The Americans with Disabilities Act

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Many issues arise when professionals provide services to individuals who are protected by both Federal and New York State laws which prohibit discrimination based on disability. The definition of a disabled individual covered by these laws is very broad and was expanded by amendments to the Federal Americans with Disabilities Act (ADA) that became effective January 1, 2009. It is important to be aware that the law protects not only those individuals with obvious impairment, but any individuals with a physical or mental/cognitive condition even if the condition is not overt. Certain diseases are also protected by this law.

The ADA defines a disability as a physical or mental impairment that substantially limits one or more of a person's major life activities including, but 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."[1]

A disability also includes having a record of an impairment and/or being regarded as having an impairment.[2] New York State defines a disability as a "physical, mental or medical impairment resulting from anatomical, physiological, genetic or neurological conditions which prevents exercise of a normal bodily function or is demonstrable by medically accepted clinical or laboratory diagnostic techniques, or a record of such an impairment, or a condition regarded by others as such an impairment."[3]

Risk Management Issues

Since private medical offices are considered to be places of public accommodation,[4] they must abide by State and Federal laws. We recommend that every physician perform a careful office assessment to evaluate and determine whether the office environment protects and facilitates the treatment of patients with disabilities. As part of the assessment, all of the following questions should be considered:

- Do barriers exist which might create a risk to the safety of a patient with a disability and could this risk result in the physician's liability or allegations of discrimination?
- Will a disabled (or even an elderly) patient be safe if left alone, even momentarily, on an examination table? Should this patient be left alone?
- If a patient who is visually or hearing impaired is left alone in an examination room, how will the patient communicate with the physician or his/her staff to obtain any necessary assistance?
- How are appointments made? Does the office have access to, or are the physician and his/her staff knowledgeable about, assistive interpretive devices and the use of interpreters and services? How does the physician communicate with a hearing-impaired patient in the event of an emergency? Is an interpreter or other assistive device or service promptly available, if needed?
- Are elevators and bathrooms handicapped accessible?
- Are sufficient office parking spots available for handicapped individuals?
- Are doors sufficiently wide for a patient to enter the office in a wheelchair? Are appropriate methods available to safely transfer such patients from the wheelchair to the examination table for examination and/or treatment, without injuring the patient, physician and/or staff?
- Is a staff member available to assist a patient with a physical disability who needs to use the bathroom to stand up safely from a chair or examination table?
- If a patient has a cognitive or mental impairment, does the office ensure that the patient is accompanied by an aide or relative who is legally authorized to provide consent for treatment as well as an accurate health and medical history, such as known allergies, a current list of medications the patient is taking, and other relevant information?
- Are visually impaired patients given verbal instructions for treatment and care? Are consent forms read to them? When providing a prescription for medication or discharge instructions after a procedure, is a careful verbal explanation given to the patient? Does the physician request that the patient repeat the consent discussion or instruction back to him/her in order to confirm that the patient understands?
- Are wheelchairs, examination tables and other equipment and furniture sufficiently large and strong enough to accommodate patients who are morbidly obese?

1. 42 U.S.C.S. § 12102 (2)(a).
2. 42 U.S.C.S. § 12102 (1).
3. Executive Law § 292 (21).
4. 42 U.S.C.S. § 12181 (7)(F).

Risk Management Recommendations

Physicians must address the environment of care inside their offices from a risk management perspective in order to avoid allegations of discrimination when patients with protected disabilities seek care at their practices. The most obvious areas of concern are the waiting room, the examination tables, the bathroom facilities, handicapped access in the parking area, and access when entering the office. Important risk management recommendations include the following areas:

Accessibility

The patient must be able to get on and off an examination table with assistance. While on the examination table, the patient must be protected from falling, and/or reasonably and safely assisted with hygiene needs, if necessary. Access into the office, the waiting room, and bathrooms must be sufficiently large and safe for the use of wheelchairs and other assistive devices and also must be free of obstacles. Liability for falls or other injuries sustained by patients due to the physical environment of the office is a concern which co-exists with discrimination.

Documentation

Another problem identified by many physicians is what to document about the patient and how to do so. This is of particular concern when the patient is HIV-positive. New York State HIV law[5] permits the documentation of all relevant HIV-related information and the patient's HIV status in the record. However, once this information is documented, whether the HIV-related information is positive or negative, it becomes highly sensitive information accorded special protections. Further, State law requires a Notice of Prohibition Against Redisclosure to be sent with a copy of the medical records when they are released.[6] Finally, any authorization

to release records containing HIV-related information to a third party must include specific consent to release such information.[7] Similar legal protection is afforded to those patients whose records include psychiatric treatment or treatment in federally funded substance abuse programs.[8]

Infection Control Guidelines

Physicians and their staff must follow Occupational Safety and Health Administration (OSHA) regulations[9] for exposure to blood and body fluids, since the HIV and hepatitis status of every patient may not be known. This requirement for protection of employees is governed by OSHA regulations. Additionally, a patient's medical record containing HIV-related information must not be specially flagged, nor otherwise made obvious to staff and others, merely to "protect" them from exposure to infection. Physicians have a legal duty to enforce compliance with the OSHA regulations.

Confidentiality

The statutory protections of patient confidentiality and against discrimination for HIV, mental health treatment, and alcohol and drug treatment are stringent. Discussions of a patient's HIV status, inpatient or outpatient treatment for mental illness, or alcohol/drug abuse must only take place in a completely private area. Only individuals who have a need to know this information for their specific duties should be informed. Finally, access to protected patient records must be limited to only those staff members who need to know or review the contents of the records to carry out their duties.[10]

Fager Amsler & Keller, LLP recommends that all medical practices have a written confidentiality policy in place so the staff clearly understands both the responsibilities and consequences they will face if they improperly disclose, at any time, a patient's Protected Health Information (PHI), and particularly

5. Public Health Law § 2700 et. seq.
6. Public Health Law § 2782 (5)(a).
7. Public Health Law § 2782(1)(b). Except for documentation of the routine offering of a test to patients ages 13-64 pursuant to PHL § 2781-a which does not require special consent, only the Notice of Prohibition Against Redisclosure.
8. 42 C.F.R. §§ 2.31, 2.33; Mental Hygiene Law §§ 33.13, 33.16.
9. 29 C.F.R. § 1910.1030.
10. Public Health Law § 2782 (1)(c), (d); 42 C.F.R. § 2.13 (a), Mental Hygiene Law § 33.13 (f).

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HIV-related, mental health or alcohol and drug treatment information. Staff must be oriented to, and annually re-educated about, infection control and confidentiality laws and guidelines. Documentation of such education must be placed in their personnel files.

Patient Restraints

The use of patient restraints is generally not acceptable when treating patients from a facility or organization governed by the Office for People with Developmental Disabilities (OPWDD). However, what is even more important, and sometimes more difficult, is restraining oneself during an examination or treatment from responding to a patient bite or agitation in an inappropriate and "abusive" manner. Such a response is often reflexive. For example, if a patient hits or bites a physician or staff member, and the individual reflexively slaps the patient, the ramifications can be severe. This may even include adverse licensure action for patient abuse, regardless of whether the action was unintentional.

Interpreters

Another very thorny issue for many practitioners is the obligation to obtain a sign language interpreter for hearing impaired patients at their request, even though there is no reimbursement for this expense. Physicians often question whether it is acceptable to use pencil and paper or other communication devices, rather than obtaining an interpreter.

A public accommodation must furnish appropriate auxiliary aids and services where necessary to ensure effective communication with individuals with disabilities.[11] The type of auxiliary aid or service necessary to ensure effective communication varies, depending on the method of communication used by the patient, the nature, length, time and complexity of the communication involved, and the context in which the communication is taking place. Medical offices should consult with individuals with disabilities whenever possible to determine what type of auxiliary aid is needed to ensure effective communication, but the ultimate decision as to what measures to take rests with the provider, so long as the method chosen results in effective communication.[12]

When a patient or a companion[13] of the patient asks a physician for a specific accommodation, such as a sign language interpreter to provide effective communication, we recommend that the physician accede to the request. Handwritten notes are often incomplete, time consuming, and cursory. The patient might miss crucial information, which can lead to errors, patient injury, and potential malpractice claims. More importantly, since a physician must frequently communicate critical information to a patient, such as an informed consent discussion about a treatment, procedure or a new medication, it may not be reasonable or appropriate to communicate this information without the aid of a qualified interpreter. A provider may not rely on an adult accompanying an individual with a disability to interpret or facilitate communication, unless:

- there is an emergency that presents an imminent threat to the patient or the public and no interpreter is available.
- an individual with a disability specifically requests that the accompanying adult interpret or facilitate communication, the accompanying adult agrees to provide such assistance, and reliance on that adult for such assistance is appropriate under the circumstances.[14]

The physician cannot require the patient and/or companion to bring another individual to interpret for him/her.[15] Moreover, a provider may not rely on a minor child to interpret or facilitate communication, except in an emergency involving an imminent threat to the safety or welfare of an individual or the public where there is no interpreter available.[16]

If acceptable to the patient, physicians may choose to provide equipment, such as telecommunication devices for the deaf (TDD), instead of an interpreter. These devices must also be able to provide effective communication between the physician and patient so they can communicate about making appointments, scheduled procedures, or any other type of information that one party must communicate to the other. However, if this equipment fails or is otherwise not acceptable to the patient after its use and the patient requests an interpreter, one should be provided. Physicians must "give primary consideration to the requests of an individual with disability."[17] Regardless, we recommend a qualified interpreter be used whenever important doctor-patient discussions, such as obtaining informed consent or a medical history, are necessary.

Informed consent discussions are crucial when obtaining consent for invasive or potentially high risk treatment. The patient must be able to receive that information from a qualified interpreter

11. 28 C.F.R. § 36.303 (c)(1).
12. 28 C.F.R. § 36.303 (c)(1).
13. Companion "means a family member, friend or associate of an individual seeking access to, or participating in, the goods, services, facilities, privileges, advantages, or accommodations of a public accommodation, who, along with such individual, is an appropriate person with whom the public accommodation should communicate." 28 C.F.R. § 36.303 (c)(1)(i).
14. 28 C.F.R. § 36.303(c)(3)(i)
15. 28 C.F.R. § 36.303(c)(2).
16. 28 C.F.R. § 36.303(c)(4).
17. 28 C.F.R. § 35.160 (b)(2).

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in order to fully understand it and provide a valid consent. The discussion must include the risks, benefits, and alternatives of the proposed plan, including the risks of no treatment, and the risks of any available alternatives. The patient's inability to hear may also necessitate the use of pictures in addition to interpreters. If possible, patients should be given simple brochures to read about a particular treatment or procedure as an adjunct to the interpretation provided. The office staff should be educated about the needs of patients with disabilities and, particularly, the special needs of deaf patients and the reasonable accommodations which must be provided to them.

Sometimes a patient with a hearing disability demands the use of the interpreter service of their choice rather than using an auxiliary assistive device such as Video Remote Interpreting (VRI). Be aware that there are times a VRI is not suited to the task because of technical or other limitations. Further, many interpreting services claim that it is a legal (ADA) requirement for a physician to provide a certified interpreter. This claim is not correct. The ADA requires only that the interpreter be a qualified interpreter, which means that the individual is "able to perform the tasks of interpretation appropriately and accurately in a given situation."[18]

The cost of retaining an interpreter is often more than the cost of the actual visit, although this fee can be taken as a business expense for tax purposes. However, it is still "negative math." The charges often include not only the time the interpreter is present, but also travel expenses and full fees for missed patient appointments. Some services demand their fees "up front." When a physician has a noncompliant patient who fails to keep multiple appointments, this cost can be discouraging. However, the cost of personally defending a discrimination proceeding is far greater than absorbing the cost of an interpreter. If you fail to provide an interpreter, the patient may commence malpractice litigation alleging a breach of informed consent and/or file a claim of discrimination with a government agency such as the Equal Employment Opportunity Commission (EEOC) or New York State Division for Human Rights (DHR). Malpractice insurers do not cover complaints filed with government agencies because it is against public policy. An insurer is precluded from defending statutory violations, as well as the payment of fines or penalties assessed by a government agency. However, you should still notify MLMIC of any claim or lawsuit made against you by an individual because it is possible that some of the allegations made will fall within your policy coverage.

Service Animals

Practitioners may believe that service animals are only used by persons who are visually impaired. This is not the case. When an individual who is visually impaired or otherwise physically disabled brings a service animal to an appointment, he/she may insist that the animal be permitted to accompany them into non-public areas of the office, such as treatment or operating rooms. How to respond to these requests may create problems for the staff.

Sometimes, patients allege that office staff must be responsible for care for the animal during the patient's examination or procedure. However, when a patient brings a service animal to an extended appointment for treatment, or to a facility where he/she will undergo a procedure, the law does not require that staff be responsible for caring for the animal.[19] It is the patient's responsibility to arrange for care of the animal, not that of a physician, staff, or facility.

Service animals can be excluded from the premises when they are either disruptive, or a "direct threat." A direct threat is a "significant risk to the health or safety of others that cannot be eliminated by reasonable accommodations."[20] A dog that is out of control, is not housebroken, or whose handler fails to take appropriate action to prevent hygiene problems and/or is not restrained on a leash or tether, can be considered a direct threat. The specifics of the "direct threat" must be documented by the physician in order to justify the exclusion of the animal and an alternative accommodation provided to the patient.

Finally, interior examination and treatment rooms are not considered to be "public areas" due to concerns about infection control. Service animals can be excluded from those areas. However, the patient must still be given a reasonable accommodation when taken to non-public areas. This accommodation may include physically assisting the patient to and from the public areas in a safe manner, such as in a wheelchair.

Due to recent changes in the law, the definition of a service animal has been limited to dogs.[21] These changes did not affect the right of a disabled patient to use a service horse to assist in movement. However, dogs used for other purposes, such as protection from violence, rescue, or emotional support, are not considered service animals and do not require any reasonable accommodations.

There are certain limitations pertaining to the use of service animals. A service dog must be trained to perform specific tasks and, as noted, not merely provide emotional support. Tasks these animals can perform include:

18. Beth Schoenberg and Beth Carlson, "Interpreters: Certified or Qualified?" (1999). Accessed at http://www.signonasl.com/doc/interpreters_certified_or_qualified.pdf.
19. 42 C.F.R. § 35.136 (e). U.S. Dep't of Justice, Civil Rights Division, ADA Standards, Service Animals (2011). Accessed at http://www.ada.gov/service_animals_2010.htm on November 5, 2015.
20. 42 U.S.C.S. § 12111 (3), 28 C.F.R. § 35.136.
21. 28 C.F.R. § 35.104.

- assisting blind individuals or others with poor vision with navigation;
- alerting deaf patients to other people, dangers, and sounds;
- pulling a wheelchair;
- assisting during a seizure;
- alerting the patient to possible allergens;
- retrieving items for the person, or accessing the telephone;
- physically supporting the individual and assisting with balance and stability; and
- helping psychologically or neurologically disabled patients prevent or interrupt impulsive or destructive behaviors.

Physicians and/or staff often are uncertain what questions they can ask a patient who brings in a service animal about the patient's need for that animal. The law does not permit the patient to be questioned about the nature of his/her disability. Nor can the patient be asked whether the dog is certified, licensed, or trained as a service animal. There are only two questions which the physician can ask the patient: 1) is the animal required because of a disability? and 2) what tasks has the animal been trained to perform?

Below are several real life scenarios which have involved problems with patients who had service animals:

- A patient who had a service animal to warn him of impending seizures requested admission to a locked mental health unit in a medical facility. The patient also demanded that the dog be admitted with him and the staff of the facility care for the dog while he was on the unit. The patients on this locked unit had unpredictable behaviors. Thus, there was a "direct threat" to both the dog and the other patients by agreeing to his demands. Additionally, the staff was not required to provide care for this service animal during this patient's admission, so the patient was informed that other arrangements would have to be made for the animal during this admission.[22]
- A patient came to the waiting room of a clinic for an appointment. He had a service horse pulling his wheelchair. The horse became nervous, broke loose from the tether, and ran around the public area of the facility, leaving excrement all over the waiting room floor. The service horse was excluded from the facility and other reasonable accommodations were provided to the patient because the horse created a direct threat to other patients, was out of control, and soiled the premises.[23]
- A 1999 case decided by the Appellate Division, 4th Department, and affirmed by the New York State Court of Appeals, is also relevant to the issue of service dogs in the medical office setting.[24] The patient was in an examination room with her service dog. When the doctor came in to the room, he allegedly yelled at the patient because the dog's head and mouth were on the examination table. The patient claimed discrimination and sued the physician.

The key issue in this case was whether an examination room was considered a public area. If it was, the physician could not bar the dog from that room. However, the court decided that an examination room is NOT a public area. This decision specifically confirmed that private offices and medical facilities may have public and private areas which co-exist under the same roof.

22. 42 U.S.C. Section 12182 (b) (3).
23. 28 C.F.R. § 36.302 (c)(9).
24. Albert v Solimon, 684 N.Y.S. 2d 375, aff'd by 94 N.Y. 2d 771 (1999).

Discharging or Refusing to Treat Patients

The most significant risk a physician faces is discharging, refusing to treat, or refusing to even accept a disabled patient because of the cost of a reasonable accommodation, e.g., an interpreter. A physician must not use the cost of the accommodation as the reason not to accept a patient, and the patient must not be charged for that cost.

In a case decided by the Eastern District Court in Michigan, the plaintiff requested an interpreter for her December 1992 visit, and the physician provided and paid for one. In January 1993, the physician wrote a letter to accompany the payment for the interpreter and sent a copy to the patient. The physician stated she could no longer use the interpreter service. The defendant charged $40 for a 15 minute visit. Medicare paid $37.17 and the patient would pay $9.29. The physician further indicated that her overhead was 70% of her gross receipts, so her profit for this visit was $13.94. When the $28 charge from the interpreter was paid, the physician contended she had lost money on the visit. The physician further stated, "I certainly hope that the Federal Government does not further slash this outrageous profit margin." The patient interpreted the physician's letter as stating that the physician would not hire an interpreter and that she had been discharged as a patient. The physician claimed the letter was meant to protect her from the ramifications of the ADA.

The Court held that the patient had clearly proven that she was disabled, that the physician's office was a place of public accommodation, and that the physician discriminated against the patient based on her disability. The physician's January 1993 letter was evidence of her intent to refuse to provide an interpreter

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and discharge the patient from care. The patient's request for interpreters for future office visits was documented in her medical record. At another office visit, the physician documented advice to the plaintiff to see an ophthalmologist and bring along someone to sign for her.[25]

Many of the early discrimination cases brought under the ADA and New York State Human Rights laws involved the alleged refusal of physicians to treat patients because of their HIV positive status, which is considered a disability. However, a physician can discharge or transfer a patient with a disability if there is a non-discriminatory and legitimate reason to do so. Therefore, it is crucial to have substantial written documentation of the reason(s) for the discharge. As long as the reason for discharge is not the cost of the accommodation, or the disability itself, and all patients are treated similarly (i.e., referral to a specialist for treatment the physician does not provide), physicians can discharge disruptive, threatening, or hostile patients, as well as consistently noncompliant or nonpaying patients who happen to have a disability. Again, it must be emphasized that this pattern of behavior must be well-documented in the medical record. The behavior should not merely occur only one time, unless the patient has exhibited actual violent acts or made serious, documented, and realistic threats of violence in the office against the physician or his staff.

In conclusion, physicians must understand that treating patients who are protected under the ADA and New York State Human Rights laws can be difficult and may be costly. However, all patients, with or without a disability, are entitled to reasonable and appropriate quality care. Patients should not be refused or discharged solely because they have a disability. Physicians must be knowledgeable of what state and federal laws consider a disability. Finally, a physician's risk of being sued for discrimination can be greatly diminished by fully complying with applicable state and federal anti-discrimination and confidentiality laws. ❖

25. Mayberry v. Von Valtier 843 F. Supp. 1160 (E.D. Michigan, 1994).

Use of Summary Judgment *continued from page 1*

not find for the opposing party based on the facts. A key component of such a motion in a medical malpractice action is an affirmation or affidavit from an expert physician attesting to the care rendered and explaining why it was consistent with the standard of practice and/or did not cause the injury claimed by the patient. Motions for summary judgment are made after the close of the "discovery" phase of the lawsuit, during which each party obtains evidence through production of medical records, depositions, and other formal demands for information.

A summary judgment motion is the paper equivalent of a trial. Much like developing the defense of a case to be tried before a jury, a summary judgment motion requires extensive preparation. To avoid having the motion denied by the judge based upon a technicality, the attorney must work to secure supporting evidence in admissible form. The supporting evidence may include the opinion of a physician, certified copies of the patient's medical records, and the sworn deposition testimony of the parties. Further, recent developments in the law have imposed the arduous requirement that attorneys redact all confidential personal information from the motion papers and supporting exhibits.

If the evidence submitted in support of a summary judgment motion is not in admissible form, i.e. uncertified records, the court may deny the motion without considering the merit of the arguments. Further, the court may reject motion papers that are not properly redacted. In addition to these requirements, the courts impose very strict deadlines for the filing of summary judgment motions. Absent "good cause," a judge will deny an untimely summary judgment motion without considering its merit.

Therefore, to avoid the risk of preclusion and losing the opportunity to obtain summary judgment, it is crucial that counsel obtain supporting evidence in admissible form so that a timely summary judgment motion can be filed. It is important to analyze a case in its early stages to explore possible ways to dispose of it before trial. If there is a potential basis for making a summary judgment motion, or if it is necessary to oppose a summary judgment motion by the plaintiff, early expert retention is recommended so that the case can be thoroughly reviewed and an expert can support the motion. If the motion is successful, the burden and expense of a trial may be avoided. ❖

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