Editorial

Physician Health Programs: Is the 'Safety Sensitive Worker' Label Being Used to Skirt the Americans with Disabilities Act?

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Two thousand years ago, leprosy, which is not a highly contagious disease, was considered a fate almost worse than death. Those who were unfortunate enough to have it were forced to live in isolation from society. They were required to shout "unclean" if a normal healthy person approached them. They were treated very poorly by society.

The "settled science" of the day was used to justify this poor treatment, essentially claiming that there was a "potential for harm" that would affect the "health and safety" of those around them.

Today we have the modern-day equivalent of the leper from Biblical times. Professionals, who are in recovery from addiction, receiving appropriate treatment, and functioning well, are often treated poorly by regulatory agencies (medical boards, boards of law examiners), Physician Health Programs (PHPs)/Lawyers Assistance Programs (LAPs), hospitals and treatment centers. They are frequently subjected to costly, burdensome, and unnecessary treatments (e.g. prolonged inpatient treatment) based on past behavior when the addiction was not being treated. Even when treatment has been successful, they are often forever labeled "unclean."

The information presented below is not intended as legal advice or opinion. Physicians should consult their own attorneys for legal advice and opinion.

The 'Safety Sensitive Worker'

Virtually all definitions of safety-sensitive worker incorporate the concept of "potential impairment" or "potential for harm." The subjective interpretation of these terms, implicit bias, and speculation result in lowering the threshold for taking action against the subject and are thus subject to abuse.

In an insightful post, the late Dr. Tom Horiagon stated:

> An area of commonality that applies to all state programs is the FSPHP [Federation of State Physician Health Programs] understanding of medicine as a "safety-sensitive" occupation that justifies the screening for a treatment of "potentially-impairing conditions." On one hand, the notion that the practice of medicine has a central concern with safety seems self-evident. But FSPHP is using a legal term of art when it writes "safety-sensitive."[1]

Dr. Horigan, who attended law school prior to his death, provided a brief review of the history of the "safety-sensitive" label as it relates to the Americans with Disabilities Act (ADA).

> The term "safety-sensitive" is claimed to first appear in regulatory language in Executive Order 12564—Drug-free Federal workplace written by President Reagan in September 1986…. The Americans with Disabilities Act was enacted in 1990 (long after the Reagan Administration Executive Order of September 1986) and was amended to strengthen its provision in 2008 with passage of the ADAAA [Americans with Disabilities Act Amendment Act]. As amended, the ADA contains 5 references to the term "sensitive" in its text and three of these can be read as "safety-sensitive."[1]

Dr. Horiagon notes that the ADA interprets the term "safety-sensitive" very narrowly.[1] He goes on to say:

> So, when FSPHP states that medicine is a safety-sensitive occupation authorizing all sorts of intrusive measures in the interest of public safety it is employing the rhetorical trick of using a deceptively simple term with very different meanings when used as a legal term of art. In general, while medicine has a great and central concern for safety, its practitioners are not in "safety-sensitive" positions under Federal law and may or may not be so designated depending on whether they are employees in certain states….[1]
>
> The publications of FSPHP portray a much broader agenda. When it repeatedly refers to medicine as a "safety-sensitive" profession, it is arguing that there is a legal basis for screening physicians for "potentially impairing conditions." That FSPHP opinion takes a position that is contrary to the protections that physicians are due under the Americans with Disabilities Act. In fact, the FSPHP PEER [Performance Enhancement and Effectiveness Review] Guidelines are written as if ADA does not exist at all.[1]

Imposing medical requirements on physicians based on the safety-sensitive label must be based on current impairment and individual assessment that the physician poses a high risk of "direct threat" to self or others (Title I)[2] or "direct threat" only to others (Title II[3] and Title III [4]) of ADA. The definition of "direct threat" is that there is "a significant risk of substantial harm to the health or safety of the individual or others that cannot be eliminated or reduced by reasonable accommodation."[1] Dr. Horiagon concludes by saying:

> "Direct threat" is a high bar for an employer or agency to clear and ADAAA raised the bar higher…. So, while FSPHP may hope for the day when state PHPs are empowered to ignore ADA in their treatment of physicians, that day has NOT arrived yet.[1]

American Society of Addiction Medicine (ASAM): Treating Addiction Illness in Licensed Professionals

As reviewed by the executive director of the Tennessee Lawyers Assistance Program, Mr. Buddy Stockwell, who himself has been in recovery from alcoholism for more than 38 years,[5] the American Society of Addiction Medicine (ASAM) recently released the 4th edition of ASAM Criteria—Blueprint for Addiction Treatment.[5]

According to Mr. Stockwell, these criteria represent the most widely used standards in addiction treatment, claiming to embrace best practices and evidence-based diagnostics.[5] The criteria advocate for profession-specific monitoring and case management including Physician Health Programs (PHPs),

Lawyers Assistance Programs (LAPs), American Bar Association's Commission on Lawyer Assistance Programs (CoLAP), and Human Intervention Motivation Study (HIMS) for airline pilots.[5] The criteria recognize that certain medications (e.g. Suboxone) may be a critical component of a treatment plan.[5] And, the criteria favor residential care (inpatient treatment) as initial treatment.[5]

In a public policy statement on physicians and other medical professionals with substance use disorder (SUD), the ASAM emphasizes that illness is not equivalent to impairment, which is a functional classification.[6] It notes that the Federation of State Medical Boards (FSMB) defines impairment as the "inability of a physician to provide medical care with reasonable skill and safety due to illness or 'injury,'" and "also applies to other healthcare providers in instances where state medical boards license multiple types of healthcare professional."[6] It notes that state laws and regulations may have different definitions of impairment.[6] It also acknowledges that treatment can be provided by a physician with expertise in the treatment of SUD with or without the oversight of a PHP.[6] Treatment can also include medications.[6] It further emphasizes that treatment should comply with the Americans with Disabilities Act (ADA) and that medical boards and boards of law examiners should not discriminate against persons based on the use of appropriate medications or based on unjustified assumptions that certain medications will automatically result in impairment.[6] It also indicates that professionals should not be discriminated against based solely on a past diagnosis of SUD when the professional has been treated and maintained successfully demonstrating sustained remission/recovery.[6]

Readers are encouraged to read the ASAM's Public Policy Statement in its entirety.[6]

The Success First Model

In a PowerPoint presentation, Mr. Buddy Stockwell reviews and promotes the "Success First" Model of addiction treatment, which advocates for initial inpatient treatment.[7] In this model, initial inpatient treatment is preferred over partial hospitalization, intensive outpatient treatment, or other outpatient treatment.[7] He indicates that Best Practices Monitoring is a way to satisfy a fitness-for-duty determination.[7] Citing a book by Jean-Jacques Rousseau, *Du Contrat Social Ou Principes Du Droit Politique*, published in 1762, he states:

> The social contract deems that individuals have consented, either explicitly or tacitly, to surrender some of their freedoms and submit to the authority of the ruler or magistrate (or to the decision of a majority), in exchange for protection of their remaining rights.[7]

In practice, physicians and other professionals are essentially forced to sign agreements that do not protect their rights under threat of adverse action being taken against their professional license. It is noted that Mr. Stockwell is an attorney.

The American Medical Association (AMA) Advocacy Resource Center (ARC) indicates that intrusive inquiries about past diagnoses or treatment for mental health disorder or SUD are not reliable indicators of current ability to practice medicine safely, and such intrusive inquiries may violate ADA.[8] The AMA cites a 2014 settlement agreement between the U.S. Department of Justice (DOJ) and the State Bar of Louisiana, in which the State Bar was forced to remove intrusive questions about past mental health diagnosis. Key provisions of that agreement are detailed in a letter, dated Jun 26, 2023, from DOJ to several U.S. Senators. The DOJ stated:

> It is clear that intrusive inquiries regarding an applicant's mental health history run afoul of the ADA to the extent that state medical boards use them as eligibility criteria to screen out applicants with disabilities and such inquiries are not necessary to determine whether an applicant is fit to practice medicine.[8]

Broccoli, Abdominal Pain, and the Success First Model

With regard to the Success First Model of evaluation and treatment, it may be instructive to consider how this might be applied to the following situation:

A physician consumed a generous serving of broccoli at dinner one night and following dinner developed bloating and abdominal pain. He mentioned these symptoms to the hospital chief executive officer (CEO) at the hospital where he worked. The hospital CEO advised him that he needed to go to the PHP. The PHP referred him to their "preferred" treatment center. The PHP provided a diagnosis of broccoli use disorder (BUD) and told him he needed to be immediately admitted to an eight-week intensive inpatient treatment program at a cost of $80,000, which the physician's insurance will not cover. The PHP justified this intensive inpatient treatment by claiming that the physician is a "safety-sensitive" worker who might be distracted by abdominal pain while treating patients and thus may present a "potential harm" to patients. The PHP threatened to recommend that his privileges and medical license be suspended or revoked for non-compliance if he refuses to go along with the program.

The "preferred" treatment center donates money to support the Organization of State PHP's "educational efforts" and for a fee of $10,000 or more the Organization will allow the "preferred" center to have a speaking slot at their annual educational conference. The "preferred" treatment center, of course, recommends in their presentation that PHPs refer physicians to *their* treatment center where they will dutifully administer the Success First Model of treatment.

Upon admission to the "preferred" treatment center, the physician was immediately prepped for surgery at its associated surgery center. The Success First Model dictates that the best way to arrive at a definitive cause of the physician's abdominal pain is to perform a laparotomy. That way they can quickly rule out tumors, masses, and obstructions. No need for less drastic or more prudent measures like waiting a period of time for the eventual passage of gas. Fortunately, the physician survived the laparotomy.

Because the physician had been given a diagnosis of BUD, the PHP recommended that, as a condition of maintaining his medical license and medical staff privileges, he needed to undergo random testing for broccoli metabolites twice per week, attend Broccoli Users Anonymous meetings three times per week, and return to the preferred center for additional counseling once per month for five years…, all at the doctor's expense. Who knew that excess gas produced from eating broccoli could be so lucrative for evaluation and treatment centers?

Performance Enhancement and Effectiveness Review (PEER) and Evaluation and Treatment Accreditation (ETA) Programs

The Federation of State Physician Health Programs (FSPHP) launched two new programs in 2025–the Performance

Enhancement and Effectiveness Review (PEER) and Evaluation and Treatment Accreditation (ETA).[9]

Seeking uniformity based on consensus and so-called "best practices," the FSPHP seeks to establish itself as the sole accrediting organization, much like the specialty boards which have promoted themselves as the sole arbiter of "quality care."[9] Interestingly, like medical specialty board programs such as maintenance of certification (MOC), which some view as simply revenue-generating programs and an example of anti-competitive conduct, these new FSPHP programs appear to be highly remunerative.

According to FSPHP, Program Criteria Metrics version 2.0 sells for $399 for FSPHP members and $599 for non-members.[10] And, the PEER Assessment Fee is $9,000 for members and $14,000 for non-members.[10] For treatment centers that want to receive ETA accreditation, the Standards for Accreditation sells for $499.[11] The ETA Assessment Fee is $14,000.[11]

As part of this accreditation initiative, the FSPHP seeks to establish the Success First Model as the standard of care for treating addiction, noting that it might pose a challenge with regard to insurance reimbursement, which typically favors a stepped-care approach.[9] Evaluation and Treatment centers obviously favor the Success First Model as it greatly enhances their revenue.

Again, it is noted that sponsors (e.g. evaluation and treatment facilities, testing labs, etc.) are given the opportunity during a FSPHP conference session at the FSPHP annual meeting to give a presentation, depending on their level of sponsorship (e.g. Diamond level $11,500, Emerald level $10,000).[12] This provides these high-dollar sponsors the opportunity to market their services to PHP attendees in the hope of becoming the preferred provider for more PHP programs.

DOJ Guidelines—Opiate Use Disorder (OUD) and the Americans with Disabilities Act

The DOJ has developed a very comprehensive set of guidelines designed to enforce the ADA and deter discrimination against people in recovery from opioid use disorder (OUD) who are not engaging in illegal drug use, including those who are taking legally-prescribed medication to treat their OUD.[13] The same guidelines apply to alcohol use disorder.

The DOJ Guidelines state:

> People with OUD typically have a disability because they have a drug addiction that substantially limits one or more of their major life activities. Drug addiction is considered a physical or mental disability under the ADA…. The ADA also protects individuals who are in recovery, but who would be limited in major life activity in the absence of treatment and/or services to support recovery…. The ADA [also] protects individuals who are "regarded as" having OUD, even if they do not in fact have OUD.[13]

The ADA also protects those who have a history of OUD but who no longer illegally use drugs.

> The ADA protects individuals with a "record of" disability…. Therefore, individuals with a "record of" having OUD usually will be protected under the ADA. Individuals would fall into this category if they have a history of, or have been misclassified as having, OUD.[13]

The ADA also protects individuals who are taking legally prescribed medication to treat their OUD.

> Under the ADA, an individual's use of prescribed medication, such as that used to treat OUD, is not an "illegal use of drugs" if the individual uses the medication under the supervision of a licensed health care professional, including primary care or other non-specialty providers. This includes medications for opioid use disorder (MOUD) or medication assisted treatment (MAT). MOUD is the use of one of the three medications (methadone, buprenorphine, or naltrexone) approved by the Food and Drug Administration (FDA) for treatment of OUD; MAT refers to treatment of OUD and certain other substance use disorders by combining counseling and behavioral therapies with the use of FDA-approved medications.[13]

The DOJ also outlines what can be done if one believes one has been a victim of discrimination because of OUD.

> Individuals may file a complaint with the Department of Justice if they believe that a public accommodation or state or local government is discriminating or has discriminated against them because of OUD. Individuals may also bring private lawsuits under the ADA…. Information about filing an ADA complaint with the Department is available at civilrights.justice.gov. More information about the ADA is available by calling the Department's toll-free ADA information line at 800-514-0301 or 800-514-0383 (TTY), or accessing its ADA website at ada.gov…. Complaints about employment discrimination (called "charges") on the basis of disability can be filed with the Equal Employment Opportunity Commission (EEOC). Information about filing an EEOC charge is available at eeoc.gov or 800-669-4000, 800-669-6820 (TTY), or 844-234-5122 (ASL Video Phone)…. There are specific filing deadlines for a charge of employment discrimination, depending on the jurisdiction where the charge is filed.[13]

Penalties for Violating ADA

An attorney who is knowledgeable about ADA issues, William D. Goren, J.D., has attempted to summarize this very complicated situation with regard to penalties for violating ADA.[14]

> PHPs are generally 501(c)(3) organizations. However, as a service establishment, they are subject to title III of the ADA per 42 U.S.C. §12181(7)(F). Where an entity covered by title III of the ADA violates the ADA, the plaintiff can get injunctive relief and attorney fees. Damages are not a possibility. With respect to medical licensing boards, which are state entities, if a showing of deliberate indifference, which we discussed here [link provided], can be made, then damages are available. Also, if the title III entity takes federal funds, then damages are in order as well under §504 of the Rehabilitation Act. With respect to damages, that may be a tough fight for a couple of reasons. First, sovereign immunity or other immunities may be in play…. Second, even though PHPs are title III entities an argument exists under this case [link provided] that PHPs are state actors. As such, they would be subject to damages under title II of the ADA. Unclear whether a state actor, a PHP, would be able to avail themselves of sovereign immunity.[14]

The DOJ can also take enforcement actions for violation of ADA, but as will be seen in the discussion of cases in Tennessee below,

the practical reality is there may or may not be consequences for violating ADA.

In a letter to General Counsel, Legal Services & Judicial Development, Tennessee Supreme Court (the Tennessee Board of Law Examiners and the Tennessee Lawyers Assistance Program operate under the authority of the Tennessee Supreme Court) regarding violation of ADA, the DOJ stated: "A complainant may file a private suit pursuant to 42 U.S.C. §12133, whether or not we [DOJ] find a violation."[15]

Tennessee Board of Law Examiners (TBLE) and Tennessee Lawyers Assistance Program (TLAP) Case

PHPs and LAPs share many things in common. Often physicians and attorneys are referred to the same "preferred" evaluation and treatment centers. Likewise, the professional's application for a license or a situation involving an existing license is frequently held hostage with threats to deny an application or revoke licensure unless the professional strictly complies with all of the recommended "treatments/monitoring." The harm done by the very costly, and at times medically unwarranted nature of imposed treatments is further compounded by the fact that professionals often must pay for this revenue-generating ruse out of their own pocket.

Based on complaints from two prospective applicants for a law license in Tennessee, the DOJ investigated and provided its findings in a letter dated Dec 17, 2024:

> We write concerning the Department of Justice's investigation of the Tennessee Board of Law Examiners (TBLE) and the Tennessee Lawyers Assistance Program (TLAP) pursuant to Title II of the Americans with Disabilities Act, 42 U.S.C. § 12132 *et seq*….
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> As stated herein, our investigation regarding these two complaints has concluded that the TBLE and TLAP violated Title II of the ADA with respect to: (1) subjecting bar applicants to burdensome supplemental investigations triggered by their status or treatment for a substance use disorder, and (2) excluding them or implementing burdensome, intrusive, and unnecessary conditions on admission that are improperly based on individuals' diagnosis of or treatment for a substance use or mental health disorder.[15]

The D.S. Case

The facts regarding the D.S. and the C.B. cases are extremely troubling. The facts as reviewed by the DOJ are as follows:

> D.S. is an attorney who lives in Clarksville, Tennessee. In the 1990s, he developed opioid use disorder (OUD), after becoming addicted to painkillers. He began receiving treatment for his OUD in 2012, and his treating physician prescribed him buprenorphine, one of three medications approved by the FDA as safe and effective for the treatment of OUD. This treatment has been highly effective for D.S., and he has engaged in this treatment continuously since 2012…. The TBLE interviewer recommended D.S. for admission to the bar, with reservations, and recommended a TLAP evaluation or a practice monitor….
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> TLAP's Director told D.S. that because he was taking buprenorphine, he would have to be evaluated at his own expense at one of several TLAP-approved facilities.... D.S. chose to be evaluated by Palmetto Addiction Recovery ("Palmetto") in Rayville, Louisiana because it was least expensive…. D.S. was evaluated by a psychiatrist, was administered a battery of psychological and cognitive tests by a psychologist, and was tested for a variety of drugs. The psychological testing showed no signs of cognitive impairment, nor was any evidence of decreased concentration noted by the examining psychiatrist. The drug testing was negative for all drugs tested, including cannabinoids, except for buprenorphine, for which D.S. had a valid prescription. D.S. was required to pay $2,000 out of pocket for the evaluation by Palmetto.
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> Even though D.S. tested negative for all tested drugs (other than the medication prescribed by his doctor), Palmetto recommended that D.S. sign a five-year monitoring contract with TLAP. In addition, Palmetto recommended that D.S. complete "a TLAP approved long term inpatient treatment program experienced in treating chemically dependent lawyers. This treatment should include complete detoxification off all controlled substances including Suboxone." Palmetto subsequently informed D.S. that the "long term inpatient treatment program" would take six months to a year at Palmetto's facility in Louisiana. Palmetto informed D.S. that the cost of this treatment program would be approximately $30,000.
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> D.S.'s treating physician, who had been successfully treating D.S. for years with buprenorphine, "emphatically" disagreed that D.S. should be required to participate in a long-term inpatient treatment program to achieve "detoxification" from the medication that effectively treats his disability. D.S.'s doctor further relayed to the TLAP that D.S. had been compliant with his treatment program for several years, had never demonstrated any behavior that would indicate a functionally problematic psychiatric or personality disorder, and that D.S. was not physically or psychologically impaired by taking buprenorphine as part of his medication-assisted treatment for OUD.
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> In November 2021, D.S.'s employment was terminated at the law firm at which he had been working because of his inability to obtain a law license. Following Palmetto's recommendation, D.S. had a conversation with TLAP's Director and TLAP's Clinical Director in which they told him he would need to complete the inpatient treatment program recommended by Palmetto at his own expense to comply with TLAP's requirements….
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> The TBLE informed D.S. that if he did not comply with TLAP's recommendations and was dismissed from TLAP, the TBLE would deny his application for admission "on Character and Fitness grounds." Thus, D.S. was left with the choice of continuing the treatment that is successful for him in treating his OUD or obtaining his license to practice law….
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> He enclosed Policy Statements from Palmetto dated March 16, 2012, and November 8, 2019, that state: "Palmetto does not recommend use of controlled medications in a professional population. We believe that such medications create side effects and physiological dependence incompatible with the practice of a profession." The Policy

Statements further state: "We believe that a professional who wishes to take controlled medications should make a choice between the medications and the profession."

D.S. subsequently obtained a second evaluation from another treatment center–Vanderbilt. The evaluating psychiatrist from Vanderbilt stated:

> [D.S.] appears to have been successful on partial agonist therapy for over a decade without legal, educational, or occupational deficiencies of consequences. Indeed, academic collateral sources who worked closely with him over multiple school terms reported surprise at the initial revelation by [D.S.] that he was taking this medication, and there have been no employment-related concerns pertaining to his performance.
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> Nonetheless, the medical report concluded that D.S. "is not fit for the practice of law, which is a safety-sensitive position."…
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> Based on advice of counsel, D.S. withdrew his application to practice law. A few months later, D.S. submitted a new application for admission to practice law to the TBLE. TLAP informed D.S. that he would need to get another evaluation by Vanderbilt and sign another monitoring agreement with TLAP in order to be compliant with TLAP. On August 11, 2023, Vanderbilt sent a letter declining to conduct a further evaluation upon D.S. On August 11, 2023, TLAP wrote D.S. informing him that TLAP would take no further action and would close his file.
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> The TBLE set a Show Cause Hearing on December 6, 2023, which was after this Office notified the State on September 29, 2023 that it was investigating complaints that the TBLE and TLAP may have violated the ADA in connection with applicants who have been diagnosed with or treated for opioid use disorder or mental health conditions and made a request for information…. At the conclusion of the hearing, the TBLE concluded that D.S. had the character and fitness necessary to practice law, and he was finally admitted to practice law in Tennessee soon thereafter without any conditions or monitoring required.[15]

C.B. Case

> C.B. is also an attorney in Tennessee. He successfully completed an inpatient rehabilitation program in 2010. C.B. graduated from law school in 2020 and passed the Tennessee bar examination in July 2021. During the application process, the TBLE inquired about several misdemeanor arrests from 2010 to 2015. In an interview with the TBLE on September 13, 2021, C.B. explained that at the time of these arrests, he was abusing alcohol and Xanax. He further explained that, as a condition of probation, he attended an inpatient substance abuse rehabilitation program which he successfully completed. The TBLE interviewer noted that she did not have any evidence of a mental or psychological disorder that, if untreated, could affect C.B.'s ability to practice law in a competent and professional manner. The interviewer further indicated she did not have any concerns regarding C.B.'s honesty and good judgment, ability to conduct himself in accordance with the law and rules of professional conduct, or ability to conduct himself with a high degree of professionalism, honesty and integrity. The TBLE interviewer thus recommended C.B. for admission to the practice of law. Nonetheless, for unknown reasons, the TBLE referred C.B. to TLAP for evaluation.
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> After the TLAP referral, TLAP informed C.B. that C.B. would need to get a comprehensive psychological and drug assessment at his own expense to determine his fitness to practice law…. The cost of the assessment was $6,000. C.B. did not have the money to pay for the assessment, so he obtained a loan from the TLAP in the amount of $4,800 to assist with paying the cost of the assessment…. The Vanderbilt assessment concluded that C.B. was fit to practice to a reasonable degree of medical certainty…. [they] recommended that he should complete an abstinence-based intensive outpatient program for substance use management approved by TLAP…. TLAP subsequently required C.B. to enter an outpatient drug treatment program for four days a week. At the time, C.B. was working for a firm in [another state]. When C.B. told his firm that he would have to enter a treatment program for four days a week, the firm terminated his employment…. As a result, C.B. was required to move from [the other state] to Tennessee to attend a treatment program.
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> C.B. subsequently entered a drug treatment program for seven weeks at Bradford Health Services in Nashville at his own expense. Upon completion of the drug treatment program, C.B. was able to obtain his law license subject to a requirement that he enter a 5-year monitoring contract with TLAP that included the following:… (2) agreement not to consume alcohol-free wine or beer, mouthwash, cough syrup, or communion wine; (3) enrollment in an app that he was required to check in every day to see if he has a random drug test that day; (4) random drug testing at his own expense; and (5) attending therapy sessions and releasing all records of such mental health treatment to TLAP.
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> C.B.'s therapist objected to providing copies of all treatment records to TLAP and requested to be able to provide confirmation that C.B. attended sessions, rather than having to provide complete mental health treatment records. When TLAP indicated that copies of all mental health records were required to be provided, C.B.'s therapist resigned from treating him any longer.[15]

DOJ's Findings

After a very thorough investigation, the DOJ provided its Findings.

> We conclude that the TBLE and TLAP violated Title II of the ADA with respect to individuals with actual or perceived substance use disorders. Under Title II of the ADA, no qualified individual with a disability shall, on the basis of disability, be excluded from participation in or be denied the benefits of the services, programs, or activities of a public entity, or be subjected to discrimination by any such entity. 42 U.S. C. § 12132; 28 C.F.R. § 35.130(a). Substance use disorders are disabilities under the ADA. 42 U.S.C. § 12102(1)(A); 28 C.F. R. § 35.108(b)(2) (listing "drug addiction" among other physical and mental impairments).

The TBLE and TLAP are public entities as defined by the statute 42 U.S.C. § 12131(1); 28 C.F.R. § 35.104.

TBLE and TLAP discriminated against D.S. in Tennessee's attorney licensing program on the basis of his disability when they subjected him to additional, burdensome examinations based on his use of lawfully prescribed medication for his OUD and forced him to choose between his law license or continued treatment as prescribed as necessary by his treating physician. These conditions were imposed on D.S., even though there was no evidence that his OUD or his use of buprenorphine to treat his OUD in any way impaired his ability to practice law. Indeed, D.S.'s treating physician relayed that he had been successfully treating D.S. for years with buprenorphine, that D.S. had been compliant with his treatment program, that D.S. had never demonstrated any behavior that would indicate a functionally problematic psychiatric or personality disorder, and that D.S. was not physically or psychologically impaired by taking buprenorphine as part of his medication-assisted treatment for OUD…. Because the withholding of a law license was based on D.S.'s disability and his treatment for his disability, TBLE and TLAP discriminated against him in violation of the ADA. *Ellen S. v. Florida Bd. Of Bar Examiners*, 859 F. Supp. 1489, 1494 (S.D. Fla. 1994) (a licensing entity discriminates against qualified disabled applicants by placing additional unnecessary burdens on them and this discrimination can occur even if these applicants are subsequently granted licenses).

C.B. was similarly subjected to restrictions and conditions on his ability to obtain a law license, due to his disability, even though there was no evidence that he was unable to meet the bar admission standards…. C.B. was subjected to costly and unnecessary examinations and his law license was subjected to a burdensome 5-year monitoring contract. As a result, C.B. lost his job, and his therapist. TBLE and TLAP persisted in these restrictions even after their own approved evaluator concluded C.B. was fit to practice law to a reasonable degree of medical certainty. Because the restrictions on C.B.'s law license were based on his actual or perceived substance use disorder and not on any current inability to meet the bar's admission standards, TBLE and TLAP discriminated against C.B. in violation of the ADA…. "The public entity must ensure that its safety requirements are based on actual risks, not on mere speculation, stereotypes, or generalizations about individuals with disabilities." 28 C.F.R. § 35.130(h). To the extent they are proffered as safety requirements, the restrictions and conditions that TBLE and TLAP imposed on D.S. and C.B. were based on speculation about their disabilities that were contrary to demonstrated conduct, and as to D.S. in particular, they were based on stigma and stereotypes about his prescribed treatment. In imposing unnecessary treatment and a monitoring agreement on C.B., TBLE and TLAP disregarded the recommendation of their own interviewer and their own approved treatment facility, both of whom concluded that C.B. was fit to practice law. They also imposed these requirements despite the lack of any current evidence demonstrating that C.B. did not meet the bar admission criteria. Thus, TBLE and TLAP imposed these restrictions, not based on actual risk, but instead based on speculation or assumptions about C.B.'s perceived substance use and/or mental health disorder. With respect to D.S., TBLE and TLAP held his law license in abeyance and imposed burdensome requirements on him based upon their and their approved providers' stereotypes about the medication D.S. takes to treat his OUD. Even though these providers noted that the treatment D.S. uses has been effective for him and has not resulted in any negative symptoms that affect his ability to practice law or in any deficiencies in legal or employment performance, they nonetheless disapproved of his use of buprenorphine based on their own, unfounded stereotypes about the medication. They disregarded the findings of D.S.'s own treating physician who had been treating D.S. for years and emphatically disagreed that D.S. should be forced to "detox" from his prescribed medicine. Thus, TBLE and TLAP's restrictions on D.S.'s bar license were based on stereotypes, rather than actual risk.

Similarly, under Title II, a public entity is not required "to permit an individual to participate in or benefit from the services, programs, or activities of that public entity when that individual poses a direct threat to the health or safety of others." 28 C.F.R. § 35.139(a). However,

> (b) In determining whether an individual poses a direct threat to the health or safety of others, a public entity must make an individualized assessment, based on reasonable judgment that relies on current medical knowledge or on the best available objective evidence, to ascertain: the nature, duration, and severity of the risk; the probability that the potential injury will actually occur; and whether reasonable modifications of policies, practices, or procedures or the provision of auxiliary aids or services will mitigate the risk. 28 C.F.R. § 35.139(b).
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> As explained above, TBLE and TLAP based their restrictions on speculation and stigma, rather than individualized assessment or current evidence by their own interviewer as well as their own approved treatment provider. And with respect to D.S., their restrictions were contrary to the individualized assessment of D.S.'s own treating physician and their own providers' conclusions that D.S.'s treatment had been successful and caused no deficiencies relevant to the practice of law. Thus, TBLE and TLAP's actions cannot be justified under the direct threat or legitimate safety requirement exceptions. TLAP and TBLE's discriminatory actions caused D.S. and C.B. significant economic harm…. The law firm that had offered C.B. a position as an attorney terminated his employment as a result of the requirement that C.B. participate in an outpatient treatment program for an extensive period of time.

Recommended Remedial Measures

To remedy these violations and to protect the civil rights of individuals with actual or perceived substance

use or mental health disorders who seek to practice law in the State of Tennessee, the TBLE and TLAP should promptly implement corrective measures, including the following:

1. Refrain from prohibiting, limiting, or restricting applicants or attorneys from taking medications for treatment of substance use disorder, including buprenorphine or methadone, when such medications are legally prescribed for a legitimate medical purpose by a medical professional acting in the usual course of his or her professional practice;
2. Refrain from inquiring into an applicant's diagnosis of or treatment or medication for a substance use disorder or mental health disorder unless the applicant voluntarily discloses this information to explain conduct or behavior that may otherwise warrant denial of admission. Any such inquiry shall be narrowly, reasonably, and individually tailored to determine whether the applicant's condition currently impairs his or her ability to practice law in a competent, ethical, and professional manner.
3. Not recommend or impose conditional admission, or conditions or restrictions on admission, solely on the basis of treatment for a substance use disorder or mental health disorder, including an applicant's use of lawfully prescribed medication for substance use disorder;
4. Ensure that conditions of admission imposed on an applicant who reveals a substance use disorder or mental health disorder, including the duration of conditional admission, are individually tailored to address the conduct that justified the recommendation; and
5. Provide training for all relevant TBLE and TLAP personnel regarding their obligations under the ADA and ensure that such personnel are aware of these remedial measures.

We hope to work cooperatively with you to resolve the Department's findings in this matter. If the TBLE or TLAP declines to enter into voluntary compliance negotiations or if our negotiations are unsuccessful, the United States may take appropriate action, as described at 28 C.F.R. §§ 35.173 and 35.174. We will also share a copy of this letter with Complainants. A complainant may file a private suit pursuant to 42 U.S.C. § 12133, whether or not we find a violation.

Please note that this letter is a public document and will be posted on the Civil Rights Division's website. If you have any questions as you review this letter, please feel free to contact us.[15]

On Jan 15, 2025, the Tennessee Supreme Court addressed the findings of the DOJ stating: "The Court strongly disagrees with DOJ's assertion that either TBLE or TLAP discriminated against the applicants based on health status or disability."[16]

Approximately seven months later, the DOJ abruptly closed the case with no further action taken against TBLE or TLAP, and they removed the letter of Dec 17, 2024, from their website. In their letter of Aug 22, 2025, the DOJ stated:

This responds to your letter of April 15, 2025, responding to the Department of Justice's December 17, 2024 Letter of Findings concerning the Tennessee Board of Law Examiners (TBLE) and Tennessee Lawyers Assistance Program (TLAP), which operate under the authority of the Tennessee Supreme Court. Based on your letter, we understand that TBLE and TLAP agree that they may consider the conduct of applicants to the bar, but cannot lawfully consider an applicant's disability as a basis for denying membership or setting conditions of membership in the bar. *See* Title II of the Americans with Disabilities Act ("ADA"), 42 U.S.C. § 12131-34 and 28 C.F.R. Part 35. This matter is now closed.[17]

Shortly thereafter, the Tennessee State Attorney General released a celebratory press release touting that the TBLE and TLAP had been "vindicated."[18]

However, it is noted that the DOJ never retracted its findings that TBLE and TLAP had violated ADA. The DOJ letter, dated Aug 22, 2025, stated only that the TBLE and TLAP agree that they "cannot lawfully consider an applicant's disability as a basis for denying membership or setting conditions of membership in the bar."[17] Despite Tennessee's implied claim of no ADA violation and no wrongdoing, that is precisely what the DOJ's investigation found.[15]

Cumberland County Sheriff's Department Case

In another case involving similar circumstances as D.S. and C.B. (albeit D.S. and C.B. involved Title II of ADA and the correctional officer's case below involved Title I of ADA), and involving the same DOJ Middle District in Tennessee, the DOJ proposed a settlement in the "first ADA case involving opioid use disorder."[19] The DOJ press release stated:

The lawsuit alleges that the County Sheriff's Department discriminated against a correctional officer on the basis of his disability, opioid use disorder (OUD), by failing to make reasonable accommodations to permit his continued employment while taking prescribed medication for OUD. The Sheriff's Department also constructively discharged him by forcing him to resign. The lawsuit also alleges that the Sheriff's Department violated ADA by preventing employees who are taking legally prescribed medications from having them present in their system while at work. This is the Justice Department's first ADA settlement resolving claims of employment discrimination based on opioid use disorder.

"Employees with opioid use disorder or other disabilities should not face termination for taking lawfully prescribed medications needed to treat their disabilities," said Assistant Attorney General Kristen Clarke of the Justice Department's Civil Rights Division.

Under the terms of the consent decree, which must be approved by the Court, the County will implement policies and procedures regarding non-discrimination in employment, and train personnel on the requirements of Title I of the ADA. The County will also pay a total of $160,000 to the former correctional officer.

This matter is based on a referral from the Nashville Area Office of the U.S. Equal Employment Opportunity Commission, which conducted the initial investigation.[19]

The *Epoch Times* published an article in January of 2023, reviewing all the details of this case.[20]

Is a 'Maintenance of Clean (MOCL)' Program on the Horizon?

In a recent post by the Executive Director of the Federation of State Physician Health Programs, Linda Bresnahan, she quoted Dr. Chris Bundy, FSMB Chief Medical Officer, as saying: "A monitored physician is a safe doctor."[21]

Like the revenue-generating maintenance of certification programs specialty boards implemented, one wonders whether a "maintenance of clean (MOCL)" program will replace 5-year monitoring contracts? Intensive and costly lifetime monitoring protocols could be instituted so as to "certify" a physician as "safe for life." Failure to participate in a recommended lifetime maintenance of clean program would likely result in a label of "unclean" or "unsafe."

Also, how is safety enhanced by forcing a physician, who has been given a false diagnosis of substance use disorder so as to justify a highly remunerative inpatient ("Success First") treatment, to enlist in long-term intensive monitoring?

Conclusions

It is abundantly clear that ADA law is an extremely complicated area of law. Physicians who believe that an entity has violated ADA and harmed them need to retain an ADA-knowledgeable attorney early on. By engaging the services of an ADA-knowledgeable attorney early on it may be possible to stop the process before irreparable harm is done.

Physicians should be generally aware of the requirements of ADA with respect to substance-use disorders and perceived or "regarded as" having a substance-use disorder.

The cases described in this editorial may be helpful to a physician's attorney in terms of being aware of the legal arguments that have successfully been made in demonstrating violation of ADA based on disability discrimination.

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