

2008

Deaf Patients, Doctors, and the Law: Compelling a Conversation About Communication

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FLORIDA STATE UNIVERSITY LAW REVIEW



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COMPELLING A CONVERSATION ABOUT COMMUNICATION

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VOLUME 35

SUMMER 2008

NUMBER 4

Recommended citation: Michael A. Schwartz, *Deaf Patients, Doctors, and the Law: Compelling a Conversation About Communication*, 35 FLA. ST. U. L. REV. 947 (2008).

DEAF PATIENTS, DOCTORS, AND THE LAW: COMPELLING A CONVERSATION ABOUT COMMUNICATION

MICHAEL A. SCHWARTZ*

ABSTRACT

Title III of the Americans with Disabilities Act (ADA) grants people with disabilities access to public accommodations, including the offices of medical providers, equal to that enjoyed by persons without disabilities. The Department of Justice (DOJ) has unequivocally declared that the law requires effective communication between the medical provider and the Deaf patient. Because most medical providers are not fluent in sign language, the DOJ has recognized that effective communication calls for the use of appropriate auxiliary aids, including sign language interpreters. The final decision on what to offer the Deaf patient is the doctor's, and under current DOJ regulations, the doctor does not have to consult with the patient or give "primary consideration" to the patient's choice of auxiliary aid as long as what the doctor offers results in effective communication. However, given the great variation in people's communication styles and skills, a standard, one-size-fits-all auxiliary aid would fail to achieve effective communication in many cases, harming not only the Deaf patient, but also the medical provider, who would be potentially liable for violating the ADA as well as hamstrung in getting accurate information for purposes of diagnosis and treatment. Moreover, most doctors are not savvy about Deafness and Deaf culture. Thus, the best way to ensure effective communication would be to require the medical provider to ask the Deaf patient for his or her choice of auxiliary aid and to give "primary consideration" to the patient's expressed choice of auxiliary aid. Such an approach is required under Title II of the ADA, which makes it mandatory for state and local governments to consult with people with disabilities and give "primary consideration" to the patient's choice of auxiliary aid. Given that there is no difference between a public doctor and a private doctor that would justify the two different approaches and that cost is not a factor, since under either title, a medical provider cannot pass on the costs to the person with a disability, the DOJ should revise its interpretation of Title III in order

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to bring it into line with its interpretation of Title II. To fail to do so would operate to frustrate both the letter and the spirit of the ADA. Until the DOJ brings the titles into line, the courts should decline to give controlling weight to the DOJ's interpretation of Title III.

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I. INTRODUCTION

Up to two million Deaf people in the United States use sign language to communicate,¹ but when they need to see a doctor, they find that many medical offices and hospitals are “aurally inaccessible,” that is, they lack appropriate auxiliary aids for Deaf patients.² Case

1. HARLAN LANE ET AL., A JOURNEY INTO THE DEAF-WORLD 42 (1996); JEROME D. SCHEIN, AT HOME AMONG STRANGERS (1989). *But see* CAROL PADDEN & TOM HUMPHRIES, INSIDE DEAF CULTURE 9 (2005) (positing the maximum number of signing Deaf people, including Canadians, at 300,000). This Author chooses the convention of capitalizing the word, “deaf,” to underline the political act of naming. To be “Deaf” is to claim membership in a cultural and linguistic minority as opposed to the popular idea of “deafness” as a medical condition. *See* PADDEN & HUMPHRIES, *supra*, at 1-2. This Author also uses the word, “Deaf,” as shorthand: it includes those who are hard-of-hearing.

2. “Aurally inaccessible” is this Author’s term to describe offices that are not equipped to meet the communication needs of patients who cannot hear or understand the spoken word and who use sign language to communicate with the world. In other words, not only are these offices lacking sign language interpreters, computer-aided real-time transcription (CART) technology, captioned material, and other visual methods for conveying information; the personnel in these offices know very little about Deafness, Deaf culture, and the communication needs of Deaf patients. *See* Lisa M. Harmer, *Health Care Delivery and Deaf People: Practice, Problems, and Recommendations for Change*, 4 J. DEAF STUD. & DEAF EDUC. 73 (1999). As exemplified by the story of James Boardman, *infra* Part I.D, Deaf people’s experiences with the lack of communication access in their doctors’ offices points to the need for cultural competence on the part of doctors in their dealings with Deaf patients. Aurally inaccessible offices are also culturally incompetent offices, and this

law is replete with stories about Deaf people encountering medical providers who are aurally inaccessible to them because the providers did not furnish a sign language interpreter or other appropriate auxiliary aid to facilitate communication between the Deaf person (whether a patient or a relative) and the provider.³ To address this problem, the Americans with Disabilities Act of 1990 (ADA), interpretive regulations of the ADA by the United States Department of Justice (DOJ), and judicial case law offer guidance on providing an appropriate auxiliary aid for Deaf patients in the medical setting. The guiding lodestone is the principle of effective communication,⁴ and numerous approaches—interpreters, computer-aided real-time transcription (CART) technology, written notes, and captioning—are listed as some of the ways to achieve that end.⁵

There is just one glitch.

The DOJ's "section-by-section analysis" of 28 C.F.R. Section 36.303, the auxiliary aid regulation promulgated under the ADA to require places of public accommodation to provide effective communication,⁶ does *not* require the doctor to consult with the Deaf patient,

Article's central argument is that one way to ensure a minimal level of cultural competence is to require a compulsory conversation between doctor and patient as to what is needed to establish effective communication between the two parties.

3. See, e.g., *Loeffler v. Staten Island Univ. Hosp.*, No. 95 CV 4549 SJ, 2007 WL 805802 (E.D.N.Y. Feb. 27, 2007); *Connors v. W. Orange Healthcare Dist.*, No. 605CV647ORL31KRS, 2005 WL 1500899 (M.D. Fla. June 23, 2005); *Constance v. State Univ. of N.Y. Health Scis. Ctr.*, 166 F. Supp. 2d 663 (N.D.N.Y. 2001); *Majocha v. Turner*, 166 F. Supp. 2d 316 (W.D. Pa. 2001); *Freydel v. N.Y. Hosp.*, No. 97 Civ. 7926(SHS), 2000 WL 10264 (S.D.N.Y. Jan. 4, 2000); *Davis v. Flexman*, 109 F. Supp. 2d 776, 791 (S.D. Ohio 1999); *Bravin v. Mount Sinai Med. Ctr.*, 186 F.R.D. 293 (S.D.N.Y. 1999), *vacated in part on other grounds*, 58 F. Supp. 2d 269 (S.D.N.Y. 1999); *Falls v. Prince George's Hosp. Ctr.*, No. Civ.A. 97-1545, 1999 WL 33485550 (D. Md. Mar. 16, 1999); *Proctor v. Prince George's Hosp. Ctr.*, 32 F. Supp. 2d 820, 823-24 (D. Md. 1998); *Naiman v. N.Y. Univ. Med. Ctr.*, No. 95 CIV. 6469(LMM), 1997 WL 249970 (S.D.N.Y. May 13, 1997); *Schroedel v. N.Y. Univ. Med. Ctr.*, 885 F. Supp. 594, 599 (S.D.N.Y. 1995); *People by Vacco v. Mid Hudson Med. Group, P.C.*, 877 F. Supp. 143 (S.D.N.Y. 1995); *Mayberry v. Von Valtier*, 843 F. Supp. 1160, 1164 (E.D. Mich. 1994); *Aikins v. St. Helena Hosp.*, 843 F. Supp. 1329 (N.D. Cal. 1994).

4. 28 C.F.R. § 36.303(c) (2007) ("A public accommodation shall furnish appropriate auxiliary aids and services where necessary to ensure *effective communication* with individuals with disabilities" (emphasis added)).

5. *Id.* § 36.303(b). The DOJ defines "auxiliary aids and services [as] a wide range of services and devices for ensuring effective communication," but cautions that the "[u]se of the most advanced technology is not required so long as effective communication is ensured." 28 C.F.R. Pt. 36, App. B, § 36.303 Auxiliary Aids and Services (published July 26, 1991). The DOJ "wishes to clarify that the list [of auxiliary aids] is not an all-inclusive or exhaustive catalogue of possible or available auxiliary aids or services. It is not possible to provide an exhaustive list, and such an attempt would omit new devices that will become available with emerging technology." *Id.*

6. See 28 C.F.R. Pt. 36, App. B, § 36.303 (revised as of July 1, 1994). A doctor's office is included in the twelve categories of public accommodations. 42 U.S.C. § 12181(7)(F) (2000); 28 C.F.R. § 36.104(5)(iii) ("Place of public accommodation means a facility, operated by a private entity, whose operations affect commerce and fall within at least one of the following categories – (6) . . . professional office of a health care provider." *Id.* at (iii)(6)). To avoid confusion, this Author will use the term, "doctor's office," in lieu of "place of public

nor to give “primary consideration” to the Deaf patient’s express choice of auxiliary aid that would ensure effective communication between the doctor and the patient.⁷ While the regulations fleshing out the ADA’s requirements obligate a doctor’s office to “take those steps that may be necessary to ensure” effective communication, the Department’s analysis of 28 C.F.R. Section 36.303 does not specify that one of these steps should require the doctor to consult with the Deaf patient prior to deciding on an appropriate auxiliary aid.⁸ Under the ADA, as interpreted by the DOJ, there are no specific enforceable steps required of a doctor’s office to ensure effective communication. As long as the communication is effective, the choice of auxiliary aid or service is entirely up to the doctor.⁹

Instead, what the Department’s analysis merely does is to “strongly encourage” a doctor to consult with a Deaf patient as to what he or she needs for effective communication; the Department also refuses to require the doctor to give “primary consideration” to the Deaf patient’s choice.¹⁰ Yet, empirical research by this Author demonstrates that the great variation of Deaf patients and the complexity of their experiences in the medical setting require the careful consideration of a panoply of appropriate auxiliary aids in order to establish effec-

accommodation” or “public accommodation” because the terms are interchangeable, and because the focus of this Article is on the doctor’s office. By the same token, this Author means for the term “doctor’s office” to include hospitals and medical clinics, both of which are included in the legal definition of a public accommodation. 42 U.S.C. § 12181(7)(F); 28 C.F.R. § 36.104.

7. What constitutes an effective auxiliary aid is a critical question, and the term “primary consideration” arose when people with disabilities urged the DOJ to require places of public accommodation to consult with people with disabilities as to their preferred choice of auxiliary aid and to give “primary consideration” to their choices. A common sense interpretation of the term, “primary consideration,” would call on the public accommodation, in this case the doctor, to give due deference to the patient’s choice of auxiliary aid. The term, “primary consideration,” does not appear in the Title III regulation and interpretive commentary, but does appear in the Title II interpretive commentary. *See infra* note 12.

8. *Id.*

9. *See* U.S. DEPT. OF JUSTICE, ADA TITLE III TECHNICAL ASSISTANCE MANUAL § 4.3200 (1993 & Supp.), available at <http://www.ada.gov/publicat.htm#Anchor-Title-47383> [hereinafter DOJ TITLE III TECHNICAL ASSISTANCE MANUAL] (“Public accommodations should consult with individuals with disabilities wherever possible to determine what type of auxiliary aid is needed to ensure effective communication. In many cases, more than one type of auxiliary aid or service may make effective communication possible. While consultation is strongly encouraged, *the ultimate decision as to what measures to take to ensure effective communication rests in the hands of the public accommodation, provided that the method chosen results in effective communication.*” (emphasis added)).

10. *Id.*; *see also* 28 C.F.R. Pt. 36, App. B, § 36.303 (1994). So instead of adopting mandatory language requiring the doctor to engage in a consultative process with the Deaf patient to determine the appropriate auxiliary aid for effective communication, the DOJ’s analysis of its ADA-enforcing regulation adopted the exhortatory language, “strongly encourage,” that in no way obligates the doctor to consult with a Deaf patient. 36 C.F.R. Pt. 36, App. B § 36.303.

tive communication access.¹¹ The data suggest that the doctor and the Deaf patient should not only have a thorough conversation about which auxiliary aids would work for both parties under a given set of circumstances, the doctor should also be required to give “primary consideration” to the Deaf patient’s expressed choice of auxiliary aid. This is not a new concept or undertaking for the DOJ: its interpretation of the ADA’s Title II regulation that governs the provision of auxiliary aids by state and local governments requires these public entities to consult with disabled people and to give their choice of auxiliary aid “primary consideration.”¹²

Thus, this Article proposes that the DOJ amend its interpretation of 28 C.F.R. Section 36.303 (Title III) to parallel its interpretation of 28 C.F.R. Section 35.160 (Title II). Just as doctors working for state or local government must have a conversation with the patient as part of the doctor’s “steps” in providing effective communication and must give “primary consideration” to the patient’s choice, so should private doctors. Using qualitative research data on Deaf patients dealing with medical personnel,¹³ this Article explores the insights and strategies revealed by these patients in their struggle to meet the challenges of working with doctors and nurses in an aurally inaccessible environment. This Article follows up with a look at the law of effective communication access for Deaf patients in the medical setting by reviewing the ADA’s statutory scheme, the controlling regulations promulgated by the DOJ, and federal case law.¹⁴ In contrast-

11. The research data was developed as part of this Author’s dissertation study for which he received a Ph.D. in Education at the Cultural Foundations of Education, which is part of the School of Education at Syracuse University. See Michael A. Schwartz, *Communication in the Doctor’s Office: Deaf Patients Talk About Their Physicians* (Apr. 10, 2006) (unpublished Ph.D. dissertation, Syracuse University) [hereinafter *Schwartz Dissertation*] (on file with author). The term “variation” refers to the wide range of hearing loss and its attendant impact on people’s language competency and cultural identity. See Harmer, *supra* note 2; see generally Michele LaVigne & McCay Vernon, *An Interpreter Isn’t Enough: Deafness, Language and Due Process*, 2003 WIS. L. REV. 843, 859.

12. 28 C.F.R. § 35.160(b)(2) (2007). According to the DOJ Manual on Title II, “When an auxiliary aid or service is required, the public entity must provide an opportunity for individuals with disabilities to request the auxiliary aids and services of their choice and must give primary consideration to the choice expressed by the individual. ‘Primary consideration’ means that the public entity must honor the choice, unless it can demonstrate that another equally effective means of communication is available, or that use of the means chosen would result in a fundamental alteration in the service, program, or activity or in undue financial and administrative burdens.”

U.S. DEPT. OF JUSTICE, ADA TITLE II TECHNICAL ASSISTANCE MANUAL § 7.1100 (1993 & Supp.), [hereinafter DOJ TITLE II TECHNICAL ASSISTANCE MANUAL] available <http://www.ada.gov/publicat.htm#Anchor-Title-49425>.

13. See Schwartz Dissertation, *supra* note 11.

14. Section 504 of the Rehabilitation Act of 1973, Pub. L. No. 93-112, 87 Stat. 355, codified as amended at 29 USC § 701 et seq (2000), the precursor to the ADA, is also included in the statutory review because the ADA borrowed heavily from the earlier law. Generally, most of the cases selected for review in this Article have had a good outcome in that the

ing a qualitative look at the relationship between Deaf patients and their doctors—the complexity of which calls for a flexible approach to providing appropriate auxiliary aids, with what the law requires (or, to put it more accurately, does *not* require)—this Article argues for a rewrite of the DOJ’s analysis of 28 C.F.R. Section 36.303 to require a two-step process. First, the doctor’s office must consult with the person with a disability, and second, the doctor’s office must give “primary consideration” to the person’s express request for a particular auxiliary aid. This new analysis would comport with the broad vision of the Americans with Disabilities Act as enacted and may have the potential to reduce the amount of litigation over appropriate auxiliary aids *by encouraging more communication about communication*.¹⁵ Put simply, the law needs to play a greater role in fostering that conversation in the medical office, not the courtroom. And, if the DOJ declines to engage in such redrafting of its interpretation of Title III regulation, the courts should decline to give controlling weight to the current interpretation.

A. *The Problem*

Hearing impairment, with a prevalence of over nine percent, is the sixth most common “chronic condition” in the United States.¹⁶ Up to two million Deaf people communicate using American Sign Language,¹⁷ and, as noted, there is enormous variation in Deaf people’s ability not only to speak and read lips, but also to read and write English fluently.¹⁸ On the other side of the equation, an overwhelming majority of doctors in America do not sign, and most medical personnel know very little about Deafness, Deaf culture, and the myriad

judge found in favor of the Deaf patient-plaintiff. *See infra* Part III.C. The argument is not that these cases were wrongly decided—to the contrary, as the DOJ’s regulations indicate, *see infra* Part III.B, for Deaf patients, many, if not most, encounters with medical personnel require sign language interpreters. Rather, the argument is that these cases represent the tip of the iceberg of communication breakdowns between doctor and patient, which might be avoided if the DOJ redrafted its analysis of 28 C.F.R. Section 36.303(c) to require physician consultation and primary consideration of the Deaf patient’s express choice of auxiliary aid. This argument will be further developed in the remainder of this Article.

15. Indeed, it is this Article’s central argument: because controlling regulations on the ADA issued by the DOJ merely “strongly encourage” communication about communication, federal case law interpreting the ADA reflects a breakdown in communication between doctor and patient. *See supra* note 3. Supporting this central argument are this Author’s dissertation interviews, case law, DOJ settlement decrees, scholarly research, and the almost twenty years of post-1990 experiences of people with disabilities under the ADA with the persistent and pervasive failures of doctors to provide effective communication despite the statute.

16. Steven Barnett & Peter Franks, *Health Care Utilization and Adults Who Are Deaf: Relationship with Age at Onset of Deafness*, 37 HEALTH SERV. RESEARCH 105 (2002); U.S. DEP’T HEALTH & HUM. SERVICES, PREVALENCE OF SELECTED CHRONIC CONDITIONS: UNITED STATES, 1990-1992 (1997).

17. *See supra* note 1.

18. *See Schwartz Dissertation, supra* note 11.

ways in which Deaf people communicate.¹⁹ Accordingly, an aurally inaccessible medical office is an ontological reality for many Deaf patients.²⁰ Because of limited access to health information, many Deaf people are often unable to make informed health care decisions for themselves and their families.²¹ The major barriers are attitudinal and communication-related.²²

B. Attitudinal Barriers

Many, if not most, physicians are insufficiently prepared to work with Deaf patients whose primary mode of communication is sign language.²³ They often lack the awareness and knowledge that would enable them to provide effective communication access in their offices.²⁴ Indeed, medical personnel hold assumptions, misconceptions,

19. Patricia Golden & Marian Ulrich, *Deaf Patients' Access to Care Depends on Staff Communication*, 52 J. AMER. HOSP. ASS'N 86, 86-90 (1978). Generally speaking, there are problems with physician readiness to serve patients with disabilities and a corresponding need for greater physician education with respect to the ADA. Ellen W. Grabois et al., *Accessibility of Primary Care Physicians' Offices for People with Disabilities: An Analysis of Compliance with the Americans with Disabilities Act*, 8 ARCHIVES FAM. MED. 44 (1999); Denise M. Lishner et al., *Access to Primary Health Care Among Persons with Disabilities in Rural Areas: A Summary of the Literature*, 12 J. RURAL HEALTH 45 (1996). There is a vast body of literature on Deaf culture. See, e.g., JAN BRANSON & DON MILLER, DAMNED FOR THEIR DIFFERENCE: THE CULTURAL CONSTRUCTION OF DEAF PEOPLE AS DISABLED (2002); CAROL PADDEN & TOM HUMPHRIES, DEAF IN AMERICA: VOICES FROM A CULTURE (1988); NORA ELLEN GROCE, EVERYONE HERE SPOKE SIGN LANGUAGE: HEREDITARY DEAFNESS ON MARTHA'S VINEYARD (1985); LANE ET AL., *supra* note 1; DEAF WORLD: A HISTORICAL READER AND PRIMARY SOURCEBOOK (Lois Bragg ed., 2001).

20. Harmer, *supra* note 2.

21. Steven Barnett, *Communication with Deaf and Hard-of-hearing People: A Guide for Medical Education*, 77 ACAD. MED. 694, 694-700 (2002); see Harmer, *supra* note 2.

22. E.E. McNeil, *Physicians' Attitudes Toward Deaf Persons and the Communication Methods Used with Their Deaf Patients* (1984), microformed on Dissertation Abstracts Int'l 45:5, 1306A (Univ. Microforms No. AAC 8418170).

23. Barnett, *supra* note 21. Very few medical schools train their students in working with Deaf patients; a bright spot is the University of Rochester School of Medicine where the Deaf Wellness Center offers training on how to work with Deaf patients. See University of Rochester Medical Center's Deaf Wellness Center, <http://www.urmc.rochester.edu/dwc/index.htm> (last visited Aug. 25, 2008). Dr. Robert Q. Pollard of the Deaf Wellness Center has initiated at the University of Rochester School of Medicine "a first-year medical student seminar organized around direct, non-clinical conversation with persons who have disabilities, following the exposure method thought to be most effective in improving beliefs and attitudes about disability." Robert Q. Pollard, *A Consumer Interview Seminar that Enhances Medical Student Attitudes Toward Persons with Disabilities*, 5 J. BEHAV. SCI. IN MED. EDUC. 27, 27-31 (1998). In addition, the University of Rochester School of Medicine adopted a unique role-reversal exercise, "Deaf Strong Hospital," for first-year medical students in which the students were "patients" in a simulated health-care setting in which the "health-care professionals" were volunteers from the local Deaf community in Rochester. Such an exercise "was designed to teach the first-year students about techniques for overcoming communication barriers as well as some of the specific challenges in communicating with deaf or hard-of-hearing patients." Julie Richards et al., *Deaf Strong Hospital: An Exercise in Cross-Cultural Communication for First Year Medical Students*, 10 J. U. ROCHESTER MED. CENTER 5 (1999).

24. Barnett, *supra* note 21, at 694; Golden & Ulrich, *supra* note 19, at 86.

and faulty information about Deaf people and Deafness that impact the delivery of health care to Deaf patients.²⁵ Many doctors share a common social attitude toward Deafness: Deaf people are “dumb” or “mute,” and their inability to speak, even their ability to sign, indicates a level of incompetence.²⁶ The problem of attitudinal barriers is of acute concern to Deaf patients and their doctors, from both a human and a legal standpoint. Health care delivery is compromised if the two parties cannot communicate adequately and effectively in the exchange.²⁷ Furthermore, a doctor’s failure to communicate effectively with a Deaf patient violates federal law.²⁸

C. Communication Barriers

Many health care professionals labor under several misconceptions.²⁹ For example, they think that lip reading is an effective means of communication for every Deaf person,³⁰ that all Deaf people can read and write English fluently, and that American Sign Language (ASL) is a manual form of the English language.³¹ For many Deaf people, their inability to read and write English fluently impacts their ability to read lips.³² ASL, not English, is their native language.³³ Not only do many Deaf patients struggle with English as a dominant language aurally not accessible to them, they confront

25. See Glen B. Anderson & Melanie Thornton, *Unresolved Issues in the Provision of Mental Health Services to People Who Are Deaf*, in RESEARCH AND PRACTICE IN DEAFNESS: ISSUES AND QUESTIONS IN EDUCATION, PSYCHOLOGY, AND VOCATIONAL SERVICE PROVISION 211 (Olga M. Welch ed., 1993); Golden & Ulrich, *supra* note 19, at 86; Harmer, *supra* note 2, at 73-74, 90; Lisa I. Iezzoni et. al, *Communicating About Health Care: Observations from Persons Who Are Deaf or Hard of Hearing*, 140 ANNALS INTERNAL MED. 356, 357 (2004).

26. See Harmer, *supra* note 2, at 74.

27. Pollard, *supra* note 23, at 27; Annie G. Steinberg et al., *Cultural and Linguistic Barriers to Mental Health Service Access: The Deaf Consumer’s Perspective*, 155 AM. J. PSYCHIATRY 982, 984 (1998).

28. 42 U.S.C. § 12182 (2000); 28 C.F.R. Pt. 36, Subpart B, §§ 36.201, 36.202, 36.302, and 36.303 (2007); see also Barnett, *supra* note 21, at 694; see, e.g., *Majocha v. Turner*, 166 F. Supp. 2d 316 (W.D. Pa. 2001); *Tugg v. Towey*, 864 F. Supp. 1201, 1205 (S.D. Fla. 1994).

29. Golden & Ulrich, *supra* note 19; Harmer, *supra* note 2, at 93.

30. Lip-reading is a difficult skill that not every Deaf or hard-of-hearing person has, and even the most skilled lip-readers do not comprehend all of what is said. GROCE, *supra* note 19, at 144 n.3 (1985).

31. Golden & Ulrich, *supra* note 19. Health care professionals are not alone in their misperceptions about Deaf people. As numerous authors have pointed out, ignorance and misunderstanding of Deaf people and Deaf culture is widespread in American society. See, e.g., HARLAN LANE, *THE MASK OF BENEVOLENCE: DISABLING THE DEAF COMMUNITY* (1992); DOUGLAS C. BAYNTON, *FORBIDDEN SIGNS: AMERICAN CULTURE AND THE CAMPAIGN AGAINST SIGN LANGUAGE* (1996).

32. B.L. Wirfs, *Not By Word of Mouth: Communication with Deaf Patients*, ASPECTS, Summer 1984, at 8; S.L. Davenport, *Improving Communication with the Deaf Patient*, 4 J. OF FAMILY PRACTICE 1065, 1065-68 (1977).

33. LaVigne & Vernon, *supra* note 11, at 859.

medical personnel who do not understand their struggle.³⁴ For instance, simply putting an interpreter in front of the Deaf patient does not automatically render an adequate and effective translation of spoken language to ASL or whatever variant of sign language the Deaf person understands.³⁵ Interpreters have varying communication skills, and not every interpreter is the right person for a particular patient in a particular setting.³⁶

Even those Deaf patients who are highly literate or well educated have to struggle in intense, stressful environments like emergency rooms and hospitals to make sense of the information flow; the struggle is much more pronounced for those whose first language is American Sign Language than it is for those with “normal” hearing whose first language is spoken English.³⁷ For a person with hearing, medical jargon and terminology can be confusing, even incomprehensible; for a Deaf person, the confusion is compounded by the fact that lip-reading involves a great deal of guessing.³⁸ Finally, even when a doctor realizes there is a communication problem, federal case law is replete with examples of physician resistance to providing an interpreter because the doctor is obligated by law to pay for the interpreter out of his or her pocket.³⁹

D. A True Story Illuminating the Problem

In April 1994, James Boardman approached the Civil Rights Bureau of the New York State Department of Law.⁴⁰ A Deaf patient at the Mid Hudson Medical Clinic, a nineteen-doctor medical facility catering to the Poughkeepsie-Fishkill, N.Y., community, Boardman

34. Harmer, *supra* note 2; Lisa I. Iezzoni et al., *Communicating About Health Care: Observations from Persons who are Deaf or Hard of Hearing*, 140 ANNALS INTERNAL MED. 356 (2004).

35. LaVigne & Vernon, *supra* note 11; Steinberg et al., *supra* note 27, at 984 (“Clinicians should never assume that the presence of an interpreter ensures adequate communication.”).

36. LaVigne & Vernon, *supra* note 11, at 868-79.

37. *Id.*

38. See GROCE, *supra* note 19.

39. See, e.g., *Gillespie v. Laurel Hosp.*, 369 F. Supp. 2d 636 (D. Md. 2005); *Majocha v. Turner*, 166 F. Supp. 2d 316 (W.D. Pa. 2001); *Falls v. Prince George’s Hosp. Ctr.*, No. Civ.A. 97-1545, 1999 WL 33485550 (D. Md. Mar. 16, 1999); *People by Vacco v. Mid Hudson Med. Clinic*, 877 F. Supp. 143 (S.D.N.Y. 1995). The DOJ explains that “[a]lthough compliance may result in some additional cost, a public accommodation may not place a surcharge only on particular individuals with disabilities or groups of individuals with disabilities to cover these expenses.” DOJ TITLE III TECHNICAL ASSISTANCE MANUAL, *supra* note 9, § 4.1400 (surcharges).

40. The Author was the Assistant Attorney General in the Civil Rights Bureau who registered Mr. Boardman’s complaint against a medical clinic treating Mr. Boardman and his family and initiated the investigation and subsequent lawsuit against the clinic. As such, the Author has personal knowledge of the following details in the text pertaining to the investigation and prosecution of the claims against the medical clinic.

communicated for many years with his doctor by writing notes. Occasionally, when Boardman brought in his young children to see the clinic's pediatrician, the doctor would communicate with the Deaf father through the signs of the little children, including one who was not older than four years of age.

Once the Americans with Disabilities Act became effective in 1992, Boardman, who also has Usher's syndrome (a form of retinitis pigmentosa, a progressive decrease of visual acuity that may result in complete blindness by midlife), decided to request the services of a sign language interpreter because he does not speak or read lips.⁴¹ Boardman's doctor could not understand why after all those years of writing notes, his patient suddenly wanted an interpreter and was demanding that the doctor pay for the service. The doctor wanted to know, "What was this law? Why do I have to pay \$60 to \$80 for a fifteen or thirty minute visit with my deaf patient? The interpreter's bill will nearly swallow up what I earned for the patient's visit!" No, the doctor insisted, Boardman would simply have to live with written notes.⁴²

For decades since the appearance of the modern doctor, many Deaf patients have had difficulty in communicating directly with their physicians and other personnel in the doctor's office.⁴³ Often, patients suffer from misdiagnoses, misinformation, incorrect dosages, and poor understanding of their health, in large part because the information from the doctor was either incomprehensible or unavailable.⁴⁴ Oral Deaf folklore is replete with anecdotal evidence of Deaf people suffering injury, even death, because the lack of effective communication access in an aurally inaccessible office led to confusion and delay.⁴⁵

41. The ADA was signed into law in July 1990, but Title III covering medical offices did not become effective until January 26, 1992. 42 U.S.C. § 12181(a) (2000); 28 C.F.R. § 36.508. However, businesses employing twenty-five or fewer employees were given an additional six months, and businesses employing ten or fewer employees and having receipts of less than \$500,000 were given an additional year. 42 U.S.C. § 12181(b). The delays gave these offices time to adjust to the requirements of the new law. See Civil Rights Division; Nondiscrimination on the Basis of Disability in State and Local Government Services; Nondiscrimination on the Basis of Disability by Public Accommodations and in Commercial Facilities, 69 Fed. Reg. 58,768 (Sep. 30, 2004). As of now, the provisions of Title III are in full force, applying to all places of public accommodation regardless of size or income.

42. These quotes paraphrase what the complainant told the Attorney General's Office the defendant doctor told him every time he requested a sign language interpreter.

43. See Harmer, *supra* note 2; Pollard, *supra* note 23; Barnett, *supra* note 21; Steinberg et al., *supra* note 27.

44. Elizabeth Ellen Chilton, *Ensuring Effective Communication: The Duty of Health Care Providers to Supply Sign Language Interpreters for Deaf Patients*, 47 HASTINGS L.J. 871 (1996); Annie G. Steinberg et al., *Deaf Women: Experiences and Perceptions of Health-care System Access*, 11 J. WOMEN'S HEALTH 729 (2002).

45. See Steinberg et al., *supra* note 44, at 730; Carol A. Padden, *The Deaf Community and the Culture of Deaf People*, in AMERICAN DEAF CULTURE: AN ANTHOLOGY 1-16 (Sher-

After Boardman signed an official complaint with the Civil Rights Bureau, two state police investigators telephoned the medical clinic. One investigator pretended to be a father who needed an appointment with an internist for his sick child; when he obtained the appointment, he said, "Oh, by the way, my son's deaf, he'll need an interpreter." The clinic responded, "No, we don't do that." The second investigator called two weeks later, pretending to be the daughter of an elderly Deaf woman who needed medical attention, and was also denied an interpreter for her "mother." Both investigators surreptitiously tape-recorded the telephone calls.⁴⁶

The State of New York filed a disability discrimination lawsuit in the United States District Court for the Southern District of New York, charging the medical clinic with violating Title III of the ADA, which affirmatively requires a doctor, as a public accommodation provider, to take those "steps as may be necessary to ensure that no individual with a disability is excluded, denied services, segregated or otherwise treated differently than other individuals because of the absence of auxiliary aids and services."⁴⁷ The lawsuit demanded that the defendant clinic provide Boardman and other Deaf patients with appropriate auxiliary aids and services, including qualified sign language interpreters.⁴⁸

Pre-trial depositions of the clinic's doctors demonstrated that not a single doctor or staff member understood the needs of Deaf patients in their medical practice. They neither consulted with James Boardman nor considered his requests for an interpreter. Rather, they insisted, heatedly, that Boardman did very well either with written notes or through the signing efforts of his minor children. The law-

man Wilcox ed., 1989). The research data consisting of narratives from Deaf interviewees collected during this Author's dissertation study reflected a perception on the part of some Deaf patients that the medical setting is a place of dangerous confusion because many doctors offer great resistance in providing sign language interpreters. See Schwartz Dissertation, *supra* note 11. Case law bears witness to the existence of this perception. See, e.g., *Constance v. State Univ. of N.Y. Health Sci. Ctr.*, 166 F. Supp. 2d 663 (N.D.N.Y. 2001); *Proctor v. Prince George's Hosp. Ctr.*, 32 F. Supp. 2d 820, 823-24 (D.Md. 1998); *Aikins v. St. Helena Hosp.*, 843 F. Supp. 1329 (N.D. Cal. 1994).

46. It is a Class E felony under New York state law to overhear or record a telephonic or telegraphic communication if one is not the sender or receiver or does not have the consent of either the sender or receiver. N.Y. PENAL LAW §§ 250.00 (2002); *id.* § 250.05. "Wiretapping" is defined as "the intentional overhearing or recording of a telephonic or telegraphic communication by a person other than a sender or receiver thereof, without the consent of either the sender or receiver, by means of any instrument, device or equipment." *Id.* § 250.00. Since the investigators were the initiators and recorders of the two telephone calls and consented to the recording of these calls, the Attorney General's Office was well within the parameters of New York law in surreptitiously recording its conversations with the medical clinic.

47. *People by Vacco v. Mid Hudson Med. Group, P.C.*, 877 F. Supp. 143 (S.D.N.Y. 1995); Americans with Disabilities Act of 1990, Pub. L. No. 101-336, § 302(b)(2)(A)(iii), 104 Stat. 327 (1990); 42 U.S.C. § 12182(b)(2)(A)(iii) (2000).

48. *People by Vacco*, 877 F. Supp. at 144.

suit against Mid Hudson Medical Group was settled by consent decree, requiring the clinic to provide qualified interpreters to its Deaf patients and to pay a \$25,000 fine to New York State.⁴⁹

Although James Boardman's experience was familiar to many members of the Deaf community, qualitative research data consisting of numerous interviews with Deaf patients showed that not everyone wanted a sign language or oral interpreter when meeting with the doctor.⁵⁰ Some wanted a family member, not a professional interpreter, to facilitate communication with the doctor.⁵¹ Not every interpreter was a good match for a particular Deaf patient, and Deaf patients themselves had strong preferences for certain interpreters that they trusted.⁵² A few patients were satisfied with writing notes.⁵³ Some preferred to speak and read lips in direct one-on-one interactions with the doctors.⁵⁴ A few wanted CART or a similar form of computer-based communication.⁵⁵ As the research revealed, what

49. Under G. Oliver Koppel, the Democratic Attorney General, the Civil Rights Bureau demanded \$200,000 in damages, but when Dennis Vacco, a Republican, took office, he ordered this Author and the bureau to settle for a fraction of what it had demanded.

50. Rooted in a social constructivist tradition, see PETER L. BERGER & THOMAS LUCKMANN, *THE SOCIAL CONSTRUCTION OF REALITY: A TREATISE IN THE SOCIOLOGY OF KNOWLEDGE* (1967), and adopting a grounded theory approach, see Kathy Charmaz, *Grounded Theory*, in *CONTEMPORARY FIELD RESEARCH: PERSPECTIVES AND FORMULATIONS* 335-52 (Robert M. Emerson ed., 2d ed. 2001), qualitative research aims for "research that produces descriptive data—people's own written or spoken words and observable behavior." STEVEN J. TAYLOR & ROBERT BOGDAN, *INTRODUCTION TO QUALITATIVE RESEARCH METHODS: A GUIDEBOOK AND RESOURCE* at 7 (1998). Qualitative research is fast emerging as a critical tool in shedding light on the lives of people with disabilities, showing the complex interrelationship among physical impairment and societal barriers. Bonnie O'Day & Mary Killeen, *Research on the Lives of Persons with Disabilities: The Emerging Importance of Qualitative Research Methodologies*, 13 J. DISABILITY POLY STUD. 9, 9-15 (2002). Many Deaf people in Rochester reported encounters with doctors that mirrored what James Boardman went through prior to his complaint to the Attorney General's Office. See Schwartz Dissertation, *supra* note 11. Rochester has one of the largest per capita Deaf communities in the United States. See Jamie Berke, *Deaf Community – Rochester, NY*, <http://deafness.about.com/cs/culturefeatures3/a/rochester.htm> (last visited Aug. 25, 2008).

51. See Schwartz Dissertation, *supra* note 11.

52. For an excellent discussion of the complexities involved in sign language interpretation, see LaVigne & Vernon, *supra* note 11, at 868-79. As La Vigne and Vernon point out, there is great variation in the Deaf community in terms of language competency, with "[t]he majority of deaf individuals fall[ing] into the vast expanse of linguistic territory in between fluency in ASL and English and minimal language skill." *Id.* at 878.

53. Schwartz Dissertation, *supra* note 11.

54. *Id.*

55. One Deaf person recalled how a doctor in the hospital took him aside and asked him if typing at a computer terminal would work as a method of communication. Schwartz Dissertation, *supra* note 11. When the Deaf person said "yes," they sat down at a computer terminal to discuss, via typing, what was happening with the person's mother, who was sick with terminal cancer. *Id.* The doctor took his time in typing, detailing at great length what was happening, what was being done, and the prognosis for the sick patient. *Id.* The doctor did not hurry the Deaf son and patiently answered all his questions. *Id.* The person recalled the doctor's patience and thoroughness in communicating this way. *Id.* Because the Deaf person was literate in English, this method of communication worked well. *Id.*

was an appropriate auxiliary aid in one instance was not in another instance, and figuring out what worked required a grasp of the complexity and nuances in communicating with Deaf patients.⁵⁶

The research data gathered from interviews with Deaf people who talked about their experiences with doctors and hospitals demonstrate the complexity of the medical setting for these patients and the variety of responses adopted by the patients as they navigate this setting. This data lends support to the idea that doctors must be obligated to consult with their Deaf patients about appropriate auxiliary aids. We now turn to a look at the Deaf narrative of the medical setting as bolstering the argument for a compulsory conversation between doctor and Deaf patient.

II. A DEAF PERSPECTIVE ON APPROPRIATE AUXILIARY AIDS

Fifteen Deaf people spoke about their experiences with medical doctors as part of a qualitative research project exploring the subjective experiences of Deaf patients in the medical setting.⁵⁷ While they told the usual stories about “bad” doctors who refused to provide interpreters in violation of federal law and who treated the Deaf patient with condescension and contempt, a more nuanced picture emerged. For example, older patients were more tolerant of traditional methods of communication (notes and lip reading) than younger patients; more-educated patients got their communication needs accommodated more readily than less-educated ones; and lesser-educated Deaf patients had more difficulty navigating the system and advocating for their needs than better-educated Deaf patients.⁵⁸ Despite those results, a few educated, affluent patients recounted how their doctors patronized them and treated them as children, notwithstanding the patient’s high socioeconomic status.

Some Deaf patients expressed ambivalence about the proper role of the interpreter in the medical office; some male patients felt embarrassed to have a female interpreter, and some patients regarded the interpreter as a “machine” with no feelings.⁵⁹ A number of Deaf people indicated their preference for a hoary method of communication: writing notes.⁶⁰ One or two preferred to read lips and speak for

56. See generally Barnett, *supra* note 21 (describing the deaf population as heterogeneous, with the age of onset of hearing loss having a significant effect on communication and socialization, which in turn impacts health services utilization).

57. Schwartz Dissertation, *supra* note 11.

58. This Author found in his research a direct relationship between the interviewee’s educational status and his or her understanding of the law. Generally, the more educated one was, the better he or she understood what rights under the law meant in the medical context. For many Deaf patients, an interpreter or family member serves to mediate the exchange between patient and doctor. See Schwartz Dissertation, *supra* note 11.

59. See Schwartz Dissertation, *supra* note 11.

60. *Id.*

themselves.⁶¹ Some wanted family members to accompany them, while others preferred an interpreter or advocate.⁶² One person wanted an interpreter only from out of town, due to concern that local interpreters could not be trusted to keep his confidences.⁶³ One person preferred lip-reading or the use of CART technology.⁶⁴ And, on the other side of the equation, one or two doctors gladly provided an interpreter and paid the bill.⁶⁵ Indeed, several medical clinics highlighted on the Internet their ADA accessibility to Deaf patients.⁶⁶ The nuanced picture that emerged from the study is largely absent from the discourse employed by lawyers and judges who grapple with what constitutes an appropriate auxiliary aid at a doctor's office or a hospital.⁶⁷

This study started with twin assumptions: all Deaf people wanted an interpreter in the medical setting, and all doctors stubbornly resisted that demand. These initial assumptions washed away as soon as the Deaf patients started talking, and their narratives quickly demonstrated that their experiences with their doctors were complex and far more interesting than the superficial, one-dimensional picture the law has of Deafness and Deaf patients in the medical setting. It was not just that there was variation in people's need for an appropriate auxiliary aid and the doctor's response to that need. Deaf people's experiences pointed to the need for cultural competence on the part of doctors in their dealings with Deaf patients. One way to ensure a minimal level of cultural competence is to require a compulsory conversation between doctor and patient as to what is needed to establish effective communication—indeed, to establish an aurally accessible office—between the two parties.

61. *Id.*

62. *Id.*

63. Sign language interpreters certified by the Registry of Interpreters for the Deaf (RID), a national certifying organization of interpreters, are bound by a Code of Professional Conduct, which requires, *inter alia*, that the interpreter "adhere[s] to standards of confidential communication." NAD-RID CODE OF PROFESSIONAL CONDUCT (2005), available at <http://www.rid.org/UserFiles/File/pdfs/codeofethics.pdf>. As the RID explains in its "Guiding Principle" on this issue, "[i]nterpreters hold a position of trust in their role as linguistic and cultural facilitators of communication. Confidentiality is highly valued by consumers and is essential to protecting all involved." *Id.*

64. See Schwartz Dissertation, *supra* note 11.

65. *Id.*

66. See, e.g., Sinai – Services and Specialities, <http://www.sinai.org/services/deaf-access/deaf-access.asp> (last visited Aug. 25, 2008).

67. See, e.g., *Bravin v. Mount Sinai Med. Ctr.*, 186 F.R.D. 293 (S.D.N.Y. 1999) (offering no illustration or explanation how an interpreter would have helped the husband access a birthing class); *Davis v. Flexman*, 109 F. Supp. 2d 776, 796 (S.D. Ohio 1999) (reasoning that the defendant did not deny the deaf plaintiffs' counseling services; rather, the plaintiffs "found the services unsatisfactory in the absence of an interpreter." The court does not explain how the absence of the interpreter had no role in denying plaintiffs access to defendant's facility).

The study uncovered a landscape of power and authority, a complex terrain that demands the Deaf patient use a set of sophisticated skills for navigation. Much of the work done by these patients in the doctor's office or the hospital is invisible. What now follows is an effort to delineate the contours of the terrain, to highlight the impact of dominant communication practices on Deaf patients, and to render visible the invisible work of Deaf patients in the medical setting. The key insights of the study bolster the argument for rewriting the DOJ's analysis of 28 C.F.R. Section 36.303 to require a conversation between doctor and patient as to the appropriate auxiliary aid for the patient and to require "primary consideration" of the patient's choice.⁶⁸

A. *The Landscape of Power and Authority*

The medical setting is a site of power, which underpins the analysis of the relationship between medical personnel and people with disabilities.⁶⁹ Since antiquity, doctors have held themselves out to be healers of humankind, and this has led to an authoritarianism that is deeply embedded in the practice of medicine.⁷⁰ Historically, the culture of health care has had a strong streak of paternalism, where the medical provider, mostly male and white, was presumed to know what was best for the patient.⁷¹ Today, power in the medical setting has three elements: the power to assess, the power to enforce the doctor's self-interest, and the power to act officially.⁷² Deaf patients acknowledge this power—very few question or challenge the doctor. Rather, they speak of their respect for the doctor's status as a healer with great knowledge. Deaf patients, like many hearing patients, are intimidated by the doctor.

68. See, e.g., 28 C.F.R. Pt. 36, App. B, §36.303 (2007). The DOJ entered into a consent decree with the Maine Medical Center, *infra* Part IV.A., where the DOJ required the medical center to consult with the Deaf patient and makes reference to the patient's "preferred" method of communication. The language of the decree represents recognition by the DOJ that consultation is required to determine effectiveness of the communication.

69. Sally French & John Swain, *The Relationship Between Disabled People and Health and Welfare Professionals*, in HANDBOOK OF DISABILITY STUDIES 734 (Gary Albrecht et al. eds., 2001).

70. JAY KATZ, *THE SILENT WORLD OF DOCTOR AND PATIENT* 1-29, 85 (1984).

71. Gerben DeJong & Ian Basnett, *Disability and Health Policy: The Role of Markets in the Delivery of Health Services*, in HANDBOOK OF DISABILITY STUDIES, *supra* note 69, at 610, 624.

72. French & Swain, *supra* note 69; IVAN ILLICH, *DISABLING PROFESSIONS* 15-16 (1977). Just as women have access to experiences men do not have and do not know about, see SUSAN WENDELL, *THE REJECTED BODY: FEMINIST PHILOSOPHICAL REFLECTIONS ON DISABILITY* (1996), Deaf people have access to experience hearing people do not have and do not know about. What Deaf patients could bring to the conversation with medical personnel has the potential to transform the delivery of health care. See Lisa Harmer, *Health Care Delivery and Deaf People: Practice, Problems, and Recommendations for Change*, 4 J. Deaf Stud. & Deaf Educ. 73, 103 (1999); Richards et al., *supra* note 23, at 4-7.

The intimidation factor for Deaf patients, however, is greater given that the medical model of disability views a patient with a disability as being "diseased" and in need of a "fix" or cure.⁷³ Indeed, pathologizing difference as disability and asserting control over treatment fueled medicine's rise to power and dominance.⁷⁴ Conditioned by their training, social conventions, and mores to regard disability and Deafness as tragic defects in the individual (as opposed to seeing the social conventions and mores themselves as disabling), medical doctors see disability and deafness as objects of professional discourse, the goal of which is to treat the condition.⁷⁵ Medical schools reinforce this paternalistic view of disability, and with its attendant loss of humanity and empathy, the attitude of medical students toward disabled people becomes more negative as their training proceeds.⁷⁶ Many providers are inadequately informed and ill equipped to understand the "particular constellation of health care needs" of their disabled patients,⁷⁷ particularly those who are Deaf or hard-of-hearing.⁷⁸

One commentator, Ian Basnett, cites Wainapel's account of "how physicians are often negative about disability, seeing inability before ability and frustrated by the lack of a prospect of cure and ill-informed about simple accommodations."⁷⁹ This is particularly applicable to Deaf patients. Some doctors see Deaf patients as suffering from a deficit and needing the doctor to measure and treat that deficit.⁸⁰ The phenomenal growth of cochlear implant technology reflects the dominant medical view that Deafness is pathology in need of repair and remediation.⁸¹

73. See generally JOSEPH P. SHAPIRO, *NO PITY: PEOPLE WITH DISABILITIES FORGING A NEW CIVIL RIGHTS MOVEMENT* 63 (1993). Doctors work hard to maintain disability as private tragedy and to enforce the dependency role of disabled people. French & Swain, *supra* note 69. But this dependency is two-way as well: doctors need disabled patients to make a living, and to protect this state of affairs doctors control language, knowledge, and social responses to disability. *Id.* This control dominates how disabled people define themselves, shapes their identity as dependent users of medical services, and structures their experiences in the medical setting. *Id.*

74. Irving Kenneth Zola, *Healthism and Disabling Medicalization*, in *DISABLING PROFESSIONS* 41 (1977).

75. LANE, *supra* note 31, at 212-30.

76. Ian Basnett, *Health Care Professionals and Their Attitudes Toward and Decisions Affecting Disabled People*, in *HANDBOOK OF DISABILITY STUDIES*, *supra* note 69, at 450, 451-52.

77. DeJong & Basnett, *supra* note 71, at 625.

78. Barnett, *supra* note 21, at 694-95.

79. Basnett, *supra* note 76, at 462.

80. Cf. Douglas Biklen & Donald N. Cardinal, *Reframing the Issue: Presuming Competence*, in *CONTESTED WORDS, CONTESTED SCIENCES: UNRAVELING THE FACILITATED COMMUNICATION CONTROVERSY* 187-98 (Douglas Biklen & Donald N. Cardinal eds., 1997).

81. LANE, *supra* note 31, at 216-38. Most Deaf patients do not view deafness as pathology. Rather, they see themselves more as a linguistic minority than as disabled people who need a fix or cure. See PADDEN & HUMPHRIES, *supra* note 1, at 123-62.

To be sure, everyone, whether deaf or hearing, experiences a power imbalance when they take off their clothes and put on a skimpy gown in a chilly examination room. Everyone is subjected to the same rules, practices, and customs that operate in the medical setting. Deaf or hearing, many patients lack the education, language competency, and knowledge to resist, interrogate, and otherwise challenge the doctor. Yet, for Deaf patients whose expressive and receptive language skills do not conform to the norm of spoken and written English, the doctor's exercise of power and authority is hierarchical and unequal,⁸² "with the professionals holding most of the power. Traditionally professional workers have defined, planned and delivered the services, while disabled people have been passive recipients with little if any opportunity to exercise control."⁸³ Because of the language difference, many Deaf patients are "passive recipients" who have little opportunity to control what happens to them in the medical setting. Their communication difficulties with doctors engender feelings of frustration and mistrust, which can lead to avoidance of health care providers for Deaf patients.⁸⁴

Because Deaf patients generally communicate differently—they look and sound different—some medical personnel cannot get past the Deafness and consequently lose the ability to respond appropriately.⁸⁵ This loss is compounded by medicine's inability to tend to patients' decisionmaking needs.⁸⁶ In one study exploring the relationship between Deaf patients and their doctors, the patients felt that their doctors failed to make a sincere effort to understand them when the patients described their symptoms; many felt they were treated like children and given medication without sufficient information and explanation.⁸⁷ That study highlights the failure of many medical

82. This phenomenon is almost always the case, regardless of one's hearing ability, but it is more pronounced for Deaf and hard-of-hearing patients as well as patients with other disabilities. Karen Peltz Strauss, *Doctor, Can You Check My Vital Signs?*, GALLAUDET TODAY, 1986 Legal Review, at 7.

83. Sally French, *Disabled People and Professional Practice*, in ON EQUAL TERMS: WORKING WITH DISABLED PEOPLE 103 (Sally French ed., 1994).

84. Steinberg et al., *supra* note 44, at 731; Chilton, *supra* note 44, at 874.

85. Golden & Ulrich, *supra* note 19, at 86.

86. KATZ, *supra* note 70, at 130.

87. Alice Nemon, *Deaf Persons and Their Doctors*, 14 J. REHAB. DEAF 19, 19-20 (1980). Indeed, as one author has pointed out, medicine is error-ridden—the processes of diagnosing and treating illness are filled with mistakes—and because these errors unfold as a series of approximations, doctors need to pay continuous attention to the patient's condition. MARIANNE A. PAGET, *THE UNITY OF MISTAKES: A PHENOMENOLOGICAL INTERPRETATION OF MEDICAL WORK* 33 (1988). As Paget describes it, medical work "is a practice of responding to the experience of illness . . . its context is a relational encounter between persons about the afflictions of the human body and the human spirit." *Id.* at 21. Dialogue creates the condition of appropriate care where the doctor can tailor the delivery and content of care to the needs of the individual patient, and this requires vigilance on the part of the doctor. This has ramifications for a medical setting that is wholly aural and communication inaccessible for many Deaf patients—forcing these patients to interact on terms not favorable

providers to provide “effective communication” as required by law. And the findings of this Author’s study drives home the importance of requiring the physician to engage in a conversation with the Deaf patient about appropriate auxiliary aids that would result in effective communication between the two. Put simply, an aurally inaccessible office does not have to be that way—talking to the Deaf patient would go a long way in helping the physician to understand what needs to be done to make his or her office aurally accessible.

There is an underlying tension between the two parties in the medical setting: the doctor sees Deafness as a deviation from the norm of “hearing,” while the Deaf patient resists that characterization.⁸⁸ Clearly if a physician regarded Deafness and sign language as cultural phenomena worthy of respect and understanding, the communication between doctor and patient would be qualitatively different than it is now, with doctors who pathologize Deafness and do not understand the communication needs of their Deaf patients. This sets the stage for discussion of dominant communication practices prevalent in the medical setting.

B. Dominant Communication Practices

For many Deaf patients, the dominance and prevalence of English places them at a disadvantage when communicating with their physician, because American Sign Language (ASL), not English, is their

to them holds the potential for tragic error. *Cf. id.* at 69 (“Mistakes are ‘intrinsic troubles’ of discourse in everyday life”).

88. The Deaf community shares a sense of culture through American Sign Language, which constitutes a continuum of language ranging from traditional sign language to Signed English. In addition to sign language, there are traditions, rituals, and other indicia of community that give expression to a feeling of identity with the Deaf world. For a fuller exploration of Deaf culture, see DEAFNESS: LIFE AND CULTURE II: A DEAF AMERICAN MONOGRAPH (1995). There is a sense of “us” versus “them,” the latter being doctors who hold traditional views of Deaf people’s competence. Many of the Deaf interviewees in this Author’s doctoral study perceive doctors as holding the view that their patients’ inability to speak equals incompetence. See Schwartz Dissertation, *supra* note 11. This sense of alienation is only reinforced when doctors use outdated terminology to refer to their patients: “deaf and dumb” or “deaf mute.” Goffman introduced the idea of stigma—how deviation from a social norm, whether physical or mental, created a spoiled identity that was stigmatized in the eyes of society. ERVING GOFFMAN, STIGMA: NOTES ON THE MANAGEMENT OF SPOILED IDENTITY (1963). Thus, managing the body to maximize a positive image and minimize the negative imagery of others became necessary—it was important to reduce the impact of harm to the self that was inflicted by the stigma of spoiled identity. This Author echoed some of his Deaf patients in feeling stigmatized by medical personnel—he could see it in their eyes and demeanor (“Deaf Man Walking!”). He could sense a number of assumptions by doctors—“He is mute, He is less intelligent, He is disabled, indeed defective. In short, he is spoiled.” Deaf people experience this stigma in the larger society, where social prejudices, biases and assumptions about deafness are reinforced in the educational system and the media. Because of a medical school curriculum that perpetuates the idea of Deafness as pathology, many doctors and nurses cannot help but reflect the larger social thinking about Deafness and Deaf people. See Harmer, *supra* note 2, at 90-92.

native language. Since the vast majority of doctors do not sign, Deaf patients are forced to read and write notes in English, and for many, this is problematic.⁸⁹ As recounted by a few Deaf patients in this Author's study, the process of writing notes with the doctor was time-consuming, incomplete, and cursory.⁹⁰ The laboriousness involved in writing under time constraints reduced both parties to brief questions and answers, and "question and answer is the customary form of communicative exchange between powerful and powerless, between adult and child."⁹¹ In addition, some Deaf patients do not have mastery of English:

When one lacks good English skills, it is very difficult to benefit from health education brochures and books, it is harder to read a newspaper and gain current health information, it is difficult to write and understand notes between the health care provider and patient, and it is difficult to read and understand prescription instructions, consent forms, and other documents associated with health care services.⁹²

Some Deaf patients in this Author's study described doctors as hurrying them through their appointments and being impatient with the process of paper-and-pen communication.⁹³ They felt disrespected and infantilized but were worried about angering the doctor further if they insisted on fuller details.⁹⁴ The doctor clearly did not want to take the time to write complex ideas and wait for the response; this echoes one commentator's finding that "[t]he overall impression of many informants was that hearing people simply didn't have the patience or motivation to work through difficult communication situations."⁹⁵ A negative consequence of this dilemma is that Deaf patients will often miss important information about their health.⁹⁶ Dominant communication practices in the medical setting, for many Deaf patients, reify and reinforce the power imbalance between patient and doctor. These practices reinforce the rigid structures of an aurally inaccessible office.

Yet, this Author's study shows a spectrum of response to the dominance of English, ranging from acceptance and accommodation to

89. Golden & Ulrich, *supra* note 19, at 86; Steinberg et al., *supra* note 44, at 730; PAUL HIGGINS, *OUTSIDERS IN A HEARING WORLD: A SOCIOLOGY OF DEAFNESS* 32-33 (1980).

90. See Schwartz Dissertation, *supra* note 11.

91. ANN ARNETT FERGUSON, *BAD BOYS: PUBLIC SCHOOLS IN THE MAKING OF BLACK MASCULINITY* 13 (2001).

92. Harmer, *supra* note 2, at 81.

93. See Schwartz Dissertation *supra* note 11.

94. *Id.*

95. Susan B. Foster, *Communication Experiences of Deaf People: An Ethnographic Account*, in *CULTURAL AND LANGUAGE DIVERSITY AND THE DEAF EXPERIENCE* 117, 124 (Ila Paransis ed., 1996).

96. *Id.* at 129 (discussing the negative consequences of communication barriers).

resistance, and this spectrum reflects the wide diversity within the Deaf community itself.⁹⁷ The degree of hearing loss varies widely, from those who are mildly hard-of-hearing and possess residual hearing and good English reading and writing skills, to those who are profoundly deaf. Even among those who are profoundly deaf, English language proficiency ranges from poor to excellent.⁹⁸ There are hard-of-hearing people with poor English skills, and there are profoundly deaf people with excellent English skills. Accordingly, in dealing with Deaf patients, doctors cannot and should not fit the patient to a particular communication method. One size does not fit all.

Rather, the doctor needs to tailor the communication method to fit the needs of the patient. The best strategy is to offer a panoply of visual markers in the environment—interpreters, captioning, communication equipment, and visual aids. The lack of these visual markers shapes the socio-spatial experiences outlined in this Author's study, even for those accustomed to lip-reading and note taking, and the absence of an accessible setting reinforces the sense of marginality and exclusion many feel. Indeed, the lack of visual markers is *res ipsa loquitur*: it shows a medical office that is aurally inaccessible, and that deprives the patient of effective communication. An aurally inaccessible office violates federal law.

C. *Rendering the Invisible Visible*

Much of the work Deaf patients do in the doctor's office or the hospital occurs below the radar. This Author's study shows that Deaf patients engage in an array of unacknowledged strategies.⁹⁹ For example, many are adept at "letting go." If a Deaf patient is feeling healthy or asymptomatic, he or she is more likely to disregard or ignore an instance of communication difficulty with the doctor or nurse. If they miss a word, phrase, or sentence on the doctor's lips, or if they do not understand a written word, they will simply nod as if they understand and agree. As one patient put it, "If I'm feeling OK, I don't bother to ask for clarification."¹⁰⁰ This Author too understands and recognizes this phenomenon: when He is feeling fine, He is less likely to probe and work his way through a communication difficulty. When He is not feeling well or when He is worried about a potential health problem, He will insist that the doctor or nurse either move their lips slowly or write down what they say.

97. See Schwartz Dissertation, *supra* note 11.

98. Michele La Vigne & McCay Vernon, *An Interpreter Isn't Enough: Deafness, Language, and Due Process*, 2003 WIS. L. REV. 843, 851-52.

99. *Id.*

100. *Id.*

Letting go, however, carries within it a kernel of anxiety. The Deaf patient wonders: "Am I missing something that might come back to haunt me?" There is always a fear that the information the patient is not obtaining by "letting go" is exactly the information that is crucial to maintaining one's health. Deaf patients rationalize what they are doing by saying the odds of that happening is so slight, and that if the doctor really wanted to let them know something was wrong, the doctor would make sure the patient understood it the first time it was raised.¹⁰¹ But given medicine's ability to commit errors,¹⁰² that is not an acceptable rationalization, and Deaf patients know it.

Active agency is another strategy. Telling your family and your doctor that you do not want a family member mediating or interceding on your behalf in the medical setting requires a volitional act of free will. Other examples of active agency and free will by Deaf patients involve checking out the doctor's background; educating the doctor about the law and about the patient's communication needs; educating oneself about the law and figuring out strategies for conveying the information to the doctor; pushing for health-related information by asking questions; and using the Internet to gather background information on one's health.

Part of this agency is the ability to draw on local knowledge: the community's pool of information regarding doctors and the law. For instance, some patients ask around in the Deaf community to find a doctor who is acknowledged as being sensitive or aware of the needs of Deaf patients. Some patients go to Deaf clubs and meetings of Deaf people to learn more about laws that impact on the medical setting.¹⁰³

What these insights portray is a competent Deaf patient, notwithstanding the fact that he or she may not speak. A hearing person who is not culturally competent in Deafness fails to see that competence, and part of that failure is an assumption that a sign language interpreter will automatically fix the communication barrier posed by the interaction of speaking doctor and signing patient. In many situations the interpreter is an integral part of facilitating communication, but it is more complicated than that. Sometimes the patient requires a certain kind of interpreter, and sometimes the patient wants something else such as lip-reading or CART. The point is, the evidence derived from this Author's study shows a complex and nuanced

101. *Id.*

102. See PAGET, *supra* note 87.

103. See, e.g., Nat'l Ass'n of the Deaf, <http://www.nad.org/site/pp.asp?c=foLNKQMBF&b=91587> (last visited Aug. 25, 2008) (the upper left-most tab, "Legal Rights," offers information on captioning, education, employment, government, health care, housing, public facilities, and transportation, while the next tab, "Advocacy," has information on, inter alia, air travel and interpreting services). The NAD holds a biennial conference, which offers a forum for Deaf people to keep abreast of the latest developments in the law, technology, and other matters of concern to the community.

story going on every day in medical offices and hospitals where doctors should be talking to these patients about what auxiliary aids for communication would be effective for them.

This conclusion is supported by another study in which Deaf patients talked about the potential that inadequate communication with their doctors could lead to misdiagnosis and medication errors, as well as patient embarrassment, discomfort, and fear.¹⁰⁴ Those patients described not understanding therapeutic regimens, medication dosages, or side effects or not knowing what to expect during physical exams and procedures.¹⁰⁵ The patients suggested outright that doctors ask hearing-impaired patients about their preferred way of communicating instead of requiring them to use ineffective ways to communicate such as lip-reading (doctors often turn their head or lips are hidden by a mask or beard), writing notes, and using family members to interpret.¹⁰⁶ The patients had a number of useful suggestions for communication access if the law had required doctors to ask. These were: (1) Doctors should use interpreters who are trained specifically for medical settings, and they should speak more slowly to hard-of-hearing patients; (2) Doctors should ask patients to repeat critical information such as medication instructions, as well as put it in writing, in order to avoid potentially dangerous miscommunication; (3) Doctors should use lights as signals for required actions, such as holding one's breath during a mammogram, and find alternatives to lengthy phone message menus such as e-mail or fax; and (4) Medical offices should acquire and train staff to use a teletypewriter or telecommunications device for the Deaf, and staff should be trained to communicate better with Deaf and hard-of-hearing patients.¹⁰⁷

104. See generally Iezzoni et al., *supra* note 34. Researchers led by Dr. Iezzoni of Beth Israel Deaconess Medical Center conducted in-depth interviews with fourteen Deaf and twelve hard-of-hearing adults about their communication concerns during medical visits and procedures and how communication could be improved. *Id.* at 356.

105. *Id.* at 359-60.

106. *Id.* at 358. According to the DOJ's commentary on Title III of the ADA, family members and friends should not be called on to interpret for Deaf people. See Part 36 – Nondiscrimination on the Basis of Disability by Public Accommodations and in Commercial Facilities, app. B, <http://www.usdoj.gov/crt/ada/reg3a.html#Anchor-Appendix-53283>.

Public comment also revealed that public accommodations have at times asked persons who are deaf to provide family members or friends to interpret. In certain circumstances, notwithstanding that the family member or friend is able to interpret or is a certified interpreter, the family member or friend may not be qualified to render the necessary interpretation because of factors such as emotional or personal involvement or considerations of confidentiality that may adversely affect the ability to interpret 'effectively, accurately, and impartially'.

Id.

107. Iezzoni et al., *supra* note 34, at 358-59.

While federal statutory law and controlling regulations clearly define the kinds of appropriate auxiliary aids and the context in which such an auxiliary aid should be made available to the Deaf patient, and while the law clearly places on the doctor the responsibility of figuring out an appropriate auxiliary aid to offer the Deaf patient, the law seems to be out of sync with what we know about the communication needs of Deaf patients. The next Section demonstrates that the doctor is under no legal compulsion to consult with the patient or to give “primary consideration” to the patient’s express choice of auxiliary aid.

III. THE LEGAL PARADIGM

A. *Historical Sketch of the Federal Statutory Scheme on Disability*

In 1973, responding to a long history of discrimination against people with disabilities, Congress enacted Section 504 of the Rehabilitation Act, “the first national declaration of the rights of people with disabilities.”¹⁰⁸ Section 504 provided that various federal agencies, acting through the DOJ, could enforce the law against those who discriminated on the basis of disability, but the law applied only to those entities and organizations that received federal financial assistance.¹⁰⁹ Initially, there was no explicit private right of action, but in 1978 Congress amended the Rehabilitation Act to provide that the remedies, procedures, and rights set forth in Title VI of the Civil Rights Act of 1964, which bars race discrimination, apply with respect to actions brought under Section 504.¹¹⁰ Yet, because the law was limited to only those who received federal funding, discrimination in the wider society was left untouched.¹¹¹

108. BONNIE POITRAS TUCKER & ADAM A. MILANI, FEDERAL DISABILITY LAW IN A NUTSHELL 33 (3d ed. 2004); *see also* PETER BLANCK ET AL., DISABILITY CIVIL RIGHTS LAW AND POLICY 1-9 (2004).

109. TUCKER & MILANI, *supra* note 108, at 30-31.

110. *Id.* at 32; *see* 29 U.S.C. § 794a (2000). Initially there was some confusion as to whether Section 504, as amended, afforded a private right of action, but in *Alexander v. Sandoval*, 532 U.S. 275, 280 (2001), the Supreme Court held it was “beyond dispute that private individuals may sue to enforce,” and in *Barnes v. Gorman*, 536 U.S. 181, 185 (2002), the Court held that this reasoning applied to Section 504 and Title II of the ADA.

111. Section 504’s definition of disability was lifted almost without change from the Vocational Rehabilitation Act of 1920 and was intended to apply to the employment context. BLANCK ET AL., *supra* note 108, at 1-9. Moreover, even though Section 504 was enacted in 1973, it took the Department of Health, Education and Welfare five years to draft enforcing regulations, and this was done only after vigorous and widespread protests by the disability rights community. *See* JOSEPH P. SHAPIRO, NO PITY: PEOPLE WITH DISABILITIES FORGING A NEW CIVIL RIGHTS MOVEMENT 69 (1993) (excellent survey covering the history of the disability rights movement in the twentieth century). Finally, Section 504 reached only those who received federal financial assistance, leaving untouched vast swaths of American society—private employers that did not receive such assistance and private businesses offering goods and services to the public.

In February 1986, the National Council on Disability (NCD) issued a report titled “Toward Independence: An Assessment of Federal Laws and Programs Affecting Persons with Disabilities—With Legislative Recommendations” (“Toward Independence”).¹¹² The report’s executive summary noted that approximately sixty-six percent of working age people with disabilities were not receiving Social Security or other public assistance income, that federal disability programs overemphasized income support and underemphasized equal opportunity and independence, and that federal programs needed to promote equal opportunity and independence for people with disabilities.¹¹³ Among its recommended changes to federal disability policy, the NCD called for a comprehensive law requiring equal opportunity for people with disabilities.¹¹⁴ In January 1988, the NCD followed up with a second report, “On the Threshold of Independence,” which contained a proposed bill to implement the NCD’s recommendations.¹¹⁵

This initiative led to congressional enactment of the Americans with Disabilities Act of 1990 (ADA), which reached far more actors than Section 504, including those who did not receive federal funding.¹¹⁶ Modeled on the Civil Rights Act of 1964 and Section 504, the ADA is divided into five titles.¹¹⁷ Title I covers employment discrimination and empowers the Equal Employment Opportunity Commission (EEOC) to promulgate regulations enforcing that title; it also gives employees with disabilities a private right of action once they have exhausted their administrative remedies with the EEOC and received a right to sue letter.¹¹⁸ Title II covers state and local government, establishes a private right of action and the right to injunctive relief, and empowers numerous federal agencies to enforce the

112. The report can be obtained from the National Council on Disability’s Web site, NCD - Toward Independence 1986, <http://www.ncd.gov/newsroom/publications/1986/toward.htm> (last visited Aug. 25, 2008). The National Council on Disability (NCD) is an independent federal agency whose fifteen members are appointed by the President and confirmed by the Senate. Originally established as an advisory board to the Department of Education under the 1973 Rehabilitation Act, the NCD’s “overall purpose . . . is to promote policies, programs, practices, and procedures that guarantee equal opportunity for all people with disabilities, regardless of the nature or severity of the disability, and to empower them to achieve economic self-sufficiency, independent living, and inclusion and integration into all aspects of society.” NCD at a Glance, http://www.ncd.gov/brochure_pdfs/brochure.pdf (last visited Aug. 25, 2008).

113. NCD - Toward Independence 1986, *supra* note 112.

114. *Id.*

115. BLANCK ET AL., *supra* note 108, at 2-7, (citing NATIONAL COUNCIL ON THE HANDICAPPED, ON THE THRESHOLD OF INDEPENDENCE: PROGRESS ON LEGISLATIVE RECOMMENDATIONS FROM *TOWARD INDEPENDENCE* (Andrea H. Farbman ed., 1988), *available at* <http://www.ncd.gov/newsroom/publications/1988/pdf/threshold.pdf>).

116. TUCKER & MILANI, *supra* note 108, at 68; BLANCK ET AL., *supra* note 108, at 2-8.

117. BLANCK ET AL., *supra* note 108, at 2-1.

118. 42 U.S.C. § 12117(a) (2000).

law.¹¹⁹ Title III covers private businesses that offer services and goods to the public, adopts the remedies and procedures of Title II of the Civil Rights Act of 1964, including a private right of action, and empowers the DOJ to promulgate regulations and enforce the law.¹²⁰ In short, the ADA is an attempt to fill in the gaps that Section 504 missed. It is designed to ensure that all people with disabilities have the same access to employment, state and local government services, and public accommodations, including health care, as that provided to people without disabilities.

B. Federal Statutory Law on Disability

Section 504 of the Rehabilitation Act of 1973 lays out the first federal statutory scheme outlawing discrimination against people with disabilities.¹²¹ Section 504 reads as follows:

No otherwise qualified individual with a disability in the United States, as defined in section 705(20) of this title, shall, solely by reason of her or his disability, be excluded from the participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance or under any program or activity conducted by any Executive agency or by the United States Postal Service.¹²²

Under Section 504, the term, “program or activity,” includes “the operations of . . . an entire corporation, partnership, or other private organization, or an entire sole proprietorship . . . which is principally engaged in the business of providing . . . health care.”¹²³

The elements of a Section 504 action include the plaintiff’s disability, the plaintiff’s qualification to participate in a program or activity, the defendant’s status as a recipient of federal financial assistance, and a nexus between the complained-of action and the plaintiff’s disability.¹²⁴ In *Alexander v. Choate*, the Supreme Court concluded that “[d]iscrimination against the handicapped was perceived by Congress to be most often the product, not of invidious animus, but rather of

119. 42 U.S.C. § 12134(a) (2000). For a fuller discussion of the enforcement provisions of the various titles of the ADA, see BLANCK ET AL., *supra* note 108, at 2-26 to 2-28.

120. 42 U.S.C. § 12188(a)-(b) (2000).

121. Rehabilitation Act of 1973, Pub. L. No. 93-112, 87 Stat. 355, codified as amended at 29 USC § 701 (2000); Americans with Disabilities Act of 1990, Pub. L. No. 101-136, 104 Stat. 327 (1990).

122. 29 U.S.C. § 794(a) (2000). With respect to hospitals and doctors receiving federal financial assistance, a qualified individual with a disability is someone “who meets the essential eligibility requirements for the receipt of services.” 42 U.S.C. 12131(2) (2000).

123. 29 U.S.C. § 794(b)(3)(A)(ii); *Davis v. Flexman*, 109 F. Supp. 2d 776, 785 (S.D. Ohio 1999).

124. *Maddox v. Univ. of Tenn.*, 62 F.3d 843, 846 (6th Cir. 1995) (citing *Doherty v. S. Coll. of Optometry*, 862 F.2d 570, 573 (6th Cir. 1988)).

thoughtlessness and indifference—of benign neglect.”¹²⁵ *Alexander* has been interpreted by Courts of Appeals to stand for the proposition that plaintiffs need not establish intent to discriminate in order to prevail on a disparate impact case under Section 504.¹²⁶

Regulations promulgated by the United States Department of Health and Human Services (HHS) specifically address health, welfare, and social services programs and activities receiving federal funds.¹²⁷ The HHS’s Section 504 regulations identify the extent to which a recipient of federal funding must accommodate a Deaf patient in the medical setting:

A recipient, in providing any aid, benefit, or service, may not, directly or through contractual, licensing, or other arrangements, on the basis of handicap: (i) Deny a qualified handicapped person the opportunity to participate in or benefit from the aid, benefit, or service; (ii) Afford a qualified handicapped person an opportunity to participate in or benefit from the aid, benefit, or service that is not equal to that afforded others; (iii) Provide a qualified handicapped person with an aid, benefit, or service that is not as effective as that provided to others; (iv) Provide different or separate aid, benefits, or services to handicapped persons or to any class of handicapped persons unless such action is necessary to provide qualified handicapped persons with aid, benefits, or services that are as effective as those provided to others.¹²⁸

With respect to auxiliary aids, the HHS regulations state, “A recipient to which this subpart applies that employs fifteen or more persons shall provide appropriate auxiliary aids to persons with impaired sensory, manual, or speaking skills, where necessary to afford such persons an equal opportunity to benefit from the service in question.”¹²⁹ Auxiliary aids may include brailled and taped material,

125. *Alexander v. Choate*, 469 U.S. 287, 295 (1985).

126. *See, e.g., Nathanson v. Med. Coll. of Pa.*, 926 F.2d 1368, 1384 (3d Cir. 1991).

127. 45 C.F.R. § 84.4(a) (2005) states, “No qualified handicapped person shall, on the basis of handicap, be excluded from participation in, be denied the benefits of, or otherwise be subjected to discrimination under any program or activity which receives Federal financial assistance.”

128. 45 C.F.R. §§ 84.4(b)(1)(i)-(iv) (2005).

129. 45 C.F.R. § 84.52(d)(1) (2005). Courts have found this provision applicable to health care providers with fifteen or more employees. *See, e.g., Bravin v. Mt. Sinai Med. Ctr.*, 186 F.R.D. 293, 297 (S.D.N.Y. 1999), *vacated in part on other grounds*, 58 F. Supp. 2d 269 (S.D.N.Y. 1999) (citing 45 C.F.R. § 84.52(d) and recognizing that “[i]f the recipient . . . employs fifteen or more persons, it ‘shall provide appropriate auxiliary aids’”); *Proctor v. Prince George’s Hosp. Ctr.*, 32 F. Supp. 2d 820, 826 (D. Md. 1998) (“As a recipient of federal funds that employs fifteen or more people, PGHC must also ‘provide appropriate auxiliary aids to persons with impaired sensory, manual, or speaking skills, where necessary to afford such persons an equal opportunity to benefit from the service in question.’”); *Naiman v. N.Y. Univ. Med. Ctr.*, No. 95 CIV. 6469(LMM), 1997 WL 249970, at *2 (S.D.N.Y. May 13, 1997) (“If the recipient hospital employs fifteen or more persons, it ‘shall provide appropriate auxiliary aids to persons with impaired sensory, manual, or speaking skills, where nec-

interpreters, and other aids for persons with impaired hearing or vision.¹³⁰

A provider of medical or clinical services with fewer than fifteen employees may not be obligated under Section 504 to provide auxiliary aids, unless directed to do so by the Health and Human Services Director:

Section 84.52(d) . . . requires recipients with fifteen or more employees to provide appropriate auxiliary aids for persons with impaired sensory, manual, or speaking skills. Further, the Director may require a small provider [one with fewer than fifteen employees] to furnish auxiliary aids where the provision of aids would not adversely affect the ability of the recipient to provide its health benefits or service. Thus, although a small nonprofit neighborhood clinic might not be obligated to have available an interpreter for deaf persons, the Director may require provision of such aids as may be reasonably available to ensure that qualified handicapped persons are not denied appropriate benefits or services because of their handicaps.¹³¹

While Section 504 covers only those doctors and hospitals that receive federal funding,¹³² the Americans with Disabilities Act of 1990 is broader, covering doctors, medical clinics, and hospitals, regardless of whether they receive federal funding.¹³³ Indeed, unlike Section 504, the ADA does not require a minimum number of employees.¹³⁴ According to the “general rule” of Title III of the ADA “[n]o individual shall be discriminated against on the basis of disability in the full and equal enjoyment of the goods, services, facilities, privileges, advantages, or accommodations of any place of public accommodation by any person who owns, leases (or leases to), or operates a place of public accommodation.”¹³⁵ In terms of statutory construction, the general prohibition against discrimination envisions activities of the following sort: denial of participation,¹³⁶ participation in an inte-

essary to afford such persons an equal opportunity to benefit from the service in question.’” (citing 45 C.F.R. § 84.552(d)(1)).

130. 45 C.F.R. § 84.52(d).

131. 45 C.F.R. § 84.52, Commentary, App. A, Pt. 84, Subpart F.

132. 29 U.S.C. § 794(a) (2000).

133. 42 U.S.C. § 12181(7)(F) (2000) (the “professional office of a health care provider [or] hospital” is considered a public accommodation subject to the ADA if its operations “affect commerce”). Commerce is defined as “travel, trade, traffic, commerce, transportation, or communication—(A) among the several States; (2) between any foreign country or any territory or possession and any State; or (C) between points in the same State but through another State or foreign country.” 42 U.S.C. § 12181(1)(A)-(C) (2000).

134. *Davis v. Flexman*, 109 F. Supp. 2d 776, 788 (S.D. Ohio 1999) (“[N]othing in 28 C.F.R. § 36.303 excludes from the ADA’s ‘auxiliary aid’ requirement a public accommodation employing less than 15 workers.”).

135. 42 U.S.C. § 12182(a) (2000).

136. 42 U.S.C. § 12182(b)(1)(A)(i) (“It shall be discriminatory to subject an individual or class of individuals on the basis of a disability or disabilities of such individual or class, di-

grated setting,¹³⁷ and an opportunity to participate.¹³⁸ These prohibitions are based on the proscriptions of the earlier Section 504.¹³⁹

Title III's specific prohibitions against discrimination includes:

[T]he imposition or application of eligibility criteria that screen out or tend to screen out an individual with a disability or any class of individuals with disabilities from fully and equally enjoying any goods, services, facilities, privileges, advantages, or accommodations, unless such criteria can be shown to be necessary for the provision of the goods, services, facilities, privileges, advantages, or accommodations being offered[.]¹⁴⁰

It also prohibits discrimination for:

[A] failure to make reasonable modifications in policies, practices or procedures, when such modifications are necessary to afford such goods, services, facilities, privileges, advantages, or accommodations to individuals with disabili-

rectly, or through contractual, licensing, or other arrangements, to a denial of the opportunity of the individual or class to participate in or benefit from the goods, services, facilities, privileges, advantages, or accommodations of an entity."); *see also* 28 C.F.R. § 36.202(a) (2005) ("A public accommodation shall not subject an individual . . . on the basis of a disability . . . to a denial of the opportunity . . . to participate in or benefit from . . . a place of public accommodation.").

137. 42 U.S.C. §12182(b)(1)(B) ("Goods, services, facilities, privileges, advantages, and accommodations shall be afforded to an individual with a disability in the most integrated setting appropriate to the needs of the individual."); *see also* 28 C.F.R. § 36.203(a) (2005).

138. 42 U.S.C. §12182(b)(1)(C) ("Notwithstanding the existence of separate or different programs or activities provided in accordance with this section, an individual with a disability shall not be denied the opportunity to participate in such programs or activities that are not separate or different."); *see also* 28 C.F.R. §36.203(b).

139. The ADA makes clear that Rehabilitation Act regulations and case law are instructive to interpreting the ADA. 42 U.S.C. § 12201(a) (2000). Under the Department of Health and Human Services regulations pursuant to Section 504,

A recipient [of federal funding], in providing any aid, benefit, or service, may not, directly or through contractual, licensing, or other arrangements, on the basis of handicap: (i) Deny a qualified handicapped person the opportunity to participate in or benefit from the aid, benefit, or service; (ii) Afford a qualified handicapped person an opportunity to participate in or benefit from the aid, benefit, or service that is not equal to that afforded others; (iii) Provide a qualified handicapped person with an aid, benefit, or service that is not as effective as that provided to others; (iv) Provide different or separate aid, benefits, or services to handicapped persons or to any class of handicapped persons unless such action is necessary to provide qualified handicapped persons with aid, benefits, or services that are as effective as those provided to others.

45 C.F.R. § 84.4(b)(i)-(iv) (2005).

140. 42 U.S.C. §12182(b)(2)(A)(i); *see also* 28 C.F.R. §36.301(a) ("A public accommodation shall not impose or apply eligibility criteria that screen out or tend to screen out an individual with a disability or any class of individuals with disabilities from fully and equally enjoying any goods, services, facilities, privileges, advantages, or accommodations, unless such criteria can be shown to be necessary for the provision of the goods, services, facilities, privileges, advantages, or accommodations being offered.").

ties, unless the entity can demonstrate that making such modifications would fundamentally alter the nature of such goods, services, facilities, privileges, advantages, or accommodations[.]¹⁴¹

Finally, Title III has a specific prohibition against discrimination for:

[A] failure to take such steps as may be necessary to ensure that no individual with a disability is excluded, denied services, segregated or otherwise treated differently than other individuals because of the absence of auxiliary aids or services, unless the entity can demonstrate that taking such steps would fundamentally alter the nature of the good, service, facility, privilege, advantage, or accommodation being offered or would result in an undue burden.¹⁴²

An undue burden means “significant difficulty or expense.”¹⁴³ The absence of auxiliary aids or services forms the crux of the case law involving Deaf patients in the medical setting.¹⁴⁴

141. 42 U.S.C. §12182(b)(2)(A)(ii); *see also* 28 C.F.R. §36.302(a) (“A public accommodation shall make reasonable modifications in policies, practices, or procedures, when the modifications are necessary to afford goods, services, facilities, privileges, advantages, or accommodations to individuals with disabilities, unless the public accommodation can demonstrate that making the modifications would fundamentally alter the nature of the goods, services, facilities, privileges, advantages, or accommodations.”).

142. 42 U.S.C. §12182(b)(2)(A)(iii). The DOJ regulation echoes the statute: “A public accommodation shall take those steps that may be necessary to ensure that no individual with a disability is excluded, denied services, segregated or otherwise treated differently than other individuals because of the absence of auxiliary aids and services, unless the public accommodation can demonstrate that taking those steps would fundamentally alter the nature of the goods, services, facilities, privileges, advantages, or accommodations being offered or would result in an undue burden, *i.e.*, significant difficulty or expense.” 28 C.F.R. §36.303(a). The DOJ’s commentary states, “The Department wishes to emphasize that public accommodations must take steps necessary to ensure that an individual with a disability will not be excluded, denied services, segregated or otherwise treated differently from other individuals because of the use of inappropriate or ineffective auxiliary aids.” 28 C.F.R. §36.303, App. B; *see also* DOJ TITLE III TECHNICAL ASSISTANCE MANUAL, *supra* note 9, §4.3100. As provided in Section 36.303(f), a public accommodation is not required to provide any particular aid or service that would result either in a fundamental alteration in the nature of the goods, services, facilities, privileges, advantages, or accommodations offered or in an undue burden. 28 C.F.R. §36.303, App. B. Most courts that have addressed the issue of cost “have noted that a reasonable accommodation is both moderate and not unduly burdensome.” *Bravin v. Mt. Sinai*, 186 F.R.D. 293, 305 (S.D.N.Y. 1999) (citing *Rothschild v. Grottenthaler*, 907 F.2d at 293; *Easley v. Snider*, 36 F.3d 297, 305 (3d Cir. 1994)).

143. In determining whether an action would impose an undue burden on a public accommodation, the following factors must be considered:

(1) The nature and cost of the action needed under this part; (2) The overall financial resources of the site or sites involved in the action; the number of persons employed at the site; the effect on expenses and resources; legitimate safety requirements that are necessary for safe operation, including crime prevention measures; or the impact otherwise of the action upon the operation of the site; (3) The geographic separateness, and the administrative or fiscal relationship of the site or sites in question to any parent corporation or entity; (4) If applicable, the overall financial resources of any parent corporation or entity;

In order to establish a *prima facie* case against a medical office or hospital under Title III of the ADA, the plaintiff must prove three elements: one, that she has a disability; two, that the defendant's office is a place of public accommodation; and three, that the defendant discriminated against her by engaging in any one of the above-listed proscribed activities based on the plaintiff's disability.¹⁴⁵ Intent to discriminate is not an additional element of the plaintiff's ADA case.¹⁴⁶ It is sufficient to show a set of circumstances that give rise to an inference that the denial of the full and equal enjoyment of medical treatment is based on the plaintiff's disability.¹⁴⁷

When the ADA became law in 1990, Congress designated the Attorney General of the United States as the official responsible for promulgating regulations under Title III of the ADA that do not relate to the transportation provisions of that title.¹⁴⁸ According to the DOJ's regulations, auxiliary aids and services include qualified sign language interpreters or other effective means for making aurally-delivered materials available to individuals with hearing impairments.¹⁴⁹ These regulations define a qualified sign language inter-

the overall size of the parent corporation or entity with respect to the number of its employees; the number, type, and location of its facilities; and (5) If applicable, the type of operation or operations of any parent corporation or entity, including the composition, structure, and functions of the workforce of the parent corporation or entity.

28 C.F.R. §36.104.

144. See *supra* note 3. There is a requirement in addition to providing auxiliary aids and services; removal of communication barriers. 42 U.S.C. §12182(b)(2)(A)(iv); 28 C.F.R. §36.304(a). Communication barriers that are structural in nature (e.g., permanent signage, alarm systems, sound buffers, and walls) must be removed only if it is "readily achievable." 28 C.F.R. §36.304(a). However, the obligation to remove structural communication barriers is independent of any obligation to provide auxiliary aids and services. See 28 C.F.R. §36.304(a), App. B.

145. *Mayberry v. Von Valtier*, 843 F. Supp. 1160, 1164 (E.D. Mich. 1994).

146. *Id.* at 1166. Because the ADA is similar to Section 504, the analysis of cases arising under Section 504 applies to the ADA. *Id.*

147. *Id.*

148. 42 U.S.C. § 12186(b) (2000). Numerous federal agencies share in the responsibility of promulgating and enforcing regulations under the ADA, including the Equal Employment Opportunity Commission, Department of Transportation (public transportation), Federal Communications Commission (telephone relay services), Access Board (design guidelines), Department of Education, Department of Health and Human Services (health care), Department of Labor, Department of Housing and Urban Development, Department of the Interior (parks and recreation), and Department of Agriculture. See ADA Regulations & Technical Assistance Materials, <http://www.usdoj.gov/crt/ada/publicat.htm#anchor-invest%20agencies> (last visited Aug. 25, 2008).

149. 28 C.F.R. § 36.303(b) (2008).

Examples. The term 'auxiliary aids and services' includes – (1) Qualified interpreters, notetakers, computer-aided transcription services, written materials, telephone handset amplifiers, assistive listening devices, assistive listening systems, telephones compatible with hearing aids, closed caption decoders, open and closed captioning, telecommunications devices for deaf persons (TDD's), videotext displays, or other effective methods of making aurally delivered materials available to individuals with hearing impairments.

preter as an interpreter “who is able to interpret effectively, accurately and impartially both receptively and expressively, using any necessary specialized vocabulary.”¹⁵⁰ A person who is deaf or hard-of-hearing cannot be charged for receiving an interpreter or any other aid or for the reasonable modification of a policy, practice, or procedure.¹⁵¹

The key is effective communication access: “A public accommodation shall furnish appropriate auxiliary aids and services where necessary to ensure effective communication with individuals with disabilities.”¹⁵² The auxiliary aid requirement is a flexible one. A public accommodation can choose among various alternatives as long as the result is effective communication.¹⁵³ “What constitutes ‘effective communication’ is a question of fact”¹⁵⁴ Even if the original auxiliary aid or service is too expensive or fundamentally alters the program or service of the public accommodation, the public accommodation is still obligated to provide an alternative auxiliary aid or service.¹⁵⁵ The public accommodation does not have to provide the per-

Id. Another example of “auxiliary aids and services” is the “[a]cquisition or modification of equipment or devices” 28 C.F.R. § 36.303(b)(3); *see also* DOJ TITLE III TECHNICAL ASSISTANCE MANUAL, *supra* note 9, § 4.3300. According to a Senate committee report, “The list is not meant to be exhaustive; rather, it is intended to provide general guidance about the nature of the obligation.” S. REP. NO. 101-116, at 161 (1989).

150. 28 C.F.R. § 36.104 (2007); *see also* *Clarkson v. Coughlin*, 898 F. Supp. 1019, 1027 (S.D.N.Y. 1995).

151. 28 C.F.R. § 36.301(c).

A public accommodation may not impose a surcharge on a particular individual with a disability or any group of individuals with disabilities to cover the costs of measures, such as the provision of auxiliary aids, barrier removal, alternatives to barrier removal, and reasonable modifications in policies, practices, or procedures, that are required to provide that individual or group with the non-discriminatory treatment required by the Act or this part.

Id.

152. 28 C.F.R. § 36.303(c) (2007); *see also* DOJ TITLE III TECHNICAL ASSISTANCE MANUAL, *supra* note 9, § 4.3200. As the DOJ’s commentary explains,

Implicit in this duty to provide auxiliary aids and services is the underlying obligation of a public accommodation to communicate effectively with its customers, clients, patients, or participants who have disabilities affecting hearing, vision, or speech Auxiliary aids and services include a wide range of services and devices for ensuring effective communication. Use of the most advanced technology is not required so long as effective communication is ensured.

28 C.F.R. pt. 36, app. B § 36.303 (2007). Despite the urgings of commenters, the DOJ refused to enumerate the list of possible appropriate accommodations because “such an attempt would omit new devices that will become available with emerging technology.” *Id.*

153. 28 C.F.R. § 36.303(c) (2008). For example, a bookstore would not be required to provide a sign language interpreter because a notepad and pen would be effective under the circumstances. 28 C.F.R. pt. 36, app. B § 36.303. However, were the bookstore to offer to the public a lecture by a guest author, it would be obligated to provide an interpreter. *Id.*

154. *Bravin v. Mount Sinai*, 186 F.R.D. 293, 302 (S.D.N.Y. 1999) (citing *Borkowski v. Valley Cent. Sch. Dist.*, 63 F.3d 131 (2d Cir. 1995); *Mohamed v. Marriott Int’l, Inc.*, 905 F. Supp. 141 (S.D.N.Y. 1995)). For this reason, the issue is not appropriately disposed of on a Rule 12(b)(6) motion to dismiss a complaint. *See Bravin*, 186 F.R.D. at 302.

155. 28 C.F.R. § 36.303(f).

son with a disability with a personal aid or device like a hearing aid, a cochlear implant, a prosthetic device, or a cane.¹⁵⁶ On the flip side, nothing in the law or regulations obligates a person with a disability to accept “an accommodation, aid, service, opportunity, or benefit available” offered by the public accommodation.¹⁵⁷

DOJ regulations define the appropriateness of an auxiliary aid as dependent on the length and complexity of the interaction:

ILLUSTRATION 2a: H goes to his doctor for a biweekly check-up, during which the nurse records H’s blood pressure and weight. Exchanging notes and using gestures are likely to provide an effective means of communication at this type of check-up.

BUT: Upon experiencing symptoms of a mild stroke, H returns to his doctor for a thorough examination and a battery of tests and requests that an interpreter be provided. H’s doctor should arrange for the services of a qualified interpreter, as an interpreter is likely to be necessary for effective communication with H, given the length and complexity of the communication involved.¹⁵⁸

Indeed, commentary by the DOJ states, “It is not difficult to imagine a wide range of communications involving areas such as health, legal matters, and finances that would be sufficiently lengthy or complex to require an interpreter for effective communication.”¹⁵⁹

Although DOJ regulations and commentary state that doctors must take steps to provide appropriate auxiliary aids in order to provide effective communication, neither states explicitly that the steps

If provision of a particular auxiliary aid or service by a public accommodation would result in a fundamental alteration in the nature of the goods, services, facilities, privileges, advantages, or accommodations being offered or in an undue burden, i.e., significant difficulty or expense, the public accommodation shall provide an alternative auxiliary aid or service, if one exists, that would not result in an alteration or such burden but would nevertheless ensure that, to the maximum extent possible, individuals with disabilities receive the goods, services, facilities, privileges, advantages, or accommodations offered by the public accommodation.

Id. This is consistent with regulations implementing Section 504 in federally conducted programs, which supports the idea that the undue burden of a particular auxiliary aid or service does not relieve a public accommodation of its duty to furnish an alternative auxiliary aid or service, if available, that would not result in such a burden. 28 C.F.R. pt. 36, app. B § 36.303.

156. 28 C.F.R. § 36.306 (“Personal Devices and Services. This part does not require a public accommodation to provide its customers, clients, or participants with personal devices, such as wheelchairs; individually prescribed devices, such as prescription eyeglasses or hearing aids; or services of a personal nature including assistance in eating, toileting, or dressing.”); *see also* 28 C.F.R. pt. 36, app. B § 36.303.

157. 28 C.F.R. § 36.203(c).

158. 28 C.F.R. pt. 36, app. B § 36.303; *see also* Proctor v. Prince George’s Hosp. Ctr., 32 F. Supp. 2d 820, 827-28 (D. Md. 1998) (“[C]ourts have focused on specific instances during the interaction between the disabled individual and the public accommodation or public entity.”).

159. 28 C.F.R. pt. 36, app. B § 36.303.

include a duty to consult with the deaf patient. And while the regulations are silent on whether a public accommodation must give “primary consideration” to the disabled person’s request, the DOJ’s commentary states outright that public accommodations are not required to give such consideration to the disabled person’s request.¹⁶⁰ Instead, the public accommodation is merely “strongly encourage[d]” to consult with the disabled person.¹⁶¹

Put simply, the law allows the doctor to refuse to consult with the Deaf patient regarding the appropriateness of a particular auxiliary aid and allows him or her not to give “primary consideration” to the patient’s express choice of an auxiliary aid. All the law says is that “[a] public accommodation shall furnish appropriate auxiliary aids and services where necessary to ensure effective communication with individuals with disabilities.”¹⁶² That means that the doctor has to get it right or get sued.¹⁶³

Despite the urgings of public commenters who wanted the inclusion of “primary consideration” language,¹⁶⁴ the DOJ determined,

160. *Id.* Under the ADA, a public accommodation is “strongly encourage[d]” to consider a disabled person’s choice of an auxiliary aid or service for the purpose of assisting the person in communicating with the public accommodation, but it is not required to give deference to the disabled person’s preference. *See id.*

161. *Id.* Section 504 has no equivalent requirement that obligates a doctor to ask the Deaf patient for his or her express choice of an appropriate accommodation for purposes of effective communication, or to give “primary consideration” to the patient’s express choice.

162. 28 C.F.R. § 36.303(c).

163. The DOJ says of doctors faced with the issue of what appropriate auxiliary aid to provide, “While consultation is strongly encouraged, the ultimate decision as to what measures to take to ensure effective communication rests in the hands of the public accommodation, provided that the method chosen results in effective communication.” DOJ TITLE III TECHNICAL ASSISTANCE MANUAL, *supra* note 9, § 4.3200. However, as the cases show, “getting it right” is hard enough for a medical practitioner unversed in Deafness and Deaf culture and who does not ask the Deaf patient for advice or input on what would work under the circumstances. Moreover, it is probably safe to say that most practitioners who do not “get it right” are not sued (this would be a rich area for empirical inquiry), and the intents and purposes of the statute are frustrated.

164. *See* 28 C.F.R. pt. 36, app. B § 36.303. As the DOJ stated,

A critical determination is what constitutes an effective auxiliary aid or service. The Department’s proposed rule recommended that, in determining what auxiliary aid to use, the public accommodation consult with an individual before providing him or her with a particular auxiliary aid or service. This suggestion sparked a significant volume of public comment. Many persons with disabilities, particularly persons who are deaf or hard of hearing, recommended that the rule should require that public accommodations give ‘primary consideration’ to the ‘expressed choice’ of an individual with a disability. These commenters asserted that the proposed rule was inconsistent with congressional intent of the ADA, with the Department’s proposed rule implementing title II of the ADA, and with longstanding interpretations of section 504 of the Rehabilitation Act.

upon review of the ADA's legislative history,¹⁶⁵

that Congress did not intend under title III to impose upon a public accommodation the requirement that it give primary consideration to the request of the individual with a disability [and] . . . finds that strongly encouraging consultation with persons with disabilities, in lieu of mandating primary consideration of their expressed choice, is consistent with congressional intent.¹⁶⁶

As the preceding discussion of statutory law and regulations shows, the law allows the doctor to make a decision about the appropriate auxiliary aid without consulting with the person with a disability and without having to consider that person's expressed choice for an auxiliary aid. The only requirements are that the doctor takes steps to implement effective communication in his or her office and that he or she be correct in offering an appropriate auxiliary aid under the right circumstances.¹⁶⁷ Not surprisingly, then, federal case

165. According to a Senate committee report, "The Committee expects that the covered entity will consult with the individual with a disability before providing a particular auxiliary aid or service. Frequently, an individual with a disability requires a simple adjustment or aid rather than an expensive or elaborate modification often envisioned by a covered entity." S. REP. NO. 101-116, at 161 (1989).

166. 28 C.F.R. pt. 36, app. B § 36.303. The full quotation is as follows:

Based upon a careful review of the ADA legislative history, the Department believes that Congress did not intend under title III to impose upon a public accommodation the requirement that it give primary consideration to the request of the individual with a disability. To the contrary, the legislative history demonstrates congressional intent to strongly encourage consulting with persons with disabilities. In its analysis of the ADA's auxiliary aids requirement for public accommodations, the House Education and Labor Committee stated that it 'expects' that 'public accommodation(s) will consult with the individual with a disability before providing a particular auxiliary aid or service' (Education and Labor report at 107). Some commenters also cited a different committee statement that used mandatory language as evidence of legislative intent to require primary consideration. However, this statement was made in the context of reasonable accommodations required by title I with respect to employment (Education and Labor report at 67). Thus, the Department finds that strongly encouraging consultation with persons with disabilities, in lieu of mandating primary consideration of their expressed choice, is consistent with congressional intent.

Id.

167. According to the DOJ's Technical Assistance Manual, "*While consultation is strongly encouraged, the ultimate decision as to what measures to take to ensure effective communication rests in the hands of the public accommodation, provided that the method chosen results in effective communication.*" DOJ TITLE III TECHNICAL ASSISTANCE MANUAL, *supra* note 9, § 4.3200 (emphasis added). By way of illustration, the Manual cites the example of a Deaf patient who brings his own sign language interpreter for an office visit without prior consultation and bills the physician for the cost of the interpreter. *Id.* According to the DOJ, the physician would not be obligated to comply with the unilateral determination by the patient that an interpreter is necessary; instead, the physician must be given an opportunity to consult with the patient and make an independent assessment of what type of auxiliary aid, if any, is necessary to ensure effective communication. *Id.* If the patient believes that the physician's decision will not lead to effective communication, then the patient may challenge that decision under Title III by initiating litigation or filing a complaint with the DOJ. *See id.*

law interpreting the statutes and the regulations reflect a breakdown in communication between doctor and patient.

C. Federal Case Law on Appropriate Auxiliary Aids

In *Connors v. West Orange Healthcare District*, Jennifer Connors, her husband, Robert Connors, and Dawn Borque Rochette, all three deaf residents of Maitland, Florida, sought emergency medical attention at defendant's facility.¹⁶⁸ Due to the lack of interpreters, plaintiffs alleged they were unable to communicate with defendant's medical personnel, who insisted on writing notes instead of calling for an interpreter.¹⁶⁹ Plaintiffs claimed this deprived them of the ability to understand the treatment provided and the procedures performed.¹⁷⁰ In addition, plaintiffs said that they signed forms they did not fully understand and that defendant's employees did not explain the risks and benefits of the treatments.¹⁷¹ Defendants responded that there was no denial of services based on disability because plaintiffs "communicated with the Defendant's employees both verbally and in writing."¹⁷²

Citing cases where a defendant's refusal to provide sign language interpreters violated the ADA,¹⁷³ the court found that plaintiffs established the elements of a successful claim under the ADA;¹⁷⁴ plaintiffs alleged that in the absence of an interpreter, they could not understand what the doctors and nurses were saying to them, could not question the doctors about what they wrote, and had no idea how the doctors planned to treat their conditions.¹⁷⁵ Because plaintiffs alleged an inability to communicate with defendant's employees, the court found that these allegations were sufficient to state a claim under

168. *Connors v. W. Orange Healthcare Dist.*, No. 605CV647ORL31KRS, 2005 WL 1500899, at *1-2 (M.D. Fla. June 23, 2005).

169. *Id.*

170. *Id.* at *2.

171. *Id.* Count One of the complaint contended that defendant violated Title II of the ADA by

(1) failing to maintain policies and procedures to ensure compliance with the ADA; (2) failing to ensure that communications with the Plaintiffs were as effective as communications with non-disabled patients; (3) failing to provide auxiliary aids and services; (4) failing to provide notice of the Plaintiffs' rights; and (5) excluding the Plaintiffs from, and denying them the benefits of, services due to their disability.

Id. at *3. Count Two focused on Section 504 and included a contention that the defendants "refused to accommodate the Plaintiffs with appropriate auxiliary aids and services." *Id.* Plaintiffs sought a declaratory judgment condemning defendant's practices and policies, injunctive relief, and compensatory damages. *Id.*

172. *Id.* at *3.

173. *Id.* at *5 (citing *Rothschild v. Grottenthaler*, 907 F.2d 286, 289 (2d Cir. 1990); *Proctor v. Prince George's Hosp. Ctr.*, 32 F. Supp. 2d 820, 827 (D. Md. 1998)).

174. *Connors*, 2005 WL 1500899, at *6.

175. *Id.*

the ADA and Section 504.¹⁷⁶ The facts outlined in *Connors* establish that defendant's employees refused to talk to the Deaf patients and their families about what was needed to establish effective communication between the parties, insisting on one approach—written notes—notwithstanding the plaintiffs' protestations.

The arguments of the parties in *Falls v. Prince George's Hospital Center*¹⁷⁷ reflect a similar scenario. Plaintiffs, a hearing mother and her deaf daughter, a young child, sued Prince George's Hospital Center in Maryland, alleging that it discriminated against the daughter when she was admitted to and treated at defendant's medical facility, because it failed to provide the daughter with an interpreter during her nearly week-long stay at the hospital.¹⁷⁸ Despite repeated requests from the Deaf child's mother, the hospital refused to give the child an interpreter when she underwent invasive procedures:¹⁷⁹

Defendant misguidedly argues that here, no interpreter was necessary under the regulations because the hospital did not need to receive medical information from Latia, or impart medical information to her. However, the crucial question is whether an interpreter was necessary to afford Latia, a hearing-impaired child, an equal opportunity to benefit from the services provided by Defendant to children who do not suffer from a hearing-impairment. Plaintiffs correctly state that in order to evaluate whether Latia was denied services or benefits available to hearing children, there

176. *Id.* In order to state an ADA claim, plaintiffs must allege that they are qualified individuals with a disability and that they were excluded from, or denied the benefits of, the services, programs, and activities of a public accommodation because of their disability. *Id.* at *5. Stating a claim under the ADA also states a claim under Section 504. *Id.* at *6 n.9 (citing *Cash v. Smith*, 231 F.3d 1301, 1305 n.2 (11th Cir. 2000); *Sutton v. Lader*, 185 F.3d 1203, 1207 n.5 (11th Cir. 1999)). Injunctive relief requires an injury-in-fact, a causal connection between the injury and defendant's action, the likelihood or lack thereof of a real and immediate threat of future harm, and the likelihood of redressability by a favorable decision. *Id.* at *4. Plaintiffs lost standing because they said they would likely not return to defendant but might do so in the event of an emergency. *Id.* Because plaintiffs did not establish the likelihood of returning to defendant for treatment, they failed to establish "a real and immediate threat of future harm" and lacked standing to pursue injunctive relief. *Id.* (citing *Freydel v. N.Y. Hosp.*, 242 F.3d 365 (2d Cir. 2000); *Constance v. State Univ. of N.Y. Health Sci. Ctr. at Syracuse*, 166 F. Supp. 2d 663, 667 (N.D.N.Y. 2001); *Proctor v. Prince George's Hosp. Ctr.*, 32 F. Supp. 2d 820, 832-33 (D. Md. 1998); *Schroedel v. N.Y. Univ. Med. Ctr.*, 885 F. Supp. 594, 599 (S.D.N.Y. 1995); *Aikins v. St. Helena Hosp.*, 843 F. Supp. 1329, 1334 (N.D. Cal. 1994)). For an analysis of the challenges that standing poses for ADA plaintiffs, see Adam Milani, *Wheelchair Users Who Lack "Standing": Another Procedural Threshold Blocking Enforcement of Titles II and III of the ADA*, 39 WAKE FOREST L. REV. 69 (2004). The court's standing decision did not end the inquiry because plaintiffs also asserted a claim for compensatory damages, which are available under Section 504 and the ADA for "intentional discrimination." *Connors*, 2005 WL 1500899, at *5. Because plaintiffs alleged that defendant's acts, "both of omission and commission, were intentional acts of discrimination," the court looked at the specific claims to see if plaintiffs stated a claim for relief under Section 504 and the ADA. *Id.*

177. No. Civ. A. 97-1545, 1999 WL 33485550 (D. Md. Mar. 16, 1999).

178. *Id.* at *1.

179. *Id.* at *3-4.

must first be a determination of what benefits and services are provided to such children by Defendant.¹⁸⁰

As the court found,

[i]n contrast to the type of care and communication given to hearing children, it appears that during Latia's six-day hospital stay, no doctor or nurse communicated with her directly or through an interpreter to question her regarding her symptoms. Defendant admits that in general, when procedures are performed on hearing children, doctors and nurses try to calm and reassure their patients. In contrast to the testimony regarding explanations and reassurance given to hearing children before and during medical procedures, it appears that no doctor, nurse or other personnel provided any explanation or reassurance to Latia regarding (1) drawing her blood, (2) taking her urine sample, (3) giving her a suppository, (4) taking her x-rays, or (5) giving her a renal sonogram. Accordingly, a jury could conclude that Latia was not provided benefits and services equal to those provided hearing children.¹⁸¹

Defendant moved for summary judgment, and the court granted the motion in part based on plaintiffs' lack of standing to sue for injunctive relief under the ADA and failure to establish the elements of state law claims for intentional infliction of emotional distress.¹⁸² However, it denied the motion as to plaintiffs' section 504 claim for damages.¹⁸³

A hospital's steadfast refusal to provide sign language interpreters despite plaintiffs' repeated requests, instead relying on "short, confusing and cryptic" notes, underlined the dispute in *Gillespie v. Dimensions Health Corp.*¹⁸⁴ Although there was a VRI device, the hospital provided it only once and "failed and/or refused to provide access to the VRI device, and denied [plaintiffs'] repeated requests for a live sign language interpreter or an effective alternative mode of communication."¹⁸⁵ Instead, the hospital brushed aside the plaintiffs' pleas for an interpreter and forced them to read lips and rely on written notes even though "the hospital staff limited its writing to a

180. *Id.* at *8 (citation omitted).

181. *Id.* at *9 (citation omitted).

182. *Id.*

183. *Id.* at *8-9.

184. 369 F. Supp. 2d 636, 637, 639 (D. Md. 2005).

185. *Id.* at 638. VRI stands for "video remote interpreting," where a sign language interpreter at a remote location appears on a television screen that is available to both doctor and Deaf patient who are sitting side by side. The doctor can hear and the Deaf patient can see the interpreter, while the interpreter can hear and see both; the interpreter signs what the doctor is saying and voices what the Deaf patient is signing. See Video Remote Interpreting, http://www.michdhh.org/assistive_devices/video_remote_interp.html (last visited Aug. 25, 2008).

'few words.'¹⁸⁶ The court held that given the proximity of plaintiffs' residences to the hospital, the likelihood they would return in the event of an emergency, and evidence of past continuing violations of the hospital's obligation to provide appropriate auxiliary aids, plaintiffs had standing to sue for injunctive relief.¹⁸⁷ The court found it significant that plaintiffs were challenging a policy rather than a past action.¹⁸⁸

*Majocha v. Turner*¹⁸⁹ involved a group of ear, nose, and throat doctors that adhered to a policy of refusing to provide an interpreter to a Deaf plaintiff caring for his infant son.¹⁹⁰ In response to the plaintiff's wife's request for a sign language interpreter for her husband during the consultation, defendants sent the family a letter advising them to go elsewhere for their son's treatment.¹⁹¹ Plaintiffs sought a declaratory judgment, injunctive relief, compensatory and punitive damages, and attorney's fees under the ADA and Section 504, and defendants moved for summary judgment.¹⁹²

Defendants claimed "that Dr. Turner offered to communicate by 'note taking' and that, because they offered *one* of the auxiliary aids listed as an 'example' of acceptable aids, they *necessarily* have fulfilled their obligation under the ADA."¹⁹³ Defendants cited an example from the DOJ's commentary on auxiliary aids, which indicated that a bookstore would not be required to supply a sign language interpreter to a customer buying a book because "effective communication can be conducted by notepad."¹⁹⁴

Plaintiffs responded that the examples of auxiliary aids and services listed in section 36.303(b) were not exclusive and that defendants could not argue "one size fits all;" that is, an offer of one accommodation and nothing else could not be relied on as meeting the ADA obligation.¹⁹⁵ The court sided with the plaintiffs:

As the [DOJ] makes clear, a bookstore is not a health care provider, and the nature of the information accompanying the respective transactions are vastly different. The information ordinarily needed by a purchaser of a book is *far less* complicated than the in-

186. *Gillespie*, 369 F. Supp. 2d at 638.

187. *Id.* at 645.

188. *Id.*

189. 166 F. Supp. 2d 316 (W.D. Pa. 2001).

190. *Id.* at 318.

191. *Id.*

192. *Id.* at 319.

193. *Id.* at 321.

194. *Id.* (emphasis omitted). Defendants' reference was to an excerpt from the Attorney General's Report, *Nondiscrimination on the Basis of Disability by Public Accommodations and in Commercial Facilities*, 56 Fed. Reg. 35544 (July 26, 1991) (codified at 28 C.F.R. pt. 36).

195. *Majocha*, 166 F. Supp. 2d at 321.

formation that must be communicated to the parents of a child with chronic ear infections who are considering invasive surgery to implant tubes in the child's ears, in order that the parents may make an informed and intelligent decision.¹⁹⁶

Defendants countered by arguing that plaintiffs could not insist on a particular auxiliary aid.¹⁹⁷ The court said although that was true, plaintiffs went beyond expressing a mere preference for an interpreter; they introduced evidence "to support their contention that the *only* effective means of communication possible in this case [was] through a qualified ASL interpreter."¹⁹⁸ Because there was a genuine dispute as to whether the defendants offered an interpreter and whether notetaking would be as effective as an interpreter, the court denied defendants' motion for summary judgment.¹⁹⁹ The *Majocho* case is a prime illustration of the problem of a doctor refusing to listen to a deaf patient or consider the patient's choice of auxiliary aid.

In *Davis v. Flexman*,²⁰⁰ a psychological counseling clinic was charged with failing to provide interpreters to a Deaf couple in marital strife.²⁰¹ A central issue was whether the director of the clinic, Jerry Flexman, "acted with deliberate indifference to the Davises' requests for an interpreter."²⁰² The record reflected multiple requests on the part of the Deaf couple for sign language interpreter services during counseling sessions and Flexman's repeated refusals to provide interpreters.²⁰³ Indeed, the evidence showed that despite being told about the ADA and given a copy of the statute—which he did not read—Flexman continued to drag his feet on the provision regarding a sign language interpreter.²⁰⁴ Because the evidence demonstrated a genuine issue of material fact with respect to Flexman's deliberate

196. *Id.* at 322.

197. *Id.* at 323.

198. *Id.* The evidence consisted of expert testimony by a teacher of the Deaf that focused on plaintiff's family history, including his life long use of ASL as his primary language and his high level of proficiency in ASL. *See id.* The court quoted from the expert's report:

The use of ASL is strongly advised in order to ensure effective communication with Mr. Majocho. Given a situation in which an individual who is not proficient in ASL has a need to communicate with Mr. Majocho, the services of a qualified sign language interpreter would be necessary to ensure effective communication.

Id. (emphasis omitted). The court credited the expert's testimony. *Id.*

199. *Id.* at 323-24.

200. 109 F. Supp. 2d 776 (S.D. Ohio 1999).

201. *Id.* at 780.

202. *Id.* at 791.

203. *Id.*

204. *Id.* at 780-82, 791-92. Continuing to insist the law imposed no obligation on him, Flexman promised to provide a computer to help the Davises communicate with their therapist, but he never did so. *Id.* at 781, 791.

indifference to the Davises' communication needs, the court denied defendant's motion for summary judgment on the issue.²⁰⁵

The dispute in *Bravin v. Mount Sinai Medical Center*²⁰⁶ centered squarely on a hospital's refusal to grant an interpreter to another plaintiff.²⁰⁷ Attending Lamaze birthing classes at Mount Sinai Medical Center, Jeff Bravin and his wife, Naomi, a Deaf couple, asked for a sign language interpreter, contending that without an interpreter, the husband would be denied an equal opportunity to benefit from the classes.²⁰⁸ The hospital rejected the husband's requests on the ground he was not "the patient."²⁰⁹ Arguing that its offer of a TTY to the husband was sufficient to meet its obligation under the law, the hospital claimed that plaintiff could not "premise [his] claim[] of intentional discrimination upon [his] preference for an ASL interpreter over a TTY."²¹⁰

In terms of damages, the court weighed plaintiff's argument that a TTY was not an effective substitute for an interpreter against defendant's argument that an interpreter was not always required and

205. *Id.* at 795. What is interesting about *Davis v. Flexman* is the court's tortured interpretation of Ohio's antidiscrimination regulation, OHIO ADMIN. CODE 4112-5, promulgated by the Ohio Civil Rights Commission, which defines unlawful discrimination as the denial by a place of public accommodation, on the basis of disability, "any term, condition, privilege, service or advantage which, upon entrance to such facility, accrues to the public in general." See *Davis*, 109 F. Supp. 2d at 796. Plaintiffs contended that Flexman's failure to provide interpreters violated this section of Ohio's administrative regulations, but the court rejected the claim:

On its face, this regulation states only that a place of public accommodation may not, because of an individual's handicap, deny that person any term, condition, privilege, service, or advantage that is available to the public in general. In the present case, the Defendants did not deny Julia Davis their counseling services. Rather, she found the services unsatisfactory in the absence of an interpreter.

Id. (second emphasis added). The court failed to understand that the absence of an interpreter resulted in the denial of counseling services. Indeed, the court disregarded or forgot Joanne Voelkel's deposition in which she stated that when plaintiffs brought their own interpreter, at their expense, the presence of the interpreter "had been beneficial." *Id.* at 781. This conclusion represents a stunning ignorance of plaintiffs' communication needs and an inability to understand that opening the door to the clinic without an interpreter served as a barrier as real as a wall or curb for wheelchair users. Substitute "wheelchair user" for the Deaf plaintiff, and the flaw in the court's logic becomes readily apparent: the clinic's failure to ramp its entrance door did not deny plaintiff her counseling services. Rather, she found the services unsatisfactory in the absence of a ramp. The services were unsatisfactory because the plaintiff could not get in.

206. 186 F.R.D. 293 (S.D.N.Y. 1999), *vacated in part*, 58 F. Supp. 2d 269 (S.D.N.Y. 1999).

207. *Bravin*, 186 F.R.D. at 296.

208. *Id.*

209. *Id.*

210. *Id.* at 302. The term, "TTY," refers to "a special device that lets people who are deaf, hard of hearing, or speech-impaired use the telephone to communicate, by allowing them to type messages back and forth to one another instead of talking and listening. A TTY is required at both ends of the conversation in order to communicate." AboutTTY.com, <http://www.abouttty.com> (last visited Aug. 25, 2008).

found that defendant's motion to dismiss the damages claims was inappropriate.²¹¹ With respect to plaintiff's motion for summary judgment on the issue of defendant's liability for failing to provide an interpreter, the court reasoned that since the wife needed her husband as her "birthing partner" at the Lamaze class, the husband needed a reasonable accommodation and had successfully met his burden of production in establishing a prima facie case showing that such an accommodation was available.²¹² The court's analysis of this issue focused exclusively on whether a qualified interpreter was a "reasonable accommodation," and because the defendant hospital failed to meet its burden of persuasion with respect to whether providing an interpreter would be an "undue hardship," the court granted plaintiff summary judgment with respect to defendant's liability for failing to accommodate the husband.²¹³ Mt. Sinai did not consult with Jeff Bravin or consider his request, and the hospital's failure to do either increased the likelihood it would end up violating the ADA.

211. *Bravin*, 186 F.R.D. at 302.

212. *Id.* at 304-05. The court termed the issue as one of "reasonable accommodation." *Id.* That is a term of art reserved for Title I, where

[t]he term, "reasonable accommodation" may include – (A) making existing facilities used by employees readily accessible to and usable by individuals with disabilities; and (B) job restructuring, part-time or modified work schedules, re-assignment to a vacant position, acquisition or modification of equipment or devices, appropriate adjustment or modifications of examinations, training materials or policies, the provision of qualified readers or interpreters, and other similar accommodations for individuals with disabilities.

42 U.S.C.A. § 12111 (West 2008). Under Title I, it is discrimination to (A) not mak[e] reasonable accommodations to the known physical or mental limitations of an otherwise qualified individual with a disability who is an applicant or employee, unless such covered entity can demonstrate that the accommodation would impose an undue hardship on the operation of the business of such covered entity; or (B) deny[] employment opportunities to a job applicant or employee who is an otherwise qualified individual with a disability, if such denial is based on the need of such covered entity to make reasonable accommodation to the physical or mental impairments of the employee or applicant.

42 U.S.C.A. § 12112(b)(5)(A),(B) (West 2008). Under Title III, however, discrimination is the

failure to take such steps as may be necessary to ensure that no individual with a disability is excluded, denied services, segregated or otherwise treated differently than other individuals *because of the absence of auxiliary aids and services*, unless the entity can demonstrate that taking such steps would fundamentally alter the nature of the good, service, facility, privilege, advantage, or accommodation being offered or would result in an undue burden.

42 U.S.C.A. § 12182(b)(2)(A)(iii) (emphasis added). "Reasonable accommodation" language does not appear in Title III.

213. *Bravin*, 186 F.R.D. at 306. On defendant's motion to reconsider the grant of summary judgment to plaintiff, the court reaffirmed its decision, stating, "Given that Mt. Sinai did not provide Bravin with any accommodation, it seems obvious that 'effective communication' could not have been achieved." *Bravin v. Mount Sinai Med. Ctr.*, 58 F. Supp. 2d 269, 273 (S.D.N.Y. 1999).

Initially, the doctor in *Mayberry v. Von Valtier*²¹⁴ wrote to plaintiff's daughter informing her that the doctor wanted plaintiff to have an interpreter when she came in for a consultation, and in fact the doctor did provide her with an interpreter.²¹⁵ However, after this visit the doctor wrote a letter to the interpreter implying that she would be unable to utilize her services or provide care to the patient in the future because of the cost associated with providing interpreter services.²¹⁶

Plaintiff's proof of discrimination consisted of "defendant's own words in the February 22, 1993 letter to Ms. Ferrero [and] the affidavit of [plaintiff's daughter] which states that defendant wanted plaintiff to bring an interpreter to future appointments."²¹⁷ Plaintiff also pointed to a note written by defendant on plaintiff's chart, indicating defendant's confusion over the exact location of plaintiff's pain, which plaintiff claimed was due to poor communication.²¹⁸ Finally, plaintiff submitted a note written by defendant, instructing plaintiff to consult an ophthalmologist and suggesting that she "take someone with her who signs so you can explain problem & answer their questions completely."²¹⁹

In response to defendant doctor's motion for summary judgment, the court held that plaintiff established a prima facie case of discrimination under the ADA and section 504 by setting forth enough evidence that she was being denied treatment based on her disability.²²⁰ Because defendant failed to satisfy her burden of proof on the issue of whether she refused to hire an interpreter for plaintiff, the court denied her motion for summary judgment.²²¹ Once again, a stubborn doctor ran afoul of the law because she did not listen.

The above cases have a recurring theme: an aurally inaccessible office frustrates a Deaf patient who asks for a sign language interpreter and gets a negative response from the doctor. The doctor reflexively claims that writing notes or reading lips are sufficient auxiliary aids but remains unmindful of the Justice Department's admonition that most medical encounters envision a sign language interpreter.²²² More importantly, the doctor is unmindful of the fact the deaf patient is a valuable source of information on appropriate auxiliary aids; all the doctor has to do is to ask a simple question: "What works for you?" That question is rarely asked, because the law does

214. 843 F. Supp. 1160 (E.D. Mich. 1994).

215. *Id.* at 1162.

216. *Id.*

217. *Id.* at 1166.

218. *Id.*

219. *Id.*

220. *Id.* at 1167.

221. *Id.*

222. See 28 C.F.R. pt. 36, app. B § 36.303.

not require it. Perhaps if the doctor was required to ask the question and had to accord due weight to the patient's response, we would see a different outcome: an exchange of creative and innovative ideas on how to make communication in the medical setting easier and more efficient.

What might those creative and innovative ideas for building an aurally accessible office be? It depends on the patient and on the context of the encounter with the doctor. Of course, many patients will need an interpreter, and if they say they need one, that choice ought to be accorded respect and deference. But doctors and lawyers make a mistake if they assume that every Deaf patient wants an interpreter. For example, CART and VRI can ensure that a variety of deaf patients are served appropriately according to their needs and the circumstances.²²³ Sometimes pen and paper or lip-reading will suffice. Doctors need to ask the question and listen to the reply, and the law needs to enforce that by way of properly drafted commentary and analyses that require a consultation with the Deaf patient (or any other person with a disability) and "primary consideration" of the person's choice of an auxiliary aid.

IV. THE JUSTICE DEPARTMENT'S STANCE

Ironically, the Justice Department fully understands the need for a doctor to consult with a Deaf patient and give the patient's express choice "primary consideration." As this Part shows, the Department's own consent decrees and settlement agreements with medical providers adopt language calling for compulsory consultation between doctors and deaf patients, with an implicit understanding that the doctors will give "primary consideration" to the Deaf patients' choices of auxiliary aids.

223. CART is an acronym for "computer-aided real-time transcription" or "communication access real-time translation," where the spoken word is instantly translated into English text using a stenotype machine, notebook computer, and real-time software. See Communication Access Information Center, What Exactly Is CART?, <http://www.cartinfo.org> (last visited Aug. 25, 2008). The text appears on a computer monitor or other display. *Id.* As discussed *supra* note 185, VRI is an acronym for "video remote interpreting," where both the ASL user and the hearing person are located in the same room and the video relay interpreter is in a remote location. See, e.g., *Gillespie v. Dimensions Health Corp.*, 369 F. Supp. 2d 636, 638 n.2 (D. Md. 2005); AT&T, Video Relay FAQs, <http://www.consumer.att.com/relay/video/faqs.html#8> (last visited Aug. 25, 2008). VRI, however, ought to serve as a temporary measure until an interpreter arrives on the scene. VRI cannot and should not ever serve as a permanent substitute for a live in-person interpreter.

A. Consent Decrees and Settlement Agreements

In *Devinney v. Maine Medical Center*,²²⁴ the Justice Department helped establish a consent decree against the Maine Medical Center, which contained language calling for consultation with Deaf patients.²²⁵ In this case, plaintiffs Janet Devinney and the United States sued the medical center, alleging it failed to provide auxiliary aids and services, including qualified sign language interpreters, where such aids and services were necessary for effective communication between Deaf patients and defendant's medical staff, as required by the ADA, section 504, governing regulations, and state law.²²⁶ The outcome of the lawsuit was the entry of a consent decree. As the court recognized, "Sign language interpreters and other auxiliary aids and services are necessary to provide equal access to hospital services for deaf and hard of hearing individuals."²²⁷

The consent decree calls for defendant Maine Medical Center to consult with the Deaf patient as to his or her choice of accommodation and to recognize the importance of registering his or her preference: "[Defendant's] personnel shall consult with the person who is deaf to ensure the deaf person's preferred method(s) of communication as well as the equipment necessary to ensure effective communication are expressed on the Notice."²²⁸ Once defendant is aware that a Deaf patient is coming in, it must hand the patient a copy of "Ser-

224. No. Civ. 97-276-P-C, 1998 WL 271495 (D. Me. May 18, 1998) (consent decree).

225. See *id.*

226. *Id.* at *1.

227. *Id.* The term, "qualified interpreter," rooted in the legal definition outlined in the regulation, is fleshed out in the decree: "[A]n interpreter who is able to interpret competently, accurately, and impartially both receptively and expressively, using any specialized terminology necessary for effective communication in a medical setting." *Id.* at *4; see also 36 C.F.R. § 36.104. Specifically, that definition excludes people who have only a rudimentary familiarity of sign language or finger spelling, or who are fluent in sign language but do not possess the ability to translate spoken communication into the proper signs or to observe someone else signing and change their signed or finger spelled communication into spoken words. *Devinney*, 1998 WL 271495, at *4.

228. *Devinney*, 1998 WL 271495, at *4. Effective communication is defined as follows:

[Defendant] shall provide appropriate auxiliary aids and services, including sign language interpreters, where such aids and services are necessary to ensure effective communication with persons who are deaf and shall provide persons who are deaf with the full and equal enjoyment of the services, privileges, facilities, advantages and accommodations of MMC as required by this Decree, the ADA and Section 504.

Id. Auxiliary aids and services include

qualified interpreters, telecommunication devices for the deaf (TDDs), assistive listening devices (ALDs), captioned televisions, trained note-takers, computer assisted real time transcription (CART), telephone "flashers" to indicate incoming calls (where appropriate, such as in patient rooms) and other similar aids and services as defined by 36 C.F.R. § 36.303(b)(1). Appropriate auxiliary aids do not include new or experimental technology that is not generally available and is not widely used in the United States.

Id. at *3.

vices for Deaf and Hard of Hearing Persons at Maine Medical Center” and assist the patient, if necessary, in filling it out.²²⁹

In addition, the decree commands defendant to never request “a family member, companion, case manager, advocate or friend” of the deaf patient to serve as interpreter, and in the event the patient wants a relative or friend to interpret, defendant must secure a signed refusal (or notation of a refusal of both the hospital-supplied interpreter and the signed refusal form), ascertain that the relative or friend is willing to facilitate communication, and explore with the patient “other more effective means of communication (including repeating the offer of a qualified interpreter)” when it appears that there is a lack of effective communication between the patient and the hospital personnel.²³⁰

The decree also requires defendant to post signs letting deaf patients know they can ask for assistance with communication:

[Defendant shall post signs] of conspicuous size and print at all hospital admitting stations and at the general public entrance stating, “Maine Medical Center provides sign language interpreting services, telecommunication devices (TTYs), and other aids and services to persons who are deaf or hard of hearing. These services are provided by [Maine Medical Center] free of charge. Please ask for assistance.”, or such other comparable language as meets the approval of the Office of the United States Attorney. These signs will include the international signs for “interpreter,” “TDD,” “deaf”

229. *Id.* at *4.

230. *Id.* at *6-7. Contrast this with this Author’s experience at a New York-based hospital where the hospital insisted he had to work with an interpreter on its staff. At no time did the staff offer him a choice or an opportunity to sign a refusal form. He did not complain because the interpreter was superb, and he had the full and equal enjoyment of the hospital’s medical services. The *Devinney* decree outlines very specific contexts that require an interpreter:

[Maine Medical Center] shall provide a qualified sign language interpreter and/or other appropriate auxiliary aids and services in all circumstances where necessary for effective communication as required by the ADA and Section 504, including, but not limited to the following circumstances: (i) determination of a patient’s medical history or description of ailment or injury; (ii) provision of patient rights, informed consent or permission for treatment; (iii) explanation of living wills or powers of attorney (or their availability); (iv) diagnosis or prognosis of an ailment or injury; (v) explanation of procedures, tests, treatment, treatment options or surgery; (vi) explanation of medications prescribed including dosage as well as how and when the medication is to be taken and any possible side effects; (vii) explanation regarding follow-up treatment, therapy, test results or recovery; (viii) discharge instructions; (ix) provision of psychiatric evaluation, group and individual therapy, counseling and other therapeutic activities, including grief counseling and crisis intervention; (x) explanation of any billing or insurance issues that may arise; (xi) classes concerning birthing, nutrition, CPR, weight management, etc.; (xii) informational presentations for patients or the public; (xiii) regularly scheduled religious services provided at [Maine Medical Center]; and (xiv) blood donation or apheresis.

Id. at *5.

and “assistive listening device.” [Maine Medical Center] will also offer to post on the door of the room of each deaf patient a sign of appropriately conspicuous size and print that states: “Deaf Patient.”²³¹

In the case of an emergency where the patient has not refused an interpreter but doctors could not wait for the interpreter to start treatment, defendant must, once a call for an interpreter has gone out, use “flash cards, pictograph forms, written notes, charts, diagrams and its best efforts to provide the most effective communication possible until such time as the qualified interpreter arrives at [Maine Medical Center].”²³²

The decree calls for the provision and use of CART, an array of telecommunication services (including TDDs and closed-captioned televisions), fire alarms, assistive listening devices, and “pictograph forms and flash cards.”²³³ Deaf people who enter defendant’s medical center not as patients but as relatives or friends authorized to communicate with medical personnel about the patient are to be covered by the decree.²³⁴ If the medical center offers any educational or support activities, it shall offer deaf participants the appropriate auxiliary aids and services, including sign language interpreters, “as are necessary to ensure effective communication whenever [Maine Medical Center] has adequate notice of such a need in advance of the activity.”²³⁵

The *Devinney* decree clearly evinces the Justice Department’s understanding that notwithstanding the hortatory nature of the regulation on consulting with Deaf patients, it was important and beneficial to require the doctor to have a conversation with the Deaf patient about appropriate auxiliary aids. The decree also recognizes the importance of providing the Deaf patient with a panoply of auxiliary aids. Most importantly, the Deaf patient is rightly seen as a valuable resource in figuring out an appropriate solution.

Similarly, in a settlement agreement with Modern Dental Professional, Indiana, P.C., the Justice Department required Modern Den-

231. *Id.* That would have raised the hackles of a few of the respondents in this Author’s dissertation study who chafed at being labeled “deaf” because they felt it invaded their privacy. See Schwartz Dissertation, *supra* note 11.

232. *Devinney*, 1998 WL 271495, at *7.

233. *Id.* at *7-10. The pictograph forms and flash cards “shall be used merely as a means to facilitate, rather than as a substitute for, other more effective means of interaction with hospital personnel.” *Id.* at *10.

234. *Id.* at *10.

235. *Id.* at *11. The decree is silent as to when the defendant is obligated to give Deaf patients and their relatives or friends notice of educational or support activities. If an activity is scheduled at the spur of the moment, the Deaf participant may not have time to give adequate notice and defendant medical center may not have sufficient time to secure an interpreter.

tal to adopt a policy requiring consultation with the Deaf patient.²³⁶ Deaf and hard-of-hearing patients “are to be informed that Modern Dental Professionals, Indiana, P.C. d/b/a Monarch Dental Associates will arrange for appropriate auxiliary aids and services needed for effective communication at all dental appointments or when requested by the patient.”²³⁷ In order to determine what constitutes an appropriate auxiliary aid under the circumstances (“timing, duration, and frequency”), Modern Dental personnel “who are otherwise primarily responsible for coordinating and/or providing patient care services [will consult] with the patient or companion where possible.”²³⁸ When the office consults with the Deaf patient, it must consider “(a) the nature, length and importance of the communication at issue; (b) the individual’s communication skills and knowledge; (c) *the patient’s request for or statement of need for an interpreter*; (d) the availability at the required times, of appropriate auxiliary aids and services, including qualified sign language interpreters.”²³⁹ In addition, the timing of such an assessment is important:

The determination of which appropriate auxiliary aids and services are necessary, must be made at the time an appointment is scheduled. Modern Personnel will perform and document in the patient’s dental chart a communication assessment as part of each initial inpatient assessment. The Modern Personnel shall reassess which appropriate auxiliary aids and services are necessary, in consultation with the patient or companion where possible, in the event that communication is not effective.²⁴⁰

Significantly, Modern Dental was required to generate and furnish each Deaf patient who entered the offices of the dental practice with a “Model Communication Assessment Form” that would enable Modern Dental’s employees “to make an assessment as to whether a patient who is deaf or hard of hearing requires appropriate auxiliary aids and services, such as interpreters, for effective communication.”²⁴¹ In the form, the Deaf patient is asked, “Does the patient with a disability need/require a professional qualified sign language or oral interpreter (which will be provided free of charge) to communicate effectively with Modern personnel?”²⁴²

236. Settlement Agreement between the United States of America and Modern Dental Professional, Indiana, P.C., DJ No. 202-26s-114, available at <http://www.usdoj.gov/crt/ada/moddentpro.htm>.

237. *Id.*, App. A (“Monarch Dental Associates Effective Communication Policy”).

238. *Id.*

239. *Id.* (emphasis added).

240. *Id.*

241. *Id.* App. B (“Modern Dental Professionals d/b/a/ Monarch Dental Associates Model Communication Assessment Form”).

242. *Id.* The form offers a checklist of possible scenarios: the patient does not sign and does not need an interpreter; the patient prefers a family member or friend to assist with

Finally, Modern Dental Associates was required to post a sign stating that it would provide qualified sign language interpreters or other auxiliary aids or services, free of charge, and list a telephone number where the patient could call for communication assistance.²⁴³ This settlement agreement drives home the Justice Department's belief that in order for the parties to have effective communication, they must be required to talk about appropriate auxiliary aids and give weight to the patient's choice.²⁴⁴ It is rather odd that the Justice Department requires in its decrees and consent settlements what it will not require in its interpretation of 28 C.F.R. section 36.303.

B. Comparing Title II with Title III

When it comes to state and local government services, the Justice Department takes the opposite tack. Like the private sector, the public sector must ensure that its communications with individuals with disabilities are as effective as communications with others and, in order to do so, the government must provide "appropriate auxiliary aids and services when necessary to ensure effective communication."²⁴⁵ As the Department explains in the Appendix to its Commen-

communication; the patient prefers to write notes; the patient prefers an interpreter and is asked for a preference (ASL, Signed English or oral). *Id.* There is a line, "Other," to allow for an alternative auxiliary aid or service. *Id.*

243. *Id.*

244. This was not the only settlement agreement evidencing the DOJ's emphasis on compulsory communication between doctor and patient. Provisions strikingly similar to the Modern Dental agreement are found in the settlement agreement between the United States and South Florida Baptist Hospital, DJ No. 202-17M-195, available at <http://www.usdoj.gov/crt/ada/southflor.htm> (last visited Aug. 25, 2008). In the South Florida Baptist agreement, the hospital must consult with Deaf patients and, in the event a patient does not make a request but hospital personnel believe an auxiliary aid would be helpful, the hospital must inform the patient that such aids and services are available. *Id.* § 34. In a lawsuit against an LSAT test preparer in the District Court for the Central District of California, the DOJ secured a consent decree requiring defendant to "establish written procedures for students requesting accommodations" and post the material on defendant's Web site, which would allow students to file an electronic request for accommodations. *United States of America v. Robin Singh Educational Services, Inc., d/b/a/ Testmasters*, CV06-3466 § 3.4 available at <http://www.usdoj.gov/crt/ada/testmaster.htm#Anchor-The-49575> (last visited Aug. 25, 2008). Upon receipt of the request, defendant is required to evaluate the request and contact the student with a decision; if it is not what the student requested, defendant must provide a written explanation. *Id.* § 3.5. Finally, in a settlement agreement involving a medical center, the defendant medical center agreed to consult with Deaf patients regarding their communication needs. Settlement Agreement between the United States of America and the Central Mississippi Medical Center, DJ No. 202-41-20, available at <http://www.usdoj.gov/crt/foia/ctlmisssm.htm> (last visited Aug. 25, 2008).

245. See *Nondiscrimination on the Basis of Disability in State and Local Government Services*, Subpart E, Communications, 28 C.F.R. § 35 (1992), available at <http://www.ada.gov/reg2.html> (last visited Aug. 25, 2008). 42 U.S.C.A. Section 12134 states the general rule that public entities such as state and local governments cannot discriminate against people with disabilities. Thus, according to 28 C.F.R. Section 35.160(a), "A public entity shall take appropriate steps to ensure that communications with applicants, participants, and members of the public with disabilities are as effective as communica-

tary, section 35.160 requires the public entity to take such steps as may be necessary to ensure that communications with applicants, participants, and members of the public with disabilities are as effective as communications with others.²⁴⁶ To perform this duty, the public entity must “furnish appropriate auxiliary aids and services when necessary to afford an individual with a disability an equal opportunity to participate in, and enjoy the benefits of, the public entity’s service, program, or activity.”²⁴⁷

But unlike places of public accommodations under Title III, state and local government services under Title II must give the person with a disability an opportunity to make an express choice, and the “public entity shall give primary consideration to the requests of the individual with disabilities.”²⁴⁸ According to the Justice Department, individuals with disabilities must be given “an opportunity . . . to request the auxiliary aids and services of their choice.”²⁴⁹ The public entity must honor the choice unless it can demonstrate that another effective means of communication exists or that use of the means chosen would not be required under section 35.164.²⁵⁰

The Justice Department justifies placing this obligation on the public entity:

Deference to the request of the individual with a disability is desirable because of the range of disabilities, the variety of auxiliary aids and services, and different circumstances requiring effective communication. For instance, some courtrooms are now equipped for “computer-assisted transcripts,” which allow virtually instantaneous transcripts of courtroom argument and testimony to appear on displays. Such a system might be an effective auxiliary aid or service for a person who is deaf or has a hearing loss who uses

tions with others.” 28 C.F.R. § 35.160(a). Section 35.160(b)(1) states, “A public entity shall furnish appropriate auxiliary aids and services where necessary to afford an individual with a disability an equal opportunity to participate in, and enjoy the benefits of, a service, program, or activity conducted by a public entity.” 28 C.F.R. § 35.160(b)(1); *see also* DOJ TITLE II TECHNICAL ASSISTANCE MANUAL, *supra* note 12, § 7.1000. Much of the DOJ’s Title II regulations are based on the its Section 504 regulations.

246. 28 C.F.R. pt. 35, app. A § 35.160.

247. *Id.*

248. 28 C.F.R. § 35.160(b)(2).

249. *Id.* According to the DOJ TECHNICAL ASSISTANCE MANUAL ON TITLE II,

When an auxiliary aid or service is required, the public entity must provide an opportunity for individuals with disabilities to request the auxiliary aids and services of their choice and must give primary consideration to the choice expressed by the individual. “Primary consideration” means that the public entity must honor the choice, unless it can demonstrate that another equally effective means of communication is available, or that use of the means chosen would result in a fundamental alteration in the service, program, or activity or in undue financial and administrative burdens.

DOJ TITLE II TECHNICAL ASSISTANCE MANUAL, *supra* note 12, § 7.1100.

250. 28 C.F.R. Pt. 35, App. A (1992).

speech to communicate, but may be useless for someone who uses sign language.²⁵¹

The Department explains further:

It is important to consult with the individual to determine the most appropriate auxiliary aid or service, because the individual with a disability is most familiar with his or her disability and is in the best position to determine what type of aid or service will be effective. Some individuals who were deaf at birth or who lost their hearing before acquiring language, for example, use sign language as their primary form of communication and may be uncomfortable or not proficient with written English, making use of a notepad an ineffective means of communication.²⁵²

The statutory language of Title II is similar to that of Title III; both public entities and private businesses must ensure their programs, activities, and services are accessible to people with disabilities.²⁵³ There is nothing in the statutes calling for compulsory conversation with a person with a disability, let alone for giving "primary consideration" to the person's choice of auxiliary aid, and yet the Justice Department's regulations interpreting a public entity's obligations under Title II construes the statute to require such a conversation. If it is desirable for a public entity to defer to the wishes of a

251. *Id.* The Appendix goes on to stress flexibility in deciding on an appropriate accommodation:

Although in some circumstances a notepad and written materials may be sufficient to permit effective communication, in other circumstances they may not be sufficient. For example, a qualified interpreter may be necessary when the information being communicated is complex, or is exchanged for a lengthy period of time. Generally, factors to be considered in determining whether an interpreter is required include the context in which the communication is taking place, the number of people involved, and the importance of the communication.

Id.

252. DOJ TITLE II TECHNICAL ASSISTANCE MANUAL, *supra* note 12, § 7.1100. The Manual goes on to say,

Individuals who lose their hearing later in life, on the other hand, may not be familiar with sign language and can communicate effectively through writing. For these individuals, use of a word processor with a videotext display may provide effective communication in transactions that are long or complex, and computer-assisted simultaneous transcription may be necessary in courtroom proceedings. Individuals with less severe hearing impairments are often able to communicate most effectively with voice amplification provided by an assistive listening device.

Id.

253. Pursuant to Title II of the ADA, "Subject to the provisions of this subchapter, no qualified individual with a disability shall, by reason of such disability, be excluded from participation in or be denied the benefits of the services, programs, or activities of a public entity, or be subjected to discrimination by any such entity." 42 U.S.C. § 12132. Pursuant to Title III of the ADA, "A public accommodation shall take those steps that may be necessary to ensure that no individual with a disability is excluded, denied services, segregated, or otherwise treated differently than other individuals because of the absence of auxiliary aids and services." 28 C.F.R. § 36.303(a).

person with a disability “because of the range of disabilities, the variety of auxiliary aids and services, and different circumstances requiring effective communication,”²⁵⁴ why is that a less compelling rationale in the private sector? If it is important for a public entity to consult with a disabled person “because the individual with a disability is most familiar with his or her disability and is in the best position to determine what type of aid or service will be effective,”²⁵⁵ why is that not the case in the private sector? Nowhere does the Justice Department explain why public entities must consult with disabled people and give “primary consideration” to the person’s express choice, but private businesses do not have to. Nowhere does the Department explain the difference between a local government doctor and a private hospital doctor. It can’t, because there isn’t one.

C. *The Legislative History Defense*

The Justice Department argues that legislative history evinces a congressional intent merely to “strongly encourage” doctors and other public accommodations to consult with patients with disabilities.²⁵⁶ This reliance on legislative history is misplaced. First, the qualitative research data compiled from 2002 to 2004 shows the complexity and variety of Deaf patients, evidence that was not available to congressional legislators considering the new bill in the late 1980s and early 1990. The extent to which private doctors have resisted Deaf patients’ requests for auxiliary aids under the ADA was unknown in 1990 when the law was passed. Now that we have actual experience with how doctors are responding to the requests of Deaf patients for appropriate auxiliary aids, including sign language interpreters, we need to rethink the Justice Department’s original reliance on the statements of a few legislators.

Second, the Justice Department’s own consent decrees and settlement agreements belie its reliance on legislative history: if the Department was convinced that merely “strongly encouraging” doctors to consult with Deaf patients was sufficient, why would it structure its decrees and agreements to require consultation?

Third, the statement of one or two legislators ought not trump the needs of Deaf patients, particularly where it is clear that the medical setting is a complex and nuanced one for Deaf patients and where these patients are a good resource for figuring out the appropriate auxiliary aids for effective communication.²⁵⁷

254. 28 C.F.R. Pt. 35, App. A § 35.160.

255. DOJ TITLE II TECHNICAL ASSISTANCE MANUAL, *supra* note 12, § 7.1100.

256. 28 C.F.R. pt. 36, App. B § 36.303.

257. In his concurring opinion in *Conroy v. Aniskoff*, 507 U.S. 511 (1993), Justice Scalia wrote, “The greatest defect of legislative history is its illegitimacy. We are governed by

D. What's Good for the Goose is Good for the Gander

There is also an element of unfairness in the allocation of opportunity to consult. Recall the Department of Justice Technical Assistance Manual: “*While consultation is strongly encouraged, the ultimate decision as to what measures to take to ensure effective communication rests in the hands of the public accommodation, provided that the method chosen results in effective communication.*”²⁵⁸ By way of illustration, the Manual cites the example of a Deaf patient who brings his own sign language interpreter for an office visit without prior consultation and bills the physician for the cost of the interpreter.²⁵⁹ According to the Department, the physician would not be obligated to comply with the unilateral determination by the patient that an interpreter is necessary; instead, the physician must be given an opportunity to consult with the patient and make an independent assessment of what type of auxiliary aid, if any, is necessary to ensure effective communication.²⁶⁰ The Department says that if the patient believes that the physician’s decision will not lead to effective communication, then the patient may challenge that decision under Title III by initiating litigation or filing a complaint with the Department of Justice.²⁶¹ But just as the doctor must be given an opportunity to consult with the patient, so should the patient be given an opportunity to consult with the doctor. Just as society sees it fit to

laws, not by the intentions of legislators.” *Id.* at 519. The Supreme Court held unanimously in *Zedner v. United States*, 547 U.S. 489 (2006), that a criminal defendant may not prospectively waive the application of the Speedy Trial Act, rendering his agreement to waive the Act’s protections “for all time” in a pending prosecution null and void. *Id.* at 494. Citing the Act’s legislative history, Justice Alito’s majority opinion held that the language and purposes of the Speedy Trial Act did not permit prospective waivers. *Id.* In response, Justice Scalia wrote a concurring opinion criticizing the majority’s use of legislative history:

It may seem that there is no harm in using committee reports and other such sources when they are merely in accord with the plain meaning of the Act. But this sort of intellectual piling-on has addictive consequences. To begin with, it accustoms us to believing that what is said by a single person in a floor debate or by a committee report represents the view of Congress as a whole—so that we sometimes even will say (when referring to a floor statement and committee report) that “Congress has expressed” thus-and-so. . . . There is no basis either in law or in reality for this naive belief. Moreover, if legislative history is relevant when it confirms the plain meaning of the statutory text, it should also be relevant when it contradicts the plain meaning, thus rendering what is plain ambiguous. Because the use of legislative history is illegitimate and ill advised in the interpretation of any statute—and especially a statute that is clear on its face—I do not join this portion of the Court’s opinion.

Id. at 510-11 (Scalia, J., concurring). For an interesting analysis of Justice Scalia’s treatment of legislative history, see JOSEPH L. GERKEN, WHAT GOOD IS LEGISLATIVE HISTORY? JUSTICE SCALIA AND THE FEDERAL COURTS OF APPEALS (2007).

258. DOJ TITLE III TECHNICAL ASSISTANCE MANUAL, *supra* note 9, § 4.3200 (emphasis added).

259. *Id.*

260. *Id.*

261. *Id.*

give the doctor that opportunity, there is nothing in law or logic that says we cannot do that for the Deaf patient. After all, the ADA is for the benefit of both the Deaf patient and the doctor.²⁶²

E. Whither the American Medical Association?

Ironically, it is the American Medical Association (AMA) that undercuts the Justice Department's refusal to require doctors to consult with Deaf patients. The AMA's Web site deals with the applicability of the ADA to the medical profession and discusses the auxiliary aid requirement as follows:

The first step is to determine, *in consultation with the patient*, the appropriate auxiliary aid or service. In some instances, such as when a conversation is particularly important relative to the care and services being provided, or is particularly complex, effective communication may only be ensured through the use of a qualified interpreter.²⁶³

This offers an example of language stronger than the "strongly encouraging" terminology used by the Justice Department. Indeed, the AMA is on record as advising America's doctors to consult with the patient. Moreover, the AMA takes a position contrary to the Justice Department on the issue of giving "primary consideration" to the patient's choice: "Although the health care professional makes the final decision regarding use of an interpreter or other alternative, the patient's choice should be given primary consideration."²⁶⁴

With the AMA in my corner, I rest my case.

V. CONCLUSION

Generally, the courts may properly rely on the well-reasoned views of the agency implementing a statute, because the agency has a body of experience and informed judgment.²⁶⁵ Thus, judges should give controlling weight to the Justice Department's regulations unless they are plainly erroneous, arbitrary, capricious, or clearly con-

262. While the protections of the ADA extend only to people with disabilities, public accommodations, including physicians and hospitals, benefit from bringing people with disabilities into the mainstream of American life. Doctors and hospitals generate income by treating members of this community, which is a substantial segment of the population, and society benefits by having a healthier population. In addition, by providing accessible communication to Deaf patients, doctors and hospitals reduce their liability for malpractice by reducing the risk of misdiagnosis or miscommunication.

263. See American Medical Association, *Americans with Disabilities Act and Hearing Interpreters*, <http://www.ama-assn.org/ama/pub/category/4616.html> (emphasis added) (last visited Aug. 25, 2008).

264. *Id.*

265. *Bragdon v. Abbott*, 524 U.S. 624, 642 (1998).

trary to the statute.²⁶⁶ In determining whether to give such weight to the Department's interpretation of Title III, a court must first determine if the statute has directly spoken to the precise question at issue and, if it has not, the court must decide if the agency's answer is based on a permissible construction of the statute.²⁶⁷ The Justice Department's construction of the law is not the only permissible reading of the statute,²⁶⁸ but its interpretation will be sustained so long as it is reasonable in light of the text and purpose of the statute and consistent with the statute and regulation.²⁶⁹

There is no justifiable reason for the Justice Department to distinguish between public doctors and private doctors. Doctors are not savvy enough to establish an aurally accessible environment without the help of their Deaf patients. Case law reflects the difficulty many doctors have in understanding the need for sign language interpreters as a vehicle for effective communication. Thus, the courts should reject the Department's interpretation of the effective communication regulation that does not require consultation or "primary consideration."

Moreover, the courts should disregard the Justice Department's cramped interpretation because the full participation of Deaf patients in the medical setting, where doctors are required to listen, ensures that the patient's health care needs are being addressed in a complete and adequate way. Cost will almost never be a reason to deny a Deaf patient the communication arrangement he or she needs to effectively access the medical setting.²⁷⁰ Furthermore, Deaf patients will no longer accept the argument that their requests are a burden to the medical provider's budget. Thus, a consultation requirement has two benefits: a healthier population and diminished liability for medical personnel, who, by having appropriate accommodations, minimize the risk and danger of malpractice.²⁷¹

266. *U.S. v. Cinemark USA, Inc.*, 348 F.3d 569 (6th Cir. 2003); *Johnson v. Gambrinus Co.*, 116 F.3d 1052 (5th Cir. 1997); *Speciner v. NationsBank*, 215 F. Supp. 2d 622 (D. Md. 2002); *Majocha v. Turner*, 166 F. Supp. 2d 316 (W.D. Pa. 2001).

267. *Johnson*, 116 F.3d at 1060.

268. *Id.*

269. *Paralyzed Veterans of Am. v. Ellerbe Becket Architects & Eng'rs, P.C.*, 950 F. Supp. 389 (D. D.C. 1996).

270. Most courts addressing the issue of cost "have noted that a reasonable accommodation is both moderate and not unduly burdensome." *Bravin v. Mt. Sinai*, 186 F.R.D. 293, 305 (S.D.N.Y. 1999) (citing *Easley v. Snider*, 36 F.3d 297, 305 (3d Cir. 1994); *Rothschild v. Grottenthaler*, 907 F.2d 286, 293 (2d Cir. 1990)).

271. Liability is not the sole force driving this concern; another is the realization that awareness of other people's cultures and beliefs actually assists the doctor in delivery of medical services. This realization is beautifully illustrated in a book about the collision between Hmong culture and American medicine: the doctors see epilepsy in a little girl, while her family regards her as giving expression to a higher spirituality—a spirituality not to be tampered with by drugs. See ANNE FADIMAN, *THE SPIRIT CATCHES YOU AND YOU FALL*

Medical service providers, judges, and lawyers face a unique challenge in devising ways to ensure effective communication access—a right guaranteed by law—between Deaf patients and their medical care providers. Such thinking cannot take place in a vacuum; rather, a conversation between doctors and patients needs to take place and the law needs to do its part to make that conversation happen in the medical office, not the courtroom. When the conversation does move into a courtroom, the deference to a Deaf patient's express choice of auxiliary aid should lead to a rebuttable presumption that the patient's choice is what is required for effective communication. The burden of proof would then shift to the doctor to prove that a different kind of auxiliary aid would yield equally effective communication and would not impose as much of a financial burden on the doctor.

The courts need to recognize, too, that the statutes, regulations, and case law mistakenly characterize the auxiliary aid as existing solely for the deaf patient. Instead, the auxiliary aid for a Deaf patient, however, is better visualized as either a two-way street or a bridge. Whether it is a sign language interpreter, written notes, or CART transcription, the auxiliary aid serves the needs of both the Deaf patient and the doctor. Just as the Deaf patient needs the auxiliary aid to access the doctor, the doctor needs the auxiliary aid to access the patient. The auxiliary aid serves to facilitate the communication between both parties, and both parties need the bridge in order to communicate effectively with each other.

Inspired by the disability rights movement, which has brought about great changes in American society, and the passage of Section 504 of the Rehabilitation Act of 1973 and the Americans with Disabilities Act of 1990, people with disabilities have become more visible in the American mainstream. This reflects changes not just in law, but also in social attitudes, public policy, and government programs.²⁷² Deaf and hard-of-hearing people have increasingly been demanding effective communication access in various forums: education, health care, employment, places of public accommodation, and transportation. The growing presence of this new “minority” in society poses challenges not just for medical providers who need to take care of their health care needs, but also judges and lawyers who are called upon to resolve disputes over how well medicine—as well as

DOWN: A HMONG CHILD, HER AMERICAN DOCTORS, AND THE COLLISION OF TWO CULTURES (1997).

272. REBECCA CORY ET AL., SYRACUSE UNIV. CENTER ON HUMAN POL'Y, INTRODUCTION TO BEYOND COMPLIANCE: AN INFORMATION PACKAGE ON THE INCLUSION OF PEOPLE WITH DISABILITIES IN POSTSECONDARY EDUCATION (2003), available at http://thechp.syr.edu/BCCC_PACKAGE.HTML#INTRODUCTION.

the rest of society—handles their communication needs.²⁷³ And because of the disability rights movement, which has been so influential in expanding transportation, housing, and employment options, people with disabilities, including Deaf people, see their personal situations as political issues.²⁷⁴

In short, there is a moral argument and a practical argument. In moral terms, requiring a doctor to consult with a Deaf patient and to give the patient's choice of auxiliary aid due deference, or "primary consideration," is an expression of the humanistic and progressive values that drive enforcement of the ADA: inclusion and integration of people with disabilities in the mainstream of American life. In practical terms, mandating a conversation between doctor and patient may operate to reduce litigation and preserve judicial resources. When people talk and listen to one another, it reduces the chance they end up in court.

273. The concept of "beyond compliance" was pioneered by the Beyond Compliance Coordinating Committee (BCCC), a group of students at Syracuse University "who are working to create and support a positive climate toward disability that values individual difference in all University settings." Beyond Compliance Coordinating Committee (BCCC), <http://bccc.syr.edu> (last visited Aug. 25, 2008). According to the BCCC,

Disability is more than just a physical, sensory, cognitive or mental impairment. Accessibility is more than just compliance with federal and state laws. Disability is about the human condition, and the Syracuse University community will be enhanced by a broader conceptualization of disability that calls for inclusion, equality, and social justice. Thus, compliance with the law is the starting point, not the bottom line, for the University community.

Beyond Compliance Coordinating Committee (BCCC), <http://bccc.syr.edu/bccchistory.htm> (last visited Aug. 25, 2008). A "beyond compliance" mindset is one of inclusion—inclusion of the person with a disability in the community regardless of the cost. Indeed, a cost-benefit analysis is inapplicable because it contravenes the value of inclusion and integration. Thus, the question becomes, "What will it take to include the person with a disability?" and not "How much will this cost me?" or "What is in this for me?" The answer is to look at a variety of auxiliary aids that can be drawn upon according to need.

274. CORY ET AL., *supra* note 272; *see also* C. WRIGHT MILLS, *THE SOCIOLOGICAL IMAGINATION* 226 (1959):

Know that many personal troubles cannot be solved merely as troubles, but must be understood in terms of public issues—and in terms of the problems of history-making. Know that the human meaning of public issues must be revealed by relating them to personal troubles—and to the problems of the individual life. Know that the problems of social science, when adequately formulated, must include both troubles and issues, both biography and history, and the range of their intricate relations.