

Legal Briefings

The ADA in the Healthcare Setting

By Equip for Equality¹

I. Introduction

People with disabilities have a disproportionately high need for healthcare services in comparison with the American population in general. For many people with disabilities, having timely access to quality healthcare can not only allow them to manage their medical conditions before they become even more serious or even life-threatening, but can empower them to live independently in the community rather than having to reside in institutional settings. To this end, and in many different respects, the Americans with Disabilities Act (“ADA”) helps to ensure access to healthcare and medical services for people with disabilities comparable to that enjoyed by their nondisabled peers. This brief provides an overview of various applications of the ADA in the healthcare context, with a particular exploration of nationwide case law and federal regulatory actions from the past several years.

II. Title I in the context of healthcare

Title I of the ADA is intended to protect individuals from disability-related discrimination in the workplace and when applying for employment.² Such discrimination includes employers “not making reasonable accommodations to the known physical or mental limitations of an otherwise qualified individual with a disability.”³ Reasonable accommodations are defined as “[m]odifications or adjustments ... that enable a qualified individual with a disability to perform the essential functions of [a] position ... or ... enjoy equal benefits and privileges of employment.”⁴ An employer is required to provide such accommodations absent a showing of undue hardship, which is defined as “an action requiring significant difficulty or expense.”⁵ To be considered “otherwise qualified,” an employee must demonstrate his ability to perform the essential functions of a given position with or without a reasonable accommodation.⁶ An employer is obliged to engage in an interactive process with any otherwise-qualified employee with a disability who has requested an accommodation to identify accommodations that may be reasonable and appropriate for the situation at hand.⁷ Following is an exploration of recent federal case law examining and applying these Title I standards to employment cases arising in the healthcare field.

A. Essential Job Functions

Courts have identified ensuring patient safety as one of the very most essential job functions of healthcare workers, and thus true risks to patient safety can be adequate grounds for denying employment or accommodations requested by employees. However, employers must remember to always consider whether an accommodation would enable the employee to meet the essential function of ensuring patient safety when engaging in this analysis. Further, as the cases below outline, issues of patient safety can also be evaluated as a direct threat.

For example, in *Leme v. Southern Baptist Hospital of Florida*, a Florida district court reviewed the Title I claim of a plaintiff with a visual impairment who had been employed by a hospital as an anesthesia technician.⁸ During plaintiff's initial training period, he had had difficulty on account of his limited vision in performing some of the standard functions of his position. For example, he had difficulty visually inspecting lines to ensure that they were free of bubbles before connecting those lines to patients, as well as correctly connecting the lines themselves.⁹ In light of these difficulties and defendant's resulting concerns for patient safety, defendant advised plaintiff that he could no longer work in this position, and allowed him to apply for other positions at the hospital.¹⁰ In response, plaintiff proposed various possible accommodations to enable him to continue in the role of technician. However, the record provided evidence as to why each of these accommodations was either an undue burden or presented further safety risks.¹¹ As such, the court found that plaintiff failed to establish that he was a qualified individual who was able to perform the essential functions of the job with or without accommodation, and granted defendant's motion for summary judgment.¹²

Other courts have also found for employers on the grounds that plaintiffs have failed to identify any available reasonable accommodations at all in light of the essential nature of the job or workplace in question. In *Dickerson v. Secretary, Dept. of Veterans Affairs Agency*, the Eleventh Circuit reviewed a Rehabilitation Act discrimination claim brought by a nurse with scent allergies and chemical sensitivities against the VA medical center where she had been employed.¹³ The court found that plaintiff had failed to identify any reasonable accommodation that would enable her to perform the essential functions of her job on defendant's premises, as she had identified no areas where she could work free of exposure to the substances to which she would react adversely.¹⁴ Therefore, the court affirmed the summary judgment ruling in favor of defendant.

Elsewhere, in ***Wulff v. Sentara Healthcare***, a nurse sued her former employer, a hospital, based upon its refusal to accommodate her total restriction from lifting in the workplace, as prescribed by her doctor.¹⁵ Defendant had in fact accommodated plaintiff's initial prescribed lifting limit of ten pounds with one arm.¹⁶ However, after plaintiff's doctor changed the restriction to ban plaintiff from lifting altogether, defendant asserted that lifting was an essential function of plaintiff's job, and that as such this accommodation could not be granted.¹⁷ Defendant placed plaintiff on medical leave in light of this total lifting restriction, prompting plaintiff to sue claiming that her rights under the ADA had been violated. In her suit, plaintiff did not focus directly upon defendant's failure to accommodate her total lifting restriction. Rather, she claimed that her doctor erred in so broadening the restriction, and that defendant should have recognized in light of all circumstances that plaintiff was fit to continue working within the original limit.¹⁸ However, the Fourth Circuit disagreed and affirmed summary judgment for defendant. The court noted that it had been plaintiff's duty to present her disagreement with the total ban to her prescribing physician, rather than to defendant, though she never did so.¹⁹ Additionally, the court found that Title I affords employers the right to rely upon the opinions of employees' physicians, and that employers have no duty to conduct their own analyses or formulate their own medical conclusions in such circumstances.²⁰

Similarly, in ***Anderson v. Eastern Connecticut Health Network***, plaintiff was an experienced surgeon who had begun to decline in his work due to depression.²¹ He sometimes "slurred his speech and mumbled," "repeatedly sutured his own glove" during surgery, had toothpaste on his face while meeting patients, and asked an anesthesiologist to give him an injection of painkillers for his back pain while in the middle of an operation.²² Plaintiff took 60 days of paid leave and began to negotiate the terms of his return. Defendant hospital proposed to accommodate plaintiff by limiting the kind of procedures he could perform and providing a proctor to monitor him until his performance improved. Plaintiff objected to these terms on the basis that they would technically constitute a disciplinary action that would have to be reported to the national medical malpractice oversight board.²³ The court ruled for defendant, finding its proposed accommodations to have been adequate, and that it was unreasonable to expect an employer to tailor accommodations in order to avoid standard reporting procedures designed to ensure patient safety.²⁴

However, courts have also found that patient safety cannot be used as an excuse to disqualify an applicant or employee without true evidence to support it, especially when the defendant claims the employee posed a direct threat. For instance, in **Osborne v.**

Baxter Healthcare Corp., the Tenth Circuit reviewed a Title I claim brought by a woman who was deaf and who had been conditionally hired as a monitor for plasma donors, but whose employment offer was rescinded by defendant plasma donation center after her physical examination revealed her disability.²⁵ The hiring managers contended that plaintiff's disability would make it impossible for her to fulfill essential functions of the job, including hearing audible alarms on medical equipment and hearing donors calling for assistance when in need or distress.²⁶ Defendant argued that both these limitations presented direct threats to donor safety. Plaintiff proposed several possible accommodations to mitigate the risks, including the installation of flashing or vibrating alerts and providing call buttons for individual donors. However, defendant was unwilling to accept any of the proposed accommodations in order to facilitate plaintiff's employment.²⁷

The Tenth Circuit reversed the district court's grant of summary judgment for defendant and remanded for further proceedings, finding that material issues of fact existed as to whether defendant could provide plaintiff with the requested accommodations. In its ruling, the court considered the statistical evidence presented by both sides and applied the direct threat criteria set forth in **School Board of Nassau County v. Arline**.²⁸ It noted that donors experienced adverse reactions to plasmapheresis fewer than 5 times annually. And while it acknowledged that relatively minor adverse reactions such as dizziness can progress to serious conditions without prompt medical attention, nevertheless it noted that "plasma donation carries a historically low risk—about 0.0004%—of significant adverse donor reactions," a risk that would be further decreased by the proposed accommodations.²⁹ The court found that the "infinitesimal risk" that a donor would experience a significant adverse reaction *and* that plaintiff would fail to notice a visual or vibrating alert did not constitute a direct threat.³⁰ Plaintiff "must only show that her proposed accommodation is reasonable on its face...she need not show that the accommodation would eliminate every de minimis health or safety risk that [defendant] can hypothesize."³¹

Employers should also consider reasonable accommodations that would reduce the threat; the following cases are examples where employers prevailed due, in part, to their

exploration and attempts to find workable accommodations to address safety issues. In ***Stern v. St. Anthony's Health Ctr.***, the Seventh Circuit affirmed summary judgment in favor of a hospital that had terminated one of its doctors on account of the doctor's memory problems.³² The court agreed with the hospital's conclusion that the doctor's memory issues precluded him from performing essential functions of his job, and that the accommodations that the doctor had proposed prior to being terminated were less than reasonable in light of the hospital's legitimate concern for the safety of its patients.³³ Indeed, the court noted that "[t]he ADA does not require an employer to walk on a razor's edge – in jeopardy of violating the [ADA] if it fired such an employee, yet in jeopardy of being deemed negligent if it retained him and he hurt someone."³⁴

Likewise, in ***Olsen v. Capital Region Medical Center***, the Eighth Circuit affirmed summary judgment in favor of a healthcare facility which had removed plaintiff as a mammography technician after finding that her epilepsy posed a risk to patient safety and prevented her from performing the essential functions of her job.³⁵ The court found that plaintiff's epileptic seizures caused her to frequently lose consciousness, including while performing her work and caring for patients, and thus posed a clear and imminent risk with regard to her own safety and that of others in the workplace.³⁶ Plaintiff's seizures persisted despite the various measures that defendant had implemented in its earnest efforts to accommodate plaintiff's condition.³⁷ The court thus found the evidence to establish that the direct threat posed by plaintiff's disability could not be adequately mitigated through reasonable accommodations in order to ensure patient and workplace safety.

In ***EEOC v. St. Joseph's Hospital***, the Eleventh Circuit reviewed a Title I claim brought by a nurse who had been reassigned from her position based on defendant's contention that she posed a direct threat in light of her disability.³⁸ Defendant required a cane in order to ambulate, and defendant said that the cane posed a safety hazard within the psychiatric ward within which the nurse was working. The hospital removed her from her station in the psychiatric ward, whereupon she was permitted to apply for other positions within the hospital.³⁹ However, plaintiff was never hired for any of the other positions for which she applied, and was then terminated at the end of defendant's standard internal transfer period.⁴⁰ The court found that defendant had provided plaintiff with a reasonable accommodation by allowing her to apply for other positions through the hospital's internal job board, even though defendant did not exempt plaintiff from its

competitive hiring process. The court noted that the ADA “does not require reassignment without competition for, or preferential treatment of, the disabled.”⁴¹

In *Stevens v. Rite Aid Corp.*, a pharmacist brought a Title I discrimination claim against defendant employer after it removed him from his position on the grounds that he posed a direct threat to pharmacy customers.⁴² Plaintiff had typanophobia (a fear of needles), thus could no longer fulfill all his job responsibilities after defendant changed its corporate policy and began requiring its pharmacists to administer injections to patients who needed them. Plaintiff was unable to safely administer shots because his

condition made him prone to fainting.⁴³ He contended that defendant should have accommodated him by offering desensitization therapy or by hiring a nurse to administer shots in his stead.⁴⁴ However, the Second Circuit ruled that the ADA does not require employers to offer medical treatment or to create altogether new position simply in order to accommodate employees whose disabilities do genuinely pose a direct threat in the workplace.⁴⁵

B. Overcoming the “undue burden” defense

Some courts have taken a more employee-friendly approach to the question of reasonable accommodations in the healthcare workplace. For example, in *Searls v. Johns Hopkins Hospital*, a Maryland district court considered the matter of a hospital which had rescinded its job offer to a deaf nurse after she requested a full-time ASL interpreter as an accommodation.⁴⁶ The nurse was subsequently hired by a different hospital, where she was provided with her requested accommodation and consistently received positive work evaluations.⁴⁷ In response to the nurses Title I discrimination claim, defendant offered three justifications for its refusal to provide the interpreter and its decision to cancel the job offer. First, it maintained that, even with an ASL interpreter, the nurse would not have been able to communicate with patients, which was an essential function of the job.⁴⁸ Second, it claimed that the cost of providing the nurse with a full-time interpreter presented an undue burden for defendant.⁴⁹ Third, defendant alleged that the nurse’s inability to hear audible alarms in the workplace presented a direct threat to patient safety.⁵⁰

In light of the nurse’s successful job performance at the other hospital, the court found that she had been capable of performing the essential functions of the original position.

Furthermore, the court noted that, although an interpreter relays information between the nurse and her patients, it is the nurse who decides which questions to ask and who makes medical decisions for herself. The court accepted this as proof that she could have performed the essential functions of the original job. The evidence also indicated that the primary reason the defendant had revoked its job offer to plaintiff was the \$120,000 annual cost of providing the interpreter plaintiff had requested.⁵¹ However, the court noted that this cost still constituted only a negligible portion of defendant's annual operating budget, and thus was unpersuaded by defendant's argument that this cost presented an undue burden. Indeed, defendant presented no evidence to this effect, instead emphasizing the fact that the budget included no provision for such accommodations.⁵² The court ruled that whether an employer budgeted for reasonable accommodation is "an irrelevant factor in assessing undue hardship." If it were relevant, "the employer could budget \$0 for reasonable accommodations and thereby always avoid liability."⁵³

The court was similarly unpersuaded by defendant's direct threat argument, finding it to be based on "post-hoc rationalizations and [was] therefore suggestive of pretext."⁵⁴ Defendant had made no individual assessment of the nurse's ability to do her job with the assistance of an interpreter; it simply assumed that she would not be able to respond to auditory alerts.⁵⁵ Finding all three of defendant's arguments to have failed, the court granted plaintiff's motion for partial summary judgment.

C. Employee leave as a reasonable accommodation

The question of employee leave as a reasonable accommodation is another issue that arrives frequently in the healthcare context. The U.S. Equal Employment Opportunity Commission ("EEOC") has weighed in on this issue by way of some of its recent regulatory actions. In one recent example, the EEOC reached a settlement with a healthcare clinic which had terminated one of its nurses who had taken medical leave in order to undergo breast cancer treatment.⁵⁶ When the nurse had exhausted the initial three months of leave to which she was legally entitled, she advised her employer that she was still undergoing treatment, and thus was not yet able to return to work. After four months, the clinic terminated the nurse, despite her advising them that she would be able to return to her job without restrictions in just two more months. After her termination, the nurse brought suit against the clinic alleging employment discrimination based on her disability, and the EEOC ultimately reached a settlement wherein the clinic agreed to substantial financial damages for the nurse, as well as to revise its leave

policies and to enhance disability-awareness training for its staff and administrators. The Commission reached a similar settlement with a healthcare provider which had a policy of awarding attendance points for medical-related absences, did not permit intermittent leave, and did not allow leave or extensions of leave as a reasonable accommodation.⁵⁷

D. Medical marijuana use by employees as a reasonable accommodation

With their focus on ensuring patient and workplace safety, many healthcare employers require drug testing for their employees and applicants, and have commonly maintained zero-tolerance policies with regard to employee use of drugs, including marijuana. Until very recently, employers were consistently able to defend against wrongful termination claims brought by employees who were licensed medical marijuana users under their respective state laws, simply by claiming preemption under the federal Controlled Substance Act (“CSA”).⁵⁸ The CSA classifies marijuana as an illegal controlled substance, and makes no exception for its medicinal use. Additionally, the ADA excludes “any employee or applicant who is currently engag[ed] in the illegal use of drugs, when the covered entity acts on the basis of such use.”⁵⁹ However, recently a number of courts in states with laws authorizing medical marijuana use, and which provide explicit employment protections in that context, have ruled in favor of employees who used medical marijuana, and have specifically found that federal law does not preempt the applicable state law protections. With a majority of states now having adopted legislation authorizing the legal use of medical marijuana, this trend in the case law suggests that employers will no longer simply be able to rely on CSA preemption, will need to take greater care to engage in the interactive process with employees who are medical marijuana users, and must be prepared to accept this use at least in certain cases as a reasonable accommodation in accordance with Title I.

The first state court rule signaling this new trend appears to have been *Callaghan v. Darlington Fabrics*, wherein the Rhode Island Superior Court found that an employer had violated the anti-discrimination provisions of the state’s medical marijuana law by denying employment to an applicant who held a state-issued medical marijuana card.⁶⁰ In its ruling, the court noted that plaintiff’s possession of the card should have put the employer on notice of plaintiff’s status as a person with a disability (in this case, a chronic and debilitating medical condition), which the employer should have recognized

was the basis on which plaintiff had qualified for the card to begin with.⁶¹ This in turn placed an obligation upon the employer to engage in the interactive process with plaintiff and to provide reasonable accommodations, and its failure to do either constituted disability discrimination.⁶² Furthermore, the court found that the CSA did not preempt the anti-discrimination provisions of the state law, as the purposes of the state and federal laws were different.⁶³

Also, in ***Barbuto v. Advantage Sales and Marketing***, the Massachusetts Supreme Judicial Court ruled in favor of an employee with Crohn's Disease and who used marijuana legally, but who was terminated from her job after failing a drug test.⁶⁴ The court reversed an earlier dismissal in favor of the defendant employer, finding that the employee could make a cognizable claim under the state's anti-discrimination statute.⁶⁵ Recognizing potential legitimate purposes for the off-site use of medical marijuana, and that such use is not automatically preempted by the CSA, the court found that in some cases employers may have a duty to permit such use by employees as a reasonable accommodation.⁶⁶

And, at the federal level, in ***Noffsinger v. SSC Niantic Operating Co. LLC***, the U.S. District Court for the District of Connecticut ruled in favor of a medical marijuana user whose employment was terminated after she tested positive for marijuana in the course of the job application process.⁶⁷ The court found that the ADA did not preempt the state medical marijuana law's anti-discrimination employment provision, and that the state statute did not conflict with the relevant federal laws because the latter were not intended to preempt state anti-discrimination laws.⁶⁸ This represents the first federal ruling to recognize that the CSA does not preempt a state law's anti-discrimination provisions.

E. Employee rights to medical privacy

1. Medical examinations

Courts have also examined the issue of employee medical privacy in the context of Title I. For example, courts have reviewed the extent to which employees and applicants are entitled to keep their medical information confidential where this information may be relevant to their work performance. In ***Port Authority Police Benevolent Association, Inc. v. Port Authority of New York and New Jersey***, a New York federal district court

reviewed a suit brought by a union of police officers, challenging their employer's administration of three different medical examinations as a condition of their employment.⁶⁹ These included an annual general examination as well as two fitness for duty ("FFD") examinations. In considering the viability of defendant's policy requiring these examinations in light of plaintiff's concerns regarding the medical privacy of union members, the court noted that, per the requirements of the ADA, such examinations must be job-related and consistent with business necessity.⁷⁰ More specifically, it stated that defendant's policy must be vital to defendant's business, that the group subject to the policy must be consistent with the policy's purpose, and that the policy must be narrowly tailored to serve its objectives.⁷¹

With regard to the annual general examination, the court granted summary judgment in favor of the union. While as a general matter the court acknowledged that these examinations served the vital purpose of ensuring that officers were capable of performing their safety-sensitive jobs, it also noted that the subject class was too broad, as defendant administered these examinations to all officers, regardless of their titles and job assignments, which the court noted was not consistent with the policy's public safety rationale.⁷² Additionally, the court found that the exam was overbroad in its own scope, as it could identify conditions that had no bearing on officers' abilities to do their jobs.⁷³

As to defendant's FFD examination for workplace injuries, the court granted summary judgment in favor of defendants. The court found that these examinations did serve vital purposes, insofar as they helped to determine workers' eligibility for compensation, and helped defendant to review workers' claims before authorizing treatment.⁷⁴ Additionally, the court recognized that defendant applied these examinations to only a narrow group, those officers who were injured on the job, and that the examination itself was narrow in scope, investigating only each employee's "chief complaint" and limited to formulating a working diagnosis.⁷⁵

However, the court granted summary judgment for plaintiffs with regard to the other FFD, which defendant administered to officers who had non-workplace injuries and who afterward took five days or more of sick leave. In its analysis, the court addressed each of defendant's justifications for this examination. It was unpersuaded by the defendant's argument that the examination served the vital purpose of curbing excessive employee absences (the court finding that this was not necessarily a vital business purpose), but agreeing that the examinations were essential to ensuring that employees were fit and

safe to return to their positions after incurring injuries.⁷⁶ Even so, much as with the annual examinations, the court found these examinations to be overbroad, as they were administered to all such officers regardless of their job tasks, and as defendant had offered no evidence that officers taking five or more days of sick leave posed any particular safety risks upon returning to work.⁷⁷

In another case considering medical examinations in light of ADA protections, ***Wright v. Illinois Dep't of Children & Family Services***, the Seventh Circuit reviewed a claim brought by an Illinois social worker who had been removed from contact with children in her work in response to concerns expressed regarding her conduct.⁷⁸ Following plaintiff's encounter with a child who resided at a state-administered facility, the facility's doctor barred plaintiff from further contact with the child.⁷⁹ The doctor issued a medical report questioning plaintiff's ability to work with children, and stating that "her mental health needs to be assessed."⁸⁰ A supervising administrator had also expressed concern regarding plaintiff, given her long-standing behavior patterns including her failures to follow orders.⁸¹ Consequently, defendant ordered plaintiff to undergo a FFD examination, which plaintiff repeatedly refused to do, and then brought suit alleging that this examination constituted discrimination under Title I.⁸²

At trial, the jury found that the examination was neither job-related nor consistent with business necessity. The district court thus denied defendant's motion for judgment as a matter of law. On appeal, the Seventh Circuit upheld the decision in plaintiff's favor, reiterating the lower court's findings and noting that all employees, regardless of whether they have a qualifying disability under the ADA, are protected by the ADA's restrictions on medical examinations and inquiries.⁸³ An employer must have a reasonable belief based on objective evidence that a medical condition will impair the employee's ability to perform essential job functions OR that the employee will pose a threat due to a medical condition.⁸⁴ The employer bears the burden of establishing the existence of a business necessity, and this burden is "quite high."⁸⁵

The appellate court cited rather extensive evidence to support its conclusion regarding the lack of any apparent business necessity. It noted testimony that when a FFD examination was pending, standard agency practice was to place the employee on desk duty, and yet here Plaintiff was permitted to continue overseeing her normal case load (of 22 cases) for almost 2 months, and was actually assigned to an additional case during that time.⁸⁶ This inconsistent application of agency policy suggested that there was no genuine concern for children's safety.⁸⁷ Additionally, an administrator testified

that had she truly believed that the Plaintiff was a risk to children, she would have removed her cases.⁸⁸ Internal agency e-mails also indicated that the examination was unrelated to the Plaintiff's ability to do her job.⁸⁹

Also, in ***Kroll v. White Lake Ambulance Authority***, the Sixth Circuit reviewed a claim brought by an emergency medical technician who, several years into her employment with an ambulance company, begun a "tumultuous" affair with a married colleague.⁹⁰ After the affair went bad, plaintiff's co-workers began to report instances of plaintiff behaving erratically, including several occasions on which she was seen crying in the parking lot, and at least one on which she was seen arguing on her cell phone while driving an ambulance.⁹¹ Plaintiff's manager decided to force her to seek mental health counseling, observing that her "life was a mess" and stating his wish to help her.⁹² At no time did the manager express any concerns about plaintiff's job performance.⁹³ Plaintiff acknowledged that she had some emotional issues, but refused to enter treatment because she could not afford it.⁹⁴ After plaintiff refused treatment, she was not scheduled to work any further shifts.⁹⁵

Plaintiff filed a complaint alleging defendant had violated the ADA by forcing her to submit to a medical examination that was not "shown to be job-related with business necessity."⁹⁶ Defendant argued that the examination was necessary because plaintiff's recent behavior constituted a direct threat to patient safety. However, the court was not persuaded. In its ruling, the court acknowledged that in "public safety" workplaces, an employer may require a psychological examination on "slighter evidence than in other types of workplaces because employees are 'in positions where they can do tremendous harm if they act irrationally,' and thus pose a greater threat to themselves and others."⁹⁷ Nevertheless, the court noted that a few isolated incidents of abnormal behavior do not amount to a direct threat, even in a public safety workplace.⁹⁸ Defendant cited no objective evidence to support its belief that plaintiff's behavior threatened either any business necessity or patient safety.⁹⁹ Indeed, the court noted that defendant's actions appeared to have been driven more by its moral convictions than by any objective concerns regarding safety.¹⁰⁰ Therefore, the Sixth Circuit reversed the lower court's summary judgment ruling in favor of defendant.

Elsewhere, the U.S. Department of Justice ("DOJ") recently finalized a settlement agreement with an Indiana municipality in the wake of inappropriate disclosures of a

police officer's medical information made during public proceedings.¹⁰¹ In that case, the municipality's police chief had requested medical information from the officer in question, who was at that time on medical leave from his job. The chief then recommended charges to the municipality's Merit Commission, forwarding the officer's medical information to the Commission in the process. In the ensuing public hearing, the Commission voted to permit the officer to keep his employment, but the officer's medical privacy was violated in the course of the proceedings. Both the police chief and the municipality's attorney publicly disclosed private information regarding the officer's disability, as well as their concerns regarding the officer's fitness for work. Additionally, the Commission attorney provided the media with the charging documents, which contained information regarding the officer's prescription medications, medical treatment, and psychological evaluations. In the agreement with DOJ, the municipality agreed to a financial settlement with the officer, as well as to revise its policies, practices and procedures regarding confidentiality, and to provide training to employees regarding confidentiality requirements

2. Wellness plans

Another developing issue presenting questions of medical privacy is that of employee wellness plans. These plans often require employees to submit to medical examinations and inquiries in order to participate. Some of these plans are tied to employer-sponsored health insurance, while others are not. Employers often provide strong "incentives" for employees to participate in their wellness plans, including greatly reduced healthcare costs. And while the ADA imposes restrictions on certain medical examinations and inquiries, employers find limited exceptions to these restrictions by way of the ADA's safe harbor provision and the "voluntary" nature of employee participation.¹⁰²

The EEOC recently litigated cases regarding wellness programs. In one such case, ***EEOC v. Orion Energy Systems***, the EEOC settled with an employer after an employee whom it had terminated accused the employer of retaliating against her for complaining that the employer's wellness program violated the ADA. Employees who opted out of this wellness plan were required to pay their entire monthly health insurance premium. After investigating the claim, the EEOC filed suit in a Wisconsin district court. The court dismissed cross-motions for summary judgment, and set the case for trial. In its ruling, the court found that the ADA safe harbor provision was inapplicable in these circumstances, but that the employer could still avail itself of the

“voluntariness” exception in spite of the very strong financial incentives for its employees to join in the wellness program.¹⁰³ The parties settled prior to trial, with the consent decree providing for a financial settlement for the employee in question, and with the employer agreeing to ensure that its wellness plans going forward would comply with the ADA’s voluntariness provisions, and that it would not retaliate against any employees raising concerns of this nature in the future.¹⁰⁴

The EEOC filed suit in a different Wisconsin federal district court in order to challenge another employer’s wellness program on ADA grounds. In *EEOC v. Flambeau*, the central issue was whether a wellness plan falls within the ADA’s safe harbor provision if it is part of the employer’s health insurance plan. The Seventh Circuit ultimately upheld the lower court’s ruling that this is so, dismissing the EEOC’s appeal on the narrow grounds that the claim was moot due to the complaining employee having since resigned his position.¹⁰⁵

More recently and significantly, the District Court for the District of Columbia vacated EEOC rules pertaining to wellness plans, in *AARP v. United States Equal Employment Opportunity Commission*, finding that the agency was moving too slowly in revising these rules per the earlier instruction of the court. In 2016, AARP filed suit seeking an injunction against a recently-adopted EEOC rule that permitted employers to impose penalties of up to 30% of the cost of coverage to encourage employees to disclose information that was protected under the ADA and the Genetic Information Nondiscrimination Act (“GINA”), without rendering such disclosures involuntary. In August 2017, the court agreed that the EEOC’s rulemaking process had been arbitrary, and sent the rule back to the agency for further revision. Finding the EEOC’s projected timeline for completing its revisions to be unacceptably slow, the court responded to AARP’s motion to alter or amend its earlier judgment by vacating the rule altogether, effective January 1, 2019.¹⁰⁶ As of the time this brief was written, it remained unknown whether the EEOC would complete its new rule prior to that date.

F. Doctors as Independent Contractors

As a final point regarding Title I, it may be noted that doctors are frequently not able to position avail themselves of Title I protections. This is because doctors seldom work as direct employees of hospitals and healthcare facilities, and more commonly serve as independent contractors who provide medical services in and use the facilities of privately-owned hospitals and clinics. As such, a common issue in the healthcare

context is whether doctors who work as independent contractors can bring claims for disability discrimination under Section 504 of the Rehabilitation Act. A recent case on this issue is *Flynn v. Distinctive Home Care, Inc.*, where the Fifth Circuit concluded that independent contractors can sue under Section 504 for employment discrimination.¹⁰⁷ The court reasoned that Section 504 is broad and applies to all of a covered entity's programs and activities. It also found that while the Rehabilitation Act incorporates the ADA's substantive non-discrimination provisions, it does not incorporate the ADA's definition of employer. This is the majority position, although other courts have found that independent contractors cannot sue under the Rehabilitation Act.¹⁰⁸

III. Titles II and III in the context of healthcare

It is a violation of Titles II and III of the ADA for state and local government entities and places of public accommodation to discriminate on the basis of disability.¹⁰⁹ Depending on whether they are public or private, hospitals and doctor's offices are either entities of state or local government, or places of public accommodations under the ADA.¹¹⁰

With respect to Title III, disputes sometimes arise as to what services and facilities actually qualify as places of public accommodation for purposes of Title III coverage; this applies to healthcare providers as well. For example, the Tenth Circuit analyzed this very question in the case of *Levorsen v. Octapharma Plasma*, involving a Title III discrimination claim brought by an individual with borderline schizophrenia against a defendant which was a plasma donation center.¹¹¹ Defendant's business involved drawing and processing blood from donors, then separating and reserving the plasma, and returning the blood to the respective donors. Defendant paid donors for their blood, and sold the plasma to pharmaceutical companies.¹¹² Though plaintiff had donated his blood at defendant's facility many times previously, on one occasion an employee who learned of plaintiff's psychiatric disability refused him the opportunity to donate on that basis alone, which in turn prompted plaintiff to file his Title III discrimination claim.¹¹³ The Tenth Circuit found for plaintiff, reversing the district court's ruling that defendant did not qualify as a place of public accommodation, and remanded for further proceedings.¹¹⁴ Reviewing the relevant ADA language, the court found defendant to be a place of public accommodation insofar as it was a "service establishment" in the ordinary meaning of the word. Specifically, the court noted that defendant was a place of business whose work benefited or assisted others, even though it produced no tangible goods in the course of its operations.¹¹⁵ The court expressly rejected defendant's argument that it was not a service establishment because it received no direct payment from its donor customers, finding nothing in the ADA language to support such an interpretation.¹¹⁶

A. Title III standing

Another issue specific to Title III is that of standing. Article III of the U.S. Constitution limits federal court jurisdiction to cases or controversies.¹¹⁷ Courts have fleshed out this constitutional phrase and interpreted it as requiring that all cases be justiciable, requiring that every plaintiff have legal standing to bring a claim before federal court. Standing is a doctrine stemming from both constitutional and prudential roots, which ensures that the proper plaintiff is bringing the claim before the court by requiring that the plaintiff have a personalized stake in the outcome.¹¹⁸ It requires the plaintiff to demonstrate three components.¹¹⁹ First, the plaintiff must suffer a personalized and concrete injury-in-fact of a legally cognizable interest.¹²⁰ Second, the injury must be fairly traceable to the defendant's conduct. Finally, it must be likely, as opposed to speculative, that the injury be redressable through a favorable court decision.¹²¹ In the healthcare context, courts have applied this analysis in assessing whether a given plaintiff has standing to seek injunctive relief under Title III, especially in consideration of whether a plaintiff is likely to incur specific harm in the future due to barriers in accessing a given place of public accommodation

In *McCullum v. Orlando Regional Healthcare Systems*, the Eleventh Circuit reviewed a Title III discrimination claim brought against a hospital system by a husband and wife who were both deaf.¹²² The couple's child had been treated at the hospital, and the couple alleged that the hospital had discriminated against them during their child's stay by failing to accommodate their disability by way of providing effective communication. The court found that individuals with disabilities may only seek relief under the ADA or the Rehabilitation Act for injuries that they themselves have suffered through direct discrimination.¹²³ Furthermore, the court found that defendant had provided the child with adequate treatment given his circumstances; his condition was not chronic, and he had had no occasion to return to the hospital in four years.¹²⁴ In addition, the court noted that the hospital already had a written policy to provide reasonable accommodations for patients who are hard of hearing, including providing live sign language interpreters.¹²⁵ The parents had simply been unaware of the policy, and thus had not requested an interpreter.¹²⁶ Taken together, the latter two points indicated that the child was unlikely to return to the hospital, and that even if he did, he would presumably receive any reasonable accommodations he might need.

Similarly, in *Hollinger v. Reading Health Sys.*, plaintiff was a man who had been admitted to the hospital for alcohol-related seizures.¹²⁷ Due to alcohol withdrawals, he

“began screaming obscenities at hospital staff and refusing to answer their questions.”¹²⁸ Ten days into his stay, he slapped a nurse and was charged with aggravated assault. He subsequently brought a claim under Title III of the ADA, asserting that he had suffered discrimination because of his alcoholism. His case was dismissed for lack of standing. The court outlined two theories by which a plaintiff can prove standing under Title III: (1) the intent to return method, and (2) the deterrent effect doctrine. Under the intent to return method, the plaintiff must prove that (a) defendant engaged in past discriminatory conduct in violation of the ADA; (b) it is reasonable to infer that the discrimination will continue; and (c) it is reasonable to infer that the plaintiff will return to the place in the future.¹²⁹ According to evidence, the plaintiff had a fifty percent chance of returning to the hospital, he had never been to the hospital before, and there was a different emergency room closer to his home.¹³⁰ Plaintiff failed under the first test. Under the deterrent effect test, the plaintiff must show that he is “deterred from patronizing a public accommodation because of accessibility barriers.”¹³¹ To do so, he must (1) have actual knowledge of the barriers; and (2) show a reasonable likelihood that he would use the facility in the future if not for its inaccessibility. According to evidence, the first element was not met because the hospital has a policy of discharging violent patients into police custody, regardless of their disability. The second element also failed because the plaintiff was unlikely to return to the hospital.

However, in *Perez v. Doctors Hosp. at Renaissance, Ltd.*, the Fifth Circuit considered whether the deaf parents of an infant who had received treatment for a brain tumor had standing to request injunctive relief under Title III.¹³² Plaintiffs had made numerous hospital visits with their child over several years. During their initial visits, the hospital repeatedly failed to provide a sign language interpreter for plaintiffs. Eventually in later visits, the hospital began providing video remote interpreting (“VRI”) services, but the VRI equipment sometimes malfunctioned and hospital nurses sometime did not know how to operate it. The pivotal issue was whether plaintiffs faced a “real and immediate threat” of future harm, and it was upon this question that plaintiffs’ standing to seek injunctive relief depended.¹³³ The hospital argued that because the family experienced no problems with communication during several of their many visits over the years, there was no threat of future harm. The Fifth Circuit disagreed, finding that the hospital’s failure to train its staff and revise its ADA compliance policy demonstrated a definite possibility that plaintiffs would incur harm during future visits.¹³⁴

In *Alexander v. Kujok*, deaf plaintiffs in search of a new primary care physician sought care from six different offices within one healthcare network, and were denied ASL interpreters by each office.¹³⁵ All six offices were named as defendants. Because they

were unable to find a healthcare provider within the network, plaintiffs found an out-of-network provider willing to provide adequate accommodations. Based on this fact, all defendants moved to dismiss for lack of standing, arguing that the plaintiffs would not return to their offices in the future. Plaintiffs argued that although they had temporarily found an out-of-network provider, the higher costs would eventually compel them to once again seek care from an in-network provider.¹³⁶ The court found that this was sufficient evidence to prove that plaintiffs were likely to seek services in the future. The court also noted that although plaintiffs must prove future harm, they “need not engage in the futile gesture of attempting to return to the physician if the plaintiff already knows that reasonable accommodations will not be provided.”¹³⁷

B. Direct threat and HIV

The issue of direct threat also comes up in healthcare cases arising under Titles II and III, as healthcare providers sometimes assert it as a defense to their duties to provide reasonable accommodations and to make their facilities accessible. This has given rise to some amount of federal litigation, as well as to numerous DOJ regulatory initiatives. In a great many cases, providers have asserted the direct threat to justify denying services to patients or prospective patients with HIV.

By way of background, the U.S. Supreme Court explored the question of direct threat in the first ADA case that it ever heard, one which coincidentally involved a plaintiff with HIV. *Bragdon v. Abbott*, involved a dentist who had denied treatment to an HIV-positive patient, citing the direct threat to his own safety that he alleged treating this patient would pose.¹³⁸ In its ruling for the plaintiff, the Court reiterated the duty of a defendant provider to make an individualized inquiry as to the circumstances of the particular plaintiff, and noted “that courts should assess the objective reasonableness of the views of health care professionals without deferring to their individual judgments.”¹³⁹

More recently, in *United States v. Asare*, a New York federal district court reviewed a Title III claim brought by three plaintiffs who had HIV, all of whom had sought male breast reduction surgery from defendant doctor.¹⁴⁰ Defendant refused to perform the procedure on any of the plaintiffs, citing his blanket policy against operating upon HIV-positive patients who were also taking antiretroviral medications, as plaintiffs all were. The court granted summary judgment in favor of plaintiffs, finding that defendant had failed to meet his duty, established under *Arline*, to conduct an individualized inquiry

with regard to each plaintiff, instead relying on a blanket policy to deny service to a defined class of patients.¹⁴¹ As defendant had produced no evidence that this blanket policy was necessary for his safety or his business, the policy did not withstand Title III scrutiny.¹⁴² Furthermore, the court noted that, even if defendant had established that plaintiffs did pose safety risks, he had still failed to offer any reasonable accommodations, or to consider any of those which plaintiffs had themselves proposed.¹⁴³ Nor could defendant claim that such accommodations would constitute a fundamental alteration to his workplace, as he had failed to even investigate any such accommodations by way of the interactive process.¹⁴⁴

As mentioned, DOJ has entered into settlement agreements with a number of healthcare providers and facilities after pursuing claims against them for discriminating against individuals with HIV. Typical of such an agreement is a pledge by the provider to adopt and implement a non-discrimination policy, to submit to ongoing monitoring by DOJ, and to provide Title III training for staff and administrators. Many agreements also include financial settlements for the aggrieved parties involved.¹⁴⁵

C. Accessible medical facilities and equipment

In accordance with the accessibility requirements of Titles II and III, hospitals, doctor's offices and other healthcare providers have a general obligation to make their facilities accessible to people with disabilities wherever possible, including to remove physical access barriers and to purchase and maintain medical equipment that accommodates the needs of patients with disabilities. In July 2010, DOJ issued guidance in a fact sheet pertaining to these requirements with regard to people with mobility disabilities.¹⁴⁶

This document reiterates the duty of medical facilities to provide:

- full and equal access to their health care services and facilities; and
- reasonable modifications to policies, practices, and procedures when necessary to make health care services fully available to individuals with disabilities, unless such modifications would fundamentally alter the nature of the services.

As mentioned, healthcare providers also have an obligation to purchase and maintain accessible medical equipment. Just a few examples of such equipment are:¹⁴⁷

- Wheelchair accessible scales
- Adjustable exam tables
- Accessible mammography equipment

D. Service animals

The ADA administrative regulations define a service animal under Titles II and III as “[A]ny dog that is *individually trained to do work or perform tasks* for the benefit of an individual with a disability.”¹⁴⁸ Service animals may be trained to perform any of a wide assortment of tasks, including, but not limited to, guiding an individual who is blind, retrieving or carrying items, pulling a wheelchair, assisting an individual with balance and stability, alerting an individual to certain sounds or allergens, and reminding an individual to take medication.¹⁴⁹ The regulations further specify that all places of public accommodation are required to “modify policies, practices, or procedures to permit the use of a service animal by an individual with a disability.”¹⁵⁰

Because, as mentioned previously, Titles II and III applies to hospitals, doctor’s offices and many other types of healthcare service providers, the duty to accommodate service animals likewise applies within the healthcare context. To that end, DOJ has offered its own comments as to the foregoing provisions. “Under the ADA, State and local governments, businesses, and nonprofit organizations that serve the public generally must allow service animals to accompany people with disabilities in all areas of the facility where the public is normally allowed to go. For example, in a hospital it would be inappropriate to exclude a service animal from areas such as patient rooms, clinics, cafeterias, or examination rooms. However, it may be appropriate to exclude a service animal from operating rooms or burn units where the animal’s presence may compromise a sterile environment.”¹⁵¹ Furthermore, providers may not impose blanket bans against service animals, even if justifying those bans with arguments regarding safety and/or fundamental alteration, without engaging in the interactive process in an earnest effort to identify potential reasonable accommodations.¹⁵²

E. Inclusion of children with diabetes

In recent years, DOJ has undertaken numerous enforcement actions on behalf of children with insulin-dependent diabetes to help ensure that those children enjoy equal access to places of public accommodation. All too commonly, children with insulin-dependent diabetes have found themselves effectively excluded by institutions that were unwilling to modify their policies in order to provide basic diabetes management care. The needs of children with diabetes differ, but these children generally need assistance with blood glucose monitoring and with the administration of insulin and emergency medication.

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For example, in 2018 DOJ announced a settlement with one of the nation's largest for-profit child care providers, whereby the corporation and its subsidiaries agreed to provide reasonable accommodations for attendee children with insulin-dependent diabetes, as well as financial settlements with the parties who initially alerted DOJ of the corporation's discriminatory practices.¹⁵³ Also, in 2015 DOJ settled with a day camp in New Jersey which had refused to provide the accommodations necessary for a prospective camper with diabetes to attend its program. In the settlement agreement, the camp pledged to develop an ADA/diabetes policy, to henceforth Individually assess the needs of each camper and prospective camper with diabetes, to assist all such campers and to make reasonable efforts to comply with their diabetes medical management plans ("DMMPs", and to provide training for camp staff by a qualified professional, including instruction on the administration of insulin and emergency medication (glucagon).¹⁵⁴

Additionally, beginning in 2016, DOJ entered into settlement agreements with a number of local YMCAs, in order to ensure inclusion of children with diabetes at those facilities as well. By way of these agreements the individual YMCAs have generally committed to modifying their existing policies, including by adopting DMMPs, to training staff regarding basic diabetes management, monitoring, and the administration of insulin and glucagon, to promoting general awareness of Title III nondiscrimination principles, and to ongoing oversight by DOJ.¹⁵⁵

F. Effective communication

A public accommodation must provide auxiliary aids and services when necessary to ensure effective communication.¹⁵⁶ Auxiliary aids and services include equipment or services a person needs to access and understand aural information and to engage in effective communication. This can include qualified sign language interpreters, where the interpreter enables a person who is deaf or hard of hearing to communicate and thus access the services offered by a public accommodation.¹⁵⁷

DOJ has settled numerous complaints in which it has affirmed the need for places of public accommodation, and of healthcare providers in particular, to provide reasonable accommodations in order to ensure effective communication. Many of these settlement agreements have included "primary consideration" language, lending particular deference to the preference expressed by the affected individual for a particular auxiliary aid or service.¹⁵⁸ DOJ has reiterated the obligation of doctor's offices in

particular to provide sign language interpreters or other auxiliary aides and services that maybe appropriate to facilitate communication for individuals who are deaf or hard of hearing.¹⁵⁹

1. Sign language interpreters

When a person who is deaf or hard of hearing seeks medical services from a healthcare provider, there may be different means available by which the provider can effectively communicate with that individual. Where the individual in question communicates using sign language, there are some circumstances in which live sign language interpretation is the only appropriate communication method. However, alternative methods of communication may suffice in some other situations. In some cases, it may be sufficient for a provider to communicate with the individual simply by means of typed or handwritten notes. For example, written notes may suffice in cases involving simple and routine procedures wherein conversation is minimal, such as with routine lab tests or regular allergy shots. However, sign language interpreters should be used for communications that are more complex, such as discussions of medical history, diagnoses, procedures, treatment decisions, or communications regarding in-home care.¹⁶⁰

In assessing the question of when sign language interpreters are required in the healthcare setting, federal courts have reached different conclusions. Indeed, in some cases courts have found healthcare providers to be under no obligation to provide sign language interpreters at all. For example, in *Martin v. Halifax Healthcare Systems*, the Eleventh Circuit reviewed the claims of several plaintiffs who were deaf and who had at various times been treated at defendant hospital.¹⁶¹ Defendant had afforded plaintiffs a range of accommodations for their various visits, including at different times live sign language interpreters, VRI, and even written notes. On one occasion, one of the plaintiffs visited defendant's emergency room with what was described as simply a "bump on the head." On this occasion, he was not provided with sign language interpreting, but rather received all communications from hospital staff by way of written notes. In response to plaintiff's Title III discrimination claim based on defendant's alleged failure to facilitate effective communication, the court affirmed summary judgment in favor of defendant. In its ruling, the court noted that an interpreter had not been necessary in these circumstances, because plaintiff had received typed instructions, which he clearly indicated he was able to understand.¹⁶²



However, the Eleventh Circuit has separately ruled that when an individual who is deaf and uses ASL communicates about a complicated medical procedure, especially a surgery, the exchange of written notes is inadequate to achieve effective communication. In *Liese v. Indian River County Hospital District*, the court considered a discrimination claim brought by two plaintiffs, a husband and wife who were both deaf, after one of them had undergone an emergency procedure to remove her gallbladder through laparoscopic surgery.¹⁶³ Despite plaintiffs' requests for a live sign language interpreter, defendant hospital had communicated with plaintiffs only by mouthing words, writing notes, and pantomiming.¹⁶⁴ In this case, finding sufficient evidence that the limited auxiliary aids that defendant had provided were ineffective, the court ruled in favor of plaintiffs, reversing the district court's decision to grant summary judgment. The appellate court noted that, "under circumstances in which a patient must decide whether to undergo immediate surgery involving the removal of an organ under a general anesthetic, understanding the necessity, risks, and procedures surrounding the surgery is paramount."¹⁶⁵ The court determined that the aforementioned communication methods utilized by defendant were neither appropriate nor adequate for the circumstances, and may have deprived plaintiffs of the full benefits of the services provided.¹⁶⁶

Additionally, in some cases the use of written notes by healthcare providers to communicate with individuals who are deaf may not only be ineffective, but may simply be insensitive and socially inappropriate. In *Shaika v. Gnadon Huetten Memorial Hosp.*, a Pennsylvania federal district court reviewed a claim brought for negligent infliction of emotional distress against a hospital by a woman who was deaf, and whose daughter had died at the hospital after being rushed there for emergency treatment as a result of a heroin overdose.¹⁶⁷ When plaintiff arrived at the hospital, she requested a sign language interpreter, which the hospital did not provide her. As the hospital's VRI system was out of order, hospital staff resorted to communicating with plaintiff through written notes, which was how plaintiff learned that her daughter had died.¹⁶⁸ Beyond that, it was very difficult for plaintiff to receive any further information from the hospital regarding the circumstances or cause of her daughter's passing. The court denied defendant's motion to dismiss plaintiff's claim that defendant had acted with deliberate indifference to plaintiff's rights to effective communication.¹⁶⁹

2. Video remote interpreting ("VRI") v. Sign language interpreting

VRI connects the user with an off-site interpreter through the use of a video conferencing system in order to facilitate communication. For VRI to function effectively, there must be a high-speed, wide-bandwidth video connection available in order to prevent low-quality video images, and staff must be properly trained in order to set up and operate the VRI system efficiently.¹⁷⁰ VRI offers some potential advantages, including cost savings for short appointments and the fact that it may be used for patients in rural areas where sign language interpreters may not be readily available, or in emergency situations where interpreters are not available on site. However, VRI is not the most appropriate communication tool for all circumstances, and has certain inherent limitations.

For example, DOJ has expressed concerns regarding the use of VRI to communicate with individuals who may have difficulty accessing the screen because they have limited vision, or because of their positioning due to injury.¹⁷¹ Likewise, the National Association of the Deaf (“NAD”) has voiced its own concerns that providers may rely too heavily on VRI at the exclusion of more appropriate methods of communications, and that VRI can be ineffective where systems experience technical issues or where provider staff are not properly trained in its use.¹⁷²

Turning again to case law from the Eleventh Circuit, that court acknowledged many of these concerns regarding VRI in its ruling in *Silva v. Baptist Health South Florida*.¹⁷³ In that case, plaintiffs were hard of hearing, and sued the defendant hospital system for its alleged failure to provide them with effective communication over the course of their many medical visits. Defendant had not accommodated their requests for live sign language interpreters, and had instead persistently relied upon VRI to communicate with plaintiffs during their visits.¹⁷⁴ Plaintiffs alleged that defendant’s use of VRI violated their rights under both Title III and the Rehabilitation Act, due to chronic technical difficulties and practical limitations incurred during use of defendant’s VRI system. Specifically, plaintiffs asserted that the VRI machine was often inoperable or unusable, that the picture on the monitor was commonly blocked, frozen or degraded, and that hospital staff frequently did not know how to use the equipment or to resolve technical problems.¹⁷⁵

The district court ruled in favor of defendants, finding that it had provided plaintiffs with effective communication. In its ruling, the court noted that plaintiffs had presented no evidence that defendants had ever misdiagnosed them or given them improper medical treatment, and that plaintiffs had not identified any particular information that defendants

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had communicated but that plaintiffs had not understood.¹⁷⁶ Accordingly, the court found that plaintiffs lacked standing to seek injunctive relief, and granted defendants' motion for summary judgment.¹⁷⁷

On appeal,¹⁷⁸ the Eleventh Circuit reversed, and remanded the case for further proceedings. The court found that the lower court had applied the incorrect standard in its review, and that ADA and Rehabilitation Act claims are not to be evaluated by the same criteria as those applied to medical malpractice claims.¹⁷⁹ Specifically, the court noted that the proper focus should be upon the nature of the communication itself, not the consequences of the failed communication. The court considered the question of whether any of the plaintiffs had experienced a real hindrance due to their disability, affecting their ability to exchange material medical information with their health care professionals.¹⁸⁰ Here, Plaintiffs provided evidence that they were hindered due to the difficulties using VRI, and the absence of live interpreters. Furthermore, the court noted that plaintiffs had no duty to identify exactly what information they were unable to understand or convey.¹⁸¹ As a point of reference, the court cited DOJ regulations regarding the appropriate use of and training for VRI.¹⁸² Finally, the court found that plaintiffs did in fact have standing, as they regularly used this Hospital, lived nearby and were likely to return in the future.¹⁸³

Additionally, DOJ has entered into settlement agreements regarding the use of VRI by healthcare providers. In one indicative settlement, *Morales v. Saint Barnabas Medical Center*, a hospital that used VRI committed henceforth to satisfy DOJ regulatory requirements, including an assurance that its VRI equipment would only be used so long as it projected a clear and high-quality image.¹⁸⁴ Furthermore, the hospital promised never to use VRI in circumstances where it was not effective or appropriate, such as where a patient cannot readily see or understand it, where the information exchanged is highly complex, where hospital staff cannot activate or operate the equipment expeditiously, or where no designated high speed Internet line is available. The hospital further agreed to provide a live interpreter whenever VRI is not effective, or where a patient indicates that it is not meeting his or her needs.¹⁸⁵

3. Companion communication

It is well-settled that the ADA's effective communication obligations extend to companions with disabilities. For purposes of the ADA, a "companion" is defined as "a family member, friend, or associate of an individual" accessing either the public entity or place of public accommodation, "who, along with such individual, is an appropriate person with whom the [public entity or public accommodation] should communicate."¹⁸⁶

To date, there has not been significant litigation disputing whether an individual qualifies as a companion, perhaps because of the broad definition of the term “companion” provided in the administrative regulations. Instead, most cases involving companions simply accept that the individual is a companion, and then determine whether the communication provided was effective.

DOJ addressed the issue of companion communication in a settlement that it reached with a nursing home facility, stemming from a complaint filed by the daughter and granddaughter of one of the facility’s residents.¹⁸⁷ Complainants were both hard of hearing and had requested that the facility provide them with a sign language interpreter to aid in their communications with staff regarding the resident’s status and care. When the facility denied this request, complainants asserted that this was a violation of their right to effective communication.

DOJ maintained that the nursing facility had an obligation to provide auxiliary aids and services to both Complainants as “legally cognizable companions.” It noted that the daughter was listed as the patient’s emergency contact and next of kin, thus should have had an interpreter for various communications, including communications with staff regarding care issues, treatment options, and discharge planning. Instead, the facility relied on an unqualified staff member who lacked the requisite skills to interpret for complainants. In the settlement, the facility agreed to amend its policies to provide appropriate auxiliary aids and services to both patients and their companions going forward.

Courts have also considered whether a non-disabled family member may bring a claim for discrimination under the ADA for association discrimination. For example, in ***Loeffler v. Staten Island University Hosp.***, the Second Circuit reviewed a case involving a hospital patient and his wife, both of whom were deaf and required sign language interpreters for effective communication.¹⁸⁸ Because the hospital failed to provide either interpreters or any viable alternative means of communication during the patient’s stay, his adolescent children were forced to provide interpretation, at least to the best of their abilities.¹⁸⁹ The court found that the children had suffered an independent injury, causally related to the hospital’s failure to provide auxiliary aids and services to their parents. As it was, the children had been required to fill the gap left by the hospital’s indifference and ADA violations.¹⁹⁰ The court noted that the children were required to miss school because they had to be on-call to provide interpretation, and that they were “needlessly and involuntarily exposed to their father’s condition,” placing them at risk of emotional trauma due to their young age.¹⁹¹



However, the Eleventh Circuit subsequently reached a different conclusion in a case involving facts that were in many ways similar to those in *Loeffler*. The case *McCullum v. Orlando Regional Healthcare Sy.*, referenced above regarding standing, involved a lawsuit brought on behalf of a fourteen year-old patient who was deaf, along with his sister, by the children's parents, alleging that defendant hospital had failed to facilitate effective communication because it had not provided sign language interpreters, instead relying on the sister and parents for that purpose.¹⁹² In this case, the court affirmed the lower court's decision to dismiss the claims brought by the patient's sister and parents, finding that "[N]on-disabled persons are [not] denied benefits when a hospital relies on them to help interpret for a deaf patient," even though as a general matter patients with disabilities are entitled to appropriate accommodations.¹⁹³ The court explicitly distinguished the facts of this case from those in *Loeffler*, noting that here, the family never requested an interpreter, nor was there evidence that any of the patient's family members had suffered independent injury, such as by having to miss work or school.¹⁹⁴

It may be reasonable to ask whether the *McCullum* decision would turn out differently if it were issued today, in light of updated federal regulations regarding companion and association communication. Under the existing regulations, a provider may not rely on an adult 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," or where an individual specifically requests that an accompanying adult provide the interpretation, the adult agrees, and the reliance is appropriate. Nor may a provider use 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.¹⁹⁵

4. "Talking" prescription containers

For many people, prescription medications are an important component of managing their medical condition and of maintaining good health. But for people with disabilities, and with sensory disabilities especially, it can be difficult to access the information printed on prescription medication containers, which in turn can make it difficult to follow prescription instructions. This can be another challenge particular to people with disabilities in managing their own health, and can put people at risk of taking their medications improperly. Fortunately, "talking" prescription containers are a recent and welcome innovation that can accommodate the needs of many prescription-holders with disabilities. This typically involves a device that attaches to the label on a prescription



container and can read its printed information aloud, as well as emitting an audible alarm to remind the prescription-holder that it is time to take the medication, all of which can be especially helpful for people who are blind or visually impaired. This is an excellent example of the various types of auxiliary aids and services that can lead to effective communication, especially with the advance of new technologies.

Attorney Lainey Feingold has had great success over many years in orchestrating structured negotiations to improve accessibility for people with disabilities. Structured Negotiations are a collaborative and solution-driven advocacy and dispute resolution method conducted without litigation. Many of the aforementioned successes have come through negotiations with medical facilities and providers of healthcare services, including with leading pharmacy corporations in order to make talking prescription containers widely available.¹⁹⁶

5. Website accessibility

The accessibility and effective communication requirements of the ADA are applicable not only to the physical facilities of healthcare providers and direct personal interactions with their representatives, but to all their digital properties as well. Among the many barriers encountered by people with disabilities seeking quality and timely healthcare services, issues of digital accessibility can be among the thorniest. These barriers often arise from the individual's initial interaction with the provider's website. When a person with a disability cannot readily access a provider's digital resources in order to retrieve basic information, book an appointment, or take advantage of any of the electronic conveniences enjoyed by nondisabled members of the public, this can substantially inhibit the individual's ability to access the provider's services, and more generally can make it more difficult for the individual to manage his or her own healthcare.

Different types of disabilities present different challenges with regard to accessing digital material, and in many cases people with disabilities may utilize adaptive technologies in order to do so. For example, people who are blind may use screen-reading technology in order to access the content of websites or of electronic documents. Thus, it is essential that digital resources be developed to include alternative text for images, as otherwise those users will be excluded from information that is available to everyone else. Additionally, some people have disabilities that impact manual dexterity and thus can make it difficult to control a mouse. Those people may find it exceptionally difficult

to navigate a website featuring links and buttons that are not spaced and ordered thoughtfully on the page.

Though the ADA does not specify website accessibility per se, this does not relieve healthcare providers of the legal duty to make their digital resources accessible to people with disabilities. Should providers fail to make their digital resources comply with the technical requirements of the Web Content Accessibility Guidelines (“WCAG”) 2.0, those resources may very well be inaccessible to at least some individuals with disabilities. As such, providers may in fact be in violation of the ADA requirements for accessibility, and may thus be exposed to liability.

IV. Conclusion

The ADA plays an indispensable role in ensuring the rights and opportunities of people with disabilities to access healthcare and medical services. In view of the many challenges with which this population still must contend, regular quality medical care remains especially critical for most people with disabilities in maintaining their health, and for many is the determining factor in the ability to live independently in the community. This brief outlines many of the ways in which the ADA helps to make reliable healthcare a reality for so many in the disability community, and the extent to which the DOJ and many courts have recognized this important connection. Many of the regulatory and litigation trends herein are still very much evolving, and interested parties will continue to monitor them for future developments. Those developments may carry ramifications with regard to healthcare that may resonate within the disability community long into the future.

¹ This legal brief was updated in 2018 by Andrew Webb, Staff Attorney and Equal Justice Works Fellow and Aima Mori, Legal Intern, Equip for Equality. This legal brief was initially written in 2012 by Barry C. Taylor, Alan M. Goldstein, Senior Attorney, and Volunteer Attorneys Matthew Teaman and Aaron Lawee. Equip for Equality is the protection and advocacy system for the State of Illinois, and is providing this information under a subcontract with Great Lakes ADA Center. Funding for some of the legal research for this document was provided pursuant to a subcontract with the Great Lakes ADA Center, University of Illinois at Chicago, U.S. Department of Education, National Institute on Disability Rehabilitation and Research Award grant number 90DP0091.

² 42 U.S.C. § 12111.

³ 42 U.S.C. §12112(b)(5)(A).

⁴ 29 C.F.R. § 1630.2(o)(1)(ii).

⁵ 42 U.S.C. §12111(10)(A).

⁶ 29 C.F.R. § 1630.2(m).

⁷ 29 C.F.R. § 1630.2(o)(3).

⁸ *Leme v. Southern Baptist Hospital of Florida, Inc.*, 248 F.Supp.3d 1319 (M.D.Fla. 2017).

⁹ *Id.* at 1328.

¹⁰ *Id.* at 1333.

¹¹ *Id.* at 1327-28.

¹² *Id.* at 1340, 1341-42.

¹³ *Dickerson v. Secretary, Dept. of Veterans Affairs Agency*, 489 Fed.Appx. 358, 2012 WL 3892196 (11th Cir. Sept. 7, 2012) (Note that this case involves the Rehabilitation Act rather than the ADA. This is because the employer in question was a federally-funded agency, thus subject to the Rehabilitation Act. As the Rehabilitation Act was the legislative predecessor and basis for the later-enacted ADA, and applies essentially the same requirements to employers as those described above in ADA Title I, this case is included here largely as an illustrative example).

¹⁴ *Id.* at 361.

¹⁵ *Wulff v. Sentara Healthcare, Inc.*, 513 Fed.Appx. 267, 2013 WL 781958 (4th Cir. March 4, 2013).

¹⁶ *Id.* at 267-68.

¹⁷ *Id.* at 269.

¹⁸ *Id.* at 271.

¹⁹ *Id.*

²⁰ *Id.* at 271-72.

²¹ *Anderson v. E. Conn. Health Network, Inc.*, 2015 WL 4393552 at *1 (D. Conn. July 16, 2015).

²² *Id.*

²³ *Id.* at *3.

²⁴ *Id.* at *8.

²⁵ *Osborne v. Baxter Healthcare Corp.*, 798 F.3d 1260, 1264-65 (10th Cir. 2015).

²⁶ *Id.*

²⁷ *Id.* at 1272, 1274.

²⁸ *Id.* at 1269, citing *School Board of Nassau County v. Arline*, 480 U.S. 273, 287-88 (1987).

²⁹ *Id.* at 1275.

³⁰ *Id.* at 1277-78.

³¹ *Id.* at 1278.

³² *Stern v. St. Anthony's Health Ctr.*, 788 F.3d 276, 279 (7th^h Cir. 2015).

³³ *Id.* at 295.

³⁴ *Id.* at 295.

³⁵ *Olsen v. Capital Region Med. Ctr.*, 713 F.3d 1149, 1150-51 (8th Cir. 2013).

³⁶ *Id.* at 1153.

³⁷ *Id.* at 1154.

³⁸ *EEOC v. St. Joseph's Hospital, Inc.*, 842 F.3d 1333 (11th Cir. 2016).

³⁹ *Id.* at 1338.

⁴⁰ *Id.* at 1340.

⁴¹ *Id.* at 1345.

⁴² *Stevens v. Rite Aid Corp.*, 851 F.3d 224 (2d Cir. 2017).

⁴³ *Id.* at 227.

⁴⁴ *Id.* at 230-31.

⁴⁵ *Id.*

⁴⁶ *Searls v. Johns Hopkins Hosp.*, 158 F.Supp.3d 427, 430 (D. Md. 2016).

⁴⁷ *Id.*

⁴⁸ *Id.* at 437.

⁴⁹ *Id.* at 438.

⁵⁰ *Id.* at 439.

⁵¹ *Id.* at 439-40.

⁵² *Id.* at 438-39.

⁵³ *Id.* at 438.

⁵⁴ *Id.* at 439.

⁵⁵ *Id.* at 439-40.

⁵⁶ See “Dialysis Clinic To Pay \$190,000 To Settle EEOC Disability Discrimination Suit” (September 14, 2015), available online at www.eeoc.gov/eeoc/newsroom/release/9-14-15.cfm, last visited on March 16, 2018.

⁵⁷ See “Pactive to Pay \$1.7 Million to Settle EEOC Disability Discrimination Class Investigation” (November 5, 2015), available online at www.eeoc.gov/eeoc/newsroom/release/11-5-15a.cfm, last visited on March 16, 2018.

⁵⁸ 21 U.S.C. § 801 *et seq.*

⁵⁹ 42 U.S.C. § 12114 (a). For examples of past state court rulings in favor of employers in this context, see *Coats v. Dish Network, LLC*, 350 P.3d 849 (Co. 2015), in which the Colorado Supreme Court found for an employer which had been sued for violating a state “lawful activity” statute, after the employer cited its own drug policy in terminating an employee with quadriplegia who used medical marijuana in the evening to reduce muscle spasms; *Ross v. RagingWire Telecommunications, Inc.*, 174 P.3d 200 (Cal. 2008); *Johnson v. Columbia Falls Aluminum Co., LLC*, 213 P.3d 789 (Mont. 2009); *Emerald Steel Fabricators, Inc. v. Bureau of Labor & Indus.*, 230 P.3d 518 (Or. 2010); *Roe v. TeleTech Customer Care Mgmt.*, 257 P.3d 586 (Wash. 2011).

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- ⁶⁰ *Callaghan v. Darlington Fabrics Corp.*, 2017 WL 2321181 (R.I.Super. May 23, 2017).
- ⁶¹ *Id.* at *9, *11.
- ⁶² *Id.* at *13.
- ⁶³ *Id.* at *13-14.
- ⁶⁴ *Barbuto v. Advantage Sales and Marketing, LLC*, 477 Mass. 456 (July 17, 2017).
- ⁶⁵ *Id.* at *466-67.
- ⁶⁶ *Id.* at *465-66.
- ⁶⁷ *Noffsinger v. SSC Niantic Operating Co. LLC*, 2017 WL 3401260 (D. Conn. Aug. 8, 2017).
- ⁶⁸ *Id.* at *336-38.
- ⁶⁹ *Port Authority Police Benevolent Association, Inc. v. Port Authority of New York and New Jersey*, 2017 WL 4838320 (S.D.N.Y. Oct. 24, 2017).
- ⁷⁰ *Id.* at *3.
- ⁷¹ *Id.* at *5.
- ⁷² *Id.* at *5-6.
- ⁷³ *Id.* at *6.
- ⁷⁴ *Id.* at *8.
- ⁷⁵ *Id.*
- ⁷⁶ *Id.* at *9.
- ⁷⁷ *Id.* at *9-10.
- ⁷⁸ *Wright v. Illinois Dep't of Children & Family Svcs.*, 798 F.3d 513 (7th Cir. 2015).
- ⁷⁹ *Id.* at 517-18.
- ⁸⁰ *Id.* at 518.
- ⁸¹ *Id.* at 518-19.
- ⁸² *Id.* at 519-20.
- ⁸³ *Id.* at 522.
- ⁸⁴ *Id.* at 522-23.
- ⁸⁵ *Id.* at 515.
- ⁸⁶ *Id.* at 524-25.
- ⁸⁷ *Id.* at 525.
- ⁸⁸ *Id.*
- ⁸⁹ *Id.* at 525-26.
- ⁹⁰ *Kroll v. White Lake Ambulance Authority*, 763 F.3d 619, 620 (6th Cir. 2014).
- ⁹¹ *Id.* at 620-21.
- ⁹² *Id.* at 622.
- ⁹³ *Id.*

⁹⁴ *Id.*

⁹⁵ *Id.*

⁹⁶ *Id.*

⁹⁷ *Id.* at 626.

⁹⁸ *Id.* at 626.

⁹⁹ *Id.* at 626-27.

¹⁰⁰ *Id.* at 627

¹⁰¹ Settlement Agreement Between the United States and the City of New Albany, Indiana (17-cv-185 (S.D. Ind. Agreement reached Oct 4, 2017)), available online at www.ada.gov/new_albany/new_albany_sa.html, last visited on March 17, 2018.

¹⁰² In 2016, the EEOC released final rules regarding wellness programs addressing both the safe harbor and voluntariness exceptions. These regulations, along with an accompanying “Q&A,” are available online at www.eeoc.gov/laws/regulations/qanda-ada-wellness-final-rule.cfm (last visited on March 17, 2018).

¹⁰³ *EEOC v. Orion Energy Systems, Inc.*, 2016 WL 5107019 (E.D. Wis. Sept. 19, 2016).

¹⁰⁴ See “Wisconsin Employer Resolves EEOC Case Involving Wellness Program and Retaliation,” available online at www.eeoc.gov/eeoc/newsroom/release/4-5-17a.cfm, last visited on March 17, 2018.

¹⁰⁵ *Equal Employment Opportunity Commission v. Flambeau, Inc.*, 846 F.3d 941, 946 (7th Cir. 2017).

¹⁰⁶ *AARP v. United States Equal Employment Opportunity Commission*, 2017 WL 6542014 (D.D.C. Dec. 20, 2017).

¹⁰⁷ *Flynn v. Distinctive Home Care, Inc.*, 812 F.3d 422 (5th Cir. 2016).

¹⁰⁸ See also *Schrader v. Fred A. Ray, M.D., P.C.*, 296 F.3d 968 (10th Cir. 2002) (holding that Section 504 does not incorporate the ADA’s requirement that the employer have “fifteen or more employees”); *Fleming v. Yuma Reg’l Med. Ctr.*, 587 F.3d 938 (9th Cir. 2009) (“[T]he Rehabilitation Act covers discrimination claims by an independent contractor.”). But see *Wojewski v. Rapid City Reg’l Hosp.*, 450 F.3d 338 (8th Cir. 2006) (“[W]e affirm ... summary judgment to the defendants because [plaintiff] was not an employee of the hospital.”).

¹⁰⁹ 42 U.S.C. § 12182 *et seq.* Note that, while this brief focuses largely upon the requirements of ADA Titles I and III, the requirements of Title II (which apply to state and local government entities) are very much similar to those of Title III. However, whereas Title III sets accessibility requirements that every place of public accommodation is expected to meet individually, Title II is intended more to ensure overall program access for programs and services provided by state and local governments.

¹¹⁰ 42 U.S.C. 12181(F); 28 C.F.R. 36.104.

¹¹¹ *Levorsen v. Octapharma Plasma, Inc.*, 828 F.3d 1227 (10th Cir. 2016).

¹¹² *Id.* at 1229.

¹¹³ *Id.* at 1229-30.

¹¹⁴ *Id.* at 1229.

¹¹⁵ *Id.* at 1234.

¹¹⁶ *Id.* at 1232-33.

¹¹⁷ *Lujan v. Defenders of Wildlife*, 504 U.S. 555, 559 (1992).

¹¹⁸ *Id.*

¹¹⁹ *Id.* at 560.

¹²⁰ *Id.*

¹²¹ *Id.* at 561.

¹²² *McCullum v. Orlando Regional Healthcare Sy., Inc.*, 768 F.3d 1135 (11th Cir. 2014).

¹²³ *McCullum*, 768 F.3d at 1143.

¹²⁴ *Id.* at 1146.

¹²⁵ *Id.*

¹²⁶ *Id.* at 1140.

¹²⁷ *Hollinger v. Reading Health Sys.*, 2017 WL 429804, at *1 (E.D. Pa. Jan. 31, 2017).

¹²⁸ *Id.*

¹²⁹ *Id.*

¹³⁰ *Id.* at *5.

¹³¹ *Id.* at *4.

¹³² *Perez v. Doctors Hosp. at Renaissance, Ltd.*, 624 Fed.Appx. 180, 182 (5th Cir. 2015).

¹³³ *Id.* at 183.

¹³⁴ *Id.* at 184.

¹³⁵ *Alexander v. Kujok*, 158 F.Supp.3d 1012 (E.D. Ca. 2016).

¹³⁶ *Id.* at 1019.

¹³⁷ *Id.*

¹³⁸ *Bragdon v. Abbott*, 524 U.S. 624 (1998).

¹³⁹ *Id.* at 650.

¹⁴⁰ *United States v. Asare*, 2017 WL 6547900 (S.D.N.Y. Dec. 20, 2017).

¹⁴¹ *Id.* at *5.

¹⁴² *Id.*

¹⁴³ *Id.* at *6.

¹⁴⁴ *Id.*

¹⁴⁵ See Settlement Agreement Between the United States of America and Advanced Plastic Surgery Solutions (December 11, 2017), available online at www.ada.gov/adv_plastic_surgery_sa.html, last visited on March 20, 2018 (involving a medical clinic that refused to accept a prospective patient because she had HIV); Settlement Agreement Between the United States of America and Pain Management Care, P.C. (April 12, 2016), available online at https://www.ada.gov/pmc/pain_mgmt_care_cd.html, last visited on March 20, 2018 (regarding denial of medical treatment by a pain management doctor for a patient who had HIV); Settlement Agreement Between the United States of America and North Florida OB-GYN Associates, P.A. (January 19, 2016), available online at https://www.ada.gov/north_florida_sa.html, last visited on March 20, 2018 (involving a gynecologist who refused to perform a tubal ligation procedure on a patient because she had HIV); Settlement Agreement Between the United States of America and Mercy Suburban Hospital (November 18, 2015), available online at

https://www.ada.gov/mercy_hospital_sa.html, last visited on March 20, 2018 (involving a hospital which had declined to provide bariatric services for a patient who had HIV); Settlement Agreement Between the United States of America and Dentex Dental Mobile, Inc. (March 13, 2015), available online at https://www.ada.gov/dentex_sa.htm, last visited on March 20, 2018 (involving a dental clinic which discriminated against an individual with HIV by refusing to provide treatment); Settlement Agreement Between the United States of America and Genesis Healthcare System (January 15, 2015), available online at https://www.ada.gov/genesis_healthcare_sa.htm, last visited on March 20, 2018 (involving a physician who had discriminated against a patient by failing to provide treatment and by improperly referring the patient elsewhere).

¹⁴⁶ See “Access to Medical Care for Individuals With Mobility Disabilities,” available online at www.ada.gov/medcare_mobility_ta/medcare_ta.htm, last visited on March 22, 2018.

¹⁴⁷ For accessibility standards for medical diagnostic equipment, see the guidelines provided by the United States Access Board, available online at www.access-board.gov/guidelines-and-standards/health-care/about-this-rulemaking, last visited on March 22, 2018.

¹⁴⁸ 28 C.F.R. 36.104.

¹⁴⁹ *Id.*

¹⁵⁰ 28 C.F.R. 36.302(c)(1).

¹⁵¹ See *DOJ Guidelines*, available at http://www.ada.gov/service_animals_2010.htm, last visited on March 21, 2018. Healthcare providers must be prepared to accommodate individuals using service animals without inquiring about the nature or extent of the individual’s disabilities. 28 C.F.R. 36.302(c)(6).

¹⁵² See, e.g., *Tamara v. El Camino Hospital*, 964 F.Supp.3d 1077 (N.D. Cal. 2013). DOJ has also undertaken enforcement activities with regard to healthcare providers in order to ensure equal access for individuals with disabilities who use service animals. For example, see Settlement Agreement Between the United States of America and Dr. Bruce Berenson, M.D., P.A. (August 7, 2012), available online at https://www.ada.gov/berenson_settle.htm, last visited on March 22, 2018.

¹⁵³ See “Justice Department Reaches Settlement with Learning Care Group to Resolve ADA Violations” (March 20, 2018), available online at <https://www.justice.gov/opa/pr/justice-department-reaches-settlement-learning-care-group-inc-resolve-ada-violations>, last visited on March 21, 2018.

¹⁵⁴ See Winnewald Day Camp Settlement Agreement (June 2015), available online at www.justice.gov/usao-nj/file/765696/download, last visited on March 19, 2018; see also “Summer Camps and the ADA” (DOJ bulletin, available online at www.justice.gov/file/campadaflyerpdf/download, last visited on March 19, 2018).

¹⁵⁵ See, e.g., Settlement Agreement Between the United States of America and Arlington-Mansfield Area YMCA (February 24, 2016), available online at www.ada.gov/arlington_ymca.html, last visited on March 19, 2018 (agreement also included a cash settlement for complainant; Settlement Agreement Between the United States and Philadelphia Freedom Valley YMCA (May 19, 2016), available online at www.ada.gov/rocky_run_sa.html, last visited on March 19, 2018; Settlement Agreement Between the United States of America and YMCA of the Triangle (July 27, 2016), available online at www.ada.gov/ymca_triangle_sa.html, last visited on March 19, 2018; Settlement Agreement Between the United States of America and YMCA of Metro Chicago (December 21, 2016), available online at www.justice.gov/usao-ndil/pr/united-states-announces-settlement-ymca-metro-chicago-ensure-compliance-americans, last visited on March 19, 2018).

¹⁵⁶ 42 U.S.C. §§ 12182(a), 12182(b)(1)(A)(ii), 12182(b)(2)(A)(iii); 28 C.F.R. §§ 36.201(a), 36.202, 36.303.

¹⁵⁷ 28 C.F.R. 36.303(b)(1).

¹⁵⁸ See, e.g., Settlement Agreement Between the United States of America and Dekalb Regional Crisis Center, available online at http://www.ada.gov/dekalb_crisis_ctr_sa.html, whereby the provider revised its

effective communication policy, henceforth conducting a communication assessment, which includes the relevant facts and circumstances, the individual's communication skills and knowledge, the nature and complexity of the communication at issue, and by an individual.”

¹⁵⁹ See, e.g., Settlement Agreement Between the United States of America and Grady Memorial Hospital, February 9, 2016; Settlement Agreement Between the United States of America and Promedica Toledo Hospital, January 28, 2016; Settlement Agreement between the United States of America and Srivinas Mukkamala, M.D., July 17, 2015; Settlement Agreement Between the United States of America and Arshad Pervez, M.D., July 17, 2015; Settlement Agreement Between the United States of America and Fairfax Nursing Center, Inc., July 10, 2015; Resolution Agreement Between the United States of America and St. Francis Hospital and Medical Center, March 23, 2015.

¹⁶⁰ For further information, See DOJ guidance found at 28 CFR 35, App. A.

¹⁶¹ *Martin v. Halifax Healthcare Systems, Inc.*, 2015 WL 4591796 (11th Cir. July 31, 2015)

¹⁶² Separately, it should be noted that American Sign Language (“ASL”) and English are not the same, thus some people who are deaf may be fluent in ASL, but unable to read English, making passing notes ineffective even for simple communications.

¹⁶³ *Liese v. Indian River County Hospital District*, 701 F.3d 334 (11th Cir. 2012).

¹⁶⁴ *Id.* at 340-41.

¹⁶⁵ *Id.* at 343.

¹⁶⁶ *Id.*

¹⁶⁷ *Shaika v. Gnaden Huetten Memorial Hosp.*, 2015 WL 4092390 (M.D. Pa. July 7, 2015).

¹⁶⁸ *Id.*

¹⁶⁹ *Id.* at *10.

¹⁷⁰ For VRI performance standards applicable to Title III, see 28 C.F.R. § 36.303(f); for Title II standards, see 28 C.F.R. § 35.160(d).

¹⁷¹ For further DOJ guidance and comments, see “ADA Requirements: Effective Communication,” available online at www.ada.gov/effective-comm.htm, last visited on March 23, 2018.

¹⁷² See “Minimum Standards for Video Remote Interpreting Services in Medical Settings,” available online at <http://nad.org/issues/technology/vri/position-statement-hospitals>, last visited on March 23, 2018.

¹⁷³ *Silva v. Baptist Health South Florida*, 856 F.3d 824 (11th Cir. 2017).

¹⁷⁴ *Id.* at 830.

¹⁷⁵ *Id.* at 837-38.

¹⁷⁶ *Id.* at 833-34.

¹⁷⁷ *Id.* at 829.

¹⁷⁸ See DOJ amicus brief filed in support of this appeal, available online at www.justice.gov/crt/file/870846/download, last visited on March 23, 2018.

¹⁷⁹ *Id.* at 834.

¹⁸⁰ *Id.* at 835, 840.

¹⁸¹ *Id.* at 835.

¹⁸² *Id.* At 837; see footnote 8.

¹⁸³ *Id.* at 832-33.

¹⁸⁴ *Morales v. Saint Barnabas Medical Center*, 13-cv-06363 (D.N.J. Consent Order, Feb. 14, 2017).

¹⁸⁵ See also *Moss v. Newark Beth Israel Med. Ctr.*, 13-cv-4360 (D.N.J. Consent Order, Feb. 16, 2017), available online at www.equipforequality.org/news-item/health-care-consent-orders, last visited on March 23, 2018.

¹⁸⁶ 28 C.F.R. § 35.160(a)(1) (Title II); 28 C.F.R. § 36.303(c)(1)(i)(Title III).

¹⁸⁷ Settlement Agreement Between the United States of America and Fairfax Nursing Center, Inc., available online at http://www.ada.gov/fairfax_nursing_ctr_sa.html, last visited on March 23, 2018.

¹⁸⁸ *Loeffler v. Staten Island University Hosp.*, 582 F.3d 268 (2nd Cir. 2009)

¹⁸⁹ *Id.* at 272-73.

¹⁹⁰ *Id.* at 280-81.

¹⁹¹ *Id.*

¹⁹² *McCullum v. Orlando Regional Healthcare Sy., Inc.*, 768 F.3d 1135 (11th Cir. 2014).

¹⁹³ *Id.* at 1144.

¹⁹⁴ *Id.* at 1145.

¹⁹⁵ 28 C.F.R. § 36.303(c)(4) (Title III); 28 C.F.R. § 35.160(c) (Title II). *But see, Durand v. Fairview Health Servs.*, 230 F.Supp.3d 959 (D. Minn 2017), appeal docketed, No. 17-1374 (8th Cir. Feb. 17, 2017). In *Durand*, an adult patient with an end-of-life directive was admitted to the ICU and died three days later. His deaf parents requested a sign language interpreter. An interpreter was made available for a few conversations between the parents and physicians. When the interpreter was not present, the patient's sister, who could not interpret in sign language fluently, facilitated communication between hospital staff and the parents. Due to some miscommunication, the father was not at the hospital when his son died, and the family filed suit. The court ruled that because the parents "played no role in their son's health care," the hospital had no duty to ensure that they "receive certain information." The court also ruled against the sister's claim of discrimination by association.

¹⁹⁶ For example, see "Walgreens Now Offers Talking Prescription Labels," available online at www.lflegal.com/2014/06/walgreens-talking, last visited on March 19, 2018, as well as "CVS/Pharmacy Now Offers 'Talking' Prescription Labels for Individuals With Vision Impairments Through Online Pharmacy," available online at acb.org/content/cvspharmacy-now-offers-%E2%80%9Ctalking%E2%80%9D-prescription-labels-individuals-vision-impairments-through, last visited on March 19, 2018. See also information regarding the settlement with CVS MinuteClinic, which agreed to take additional steps to ensure that individuals with visual impairments receive treatment and other important information in accessible formats, and to arrange for sign language interpreters at the request of individuals who are deaf, available online at www.cvshealth.com/content/minuteclinic-enhance-accessibility-patients-disabilities, last visited on March 19, 2018.