specialties, and pathology residents must also demonstrate competency in these six areas. The ACGME therefore tasks pathologists in training with the obligation to participate in ward rounds; to communicate effectively as members of health care teams; to act as intraoperative consultants; to work with compassion, integrity, and respect; and to cultivate the insight necessary to identify one's own deficits for a career of lifelong learning.[29] After all, the competencies are not designed merely to produce competent specialists, but rather competent physicians. Most physicians, including pathologists, in some form pledge the following words upon acceptance of their medical degree: "I will remember that I do not treat a fever chart, a cancerous growth, but a sick human being, whose illness may affect the person's family and economic stability. My responsibility includes these related problems, if I am to care adequately for the sick."[34]

As to whether the hospital participated in a good-faith interactive process with Dr. Jakubowski, the hospital claimed that by meeting with him and offering an alternative accommodation in a pathology residency program, they had acted in good faith. Judge Cole concurred in the outcome of the case, but noted that an employee need not have a trial-ready proposal for reasonable accommodations at the initial disclosure of disability status to the employer (Ref. 5, pp 203–205). Ordinarily, determining reasonable accommodations for a disabled employee is an iterative process of identifying the disability and mutually exploring possible accommodations. In the instant case, these negotiations were truncated because he rejected the director's counteroffer to accommodate him by assisting him in a transfer to pathology and did not suggest alternate accommodations that "would actually succeed in remedying Jakubowski's Asperger's-related job deficiencies" (Ref. 5, p 205). Training directors and residency programs should take note of Judge Cole's comments and exercise caution not to prematurely terminate negotiations with a disabled employee who is seeking reasonable accommodations. Had Dr. Jakubowski not abandoned the negotiations himself, the hospital and training director might have been found in violation of the ADA.

Discussion

Since the passage of the ADAAA, the MHP's evaluation may not have to focus heavily on the question of whether an employee is disabled. Instead, the MHP may be most helpful by assessing and explaining the relationship between impairments and essential job functions and by discussing the pros and cons of different potential accommodations in the workplace. MHPs may be asked by medical directors or training directors to help determine whether disability-related impairments (such as Dr. Jakubowski's deficits in interpersonal communication) can be overcome, and, if so, which accommodations would be appropriate. The MHP may be called on to assist a hospital or training program when a physician's skills are deficient and the deficiencies are related to a disability. The *Jakubowski* case underscores the forensic examiner's need to have a complete understanding of job requirements when conducting a disability evaluation or advising under the ADA.

MHPs may assume three primary roles in ADA cases:

They can assist in determining whether an employee qualifies as having a disability. An MHP should investigate whether an employee carries a disorder listed in the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision (DSM-IV-TR)[35] and use that diagnosis to describe the impairment's natural history and its impact on the individual's functioning.

Having established an impairment or disability, the MHP may then comment on the employee as an otherwise qualified individual, whether or not he can fulfill the essential job functions with or without reasonable accommodations. After reviewing the job description to understand the essential requirements of the position, the MHP can describe the impact of disability-related impairments or reasonable accommodations on the individual's ability to perform the job.

Finally, the MHP should carefully describe whether the employee's impairment poses a direct threat to himself or others in the workplace, and, if so, whether this threat can be ameliorated by treatment or accommodations.

With these evaluations in hand, the MHP is in a particularly advantageous position for recommending reasonable accommodations. The MHP should examine the specific MLAs affected by the impairment and how each impinges on the employee's essential functioning. In light of this analysis, proposed accommodations can be inclusive but targeted toward specific deficits. In the context of employees like Dr. Jakubowski whose impairments might present a risk to others, it is vitally important to comment specifically on how the recommendations will protect the safety of the workers and the work environment.

Conclusions

The Sixth Circuit held that Christ Hospital had engaged in a good-faith interactive process with Dr. Jakubowski in light of the fact that they had "considered his proposed accommodations, informed him why they were unreasonable, offered assistance in finding a new pathology residency, and never hindered the process along the way" (Ref. 5, p 11). Although Dr. Jakubowski found the hospital's alternative accommodations to be unsatisfactory, the ADA does not require an employer to grant a particular requested accommodation if the request is unduly burdensome or does not address the deficiencies or if another reasonable accommodation is available that better meets the needs of both the employer and the employee.[4]

The question remains whether there is any reasonable accommodation for a person whose impairment substantially limits a skill set that is at the very essence of his profession. As Gold and Shuman explain, "[a] requested accommodation that requires extensive job restructuring on the part of the employer might . . . be considered an undue hardship" (Ref. 3, p 227). Therefore, it may prove very difficult for a medical trainee with Asperger's disorder or any other impairment that causes profound difficulty interacting within the health care system to invoke the ADA to protect himself from a residency program's decision to terminate his training.

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