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Specialty Board Certification and Federal Civil Rights Statutes

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SPECIALTY BOARD CERTIFICATION AND FEDERAL CIVIL RIGHTS STATUTES

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Medical practice in the United States is structured around physician-specialists, highly trained professionals who affect the character, quality and cost of health care. Training and credentialing of these specialists is essentially unregulated by government. Instead, a comprehensive private regulatory system has developed, based largely on standards created by the twenty-four specialty boards recognized by the American Board of Medical Specialties. These private organizations assess physician skill through an evaluation and examination process, with candidates who meet board standards being granted certification in a particular specialty or subspecialty.

The certification process is voluntary and is not legally required in order to practice medicine in any jurisdiction. Likewise, neither the boards nor any other medical organization encourages health care institutions to limit specialty practice to certified physicians alone. These realities notwithstanding, certification profoundly affects physicians' professional opportunities, raising potential questions under federal civil rights law.

I. THE SPECIALTY BOARD SYSTEM

Specialty training and board certification are more important than ever in the practice of medicine. More than ninety percent of United States medical school graduates complete a period of post-graduate training in the form of a "residency."[1] A similar percentage of recent graduates are

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1. Medical education undertaken after completion of medical school is often referred to as "post-graduate" medical education. It typically involves a residency, a period of three or more years, where a new physician learns a specialty under the supervision of experienced physicians.

either board-certified or seeking certification.[2] This broad acceptance gives certification significant impact on hospital privileges, peer and patient recognition, economic compensation, and the standard of care.

A. The Basics of Certification

As defined by the American Board of Medical Specialties (ABMS), a specialty board is a separately incorporated, financially independent body that determines its own requirements and policies for certification, selects the members of its governing body in accordance with procedures stipulated in bylaws, accepts as candidates for certification persons who fulfill stated requirements, administers examinations, and issues certificates to those who submit to and pass evaluations.[3] Currently, the ABMS recognizes twenty-four boards.[4] These boards generally have established a three-step process for achieving certification: (1) graduation from a Liaison Committee on Medical Education (LCME) accredited medical school or its equivalent; (2) completion of an Accreditation Committee for Graduate Medical Education (ACGME) accredited residency; and (3) passage of a certification examination. Even after initial certification is achieved, boards are likely to continue to affect physician-specialists through periodic recertification.

1. LCME Accredited Medical School

Candidates for certification must complete their undergraduate medi-

2. *History of Accreditation of Medical Education Programs*, 250 JAMA 1502, 1506 (1983) [hereinafter *History of Accreditation*].

3. ABMS is comprised of the 24 specialty boards: the American Medical Association, the American Hospital Association, the Association of American Medical Colleges, the Council of Medical Specialty Societies, the Federation of State Medical Boards and additional public representation. Recognition of a board by the ABMS requires approval of the Liaison Committee for Specialty Boards (LCSB), a committee composed of the ABMS and the American Medical Association's (AMA) Council on Medical Education. AMERICAN BD. OF MED. SPECIALTIES RES. AND EDUC. FOUND., 1992 ANN. REP. AND REFERENCE HANDBOOK at 34-36, 43, 94, 105 (1992) [hereinafter ABMS HANDBOOK]. Essentially, recognition by ABMS amounts to acceptance of a board by mainstream organized medicine.

4. Specialty boards exist for Allergy and Immunology, Anesthesiology, Colon and Rectal Surgery, Dermatology, Emergency Medicine, Family Practice, Internal Medicine, Medical Genetics, Neurological Surgery, Nuclear Medicine, Obstetrics and Gynecology, Ophthalmology, Orthopedic Surgery, Otolaryngology, Pathology, Pediatrics, Physical Medicine and Rehabilitation, Plastic Surgery, Preventative Medicine, Psychiatry and Neurology, Radiology, Surgery, Thoracic Surgery, and Urology. *Id.* at 105.

cal education at an LCME-accredited medical school or its equivalent.[5] The LCME includes representatives of the American Medical Association (AMA), the Association of American Medical Colleges (AAMC), the Committee for Accreditation of Canadian Medical Schools, the federal government, and medical students.[6] Specialty boards are not explicitly involved at this level of medical education.

2. ACGME Accredited Residency

A second requirement for board certification is postgraduate training in an ACGME-accredited residency.[7] As described in the AMA's Directory of Graduate Medical Education, the primary purpose of accreditation is to provide a professional judgment as to the quality of a training program, assuring the potential candidate that it meets the standards set by professionals in that specialty.[8] In addition to its importance in achieving certification, accreditation has great importance in medicine generally, as the AMA and other professional organizations implicitly recommend residency before a physician undertakes independent practice.[9]

The ACGME is composed of the AMA, AAMC, ABMS, the American Hospital Association (AHA), the Council of Medical Specialty Societies (CMSS, an organization composed of the various medical specialty societies), nonvoting representatives of the federal government and the public.[10] ACGME accreditation requirements and decisions involving individual specialties are determined in conjunction with the appropriate Residency Review Committee (RRC), a specialty-specific committee composed of the AMA, the concerned specialty board, and relevant specialty societies.[11]

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5. Graduates from a medical school accredited by the American Osteopathic Association will also qualify.

6. *History of Accreditation*, *supra* note 2, at 1504.

7. Some who are intimately familiar with the certification and accreditation process believe that specialty programs can be accredited without concurrent existence of certification programs, especially in small subspecialties where a full certification mechanism is probably unwarranted. *See, e.g.*, John A. Benson, Jr., *Certification and Recertification: One Approach to Professional Accountability*, 114 ANN. INTERN. MED. 238, 241 (1991).

8. AMERICAN MED. ASS'N DIRECTORY OF GRADUATE MED. EDUC. PROGRAMS 9 (1992) [hereinafter AMA DIRECTORY].

9. *Id.* at 16 (revising the General Requirements of the Essentials of Accredited Residencies in Graduate Medical Education).

10. *Id.* at 1.

11. *See* Joseph Neff Ewing, Jr., *Standards Affecting Training Programs*, *in* LEGAL ASPECTS OF CERTIFICATION AND ACCREDITATION 87, 89 (Donald G. Langsley ed., 1983).

The specialty boards influence ACGME decisions at several levels. The boards are represented on the ACGME by the ABMS and are important members of their respective RRCs. Another powerful influence over ACGME decisions is the certification standards themselves: as board certification is generally the ultimate goal for physicians-in-training, accreditation standards for their training programs often reflect certification standards.

3. Certification By Specialty Board

Following graduation from an LCME-accredited medical school and successful completion of an ACGME-accredited residency, a physician seeking certification must satisfy the clinical proficiency and examination requirements of a specialty board for his specialty. Clinical competence evaluations are rarely invoked to deny certification due to the subjective nature of the evaluations.[12] Consequently, the final certification requirement is usually successful performance on written, and in many cases written and oral, examinations.

4. Recertification

Originally, certification was a one-time process: once certified, a physician was certified for life. Faced with criticism that this system did little to encourage physicians to stay abreast of current medical knowledge, the ABMS issued a statement in 1973 endorsing the principle of recertification.[13] By 1992, most specialty boards had adopted mandatory recertification requirements, largely by issuing "time limited" certificates to newly-certified physicians.[14] Such certificates expire after passing a stated period of time and can only be reissued after a recertification examination.

There are two types of ACGME accreditation requirements: general and special. General requirements are applicable to all residency programs, while special requirements are specialty-specific. Decisions made regarding special requirements are made by the ACGME, acting on the proposal of the appropriate Residency Review Committee (RRC). *See also* AMA DIRECTORY, *supra* note 8, at 9. Accreditation decisions on individual programs may be made either by the ACGME, or delegated by the ACGME to an RRC. *Id.* at 1.

12. John M. Eisenberg, *Evaluating Internists' Clinical Competence*, 4 J. GEN. INTERNAL MED. 139, 140 (1989) (noting a recent study that only 2.5% of certification candidates in Internal Medicine did not receive satisfactory clinical ratings from their residency programs, while approximately 27% of first-time applicants failed the written examination).

13. ABMS HANDBOOK, *supra* note 3, at 59.

14. Donald G. Langsley, *Medical Competence and Performance Assessment*, 266 JAMA 977, 978 (1991).

B. Implications of Certification

The specialty board certification system amounts to a voluntary, private system of specialty regulation that uniformly applies standards to physician-applicants. It is largely controlled by the AMA, ABMS, and the boards themselves, with essentially no direct government oversight. The medical community's overwhelming acceptance of the system caused it to become quite pervasive and influential in American medical practice, with implications for virtually all U.S. physicians.

1. The Position of the Boards

Specialty boards tend to minimize the impact of certification on medical practitioners and the practice of medicine. The American Board of Internal Medicine (ABIM) views certification as recognition of a number of years of specialty training and the demonstration of medical knowledge and clinical judgment, the latter established by an examination administered by the Board.[15] Individual boards and the ABMS stress that certification is not a license, nor has any legislative body authorized the boards to issue such a license.[16] The boards also emphasize that certification is not necessary to practice a specialty or subspecialty.[17]

A respected authority on certification, John A. Benson, Jr., M.D., has noted that board certification has practical implications that the boards cannot control.[18] These practical implications include increased salary, lower malpractice insurance rates, admission to hospital staffs, election to membership in professional societies, and credibility in expert testimony.[19] Dr. Benson believes that boards cannot ignore these implications of certification when considering the potential effects of their certificates.[20]

2. Practical Implications of Board Certification

As Dr. Benson has noted, there are numerous real-world benefits of board certification. These benefits, the result of broad professional ac-

15. Goussis v. Kimball, 813 F. Supp. 352, 355 (E.D. Pa. 1993) (citing to affidavit of John J. Norcini, Jr., M.D., Vice President for Evaluation and Research of the American Board of Internal Medicine).

16. *Id.* (rejecting plaintiff's claim that denial of ABIM certification in endocrinology and metabolism subspecialties involved state action).

17. *Id.*

18. Benson, *supra* note 7, at 239.

19. *Id.*

20. *Id.*

ceptance of the board system, explain why nearly all U.S. physicians voluntarily subject themselves to specialty training and the board certification process. These same benefits indicate the power that certification and the boards have assumed in the health care system.

Hospital staff privileges are perhaps the most fundamental and important benefit related to certification. Such privileges allow a physician the right to admit patients and practice medicine in an institution. These privileges are important for all physicians, but they are crucial to specialists, such as surgeons and anesthesiologists whose practice absolutely requires the facilities of a hospital.

Hospitals often will limit categories of work to board-certified specialists, effectively excluding non-certified physicians.[21] The AHA has encouraged hospitals to use certification as an important factor in the decision to grant privileges.[22] The federal government, through the Health Care Financing Administration (HCFA), also recognizes certification as an important element in granting privileges.[23]

The ABMS recognizes certification as only one of a number of factors contributing to privilege decisions.[24] Its statement on "Delineation of Staff Privileges" emphasizes that there is no specific requirement that a physician be board certified in order to practice a specialty or subspecialty in a hospital.[25] The same document also stresses that staff privileges are an institutional responsibility, distinctly separate from the certification process.[26]

Peer recognition is another benefit of board certification.[27] Board certification is frequently a prerequisite for membership in prestigious professional societies,[28] membership that may be all but required to advance professionally and academically in certain specialties.[29]

Patients may also consider board certification when seeking a physician. Today's patients, particularly the more educated and affluent, will

21. STEVEN JONAS, MEDICAL MYSTERY: THE TRAINING OF DOCTORS IN THE UNITED STATES 231 (1978).

22. *See* ROSEMARY STEVENS, AMERICAN MEDICINE AND THE PUBLIC INTEREST 253 (1971).

23. Gerald E. Thomson, *The Future Effects of Failure to Be Certified, in* AMERICAN BD. OF INTERNAL MED., SUMMER CONFERENCE REPORT 44 (1989).

24. ABMS HANDBOOK, *supra* note 3, at 52-53.

25. *Id.*

26. *Id.*

27. Benson, *supra* note 7, at 239.

28. *Id.*

29. *See* Treister v. American Academy of Orthopaedic Surgeons, 396 N.E.2d 1225 (Ill. App. Ct. 1979).

often bypass generalists and directly consult specialists.[30] In such an environment, a non-certified physician may be at a competitive disadvantage.[31]

Many believe that certified physicians enjoy higher salaries than their noncertified peers. As early as the 1930s, specialists received consistently higher incomes than general practitioners.[32] Some commentators believe that this difference is the product of longer hours worked by certified specialists.[33] Others, however, note a significant income advantage without such qualification.[34]

Finally, board certification has an impact on medical malpractice, in establishing both the standards for expert testimony and the standard of practice for physicians accused of malpractice. Some believe that board-certified practitioners should be held to a higher standard of care, a standard that supersedes the "locality" rule.[35] Others see certification as having an impact upon the entire malpractice proceeding, affecting the thinking and decisions of both judges and juries.[36]

II. Certification and Civil Rights

The private system of medical specialty regulation developed by the specialty boards does not necessarily affect all physicians equally. In particular, some groups of physicians who share similar ethnic, cultural, educational, or physical characteristics fail to achieve certification in disproportionate numbers. Disparate impact raises the question of whether these results are the consequence of legitimate, uniformly applied certification standards, or whether these results are caused by other factors. This question has legal implications in federal civil rights law.

Two identifiable groups in particular, international medical graduates

30. Stevens, *supra* note 22, at 196.

31. Note that here the effect of board certification may not be as strong as recognition in the peer context because there are numerous non-ABMS boards that may be willing to certify a physician not certified by an ABMS board. In addition, a physician may be able to hold himself out to the public as a specialist, regardless of certification status. In any event, even relatively sophisticated health care consumers may be unaware of the difference between a non-ABMS board certified physician and one certified by an ABMS board.

32. Stevens, *supra* note 22, at 176.

33. Benson, *supra* note 7, at 241.

34. Thomson, *supra* note 23, at 45.

35. *See, e.g.*, Buck v. St. Clair, 702 P.2d 781 (Idaho 1985) (holding that the local standard of care for "nationally-certified specialists" is the same as the national standard of care).

36. Thomson, *supra* note 23, at 45.

and disabled medical graduates, may be representative of the uneven impact of the certification process.

A. International Medical Graduates

International medical graduates (IMGs) are graduates of medical schools outside of the United States and Canada.[37] IMGs are largely foreign-born, though a substantial number of U.S.-born, foreign-trained physicians are considered IMGs.[38] IMGs often are viewed as "second class" physicians by their U.S.-trained colleagues, tolerated largely as a solution to a perceived shortage of physicians.[39]

IMGs are historically far less successful than their U.S.- and Canadian-educated peers in obtaining board certification. Only thirty-two percent of IMGs taking the ABIM certification examination pass the first time, while eighty-two percent of U.S. and Canadian medical school graduates pass the certification exam the first time.[40] Though the cause of this discrepancy is yet to be fully explained, various non-discriminatory factors are thought to account for the difference. These factors include inferior medical school training, individual differences in ability, and lack of proficiency in the English language.[41]

Today, IMGs comprise at least twenty percent of physicians practicing in the United States and they are becoming increasingly accepted by organized medicine.[42] Despite this progress, there is tension between fully integrating IMGs into the American medical community and legitimate efforts to maintain the quality of U.S. physicians. This tension is evidenced by the extensive requirements for IMG admission to ACGME-

37. Note the term "IMG" has replaced "foreign medical graduate" (FMG). The terms are synonymous.

38. Wayne Hearn, *Medical Groups Trying to Help IMGs Overcome Discrimination*, AMERICAN MED. NEWS, Jan. 4, 1993, at 16 (noting that today, approximately 3.4% of all U.S. physicians are U.S.-born IMGs, which compares to a corresponding figure of 18.6% for foreign-born IMGs). *Id.*

39. STEVENS, *supra* note 22, at 397-98 (explaining that foreign physicians were encouraged to come to the United States at the beginning of the Korean War because of a physician shortage).

40. John J. Norcini et al., *Predictors of the Performance of Foreign Medical Graduates on the 1982 Certifying Examination in Internal Medicine*, 256 JAMA 3367, 3368 (1986).

41. *Id.* at 3367 (citations omitted). It is interesting to note that graduates from Australian and British medical schools scored significantly higher than other IMGs. *Id.* at 3369. While this information could be used to support the contention that the quality of undergraduate medical education is a key factor in obtaining board certification, the largely caucasian ethnic make-up of these IMGs may support an allegation of discrimination.

42. *Id.* at 3367.

accredited residencies and their eligibility for specialty board certification. In addition federal legislation has been enacted which is designed to limit the number of foreign-national IMGs permitted to immigrate to the United States.[43]

B. The Disabled

Persons with significant physical disabilities[44] are thought to comprise at least thirteen percent of the general population, though little attention has been paid to their civil rights until relatively recently.[45] Federal protection for the disabled became firmly established with the Rehabilitation Act of 1973,[46] protection greatly expanded by the Americans with Disabilities Act of 1990.[47]

The disabled are grossly underrepresented in medicine. Surveys estimate that only 2.6% of physicians and 0.25% of medical students are disabled.[48] Disabled rights advocates contend these disparities reflect a resistance on the part of organized medicine to recognize the differing levels of dexterity required for the various specialties, while organizations that establish standards for health care providers generally represent their standards as necessary to the practice of medicine.

III. Analysis: The Boards and Federal Civil Rights Statutes

A. Introduction to Statutory Protections

Multiple civil rights statutes provide a variety of overlapping protections to a number of identifiable groups.

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43. *See, e.g.*, AMA Directory, *supra* note 8, at 6-7, 21. *See also* Immigration and Naturalization Act § 212(j), 8 U.S.C.A. § 1182(j) (West Supp. 1994) (limiting IMG immigration).

44. Those considered "disabled" for civil rights purposes often include individuals who are mentally disabled, or who have substance abuse problems, in addition to the physically disabled. This discussion will focus exclusively on the physically disabled. Note also that terminology in this area is constantly evolving; an older term for "disabled" is "handicapped," and one often hears the term "challenged" being applied to individuals whose characteristics differ from what is subjectively considered "normal." For the sake of consistency, this analysis will refer to all such persons as "disabled."

45. Brian McCormick, *Disabled Face Barriers to Medicine*, American Med. News, Jan. 4, 1993, at 12.

46. *See infra* section III.F of this text discussing the Rehabilitation Act of 1973.

47. *See infra* section III.G of this text discussing the Americans with Disabilities Act of 1990.

48. McCormick, *supra* note 45, at 12.

B. 42 U.S.C. 1981

1. History and Application

Originally, 42 U.S.C. § 1981 was enacted shortly after the Civil War as a general civil rights statute, intended to afford nonwhites equal treatment.[49] As amended in 1991, and now known as The Civil Rights Act of 1991, it provides:

> All persons within the jurisdiction of the United States shall have the same right in every State and Territory to make and enforce contracts, to sue, be parties, give evidence, and to the full and equal benefit of all laws and proceedings for the security of persons and property as is enjoyed by white citizens, and shall be subject to like punishment, pains, penalties, taxes, licenses, and exactions of every kind, and to no other.[50]

This language addresses intentional racial discrimination by public and private actors.[51] Coverage is limited to four specifically enumerated activities: (1) making and enforcing a contract; (2) suing in court and giving evidence; (3) securing the benefits of law; and (4) receiving punishment, licenses, taxes, and penalties.[52] Amendments in 1991 reinforced both the protection of contractual rights and the applicability to non-government actions.[53]

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49. The Civil Rights Act of 1866, ch. 39, 14 Stat. 27 (1866) (codified as amended at 42 U.S.C. § 1981 (Supp. V 1993)).

50. 42 U.S.C. § 1981 .

51. *See* General Bldg. Contractors Ass'n, Inc. v. Pennsylvania, 458 U.S. 375, 382-90 (1982) (proposing that § 1981 only reaches intentional discrimination and that § 1981 protection is almost certainly unavailable to white, U.S.-born IMGs). There is some debate as to whether § 1981 covers white persons who are discriminated against on the basis of national origin, religion or race. *See* Zaklama v. Mt. Sinai Med. Ctr., 842 F.2d 291, 295 (11th Cir. 1988). Despite the reservation of some courts, it is not inconceivable that a court would find § 1981 coverage for an ostensibly "white" foreign national discriminated against on the basis of national origin, race, religious beliefs or other covered category.

52. Brown v. Federation of State Med. Bds. of the United States, No. 82-C-7398, 1985 WL 1659, at *6 (N.D. Ill. May 31, 1985).

53. Specifically, the 1991 Civil Rights Act added subsections (b) and (c) to address these issues:

> (b) For purposes of this section, the term "make and enforce contracts" includes the making, performance, modification, and termination of contracts, and the enjoyment of all benefits, privileges, terms, and conditions of the contractual relationship.
>
> (c) The rights protected by this section are protected against impairment by nongovernmental discrimination and impairment under color of State law.

42 U.S.C. § 1981(b), (c).

a. A § 1981 Claim in the Context of Board Certification

One plausible theory for § 1981 coverage is found in the protections that it affords nonwhites in making and enforcing contracts. This argument considers third party interference in the right to contract. Specifically, it may be asserted that specialty boards, by refusing to certify nonwhite physicians, are intentionally impairing those physicians' ability to establish a "contract" to practice medicine. Such a claim would require liability for the indirect actions of the specialty boards because the boards do not directly contract for physicians' medical services. Under this theory, an expansive definition of "contract," encompassing nontraditional employment arrangements, such as hospital privileges, would also be necessary.

2. Analysis: The Boards and § 1981

Section 1981 has been applied to parties having only an indirect influence on a protected individual's right to contract. In *Zaklama v. Mt. Sinai Medical Center*,[54] § 1981 was found to encompass a foreign-born and educated physician's challenge to his dismissal from a residency program.[55] Here, liability was alleged to apply to individuals with whom the physician had no contractual relationship.[56] Citing a related decision by the United States Court of Appeals for the District of Columbia Circuit, the district court held that there was nothing in the language of § 1981 which suggested that it should be limited to individuals who have a direct contractual relationship with the protected person.[57]

A traditional contract need not be at issue for an individual to maintain a § 1981 challenge. Specifically, § 1981 has been applied to situations where physicians were denied hospital privileges.[58] Together with the

54. 842 F.2d 291 (11th Cir. 1988).

55. *Id.* at 295.

56. *Id.* at 292-95. Specifically, Zaklama was employed as a resident by Jackson Memorial Hospital. As part of his training, Zaklama was expected to rotate through three other local hospitals, while still technically remaining a resident in the Jackson Memorial Program. At one of these hospitals, Mt. Sinai Medical Center, Zaklama was subject to negative evaluations and was subsequently barred by Mt. Sinai staff from the hospital. On the basis of the Mt. Sinai actions, Jackson Memorial terminated Zaklama's participation in its residency program. Note that Zaklama alleged racial, national origin, and religious discrimination in his complaint against both hospitals. *Id.* at 292-94.

57. *Id.* at 295 (citing Sibley Memorial Hosp. v. Wilson, 488 F.2d 1338 (D.C. Cir. 1973)) (involving a challenge under Title VII of the Civil Rights Act of 1964)). *See infra* notes 104-07 and accompanying text.

58. *See, e.g.*, Shah v. Memorial Hosp., No. 86-0064-D, 1988 WL 161176 (W.D. Va. July 27, 1988), *aff'd*, 875 F.2d 316 (4th Cir. 1989).

holding of *Zaklama*, these decisions suggest that a third party who interferes with a physician's ability to gain staff privileges may incur liability. Because board certification is often used as a prerequisite for staff privileges, any intentionally discriminatory use of board certification could be characterized as such third-party interference.

A § 1981 claim also requires discriminatory intent. A prima facie case is established if the party alleging discrimination: (1) is a member of a protected class; (2) was qualified for the position held; and (3) was discharged while a person outside of the class with equal or lesser qualifications was retained.[59] However, it is extremely difficult for an individual who has failed an objective, uniformly-graded certification examination to establish himself as "qualified" for board certification. Such an individual must successfully attack the validity of certification standards underlying the examination, a particularly difficult proposition given the deference courts generally have afforded academic standards in the medical setting.[60] A plausible prima facie case of discrimination may exist where a board has employed subjective criteria, such as clinical competence or character requirements, to deny a protected individual certification.[61]

C. 42 U.S.C. § 1983

1. Introduction to 42 U.S.C. § 1983

Congress enacted 42 U.S.C. § 1983 to provide an enforcement mechanism for rights guaranteed under the Fourteenth Amendment.[62] As such, its protections parallel those of the due process and equal protection doc-

59. *Zaklama*, 842 F.2d at 293 (citing Lee v. Russell County Bd. of Educ., 684 F.2d 769, 773 (11th Cir. 1982)). The court also noted that the requirements of a prima facia case under 42 U.S.C. § 1981 are essentially the same as those for a claim under Title VII. *See also infra* notes 92-117 and accompanying text discussing Title VII.

60. *See, e.g.*, Regents of the Univ. of Mich. v. Ewing, 414 U.S. 214 (1985) (explaining the deference that courts afford academic standards in the medical setting). An attack on certification standards would presumably be based on some objective demonstration of a protected individual's ability to practice medicine, a demonstration which would have to establish that individual as "qualified" to practice as a specialist. The argument would then be that certification standards somehow unfairly failed to recognize this individual as "qualified." Note how difficult it would be to develop "objective" standards for use in the plaintiff's argument.

61. Given that such criteria are very infrequently invoked where an individual has successfully completed an ACGME-accredited residency, such an argument may be difficult to establish in practice.

62. 42 U.S.C. § 1983 (1988).

trines, complete with the requirement of state action.[63] Originally adopted as part of the Civil Rights Act of 1871,[64] § 1983 now provides:

> Every person who, under color of any statute, ordinance, regulation, custom, or usage, of any State or Territory or the District of Columbia, subjects, or causes to be subjected, any citizen of the United States or other person within the jurisdiction thereof to the deprivation of any rights, privileges, or immunities secured by the Constitution and laws, shall be liable to the party injured in an action at law, suit in equity, or other proper proceeding for redress.[65]

Courts generally recognize two requirements for a successful § 1983 claim: (1) an individual must be acting under color of state law; and (2) the action must result in the deprivation of a right, privilege and/or immunity secured by federal laws or the Constitution.[66] Consequently, liability is implicated in a manner similar to Constitutional due process or equal protection claims.

2. *Section 1983 Claims Against the Specialty Boards*

Like the analysis itself, the argument for board liability under § 1983 resembles claims made under the Fourteenth Amendment concepts of due process or equal protection. To succeed, such a claim must establish that a board action amounted to a state action and intentionally deprived an individual of a legal right.[67]

3. *Analysis: The Specialty Boards and § 1983*

Section 1983 was the subject of recent litigation against the American Board of Internal Medicine. *Goussis v. Kimball*[68] involved allegations by a foreign-born and educated physician that the ABIM's certification examination in endocrinology and metabolism was prepared and graded

63. *Id.* Section 1983 does not itself provide any rights, but provides remedies for Constitutional violations. As such, it is the Constitution that provides the "protection" spoken of and not § 1983.

64. The Civil Rights Act of 1871, ch. 22, 17 Stat. 13 (1871) (codified as amended at 42 U.S.C. § 1983).

65. 42 U.S.C. § 1983.

66. *See* Goussis v. Kimball, 813 F. Supp. 352, 355 (E.D. Pa. 1993) (citing Bougher v. University of Pittsburgh, 882 F.2d 74, 78 (3d Cir. 1989)).

67. Note that § 1983 lacks the reference to "nonwhites" present in § 1981. This makes the protections of § 1983 theoretically available to all persons who are denied a right otherwise guaranteed by law, regardless of that person's race, sex, or ethnic background.

68. 813 F. Supp. 352 (E.D. Pa. 1993).

with intent to minimize the scores obtained by IMGs.[69]

The United States District Court for the Eastern District of Pennsylvania focused closely on the state action requirement in evaluating Dr. Goussis's claim.[70] The court noted that there were at least three relevant tests which might be applicable: (1) the "close nexus" test, which determines whether the state can be deemed responsible for the specific conduct of which the plaintiff complains; (2) the "symbiotic relationship" test, which examines the overall relationship of the parties to determine whether or not the state has "insinuated itself into a position of interdependence with [the acting party]" sufficiently to be recognized as a joint participant in the challenged activity; or (3) the "public function" test, which inquires whether the government is using the private party to avoid Constitutional obligations or to engage in activities that were the exclusive prerogative of the state.[71] The court further observed that more than one test may be applicable to a specific situation.[72]

In its analysis, the *Goussis* court characterized the ABIM as a private, nonprofit, charitable organization, which is neither licensed nor regulated by any government body.[73] It also observed that the ABIM did not receive any government aid.[74] The court specifically held that: (1) the actions of the ABIM cannot be treated as actions of the government itself; (2) the state had not exercised coercive power or provided significant encouragement to the ABIM; (3) certification is not necessary for the practice of medicine; and, (4) the conduct of the ABIM is not that which is traditionally the exclusive prerogative of the state.[75] Furthermore, the court commented that preparation of a widely-recognized test by the ABIM, a test on which state institutions may rely for academic decisions, is not sufficient to convert private conduct into state action.[76] Consider-

69. *Id.* at 353-55. Dr. Goussis was certified by the ABIM in general internal medicine, and had completed several fellowships in endocrinology. Four unsuccessful attempts to pass the ABIM's certification examination in endocrinology and metabolism preceded the action. Despite his lack of certification in the subspecialty, Dr. Goussis practiced as a specialist in endocrinology and metabolism. *Id.*

70. *Id.* at 355.

71. *Id.* at 356-57 (citing Rendell-Baker v. Kohn, 457 U.S. 830, 841 (1982); Jackson v. Metropolitan Edison Co., 419 U.S. 345 (1974); Evans v. Newton, 382 U.S. 296, 301 (1966); Burton v. Wilmington Parking Auth., 365 U.S. 715, 725 (1961)).

72. *Id.* at 357.

73. *Id.*

74. *Id.*

75. *Id.* at 357-58.

76. *Id.* at 358 (citing Johnson v. Education Testing Serv., 754 F.2d 20 (1st Cir.), *cert. denied*, 472 U.S. 1028 (1985)).

ing these facts, the court concluded that the ABIM was not a state actor under any of its enumerated tests or combinations thereof.[77]

Thus, *Goussis* provides strong authority against the applicability of § 1983 to the specialty boards, particularly given the *Goussis* court's characterization of the ABIM and of certification in general. Furthermore, the court's state action analysis is broadly applicable to other constitutional and statutory doctrines which contain similar requirements.

The facts and allegations underlying *Goussis* both detract from and augment the strength of the court's analysis. Initially, Dr. Goussis may not have been the strongest plaintiff to bring a civil rights action. He was already certified by the ABIM in general internal medicine and was practicing as an endocrinologist, despite his lack of certification in the subspecialty.[78] Though the court's holding seems to preclude the finding of state action regardless of a plaintiff's circumstances, a plaintiff who is unable to gain any board certification, and is consequently precluded from some aspect of medical practice, may command more favorable treatment.[79]

Goussis also demonstrates the difficulty of establishing discriminatory intent on the part of a specialty board. Dr. Goussis alleged that the ABIM selected its questions and graded its exams so as to deliberately minimize the scores of IMGs.[80] As far as is apparent from the complaint and court opinion, the only grounds for these allegations were discussions Dr. Goussis had with other IMGs who had failed the same examination.[81] There is no indication that he possessed evidence of an attempt to deny him certification, or that certification standards were not uniformly applied.[82] The cursory nature of the complaint demonstrates the extreme difficulty of establishing intent where a board has adopted certification standards without regard to the implications for various identifiable groups of physicians, and uniformly applied those standards.[83]

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77. *Id.* at 358.

78. *Id.* at 354.

79. A particularly sympathetic example may be found in a licensed, IMG physician who because of a local hospital's policy of requiring certification for staff privileges, is effectively limited in the practice of medicine.

80. *Goussis*, 813 F. Supp. at 353.

81. *Id.*

82. *See generally id.* at 352. Because the case was decided on summary judgment, there was presumably some discovery before the board's motion was granted. *Id.* at 353, 360.

83. This disregard for the particular attributes of any identifiable group of physicians in standard setting is crucial, regardless of the motives for such a policy. For example, if a board was to expressly consider the problems faced by IMGs in setting certification stan-

Finally, and perhaps most importantly, a successful § 1983 claim must prove that some legal right was infringed. While beyond the scope of this discussion, there is no indication that a court would find that certification implicates such a right, particularly given the state action requirement of the Fourteenth Amendment.[84]

D. 42 U.S.C. § 1985(3)

1. Introduction to 42 U.S.C. § 1985(3)

As a general civil rights statute, 42 U.S.C. § 1985(3) protects individuals from conspiracies designed to deprive them of legal rights or privileges.[85] The Supreme Court has held that a § 1985(3) claim must allege four elements: (1) a conspiracy; (2) for the purpose of depriving, directly or indirectly, any person or class of persons of the equal protection of the law, or of equal privileges and immunities of the law; (3) that the alleged actors have committed some act in furtherance of the conspiracy; and, (4) that the plaintiff was either "injured in his person or property" or was "deprived of having and exercising any right or privilege of a citizen of the United States."[86] Thus, a § 1985(3) action requires proof of both con-

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dards, applicants belonging to other identifiable groups adversely affected by changes implemented to assist the IMGs may be able to establish discriminatory intent in the board's actions.

84. Such a legal right for the purposes of § 1983 would almost always require an independent constitutional violation.

85. The language of § 1985(3) provides in pertinent part:

> If two or more persons in any State or Territory conspire for the purpose of depriving, either directly or indirectly, any person or class of persons of the equal protection of the laws, or of equal privileges and immunities under the laws; or for the purpose of preventing or hindering the constituted authorities of any State or Territory from giving or securing to all persons within such State or Territory the equal protection of the laws; or if two or more persons conspire to prevent by force, intimidation, or threat, any citizen who is lawfully entitled to vote, from giving his support or advocacy in a legal manner, toward or in favor of the election of any lawfully qualified person as an elector for President or Vice President, or as a Member of Congress of the United States; or to injure any citizen in person or property on account of such support or advocacy; in any case of conspiracy set forth in this section, if one or more persons engaged therein do, or cause to be done, any act in furtherance of the object of such conspiracy, whereby another is injured in his person or property, or deprived of having and exercising any right or privilege of a citizen of the United States, the party so injured or deprived may have an action for the recovery of damages occasioned by such injury or deprivation, against any one or more of the conspirators.

42 U.S.C. § 1985(3) (1988).

86. Griffin v. Breckenridge, 403 U.S. 88, 102-03 (1971).

spiracy and intent to discriminate in the presence of the deprivation of some legal right.

2. *Section 1985(3) and the Specialty Boards*

A party wishing to apply § 1985(3) to a specialty board must establish a conspiracy to intentionally deny a legally protected right. Such a claim is not limited by the race, gender, or ethnicity of the party alleging the § 1985 violation.

3. *Analysis: The Boards and § 1985(3)*

Goussis v. Kimball specifically addressed the question of § 1985(3) in the context of board certification.[87] In its analysis, the *Goussis* court noted that a § 1985(3) conspiracy between a corporation and one of its officers may only take place if that officer is acting in a personal, as opposed to an official, capacity, or if third parties are alleged to have joined the conspiracy.[88] Holding that ABIM officials named in the complaint were acting in their official capacities, the court refused to find the conspiracy required by § 1985(3).[89] Under this decision, it is unlikely that a specialty board which insures the integrity of its officers and avoids third-party participation in promulgation of its certification standards would satisfy the conspiracy requirement of § 1985(3).

Should a conspiracy be found, however, a plaintiff still must establish an intent to discriminate and demonstrate an injury that implicates a protected right. As discussed previously, intentional discrimination is difficult to prove where a board uniformly applies its certification standards.[90] Finally, there is much evidence of judicial reluctance to find a legally protected interest where a benefit or privilege is the result of an academic or professional judgment based on an individual's intellectual accomplishments.[91]

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87. Goussis v. Kimball, 813 F. Supp. 352, 359 (E.D. Pa. 1983).

88. *Id.* at 359 (citing Robinson v. Canterbury Village, Inc., 848 F.2d 424, 431 (3d Cir. 1988)). Note that a similar observation was made by the court in Weiss v. York Hosp., 745 F.2d 786, 817 (3d Cir. 1984) (finding that a hospital's medical staff could not conspire with the hospital because the staff as a whole operated as an officer of the hospital).

89. *Goussis*, 813 F. Supp. at 359-60.

90. *See supra* notes 59-60 and accompanying text.

91. *See, e.g.*, Regents of the Univ. of Mich. v. Ewing, 474 U.S. 214 (1985); Board of Curators of the Univ. of Mo. v. Horowitz, 435 U.S. 78 (1978).

E. Title VII of the Civil Rights Act of 1964

1. Perspective on Title VII

Title VII[92] is a major component of the Civil Rights Act of 1964. The Act was part of a significant effort to expand federal civil rights protections in the mid-1960s, extending coverage to many private instances of discrimination for the first time. Many of the Act's provisions were subject to modification under the Civil Rights Act of 1991. Title VII specifically addresses discriminatory employment practices, providing:

> It shall be an unlawful employment practice for an employer—
>
> (1) to fail or refuse to hire or to discharge any individual, or otherwise to discriminate against any individual with respect to his compensation, terms, conditions, or privileges of employment, because of such individual's race, color, religion, sex, or national origin; or
>
> (2) to limit, segregate, or classify his employees or applicants for employment in any way which would deprive or tend to deprive any individual of employment opportunities or otherwise adversely affect his status as an employee, because of such individual's race, color, religion, sex, or national origin.[93]

Thus, on its face, Title VII applies to employment discrimination on the basis of race, religion, gender, or national origin. Its protections are not available to white males or the disabled.

Title VII requires only a showing of disparate impact to establish a prima facie case of racial discrimination.[94] Under the 1991 amendments, once a plaintiff has carried the burden of proving disparate impact, an employer must articulate a valid "business justification" for the practice to escape liability.[95] At no point in Title VII is "business justification" defined.[96]

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92. 42 U.S.C. § 2000e-2 (Supp. V 1993).

93. *Id.*

94. Specifically, 42 U.S.C. § 2000e-2(k)(1)(A)(i) provides that an unlawful employment practice based on disparate impact is established if:

> [A] complaining party demonstrates that a respondent uses a particular employment practice that causes a disparate impact on the basis of race, color, religion, sex, or national origin and the respondent fails to demonstrate that the challenged practice is job related for the position in question and consistent with business necessity.

42 U.S.C. § 2000e-2(k)(1)(A)(i) .

95. CATHCART & SYNDERMAN, *The Civil Rights Act of 1991*, ALI-ABA Course of Study, Advanced Employment Law and Litigation (1992), at § 1.04(b)(1), (3).

96. *Id.* § 1.04(b)(3).

2. Title VII in the Context of the Specialty Boards

A Title VII claim must establish that a board practice amounts to action by an employer, for which there is no valid business justification, and that the practice causes a disparate impact on a protected group.[97] The essential components of such a claim are establishing the boards as "employers" and proving discrimination under the disparate impact test.

3. Analysis: The Boards and Title VII

a. Establishing the Boards as an Employer

A traditional employer-employee arrangement satisfies the requirements of Title VII. The traditional arrangement is not present in the relationship between the specialty boards and applicants for certification. Some courts, however, have gone beyond the traditional relationship, finding the employer-employee requirement satisfied in situations involving economic necessity and third-party interference with employment. In these situations, a cause of action was sustained even where the party alleged to have violated Title VII was not a direct employer of the plaintiff.

i. The Economic Necessity Test

Courts have applied an economic realities/common law control test to non-traditional employment situations. This test considers the practical realities of the relationship at issue, focusing on the employee's dependence on the business to which he renders service, and the extent to which the one for whom the work is being done has the right to control the details and means by which the work is to be performed.[98]

Diggs v. Harris Hospital-Methodist[99] applied the economic necessity test to the termination of an African-American physician's staff privileges.[100] In addition to the basic analysis, the *Diggs* court noted additional factors which could be considered in establishing an employer-employee relationship, including whether the work provided is an integral part of the business of the "employer" and the intention of the par-

97. Any Title VII claims must first be submitted to the Equal Employment Opportunity Commission; only after such submission can a plaintiff institute a Title VII action. These procedures are beyond the scope of this paper. *See* 42 U.S.C. § 2000-2(k) (Supp. IV 1994).

98. *See* Mares v. Marsh, 777 F.2d 1066, 1067 (5th Cir. 1985).

99. 847 F.2d 270 (5th Cir.), *cert. denied*, 488 U.S. 956 (1988).

100. *Id.*

ties.[101] Though the *Diggs* court did not find an employer-employee relationship in the case before it, the court stressed that the privileges at issue were not an economic necessity, because the plaintiff enjoyed staff privileges at other institutions.[102] This decision suggests that the existence of economic necessity may be sufficient to establish the required relationship. Thus, if a plaintiff can prove that board certification is a necessity to practice medicine, it is possible that a court applying the economic realities/common law control test would find a Title VII employment relationship.[103]

ii. Beyond Traditional Employment

Some courts examining the employment relationship required under Title VII have found the requirement satisfied where a third party interferes with a plaintiff's employment opportunities. A classic and broad articulation of this third-party interference theory is found in *Sibley Memorial Hospital v. Wilson.*[104] *Sibley* involved a male private duty nurse who claimed a hospital denied him access to potential patient-employers solely on the basis of his sex.[105] At no time was the nurse an employee of that hospital.

The *Sibley* court noted that permitting an employer covered by Title VII to interfere with a non-employee's employment opportunities in a discriminatory manner, while prohibiting such discrimination with regard to its own employees, essentially condones the use of the very employment criteria that Congress prohibited.[106] The court went on to find that the statutory language of Title VII supported coverage for individuals who were not in a direct relationship with an employer.[107]

Sibley's finding of Title VII coverage has been echoed by numerous courts.[108] The doctrine, however, is not uniformly embraced: *Diggs* re-

101. *Id.* at 272-73 (citations omitted).

102. *Id.* at 273.

103. In the absence of any legal requirement that a physician be certified to practice, it is very unlikely that any court would find board certification an economic necessity.

104. 488 F.2d 1338 (D.C. Cir. 1973).

105. *Id.* at 1339. Specifically, when a private nurse was requested at a participating institution, a nondiscriminatory dispatch system provided a nurse without regard to race, age or sex; the patient always had the right to refuse the services of any particular nurse, but was obligated to pay a "refused" nurse for an entire day. Because the plaintiff was not even allowed to present himself to female patients, he was not eligible for the pay due refused nurses.

106. *Id.* at 1341.

107. *Id.*

108. *See, e.g.*, Pardazi v. Cullman Med. Ctr., 838 F.2d 1155, 1156 (11th Cir. 1988) (impli-

fused to reach the question of third-party interference where the hospital privileges in question were not an economic necessity.[109] *Diggs*, thus, specifically invoked the economic realities/common law control test as a de facto threshold for the third-party interference test.[110]

Given the relative vagueness of the doctrine and its uneven application by the courts, it is uncertain whether the third-party interference theory could be successfully invoked against specialty boards. Most instances where the theory has been supported involved large institutional employers, such as hospitals, which are clearly covered with respect to their own employees.[111] These same institutions, while not direct employers of the individuals invoking Title VII, did have significant, direct power over the individuals' employment opportunities.[112] The specialty boards as small, independent professional organizations that only indirectly affect a physician's employment opportunities through third-party application of certification standards, are hardly comparable to such large institutions. Still, the significant impact that certification may have on an individual physician's employment opportunities could conceivably be sufficient to satisfy a liberal application of the third-party interference theory.

b. Establishing Discrimination Under Disparate Impact

Assuming that an employer-employee relationship is found, discrimination under a disparate impact test is necessary for a Title VII violation. A prima facie case requires that: (1) the plaintiff belongs to a racial minority; (2) the plaintiff was qualified for a job for which the employer was seeking applicants; (3) despite these qualifications, the plaintiff was rejected for the position; and, (4) after this rejection, the position remained open and the employer continued to seek applicants from persons of the

cating Title VII where a foreign-born physician was unable to finalize an employment contract with a professional corporation when a hospital denied him staff privileges); Doe v. St. Joseph's Hosp. of Fort Wayne, 788 F.2d. 411, 423 (7th Cir. 1986) (finding a Title VII claim where a plaintiff alleged a hospital discriminatorily interfered with her opportunities to provide service to her patients).

109. *See* Diggs v. Harris Hosp. Methodist, 847 F.2d 270 (5th Cir.), *cert. denied,* 188 U.S. 956 (1988).

110. *Id.* at 273-74 (acknowledging the acceptance of third-party interference theory by a number of courts).

111. *See, e.g., Pardazi*, 838 F.2d at 1115; *Sibley,* 488 F.2d at 1338 (demonstrating hospital's referral system affected nurse opportunities).

112. *Id.* An illustration of such power over an individual's employment opportunities is hospital privileges, as the granting of such privileges does not establish a traditional employment relationship between the hospital and a physician, but certainly affects that physician's ability to practice medicine in that institution.

complainant's qualifications.[113] The Supreme Court has specifically stated that the test is not intended to be rigidly applied, but is to serve as "a sensible, orderly way to evaluate the evidence in light of common experience as it bears on the critical question of discrimination."[114]

As discussed in the context of a nearly identical test for § 1981, it is virtually impossible to satisfy these requirements in the absence of a board's uneven application of some subjective certification standard.[115] Should a prima facie case be demonstrated, however, a claim still may be defeated by showing a valid business justification for the allegedly discriminatory practice.[116] This involves proving that the specialty board's actions at issue were a legitimate application of medical standards, or were in some other way necessary to preserve the integrity of the activity. Here, the substantial judicial deference that is afforded medical standard setting would probably allow any legitimate and necessary board standard to survive a Title VII action under the "business justification" language.[117]

F. Rehabilitation Act of 1973

1. Perspective

The Rehabilitation Act of 1973 was the first major federal legislation enacted to specifically address the civil rights of the disabled.[118] The essential provisions of the Act are found at 29 U.S.C. § 794 and are usually referred to by their public law section number, section 504. This language provides:

> No otherwise qualified individual with handicaps in the United States, as defined by section 706(8) of this title, shall, solely by reason of his or her handicap, be excluded from participation in, be denied the benefits of, or be subject to discrimination under

113. McDonnell Douglas Corp. v. Green, 411 U.S. 792, 802 (1973).

114. Furnco Constr. Corp. v. Waters, 438 U.S. 567, 577 (1978).

115. *See supra* notes 59-60 and accompanying text. The requirement that an individual be "qualified" for a position under a Title VII claim thus appears to collapse the discriminatory impact and intent tests insofar as their practical implications for the specialty boards.

116. *See supra* notes 95-96. There is no statutory definition of "valid business justification."

117. *See, e.g.*, Regents of the Univ. of Mich. v. Ewing, 474 U.S. 214 (1985).

118. The language of the Rehabilitation Act of 1973 speaks in terms of the "handicapped" to refer to those with a covered impairment. As the definition of "handicapped" under the Rehabilitation Act is identical to the definition of "disability" under the Americans with Disabilities Act, this paper will uniformly refer to those individuals meeting either definition as "disabled." *See supra* note 44 for further discussion of this terminology.

> any program or activity receiving Federal financial assistance or under any program or activity conducted by any Executive agency or by the United States postal service.[119]

Thus, section 504 requires proof of: (1) a disability; (2) denial of benefits or participation in a program solely on a basis of that disability; (3) an individual who is "otherwise qualified" for those benefits or participation; and, (4) federal funding of the activity at issue.

A threshold requirement for a section 504 claim is a disability. For the purposes of this section, a disabled person is, "[a]ny person who (i) has a physical or mental impairment which substantially limits one or more of such person's major life activities, (ii) has a record of such an impairment, and (iii) is regarded as having such an impairment."[120] This broad definition encompasses virtually anyone with a significant physical disability. The disability at issue must also be the sole reason for denial of a benefit.

A key factor in establishing a section 504 claim involves demonstrating that an individual is "otherwise qualified" for a denied benefit. Courts have applied a two-part test: (1) whether the disabled individual is able to meet the criteria necessary to receive the benefit, regardless of his or her disability; (2) if not, whether a reasonable accommodation is possible to allow the individual to receive the benefit.[121]

Finally, the program or activity at issue must be a recipient of federal funds. Given that the boards do not currently receive any government funds, satisfying this requirement is practically impossible.[122] However, an analysis of section 504 still is relevant for two reasons: (1) the boards may someday be recipients of federal funds, given increasing government involvement in health care; and (2) these cases demonstrate how courts may interpret similar language in the Americans with Disabilities Act, under which the prospect of specialty board liability is much more concrete.

2. *Analysis: The Boards and Section 504*

Most section 504 disputes involving an individual who satisfies the definition of "disability" focus on whether that individual was "otherwise qualified" for a benefit. A number of cases have addressed the definition

119. 29 U.S.C. § 794 (Supp. IV 1992).

120. *Id.* § 706(8)(B). This definition is very similar to the definition of "disability" in the Americans with Disabilities Act. *See* 42 U.S.C. § 12102(2) (Supp. V 1993).

121. *See infra* notes 127-30 and accompanying text.

122. *See* Goussis v. Kimball, 813 F. Supp. 352, 352-54 (E.D. Pa. 1993).

of this key requirement in the context of academic and medical standard setting.

Southeastern Community College v. Davis[123] involved a prospective nursing student with hearing loss.[124] There, a state college engaged in an extensive evaluation of its nursing degree requirements in conjunction with the plaintiff's application, going so far as to consult an outside nursing expert.[125] Relying heavily on the expert's conclusions that it would be impossible for the applicant to participate safely in the program and that modifications necessary for safe participation would severely interfere with its benefits, the college declined to offer the applicant admission.[126]

In evaluating the resulting section 504 claim, the Supreme Court noted that an "otherwise qualified" individual is one who is able to meet all of a program's requirements in spite of his or her disability.[127] The Court then concluded that the plaintiff was not "otherwise qualified" for the benefit sought, noting that it believed no reasonable accommodation was possible.[128] This holding created the two step inquiry to determine whether an individual is "otherwise qualified": (1) does a disabled individual meet the requirement for a benefit; and (2) if not, is a reasonable accommodation possible.[129] The Court was careful to limit the reasonable accommodation requirement, first by specifically holding that it was not a mandate for affirmative action. The Court further stated that such accommodations were limited to instances that did not involve "undue financial or administrative burdens," or require "a fundamental alteration in the nature of [a] program."[130]

Taken in its academic and medical standards context, *Southeastern Community College* stands for the proposition that disabled persons who do not meet legitimate professional standards for a benefit, standards that cannot be reasonably altered to accommodate particular disabilities, are not considered "otherwise qualified."

Lower federal courts afford similar, if not greater, deference to professional standards in interpreting the "otherwise qualified" language. The

123. 442 U.S. 397, 400 (1979).
124. *Id.*
125. *Id.* at 400-03.
126. *Id.*
127. *Id.* at 406.
128. *Id.* at 409-11.
129. *See, e.g.*, School Bd. of Nassau County, Fla. v. Arline, 480 U.S. 273, 286-89 (1987) (citing Southeastern Community College v. Davis, 442 U.S. 397, 406 (1979)).
130. *Southeastern Community College*, 442 U.S. at 412-13.

court in *Doherty v. Southern College of Optometry*[131] declined to invalidate clinical proficiency requirements that prevented a disabled student from becoming an optometrist, even though the requirements were instituted after the student's matriculation.[132] The *Doherty* court held that reasonable accommodation does not require an educational institution to eliminate a course requirement reasonably necessary to the proper use of the degree conferred.[133] The court went on to state that courts are ill-equipped to evaluate the proper emphasis of a curriculum, particularly where a degree indicates qualification to practice a health profession.[134] As certification is a professional standard that recognizes an individual's ability to practice a specialty, the *Doherty* analysis is almost certainly applicable to the boards.

This deference is paralleled in the recent First Circuit opinions in *Wynne v. Tufts University School of Medicine*[135] (*Wynne I*) and (*Wynne II*).[136] The *Wynne* cases involved a medical student with demonstrated learning disabilities. Despite considerable assistance from the University, the student continued to fail examinations and was dismissed.[137] The student subsequently contended that the University's refusal to evaluate his performance by a method other than multiple choice examination violated his section 504 right to reasonable accommodation.[138]

The *Wynne I* court initially held that the deference given academic de-

131. 862 F.2d 570 (6th Cir. 1988), *cert. denied*, 493 U.S. 810 (1989).

132. *Id.* at 572-73. Specifically, the student in question had retinitis pigmentosa and associated neurological difficulties; the latter neurological problems limited his manual dexterity to the extent he could not fulfill the clinical competency requirements. Note that while the student's retinitis pigmentosa was known to the school, he did not indicate his additional neurological abnormalities on his application. *Id.*

133. *Id.* at 575.

134. *Id.* at 576.

135. 932 F.2d 19 (1st Cir. 1991).

136. 976 F.2d 791 (1st Cir. 1992), *cert. denied*, 113 S. Ct. 1845 (1993) (*Wynne II*). *Wynne I*, the original First Circuit decision, established criteria for "otherwise qualified," and remanded the case to the district court. *Wynne II* was an appeal of the decision on remand, where the First Circuit upheld the lower court finding that no violation of section 504 existed.

137. *Wynne I*, 932 F.2d at 19. The student repeatedly failed courses throughout his first year of medical school. In an attempt to determine the problem, Tufts University Medical School provided him with psychological evaluations which revealed several learning disabilities but did not demonstrate dyslexia. The University then allowed him to repeat the failed courses, this time with the aid of tutors, note takers, and counselling. *Id.* at 20-23, 27.

138. *Id.* at 20-24. Wynne contended that he suffered from dyslexia, a condition he claimed was diagnosed subsequent to his dismissal. He claimed that this condition prevented him from indicating his true knowledge on the multiple-choice tests employed by Tufts (and all other U.S. medical schools).

cisions by the Supreme Court in *Regents of the University of Michigan v. Ewing*[139] should be extended to the Rehabilitation Act.[140] The court qualified this deference with two conditions: (1) an academic institution must submit a factual record indicating that it conscientiously sought a reasonable accommodation; and (2) the *Ewing* formulation, conditioning judicial intervention on "a substantial departure from accepted academic norms," is not a useful test in the context of reasonable accommodation, as such alternatives may involve new approaches beyond accepted norms.[141]

The *Wynne I* court outlined what its test required in practice: submission of undisputed fact showing that the academic institution considered alternative means, their feasibility, cost, and effect on the program. These facts must support a conclusion that available alternatives would result in either lowering academic standards or a substantial program alteration.[142] A court could then rule as a matter of law that the institution had met its duty of seeking a reasonable accommodation.[143] The *Wynne I* court cautioned that if the essential facts were genuinely disputed, or if there was significant probative evidence of bad faith or pretext, further fact finding would be necessary.[144] Applying this test to the single affidavit submitted by the University, the court refused to uphold a lower court's summary judgment order.[145]

Wynne I appears to set a significant hurdle before any academic institution seeking to defeat a section 504 claim. In actually applying its standard in *Wynne II*, however, the First Circuit appeared much more deferential to academic institutions.[146] Finding the duty of seeking reasonable accommodation satisfied after the submission of six additional affidavits, the *Wynne II* court stated that an academic institution's explanation need not be "airtight": a school need only demonstrate a rational decision that further accommodation cannot be made without imposing undue hardship on the academic program.[147] *Wynne II*, however, quali-

139. 474 U.S. 214 (1985).

140. *Id.* (noting that when the judiciary is asked to review the substance of a genuinely academic matter, it must show great respect for the faculty's professional judgment). This judgment cannot be overridden unless a substantial departure from normal procedure indicates a lack of professional judgment. *Id.*

141. *Wynne I*, 932 F.2d at 19, 25-26.

142. *Id.* at 26.

143. *Id.*

144. *Id.*

145. *Id.* at 27-28.

146. *Wynne II*, 976 F.2d 791, 794-95 (1st Cir. 1992).

147. *Id.* at 795.

fied its holding, cautioning that the "fact based" decision should not be read broadly.[148]

Admonitions notwithstanding, *Wynne I* and *Wynne II* support the proposition that medical standards are afforded substantial deference by the courts. Taken together, they appear to leave undisturbed the legality of legitimate medical standards under *Southeastern Community College* and *Doherty*.

G. The Americans with Disabilities Act

1. Introduction to the Americans with Disabilities Act

The Americans with Disabilities Act of 1990 (ADA)[149] was a major expansion of federal civil rights protections available to the disabled, intended to provide a clear and convincing national mandate for the elimination of discrimination against disabled individuals.[150] In essence, the ADA functions by applying the basic protections of the Rehabilitation Act of 1973 to general activities undertaken by both government and private parties.[151] The Rehabilitation Act remains in force, supplementing the ADA.

The ADA shares the Rehabilitation Act's definition of disability. Thus, a disability is defined as, "(A) a physical or mental impairment that substantially limits one or more of the major life activities of such individual; (B) a record of such impairment; [and], (C) being regarded as having such an impairment."[152] Persons meeting this broad definition are generally protected from discrimination based solely on their disability under five titles in the Act, which differ in their language and have varying exceptions.

The ADA is widely regarded as creating much broader protections than originally envisioned, largely due to its sweeping anti-discrimination language and explicit extension to private actors.[153] It has already been invoked by the Executive Branch of the federal government in denying a state special permission to "rank" and ration health care services under

148. *Id.* at 796.

149. Americans with Disabilities Act of 1990, 42 U.S.C. §§ 12101-12213 (Supp. VI 1993).

150. *Id.*

151. *See* 42 U.S.C. § 12111(5) (specifying that the ADA applies to broad areas such as employment, public services, public accommodations, and telecommunications).

152. *Id.* § 12101.

153. *See, e.g.*, Harris Meyer & John McCormick, *Disability Law Fear: What Price Equal Access*, AMERICAN MED. NEWS, Nov. 9, 1992, at 1.

Medicaid.[154] This type of broad coverage carries with it the possibility of liability for the specialty boards.

a. The Argument for ADA Liability with the Specialty Boards

The argument for ADA liability in the context of the specialty boards varies with the actual title invoked, but largely parallels an action under section 504 of the Rehabilitation Act: certification was denied to an "otherwise qualified" disabled individual solely on the basis of that disability. As with section 504 claims, the ADA contains language which presumably allows organizations such as specialty boards to avoid liability for legitimate standards which disproportionately affect the disabled.

There is no appreciable case law interpreting the recently enacted ADA. Nonetheless, its language, in combination with court decisions involving similar provisions in the Rehabilitation Act and the Civil Rights Act of 1964, allow some insight into its possible interpretation.[155] In the following sections Titles I and III of the ADA, the provisions most likely to be invoked in a challenge of the specialty boards, are analyzed.

2. Title I of the ADA: Employment

Title I forbids employment discrimination against a disabled individual in any aspect of the employment relationship.[156] It states that "[n]o covered entity shall discriminate against a qualified individual with a disability because of the disability of such individual in regard to job application procedures, hiring, advancement, or discharge of employees, employee compensation, job training, and other terms, conditions, and privileges of employment."[157]

A "covered entity" is broadly defined in § 101(2) as an employer, employment agency, labor organization, or joint labor-management committee. An "employer" is further defined as a person engaged in an industry affecting commerce, who employs more than fifteen persons. There are

154. David C. Hadorn, *The Problem of Discrimination in Health Care Priority Setting*, 268 JAMA 1454 (1992). The plan proffered by the state of Oregon involved a trade-off: all poor persons would be covered under the plan, but services under a certain priority number would not be funded. The Bush administration invoked the ADA in denying the special permission needed to institute the plan, largely citing problems in the way the priorities were established. The Clinton administration subsequently approved a similar plan.

155. For example, the implementing regulations for Title III of the ADA specifically noted that the definitions of the ADA closely parallel those used in section 504 of the Rehabilitation Act. *See* 56 Fed. Reg. 35,544, 35,546 (1991).

156. 42 U.S.C. § 12112(a).

157. *Id.*

specific exemptions for the federal government and bona fide private membership clubs exempt from taxation under section 501(c) of the Internal Revenue Act of 1986.[158]

The scope of Title I is largely determined by its definition of "discrimination" in § 102(b). Section 102(b)(2) states that discrimination may be found where there is participation in a "contract or other arrangement" that has the effect of subjecting a covered entity's qualified applicant or employee with a disability to discrimination.[159] Section 102(b)(5)(A) mandates reasonable accommodation for an "otherwise qualified" applicant or employee, unless the covered entity can demonstrate that the accommodation would impose "undue hardship"[160] on its business operations.[161] Section 102(b)(6) finds discrimination where qualification standards are used which screen out or tend to screen out disabled individuals, unless the standard is job-related for the position in question and shown to be consistent with "business necessity."[162]

Running throughout these definitions are the qualifications of the disabled person at issue. A "qualified individual with a disability" is an individual who, with or without reasonable accommodation, can perform the

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158. *Id.* § 12111(5).

159. This provision seems to parallel the third-party interference test seen in Sibley Memorial Hospital v. Wilson, 488 F.2d 1338 (D.C. Cir. 1973); *see supra* notes 104-12 and accompanying text discussing third party liability.

160. As defined under the ADA, "substantial hardship" is an action requiring "significant difficulty or expense," which is to be evaluated by considering factors including:

> (i) the nature and cost of the accommodation;
>
> (ii) the overall financial resources of the facility or facilities involved, the number of persons employed at such facility, the effect on expenses and resources, or the impact otherwise of such accommodation upon the operation of the facility;
>
> (iii) the overall financial resources of the covered entity; the overall size of the business of a covered entity with respect to the number of employees; the number, type and location of the facilities; and
>
> (iv) the type of its operation or operations of the covered entity, including the composition, structure, and function of the workforce of such entity; the geographic separateness, administrative, or fiscal relationship of the facility or facilities in question to the covered entity.

42 U.S.C. § 12111(10).

161. *See supra* notes 123-30. This parallels the second part of the Court's two-part test for "otherwise qualified" under the Rehabilitation Act of 1973, as seen in *Southeastern Community College*. Note also that "reasonable accommodation" under the ADA is specifically defined to include adjustment or modifications of examinations. 42 U.S.C. § 12111(9).

162. This language closely parallels that used in Title VII of the Civil Rights Act of 1964. *Compare* 42 U.S.C. § 2000e-2 *with* 42 U.S.C. § 12112(b)(6). *See also supra* notes 95-96 and accompanying text.

essential functions of the employment position held or desired.[163] In determining what factors of a job are essential, "consideration" is given to the employer's judgment.[164]

Title I also provides defenses for those accused of discrimination. An employer can defeat charges of discrimination by establishing that the qualifications at issue are "job-related and consistent with business necessity," and that no reasonable accommodation is possible.[165] These defenses explicitly encompass the right to include job requirements that protect the safety of others.[166]

a. Analysis: The Specialty Boards and Title I

Violation of Title I involves establishing that the specialty boards, acting as covered entities, discriminated against qualified disabled individuals in granting certification.

i. Finding the Required Employment Relationship

Because specialty boards are not traditional employers of certified physicians, they appear at first glance to be beyond the reach of Title I. An argument may be made, however, for coverage of the boards under a third party-interference theory, employing *Sibley's* interpretation of the Title VII employer-employee relationship.[167] Specifically, it can be maintained that by using the term "employer" in the ADA, Congress was explicitly incorporating past judicial interpretation in the civil rights context. This reasoning is substantially reinforced by § 102(b)(2), which extends "discrimination" to actions by third parties which have the effect of discriminating against a covered entity's disabled employees or applicants.

Hospitals and many physicians' groups qualify as covered entities under the ADA.[168] Because these entities often use certification as an important employment qualification, standards which tend to exclude disabled physicians could be characterized as third-party interference in the employment relationship. Under *Sibley* and § 102(b)(2), it appears that such standards expose the specialty boards to ADA-based liability.

163. 42 U.S.C. § 12111(8).
164. *Id.*
165. *Id.* § 12113(a).
166. *Id.* § 12113(b).
167. *See supra* notes 104-07 and accompanying text discussing third-party liability.
168. *See supra* notes 157-58 and accompanying text.

ii. Defeating Liability Under Title I

Defeating liability where the requisite employment relationship is demonstrated can occur in at least two ways. First, it may be shown that the disabled person is not a "qualified person with a disability" as defined by the ADA.[169] Second, the standard which excluded a "qualified" disabled person may be upheld if that standard is "job related and consistent with business necessity."[170] Both these defenses require that no "reasonable accommodation" is possible.[171]

The "qualified person" and "business necessity" defenses parallel the same concept: can the disabled person meet the standard at issue, or some reasonable modification of that standard. "Business necessity" provides an additional defense beyond that afforded by the "qualified person" language; the defense is applicable where a person is "qualified" but additional factors make his employment problematic. Such a situation exists where a disabled person poses a safety threat, as with an individual infected with a communicable disease.[172]

As defined by the ADA, a "qualified person with a disability" is practically identical to the two-step "otherwise qualified" test under the Rehabilitation Act of 1973: (1) is the disabled individual able to meet the standards at issue regardless of his or her disability; and (2) if not, is some "reasonable accommodation" possible.[173] *Southeastern Community College*,[174] *Doherty*,[175] *Wynne I*,[176] and *Wynne II*[177] are thus applicable by analogy to the determination of whether a disabled person is "qualified" under Title I.[178] Together, they indicate that there is no obligation to make accommodations that fundamentally alter the nature of a benefit.[179] They also show substantial judicial deference to legitimate medical standards decisions.[180] Under their analysis, it is extremely difficult for

169. 42 U.S.C. § 12112(a).
170. *Id.* § 12113(a).
171. *See id.* § 12111(8); § 12113(a).
172. For example, a physician infected with tuberculosis may be "qualified" physically to treat patients, but the infection may pose a safety hazard to patients and thus invoke the "business necessity" defense, as outlined in 42 U.S.C. § 12113(a).
173. *See* 42 U.S.C. § 12111(8); *see also supra* notes 163 and 127-30 and accompanying text.
174. 442 U.S. 397 (1979).
175. 862 F.2d 570 (6th Cir. 1988), *cert. denied*, 493 U.S. 810 (1989).
176. 932 F.2d 19 (1st Cir. 1991).
177. 976 F.2d 791 (1st Cir. 1992).
178. *See supra* notes 123-48 and accompanying text.
179. *Id.*
180. *See supra* notes 131-48 and accompanying text.

individuals not meeting legitimate, uniformly applied certification standards to establish themselves as "qualified," where a specialty board maintained in good faith that no "reasonable accommodation" was possible.[181]

Should the qualifications necessary for a disabled individual to become board certified somehow be established, a specialty board could still defeat liability by invoking the "business necessity" defenses found in § 103. A particularly powerful claim here is that board standards contribute to the safe practice of specialty medicine.[182] This parallels the language of § 103(b), and the safety rationale accepted by the Court in allowing limitations on "reasonable accommodations" in *Southeastern Community College*.[183]

3. *Title III: Public Accommodations and Services Operated by Private Entities*

a. *Provisions of Title III*

Title III broadly prohibits discrimination against disabled individuals with regard to public accommodations.[184] It provides that "[n]o 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 by any person who owns, leases (or leases to), or operates a place of public accommodation."[185] "Public accommodations" include the professional offices of health care providers and hospitals, as well as "other service establishments."[186]

Discriminatory activities need not be direct, as denial of participation via "contractual, licensing, or other arrangements" is covered under Title III.[187] In addition, various specific acts of discrimination are barred, including:

> (i) the imposition or application of eligibility criteria that screen out or tend to screen out individuals with a disability, unless

181. See *supra* Section III of this text analyzing the Specialty Boards and their relationship to section 504 of the Rehabilitation Act of 1973.

182. This argument may be difficult to make because certification is not necessary for the practice of specialty medicine.

183. *See supra* notes 123-30 and accompanying text.

184. 42 U.S.C. § 12182(a).

185. *Id.*

186. *Id.* § 12181(7)(F).

187. *Id.* § 12182(b)(a)(A)(i)-(iv).

> such criteria can be shown to be necessary for the provision of goods, services, facilities, privileges, advantages, or accommodations being offered;
> (ii) failure to make reasonable modifications in policies, practices, or procedures, unless such modification would fundamentally alter the nature of the privilege or advantage.[188]

In addition, § 309 mandates that certain examinations be given in a manner which is accessible to disabled individuals. Section 309 states that "[a]ny person that offers examinations or courses related to . . . certification . . . for . . . professional, or trade purposes shall offer such examinations or courses in a place and manner accessible to persons with disabilities or offer alternative accessible arrangements for such individuals." These accommodations need not be made if they represent an undue burden or fundamentally alter the measure of skills and knowledge sought.[189] This provision applies to the specialty boards and their certification examinations; the ABMS acknowledges as much, and publishes an unofficial handbook to assist the boards with compliance.[190] Of even greater importance is the potential applicability of Title III's general protections to substantive standards for board certification.

b. Analysis: The Boards and Title III

i. Finding General Coverage

Title III is most easily applied to the specialty boards if they are consid-

188. *Id.* § 12182(b)(2)(A)(i),(ii).

189. 28 C.F.R. § 36.309(b)(3) (1993).

190. AMERICAN BD. OF MED. SPECIALTIES, HANDBOOK ON BOARD CERTIFICATION AND THE AMERICANS WITH DISABILITIES ACT (Bashook & Dockery, eds., 1992)[hereinafter ADA HANDBOOK]. This resource suggests a number of specialty board activities for compliance with § 309:

> (1) develop a written policy on examination accommodations that appears on all board application literature; (2) establish procedures for the Board's responses to applicants requesting accommodations (including announcements, forms, responses to inquires); (3) set reasonable timetables for application, review, verification, and approval that will allow a candidate to take the examination on schedule with other applicants if the candidate supplies documentation in a timely manner; (4) identify expert consultants in various disabilities to assess documentation and perform applicant evaluation, if needed; (5) have the Board retain responsibility to determine ADA eligibility and recommend Board action on accommodations; (6) provide explicit instruction to Board staff on how to respond to various requests for accommodation; (7) keep a log of board activities in responding to applicant requests.

Id. at 9-10. The book further suggests that accommodation can only be undertaken on a case-by-case basis. *Id.* at 23.

ered a public accommodation. In defining "public accommodation," § 301(7)(F) does not explicitly cover the boards, though it does cover hospitals and providers' offices. This definition is not exhaustive because it allows "other service establishments" to be considered "public accommodations." Comments to implementing regulations further explain that "other service establishments" are establishments operated by private entities which affect commerce.[191] The specialty boards, as private entities which have an effect on the commerce of medicine, can be included plausibly among "other service establishments" under these definitions and explanations.

There is additional evidence to support the classification of specialty boards as "public accommodations." Initially, the statute itself clearly states its purpose as "provid[ing] clear, strong, consistent, enforceable standards for the elimination of discrimination against individuals with disabilities," and "invok[ing] the sweep of congressional power . . . in order to address [this discrimination]."[192] Section 309 indicates clear congressional intent to cover at least the administration of certification examinations and congressional awareness of the board certification system. Although the statutory language does not specifically classify the boards as "public accommodations," neither does it explicitly exempt them. Thus, there are grounds to suggest that classifying specialty boards as "public accommodations" is not inherently unreasonable.

Further support for such a conclusion derives from congressional treatment of judicial decisions interpreting the Rehabilitation Act. Congress demonstrated its awareness of cases such as *Southeastern Community College* by incorporating language from these decisions into the ADA.[193] As these cases involved judicial examination of substantive standards in a medical setting, the failure of Congress to specifically disavow such analysis may indicate tacit congressional approval of such examination of professional standards. The specialty boards, by providing standards for various medical specialties, are easily encompassed by such a theory of judicial review.

It is still unclear whether a court would find that the specialty boards constitute "public accommodations." The lack of specific coverage for substantive board standards, in light of explicit coverage in § 309, argues against such a classification. In addition, the fact that listed "public ac-

191. 56 Fed. Reg. 35,553 (1991).

192. 42 U.S.C. § 12102(b)(1), (4).

193. *See supra* note 161 and accompanying text.

commodations," such as hospitals and doctors' offices, are locations which must physically accommodate the disabled further suggests that the provision "other service establishments" was not meant to include standard-setting organizations.

Another theory may bring the boards under the coverage of Title III. In the Title's enumeration of prohibited activities, there are repeated references to discrimination by "contractual, licensing, or other arrangements."[194] This language suggests that any party interfering with the relationship between a disabled person and a public accommodation could be subject to liability.[195] Hospitals and physicians' professional offices are explicitly defined as "public accommodations" in the ADA.[196] Certification could constitute the "other arrangement" which interferes with a disabled physician's relationship with such public accommodations. While coverage under this theory is less convincing than defining the boards as a public accommodation, it is nonetheless a relatively reasonable interpretation of the statutory language.

ii. The Impact of Title III Coverage

If coverage under Title III is found, the specialty boards' substantive standards would be subject to the general requirements of Title III.[197] Implementing regulations would then require that the boards demonstrate that standards which screen out or tend to screen out the disabled are necessary to the benefits of certification.[198] In addition, modifications to certification standards would be required, unless such modifications fundamentally alter the certification process.[199] In short, the specialty boards would have to account for any certification standards which have an impact on disabled physicians.[200]

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194. 42 U.S.C. § 12182(b)(1)(a)(i)-(iv).

195. This statutory language parallels the third-party interference theory as discussed under Sibley Memorial Hospital v. Wilson, 488 F.2d 1338 (D.C. Cir. 1973); *see also supra* notes 104-07 and accompanying text. This theory is also discussed in the context of Title I of the ADA. *See supra* note 159 and accompanying text.

196. 42 U.S.C. § 12181(7)(F).

197. *See supra* note 157 and accompanying text.

198. 28 C.F.R. § 36.301 (1993). These regulations track ADA § 302(b)(2)(A)(i), 42 U.S.C. § 12181(b)(2)(A)(1); *see also supra* note 162 and accompanying text.

199. 28 C.F.R. § 36, 302 (1993). These regulations track ADA § 302(b)(2)(A)(ii), 42 U.S.C. § 12181(b)(2)(A)(ii); *see also supra* note 162 and accompanying text.

200. While commenting only on the implications of § 309, the recent unofficial ABMS handbook addressing the ADA and certification suggested that the specialty boards undertake a review of their examination programs from the perspective of essential clinical skills

iii. Escaping Liability Under Title III

As with Title I, liability under Title III may be defeated under a variety of theories. Any board facing liability must initially establish that its certification standards are "necessary" for bestowing the benefit of certification.[201] Because changes in a factor "necessary" for the provision of benefit must "fundamentally alter" that benefit, the test for determining necessity must be analytically similar to determining whether an accommodation is reasonable under the Rehabilitation Act.[202] Given this logic, cases such as *Southeastern Community College*, indicating substantial judicial deference to legitimate medical standards, are applicable in establishing criteria as "necessary."[203]

Once standards are proven "necessary" for certification, a board must show that no reasonable accommodation is possible to avoid their modification.[204] Modifications are not reasonable if they "fundamentally alter" a benefit, language which tracks *Southeastern Community College* and makes its analysis applicable.[205] As noted previously, *Southeastern Community College* and its line of related cases indicate a strong judicial deference to legitimate medical standards.[206]

Finally, a specialty board may escape liability under the "direct threat" exception. Specifically, implementing regulations contain a blanket exception to instances where allowing a person to participate in a benefit would pose a direct threat to the health and safety of others.[207] A specialty board, presenting its certification standards as safety standards, may be able to successfully invoke this exception, considering the demonstrated deference given medical standard settings.[208]

IV. Conclusion: Specialty Boards and Civil Rights Statutes

Certification amounts to a regulation of specialty medicine by private,

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and knowledge that are fundamental for certification. ADA Handbook, *supra* note 190, at 26.

201. *See supra* note 162 and accompanying text.

202. An accommodation under the Rehabilitation Act's "otherwise qualified" language is not reasonable if that accommodation "fundamentally alters" a benefit. *See supra* notes 127-30 and accompanying text.

203. *See supra* notes 123-48 and accompanying text.

204. *See supra* note 162 and accompanying text.

205. 42 U.S.C. § 12182(b)(2)(A)(ii); 28 C.F.R. § 36.302.

206. *See supra* notes 123-48.

207. 28 C.F.R. § 36.208. This argument parallels the safety-based defense under the "business necessity" exemption of Title I of the ADA.

208. *See supra* note 133-34 and accompanying text.

independent, quasi-academic ABMS-recognized boards. While certain identifiable groups may fail to achieve certification in proportionate numbers, this result appears to be a function of uniformly applied objective standards, not intentional discrimination. The nature of the specialty boards and their uniform application of certification standards make establishing board liability under federal civil rights laws difficult. The specialty boards' position may be further strengthened by a clear explanation of the goals of certification, including an explanation of the relationship of certification standards to achievement of those goals. Combined, the nature of the boards, uniform application of standards, and an adequate explanation of those standards should allow the specialty boards to defeat most challenges brought under federal civil rights law.