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DOCTORS Rx

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Physicians and the AMERICANS WITH DISABILITIES ACT

find out...

- Who is protected under the ADA?
- What are the legal obligations of health care practices?
- What do you need to do to comply?

A LETTER FROM THE CHAIR OF THE BOARD

Dear Colleague:

The Americans with Disabilities Act (ADA) is one of this country's most comprehensive pieces of civil rights legislation. It prohibits discrimination and guarantees that people with disabilities have the same opportunities as everyone else to participate in the mainstream of American life. This issue of *Doctors RX* will provide information on the law and discuss how the ADA affects Physicians in practice.

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MEDICAL MUTUAL Liability Insurance Society of Maryland
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ISSUE HIGHLIGHTS

DOCTORS RX

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TREATING THE SICK WHILE ACCOMMODATING THE DISABLED

Physicians and the Americans with Disabilities Act

A new patient to your practice makes an appointment with your front desk receptionist and states that she will need an interpreter for the visit because she is deaf. She also mentions that under the ADA, the practice cannot charge her for the services of the interpreter. This is all new to the receptionist and she asks you what she should do.

Do you know?

This issue of *Doctors RX* is going to provide you with the answer to that question. Since this is by its very nature a legal topic, we will begin by providing the legal foundation for your understanding of the Americans with Disabilities Act (ADA) and give you the tools that you need in order to comply with the law.

HOW DO I ACCOMMODATE DISABLED INDIVIDUALS?

While a review of the requirements of the law and the implementing regulations can seem somewhat daunting, providing full and equal access to persons with disabilities *can be achieved through:*

1. the removal of *physical* barriers;
2. providing means *for effective communication with* people who have vision, hearing or speech disabilities; and
3. making *reasonable modifications* to policies, practices and procedures.

To help you better understand your responsibility under this law, we will address the effects of the ADA within the context of health care. This will include providing an overview of the legislation and its history, discussing who qualifies as a protected individual, addressing the ADA's applicability to – and its requirements of – medical practices, and explaining the law's enforcement provisions.

WHAT IS THE ADA AND WHAT DOES IT REQUIRE?

The ADA has been referred to as "the equal opportunity law for people with disabilities," and it recognizes the importance of removing both physical and social barriers facing disabled Americans.[1] It was intended "to provide a clear and comprehensive national mandate for the elimination of discrimination against individuals with disabilities" by addressing access to the workplace (Title I), state and local government services (Title II), places of public accommodation and commercial facilities (Title III), and telecommunications for people with hearing or speech impairments (Title IV).[2]

Originally signed into law in 1990, the ADA was amended in 2008 to redefine terms within the definition of "disability." It added a rule mandating broad coverage of individuals, and prohibited discrimination "on the basis of disability." Consequently, analysis of "disability" and who qualified as "disabled" no longer centered on whether an individual could prove the *existence* of a disability, but rather whether

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Did you know?

According to the latest U.S. Census Bureau Report, approximately 56.7 million people – 19% of the total population – have a disability.

an individual could prove *discrimination* based on that disability.[3]

> *The ADA's mandate applies not only to government and other public institutions, but also to "public accommodations." Under Title III of the ADA, "professional offices of a healthcare provider, hospital, or other service establishment" are considered "public accommodations."*

Under the ADA, therefore, it is discriminatory for *public accommodations*, on the basis of a disability, to either directly or through contractual, licensing or other arrangements, deny an individual the opportunity to participate in or benefit from the goods, services, facilities, advantages or accommodations of an entity.[4]

The public accommodations requirements apply to *all* sizes of businesses (including Physician offices), regardless of the number of employees.

HOW DO I KNOW WHO IS PROTECTED UNDER THE ADA?

To qualify for protection under the ADA, an individual must have a disability. According to the latest U.S. Census Bureau Report, approximately 56.7 million people – 19% of the total population – have a disability.[5] The ADA defines "disability" to mean:

A. a physical or mental impairment that substantially limits one or more major life activities of such individual;

B. a record of such an impairment; or

C. being regarded as having such an impairment.[6]

The ADA, in requiring a broad scope of protection, provides that "[t]he definition of disability…shall be construed in favor of a broad coverage of individuals…to the maximum extent permitted by the terms of this chapter."[7]

Examples of "physical or mental impairments" include, but are not limited to, such contagious and noncontagious diseases and conditions as orthopedic, visual, speech and hearing impairments, cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, mental retardation, emotional illness, specific learning disabilities, HIV disease, tuberculosis, drug addiction and alcoholism.[8]

An impairment is "substantially limiting" if it substantially limits *one* major life activity, regardless of whether it impacts other major life activities.[9] An episodic impairment or an impairment in remission is considered substantially limiting if it limits a major life activity *when active*.[10] A determination as to whether an impairment is substantially limiting must be made "without regard to the ameliorative effects of mitigating measures" such as medication, medical supplies or equipment, or use of assistive technology.[11]

A "major life activity" includes, but is not limited to, caring for oneself, performing manual tasks, seeing, hearing, eating, sleeping, walking, standing, lifting, bending, speaking, breathing, learning, reading, concentrating, thinking, communicating and working.[12] Similarly, "the operation of a bodily function" – i.e., functions of the immune system, normal cell growth, digestive, bowel, bladder, neurological, brain, respiratory, circulatory, endocrine and reproductive functions – *all* constitute "major life activities."[13]

ADA COMPLIANCE

The ADA requires that places of public accommodation "make reasonable modifications in...policies, practices, and procedures in order to accommodate individuals with disabilities."[14] A determination of what is "reasonable" is fact-specific and made on a case-by-case basis, but factors considered include effectiveness of the modification, cost and nature of the disability.[15] Moreover, modifications are not "reasonable" if they would "fundamentally alter" the nature of the goods, services, facilities, privileges, advantages or accommodation offered.[16]

In addition to "reasonable modifications" in policies, practices and procedures, facilitation of an integrated setting *may* require the removal of architectural and structural communication barriers in existing facilities, where such removal is "readily achievable."[17] Readily achievable within the confines of the ADA means easily accomplishable and able to be carried out without much difficulty or expense, and is to be determined on a case-by-case basis in light of the resources available.[18] Removal is not readily achievable if it would fundamentally alter the nature of the public accommodation or would impose an undue burden.

Examples of what may constitute "readily achievable" steps to remove barriers can be found at https://www.law.cornell.edu/cfr/text/28/36.304

Where removal is not readily achievable, the ADA requires that places of public accommodation take "alternative measures" so that goods and services are provided on an equal basis. These alternative measures are required if they are readily achievable and will not pose a significant risk to health or safety.[19] Examples of alternative measures may include relocating activities and/or the provision of goods and services to accessible locations.[20]

Can I Refer a Disabled Patient to Another Physician?

A Physician can refer a patient with a disability to another Doctor *if* the treatment sought is outside the Physician's area of specialty or expertise *and* he would have made a similar referral if a non-disabled person sought the same services. For example, a Physician who exclusively treats burn patients may refer an individual who is not seeking burn treatments to another provider. However, that same Physician cannot refuse to treat a patient who is seeking burn treatment because that patient is HIV-positive.

Practical Considerations: Auxiliary Aids – What are They and What is Required?

The ADA requires health care providers to ensure their communications with disabled individuals – and with *disabled companions* of non-disabled persons – are as effective as communications with non-disabled individuals.[21] Consequently, *all* health care providers – from hospitals to nursing homes to private Physician practices – *must* provide auxiliary aids and services when necessary to ensure effective communication with hearing, speech or vision impaired persons.[22]

The requirement for auxiliary aids is generally triggered by the request of a disabled individual and is somewhat flexible.[23] Examples of auxiliary aids and services contemplated by the ADA include: qualified interpreters, television captioning and decoders, assistive listening headsets, telecommunications devices for deaf persons, computer-aided transcription services (CART), videotext displays, taped texts, readers, Brailled materials and materials in large print.[24]

Effective Communication and Qualified Interpreters

In the context of health care – where communication is paramount – the issue of "qualified interpreters" and what constitutes "effective communication" is of particular

Effective Communication

All health care providers – from hospitals to nursing homes to private Physician practices – must provide auxiliary aids and services when necessary to ensure effective communication with hearing, speech or vision impaired persons.

Did you know?

With limited exception, family members of the individual requiring aid are not considered "qualified interpreters."

importance. Ineffective communication increases the likelihood of medical errors, and includes those errors related to diagnosis and prescriptions.

Under the ADA, to be "effective," communication must be as understandable to individuals with disabilities as it is to those *without* disabilities.[25] The requirement is somewhat patient and context specific, with the type of aid dependent upon the abilities of the disabled individual as well as by the complexity, nature and importance of the communication.

For example, gestures and notes may be sufficient for a hearing impaired individual when the interaction does not involve a discussion of medical care. However, a qualified interpreter is likely required when discussing symptoms, a medical condition, medications and instructions on medications, medical history, tests, diagnoses, treatment options, surgery and/or informed consent.[26] Additionally, to be "effective," the auxiliary aids and services must be provided in accessible formats, in a timely manner, and in such a way as to protect the privacy and independence of the individual with a disability.[27]

A "qualified interpreter" is one who is able to convey communications effectively, accurately and impartially.[28] An interpreter *need not be* certified to be qualified. However, with limited exception, family members of the individual requiring aid are *not* considered "qualified."[29] A minor may not be relied upon to assist with communication with the patient and a patient with disabilities must not be *required* to bring another person to interpret for him or her.

FUNDAMENTAL ALTERATION AND UNDUE BURDEN

The auxiliary aid and services requirement is subject to limitation if it results in either:

1. a fundamental alteration of the health care service; or
2. an undue burden on the health care provider.[30]

The "fundamental alteration" exception will rarely, if ever, apply in a health care context and the provider bears the burden of proof. A "fundamental alteration" is a change that is *so* significant that it alters the essential nature of the goods, services, facilities, privileges, advantages or accommodations offered.

An "undue burden" is synonymous with significant difficulty or expense. Demonstrating "undue burden" is difficult, individualized, and includes factors such as: financial resources of the provider; the effect of expenses on resources; the provider's number of employees; and the impact on the provider's operation.[31] Even if a provider is able to prove an "undue burden," that provider must *still* make alternative aids or services available to the extent possible.[32]

The cost of auxiliary aids, to include interpreters, adds expense that *cannot* be passed on to the individual requiring aid.[33] However, tax credits

are available to small businesses (i.e., thirty or fewer employees or $1 million or less in gross receipts for the preceding year).

ENFORCEMENT AND PENALTIES FOR NON-COMPLIANCE

Both private parties and the attorney general may bring lawsuits for alleged discrimination under the ADA. Private parties may obtain court orders to stop discrimination, but, under federal law, may not obtain monetary damages (with the exception of reasonable attorney's fees and other "litigation expenses"). The attorney general is authorized to file suit in cases of general public importance or in cases alleging a pattern of discrimination. In such cases, monetary damages and civil penalties *may* be awarded.[34] In 2014, the Department of Justice increased the maximum civil penalty to $75,000 for a first violation under Title III and $150,000 for subsequent Title III violations.[35]

To prevail in a case under Title III of the ADA, an individual alleging discrimination must prove:

1. he/she is an individual with a disability;
2. the defendant owned, leased or operated a place of public accommodation; and
3. the alleged discrimination was made on the basis of disability.

A plaintiff need not prove "intent" to discriminate on the part of the defendant.

ADA AND MALPRACTICE

In addition to ADA discrimination lawsuits, the ADA *may* correlate directly to claims of medical malpractice. Malpractice lawsuits allege a failure to adhere to the standard of care (i.e., how a reasonably competent health care provider or institution would act in the same or similar circumstance). Consequently, a failure to make modifications or provide auxiliary aids/services as required by the ADA could potentially be evidence of "unreasonable practice," where the alleged failure was a cause of patient injury. Possible examples include:

1. a claim for lack of informed consent by a hearing impaired individual who is not provided a requested interpreter; or
2. a malpractice claim alleging miscommunication at triage resulting in subsequent improper care because of a failure to provide a requested interpreter.

Although the potential for this type of legal correlation is mostly speculative, a case from Washington state illustrates how the failure to make reasonable modifications in health care services can lead to medical injury actionable under state law, as well as federal legal violations. In *Abernathy v. Valley Medical Center*[36], the hearing impaired patient, who suffered from severe abdominal pain, was unable to receive appropriate emergency care at the defendant hospital because of inadequate accommodations in the form of written notes and a nurse who knew "some" sign language. The court concluded that the claim fell well within the legal standards governing the obligations of hospitals; however, because medical injury was alleged, a negligence action in the state where the injury occurred could also have been brought. Because the connection between ADA compliance and the quality of care can be readily seen in the case of medical injury disputes arising from the failure to make reasonable modifications, it is possible to understand ADA compliance as an aspect of health care services risk management – linking effective communication with effective health care.

TRAINING

In many instances, a Physician may not be personally aware of a patient's disability or request for accommodation. Instead, the patient or prospective patient tells the Physician's staff when making the initial appointment, as in the case of our opening scenario. To provide the best care for patients with disabilities and to ensure ADA compliance, ongoing training for staff is essential. From the first contact that a person has with the practice, staff should be knowledgeable about not refusing service, providing separate or unequal access to health care services to any individual with a disability, or giving the *appearance* of discriminating against the individual.

Civil Penalties

In 2014, the Department of Justice increased the maximum civil penalty to $75,000 for a first violation under Title III and $150,000 for subsequent Title III violations.

Be prepared

Practices should have written policies in place to address how the staff should handle disabled patients and their requests for accommodation.

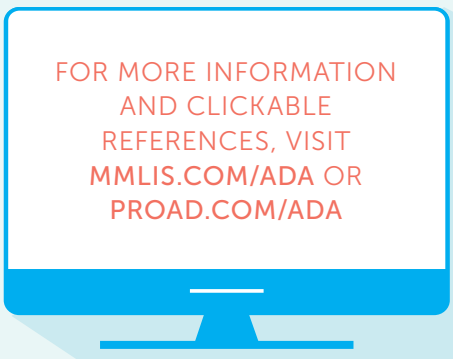
Staff members need to be trained in proper transfer techniques for patients with mobility disabilities to avoid injuries and provide proper safety for patients. They must ensure effective communications with patients who are deaf, hard of hearing, or those with visual impairments or other disabilities. Additionally, all staff must be instructed about keeping public areas accessible to all patients and maintaining clear routes to exam rooms, restrooms, etc. Staff should also be involved in updating policies and procedures to support equal access for individuals with disabilities.

For this reason, practices should have written policies in place to address how the staff should handle disabled patients and their requests for accommodation. The practice should consult with the individual with the disability to determine the type of auxiliary aid that is needed to ensure effective communication. The practice has the ultimate decision for what measures to take, provided the method chosen results in effective communication.

CONCLUSION

The ADA is a fundamental piece of civil rights legislation that is intended to integrate persons with disabilities into all aspects of society, *including* health care. It provides minimum standards with respect to policies, procedures and accessibility to which health care providers must adhere. Failure to comply with the ADA not only perpetuates the isolation of disabled individuals, but also exposes providers to lawsuits and other civil penalties.

An open dialogue between the patient, the Physician's staff and the Physician is the most likely path to achieving equality for the disabled patient and protecting the Physician from a complaint.



references

[1] See https://www.ada.gov/ada_intro.htm
[2] 42 U.S.C. § 12101(b)(1). See https://www.access-board.gov/the-board/laws/americans-with-disabilities-act-intro
[3] See H.R. Rep. No. 110-730 (2008), available at https://www.congress.gov/110/crpt/hrpt730/CRPT-110hrpt730-pt1.pdf
[4] 42 U.S.C. §12182(b)(1)(A).
[5] See https://www.census.gov/newsroom/releases/archives/miscellaneous/cb12-134.html
[6] 42 U.S.C. §12102(1)(A)-(C) (emphasis added).
[7] 42 U.S.C. §12102(4)(A).
[8] U.S. Department of Justice, Civil Rights Division, Disability Rights Section, Title III Highlights, available at https://www.ada.gov/t3hilght.htm
[9] 42 U.S.C. §12102(4)(C).
[10] 42 U.S.C. §12102(4)(D).
[11] 42 U.S.C. §12102(4)(E).
[12] 42 U.S.C. §12102(2)(A).
[13] 42 U.S.C. §12102(2)(B).
[14] U.S. Department of Justice, Civil Rights Division, Disability Rights Section, Title III Highlights, available at https://www.ada.gov/t3hilght.htm
[15] See generally Fortyune v. American Multi-Cinema, Inc., 364 F.3d 1075 (9th Cir. 2004); Staron v. McDonald's Corp., 51 F.3d 353 (2d Cir. 1995).
[16] 28 C.F.R. sec. 36.302(a).
[17] U.S. Department of Justice, Civil Rights Division, Disability Rights Section, Title III Highlights, available at https://www.ada.gov/t3hilght.htm
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[20] U.S. Department of Justice, Civil Rights Division, Disability Rights Section, Title III Highlights, available at https://www.ada.gov/t3hilght.htm
[21] See 28 C.F.R. sec. 36.303. See also Patricia Ganzzermiller et al., v. University of Maryland Upper Chesapeake Medical Center et al., 1:16-cv-03696-JFM.
[22] For example of a policy and procedure for providing auxiliary aids for persons with disabilities visit https://www.hhs.gov/civil-rights/for-providers/clearance-medicare-providers/auxiliary-aids-persons-disabilities/index.html?language=es
[23] U.S. Department of Justice, Civil Rights Division, Disability Rights Section, Title III Highlights, available at https://www.ada.gov/t3hilght.htm
[24] 28 C.F.R. sec 303(b))(1). See also U.S. Department of Justice, Civil Rights Division, Disability Rights Section, Title III Highlights, available at https://www.ada.gov/t3hilght.htm
[25] See generally 28 C.F.R. sec. 36.303. Additional information on "effective communication" available at https://www.ada.gov/effective-comm.htm
[26] See generally ADA Quick Tips – Sign Language Interpreters, available at https://adata.org/factsheet/sign-language-interpreters
[27] 28 C.F.R. sec. 36.303(c)(1)(ii).
[28] For information on how to find a qualified interpreter see the National Registry of Interpreters for the Deaf (RID) (http://rid.org). Additional resources may be available at the Maryland Governor's Office of the Deaf and Hard of Hearing (http://odhh.maryland.gov/) or from local chapters of the National Association of the Deaf (https://www.nad.org/). See also Virginia Department for the Deaf and Hard of Hearing (https://www.vddhh.org/).
[29] 28 C.F.R. sec. 35.160(c)(2) and (3). (The first exception allowing for a family member interpreter is for emergencies involving imminent threat to the safety or welfare of an individual or the public when no interpreter is available. The second exception applies in non-emergent situations where the individual requests use of a family member interpreter, the accompanying adult agrees, and reliance on the accompanying adult is appropriate under the circumstances.)
[30] 28 C.F.R. sec. 36.303(a).
[31] 28 C.F.R. sec. 36.104.
[32] 28 C.F.R. sec. 36.303(f).
[33] 28 C.F.R. sec. 36.301(c). See ADA Quick Tips – Sign Language Interpreters, available at https://adata.org/factsheet/sign-language-interpreters
[34] See generally 42 U.S.C. §12188(b).
[35] https://www.ada.gov/civil_penalties_2014.htm (Discussing the March 28, 2014 final rule adjusting civil monetary penalties assessed or enforced by the Civil Rights Division.)
[36] 2006 WL 1515600 (W.D. Wash., May 25, 2006).

CME TEST QUESTIONS

1. The ADA pertains only to the removal of physical barriers.

   A. True B. False

2. The ADA applies to the professional offices of a Physician in private practice.

   A. True B. False

3. Alcoholism and drug addiction are considered "physical or mental impairments" under the ADA.

   A. True B. False

4. Reading, concentrating and thinking are not considered "major life activities" under the ADA.

   A. True B. False

5. Determination of whether an impairment is "substantially limiting" is to be made after considering the individual ameliorative effects of mitigating measures.

   A. True B. False

6. The ADA requires health care providers to make every accommodation requested by all persons with disabilities.

   A. True B. False

7. Generally, family members are considered qualified interpreters under the ADA.

   A. True B. False

8. The individual requesting the accommodation bears the burden of proving the requested accommodation would result in a fundamental alteration of the goods or services provided.

   A. True B. False

9. The cost of auxiliary aids can be passed along to the individual requiring aid.

   A. True B. False

10. An individual is "disabled" under the ADA if he/she is regarded as having an impairment, regardless of whether that individual actually suffers from a physical or mental impairment that substantially limits one or more major life activity.

    A. True B. False

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3. Completion Deadline: August 31, 2017
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CME EVALUATION FORM

Statement of Educational Purpose

Doctors RX is a newsletter sent twice each year to the insured Physicians of MEDICAL MUTUAL/Professionals Advocate.® Its mission and educational purpose is to identify current health care-related risk management issues and provide Physicians with educational information that will enable them to reduce their malpractice liability risk.

Readers of the newsletter should be able to obtain the following educational objectives:
1) Gain information on topics of particular importance to them as Physicians
2) Assess the newsletter's value to them as practicing Physicians
3) Assess how this information may influence their own practices

CME Objectives for "PHYSICIANS AND THE AMERICANS WITH DISABILITIES ACT"

Educational Objectives: Upon completion of this enduring material, participants will be better able to:
1) Describe the intent of the Americans with Disabilities Act
2) Understand which individuals have protection under the Act
3) Determine what is a "reasonable accommodation"

	Strongly Agree				Strongly Disagree
Part 1. Educational Value:	5	4	3	2	1
I learned something new that was important.	❑	❑	❑	❑	❑
I verified some important information.	❑	❑	❑	❑	❑
I plan to seek more information on this topic.	❑	❑	❑	❑	❑
This information is likely to have an impact on my practice.	❑	❑	❑	❑	❑

Part 2. Commitment to Change: What change(s) (if any) do you plan to make in your practice as a result of reading this newsletter?

_____

_____

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Part 3. Statement of Completion: I attest to having completed the CME activity.

Signature:_____ Date:_____

Part 4. Identifying Information: Please PRINT legibly or type the following:

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Objectives

Upon completion of this live activity, participants will be better able to:

- Understand the litigation process (i.e., tort law, the theory of negligence, standard of care)
- Identify communication issues in pathology practice that impact the litigation process
- Understand the role of the pathologist as a witness or party in a civil case
- Identify risk issues for pathologists with specific case examples

DATE	*CODE*	*FACILITY*	*LOCATION*
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Tue, Sept 5	5216	Holy Cross Hospital	Silver Spring

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