

Language Access For Deaf and HOH Patients – Patients' Rights & Providers' Responsibilities

For Georgia SHRM Members

Presented by:

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INTRODUCING

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Health Equity – National Thought Leadership

- Selected by the American Hospital Association and Institute for Diversity in Health Management as national consultant to #123forEquity Program.
- Selected by BCBSA as its national vendor for cultural competence training and consulting services
- Selected by America's Essential Hospitals as national vendor/trainer on health equity for their Leadership Fellows Program
- Created nation's first e-learning program on The Law of Language Access in Healthcare (2010).
- Conducted national webinars on the law of language access in health care for the ABA, the AHA and InDemand Interpreting.
- Regularly conduct Language Access Audits for leading hospital clients.
- National and international presentations on The New Science of Unconscious Bias including keynote presentations for the American Medical Association.

Learning Objectives

This webinar will discuss Deaf, limited English proficient (LEP) and hard of hearing (HOH) patients' legal rights to language access and providers' legal obligations to accommodate those rights under the ADA and new section 1557 changes to the ACA. In particular, the webinar will address these issues:

- How are the language access rights of LEP, Deaf and HOH patients different?
- What language access rights do Deaf and Hard of Hearing patients have under the ADA and new Section 1557 changes to the Affordable Care Act?
- What must healthcare providers do to comply with federal language access laws for Deaf and Hard of Hearing patients?
- Who has the legal right to decide what form of language access accommodation will be provided to Deaf and Hard of Hearing patients? Patients or providers?
- New state and federal judicial decisions are affecting the legal rights of Deaf and HOH patients and the legal obligations of providers. How will these decisions change the legal landscape?
- Many Deaf and HOH patients dislike Video Remote Interpreting (VRI). How will recent court decisions affect the use of this rapidly emerging medium and what are language access vendors and the Deaf community doing to improve the effectiveness of VRI?
- What can be done to improve providers' level of preparedness to treat Deaf and HOH patients?
- What are emerging best practices for providing language access to Deaf and HOH patients?

AGENDA

1. Overview of Federal Laws Providing Language Access Rights to Deaf and Hard of Hearing Patients
2. What Must Providers Do to Accommodate Deaf and Hard of Hearing Patients?
3. Recent Issues, Case Decisions and Settlement Decrees
4. Improving Providers' Preparedness to Treat Deaf and Hard of Hearing Patients
5. Questions and Answers

An Overview of Federal Laws Affecting Language Access for Deaf and Hard of Hearing Patients

Overview of Language Access Laws Affecting Deaf and Hard of Hearing

- **Federal language access statutes:**
Section 504 of the Rehabilitation Act of 1973, the ADA
- **Section 1557 ACA anti-discrimination requirements**
- **All 50 states have language access laws**
- **Judicial Case law decisions**
- **Other (Non-Legal but Influential):**
DHHS CLAS Standards, Joint Commission Cultural Competence Standards



Which Federal Disability Discrimination Laws Apply to Hospitals and Health Care Providers?

Federal disability discrimination laws mandate equal access to and an equal opportunity to participate in and benefit from health care services, and effective communication with individuals who are deaf or hard of hearing.

These laws include:

- **Section 504 of the Rehabilitation Act of 1973** – applies to federal health care services and facilities; and health care providers who are also recipients of federal financial assistance, usually provided by direct funding (such as Medicaid) or by federal research grants.
- **Title II of the Americans with Disabilities Act** – applies to all public (state and local) health care providers.
- **Title III of the Americans with Disabilities Act** – applies to all private health care providers.
- **Section 1557 of the Affordable Care Act**

Are Hospitals and Medical Clinics Places of Public Accommodation For Purposes of the ADA?

- Title III of the Americans with Disabilities Act (ADA) prohibits discrimination against individuals with disabilities in places of public accommodation. 42 U.S.C. §§ 12181 – 12189. Private health care providers are considered places of public accommodation. The U.S. Department of Justice issued regulations under Title III of the ADA at 28 C.F.R. Part 36. The Department's Analysis to this regulation is at 56 Fed. Reg. 35544 (July 26, 1991).

Specifically, Which Private Health Care Providers are Covered Under the ADA?

- Title III of the ADA applies to all private health care providers, regardless of the size of the office or the number of employees. 28 C.F.R. § 36.104.
- It applies to providers of both physical and mental health care. Hospitals, nursing homes, psychiatric and psychological services, offices of private physicians, dentists, health maintenance organizations (HMOs), and health clinics are included among the health care providers covered by the ADA.
- If a professional office of a doctor, dentist, or psychologist is located in a private home, the portion of the home used for public purposes (including the entrance) is considered a place of public accommodation. 28 C.F.R. § 36.207.

A photograph of two hands performing a sign language gesture, with the index fingers touching. The hands are positioned in front of a dark grey rectangular area that contains the title text. Above this area is a solid red horizontal bar. The background of the entire image is black.

What Must Providers Do to Accommodate Deaf and Hard of Hearing Patients?

What Legal Duties Do Health Care Providers Owe to Deaf and HOH Patients Under the ADA?

Basic Rule: Health care providers have a duty to provide appropriate auxiliary aids and services when necessary to ensure that communication with people who are deaf or hard of hearing is as effective as communication with others. 28 C.F.R. § 36.303(c).

Is This Obligation Limited to Deaf or Hard of Hearing Patients?

No. A health care provider must communicate effectively with customers, clients, and other individuals who are deaf or hard of hearing who are seeking or receiving its services. 56 Fed. Reg. at 35565. Such individuals may not always be “patients” of the health care provider. They can include “companions.”

- For example, if prenatal classes are offered as a service to both fathers and mothers, a father who is deaf or hard of hearing must be provided auxiliary aids or services to ensure that he has the same opportunity to benefit from the classes as would other fathers.
- Similarly, a deaf parent or guardian of a hearing child may require an auxiliary aid or service to communicate effectively with health care providers, participate in the child’s health care, and to give informed consent for the child’s medical treatment. Classes, support groups, and other activities that are open to the public must be also be accessible to deaf and hard of hearing participants.

What Kinds of Auxiliary Aids and Services Are Required by the ADA to Ensure Effective Communication With Deaf or Hard of Hearing Individuals?

Basic Rule: Auxiliary aids and services include equipment or services a person needs to access and understand aural information and to engage in effective communication. For example, the rule includes qualified interpreters, computer-aided transcription services (also called CART), written materials, assistive listening devices, captioning, or other effective methods of making aural information and communication accessible. 28 C.F.R. § 303(b)(1).

How Does a Health Care Provider Determine Which Auxiliary Aid or Service to Provide to Deaf/HOH Patients?

- The auxiliary aid and service requirement is flexible, and the health care provider can choose among various alternatives as long as the result is effective communication with the deaf or hard of hearing individual.
- An individual who is deaf or hard of hearing likely has experience with auxiliary aids and services to know which will achieve effective communication with his or her health care provider.
- The U.S. Department of Justice expects that the health care provider will consult with the person and consider carefully his or her self-assessed communication needs before acquiring a particular auxiliary aid or service. 56 Fed. Reg. at 35566-67.

Why Are These Auxiliary Aids or Services So Important in Medical Settings?

Auxiliary aids and services are often needed to provide safe and effective medical treatment.

Without these auxiliary aids and services, medical staff run the grave risk of not understanding the patient's symptoms, misdiagnosing the patient's medical problem, and prescribing inadequate or even harmful treatment.

Similarly, patients may not understand medical instructions and warnings or prescription guidelines.

Are there any limitations on the ADA's auxiliary aids and services requirements?

Yes.

The ADA does not require the provision of any auxiliary aid or service that would result in an **undue burden** or in a fundamental alteration in the nature of the goods or services provided by a health care provider. 28 C.F.R. § 36.303(a).

Making information or communication accessible to an individual who is deaf or hard of hearing is unlikely ever to be a fundamental alteration of a health care service.

An individualized assessment is required to determine whether a particular auxiliary aid or service would be an undue burden.

When would providing an auxiliary aid or service be an undue burden?

- An undue burden is something that involves a significant difficulty or expense. (Should be regarded as a limited exception.)
- For example, it might be a significant difficulty to obtain certain auxiliary aids or services on short notice. Factors to consider in assessing whether an auxiliary aid or service would constitute a significant expense include the nature and cost of the auxiliary aid or service; the overall financial resources of the health care provider; the number of the provider's employees; the effect on expenses and resources; legitimate safety requirements; and the impact upon the operation of the provider. 28 C.F.R. § 36.104.
- Even when an undue burden can be shown, the health care provider still has the duty to furnish an alternative auxiliary aid or service that would not result in an undue burden and, to the maximum extent possible, ensure effective communication. 28 C.F.R. § 36.303(f).

Must a health care provider pay for an auxiliary aid or service for a medical appointment if the cost exceeds the provider's charge for the appointment?

- In some situations, the cost of providing an auxiliary aid or service (e.g., a qualified interpreter) may exceed the charge to the patient for the health care service.
- A health care provider is expected to treat the costs of providing auxiliary aids and services as part of the overhead costs of operating a business. Accordingly, so long as the provision of the auxiliary aid or service does not impose an undue burden on the provider's business, the provider is obligated to pay for the auxiliary aid or service.
- In a 2008 New Jersey case (Gerena v. Fogari), a physician refused to honor a patient's request to employ an American Sign Language (ASL) interpreter because the interpreter's charges would exceed the physician's hourly rate. The physician was required to pay a \$400,000 jury verdict (including \$200,000 in punitive damages) in the patient's favor as a result. ("Undue burden" not found where cost of ASL interpreter exceeded provider's own hourly rate.)

Can a health care provider charge a deaf or hard of hearing patient for part or all of the costs of providing an auxiliary aid or service?

No.

A health care provider cannot charge a patient for the costs of providing auxiliary aids and services. 28 C.F.R. § 36.301(c).

Can health care providers receive any tax credits for the costs of providing auxiliary aids and services?

- Eligible small businesses may claim a tax credit of up to 50 percent of eligible access expenditures that are over \$250, but less than \$10,250. The amount credited may be up to \$5,000 per tax year. Eligible access expenditures include the costs of qualified interpreters, CART services, and other auxiliary aids and services. Omnibus Budget Reconciliation Act of 1990, P.L. 101-508, § 44. Please consult with your financial or tax advisor on this issue.

What is the purpose of the ADA's effective communication requirement?

- The purpose of the effective communication rules is to ensure that the person with a vision, hearing or speech disability can communicate with, receive information from, and convey information to, the covered entity. US Department of Justice Civil Rights Division, Disability Rights Section guidance memo on Effective Communication.
- The key to communicating effectively is to consider the nature, length, complexity, and context of the communication and the person's normal method of communication. Id.

U.S. Department of Justice
Civil Rights Division
Disability Rights Section



Effective Communication

Overview

The Department of Justice published revised final regulations implementing the Americans with Disabilities Act (ADA) for title II (State and local government services) and title III (public accommodations and commercial facilities) on September 15, 2010, in the Federal Register. These requirements, or rules, clarify and refine issues that have arisen over the past 20 years and contain new, and updated, requirements, including the 2010 Standards for Accessible Design (2010 Standards).

People who have vision, hearing, or speech disabilities ("communication disabilities") use different ways to communicate. For example, people who are blind may give and receive information audibly rather than in writing and people who are deaf may give and receive information through writing or sign language rather than through speech.

The ADA requires that title II entities (State and local governments) and title III entities (businesses and nonprofit organizations that serve the public) communicate effectively with people who have communication disabilities. The goal is to ensure that communication with people with these disabilities is equally effective as communication with people without disabilities.

This publication is designed to help title II and title III entities ("covered entities") understand how the rules for effective communication, including rules that went into effect on March 15, 2011, apply to them.

- The purpose of the effective communication rules is to ensure that the person with a vision, hearing, or speech disability can communicate with, receive information from, and convey information to, the covered entity.
- Covered entities must provide auxiliary aids and services when needed to communicate effectively with people who have communication disabilities.
- The key to communicating effectively is to consider the nature, length, complexity, and context of the communication and the person's normal method(s) of communication.

ADA – Who Decides Which Aid or Service is Needed?

- The question of who decides which aid or service is needed is slightly different for Title II and Title III entities under the ADA. Source: US Department of Justice Civil Rights Division, Disability Rights Section guidance memo on Effective Communication.
- **Title II entities (public entities) are required to give “primary consideration” to the choice of an aid or service requested by the person who has a communication disability.** Id. The state or local government must honor the person’s choice, unless it can demonstrate that another equally effective means of communication is available, or that the use of the means chosen would result in a fundamental alteration or in an **undue burden** which is defined as significant difficulty or expense.
- **Title III entities (private, non-profit entities including hospitals) are encouraged to consult with the person with a disability to discuss what aid or service is appropriate.** Id.

Who Has the Legal Burden of Establishing Effective Communication – Patients or Providers?

- The ADA places responsibility for providing effective communication, including the use of interpreters, directly on covered entities (medical providers). US Department of Justice Civil Rights Division, Disability Rights Section guidance memo on Effective Communication.
- Covered entities/medical providers cannot require a Deaf or Hard of Hearing patient to bring someone to interpret for him or her. *Id.*
- Generally, providers must utilize the services of a qualified interpreter to establish effective communication with Deaf and Hard of Hearing patients.

Who is Qualified to Be an Interpreter in a Health Care Setting?

- A qualified interpreter is an interpreter who is able to interpret effectively, accurately, and impartially, both receptively and expressively, using any necessary specialized vocabulary. 28 C.F.R. § 36.104. Interpreters providing services in a medical setting may need to be able to interpret medical terminology.
- Note definition of qualified interpreter under Section 1557 of the ACA

In what medical situations should a health care provider obtain the services of a qualified interpreter?

- An interpreter should be present in all situations in which the information exchanged is sufficiently lengthy or complex to require an interpreter for effective communication.
- Examples may include, but are not limited to, discussing a patient's medical history, obtaining informed consent and permission for treatment, explaining diagnoses, treatment, and prognoses of an illness, conducting psychotherapy, communicating prior to and after major medical procedures, providing complex instructions regarding medication, explaining medical costs and insurance, and explaining patient care upon discharge from a medical facility.

Can a health care provider require family members or friends to interpret for deaf or hard of hearing patients?

Generally No. A covered entity can only rely on a companion (adult family members, friends or minor children) to interpret in two situations:

- 1) In an emergency involving an imminent threat to the safety or welfare of an individual or the public,** an adult or minor child accompanying a person who uses sign language may be relied upon to interpret or facilitate communication only when a qualified interpreter is not available.
- 2) In situations not involving an imminent threat,** an adult accompanying someone who uses sign language may be relied upon to interpret or facilitate communication when a) the individual requests this, b) the accompanying adult agrees and c) reliance on the accompanying adult is appropriate under the circumstances. This exception does not apply to minor children.

Can a health care provider require family members or friends to interpret for deaf or hard of hearing patients? (continued)

Even under exception (2) (previous slide), covered entities/medical providers may not rely on an accompanying adult to interpret when there is reason to doubt the person's impartiality or effectiveness.

For example:

- 1) It would be inappropriate to rely on a companion to interpret who feels conflicted about communicating bad news to the person or who
- 2) Has a personal stake in the outcome of a situation.

Source: US DOJ, Civil Rights Division Guidance Memo on Effective Communication Under the ADA

Is lipreading an effective form of communicating with individuals who are deaf or hard of hearing?

Not often.

The ability of a deaf or hard of hearing individual to speak clearly does not mean that he or she can hear well enough to understand spoken communication or to lipread effectively. Forty to 60 percent of English sounds look alike when spoken. On average, even the most skilled lipreaders understand only 25 percent of what is said to them, and many individuals understand far less.

Lipreading is most often used as a supplement to the use of residual hearing, amplification, or other assistive listening technology. Because lipreading requires some guesswork, very few deaf or hard of hearing people rely on lipreading alone for exchanges of important information.

Lipreading may be particularly difficult in the medical setting where complex medical terminology is often used. Individuals who are deaf or hard of hearing who rely on lipreading for communication may need an oral interpreter to ensure effective communication.

Do written notes offer an effective means of communicating with deaf and hard of hearing individuals?

- Exchanging written notes may be effective for brief and simple communication. Communication through the exchange of written notes is inherently truncated; information that would otherwise be spoken may not be written. Moreover, written communication can be slow and cumbersome. If a health care provider is communicating less or providing less information in writing than he or she would provide when speaking to a patient, this is an indication that writing to communicate is not effective in that context.
- Understanding written material may also depend on the reading level or literacy skills of the individual. The reading level of deaf and hard of hearing individuals is as variable as the reading levels found in the general population. Additionally, for some deaf and hard of hearing people, American Sign Language (ASL) is their first language. Because the grammar and syntax of ASL differs considerably from English, exchanging written notes may not provide effective communication between a deaf or hard of hearing patient and a health care provider. For some deaf or hard of hearing individuals, the services of a qualified sign language interpreter offer the only effective method of communication.

Common ADA Violations

- Failure to provide **any** language access services.
- Failure to provide **competent/qualified** interpreters.
- Requiring the Deaf or hard of hearing patient to bring someone to interpret for him or her.
- Failing to provide an accommodation that establishes effective communication.
- Failure to provide language access services in a **timely** manner.
- Failure to provide language access services to “companions” of Deaf and hard of hearing patients.
- **Charging** patients for language access services or refusing to provide an accommodation if it costs more than the provider’s hourly fee.
- **Insisting that patients provide their own interpreters.** (Conditioning the receipt of medical services on patients providing their own interpreter.)
- **Failing to inform** patients of their legal right to language access services at no cost to them.



Recent Case Law Decisions Affecting Deaf People's Language Access Rights

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Key Cases to be Discussed

1. Liese v. Indian River Cty. Hospital., 701 F.3d 334, (11th Cir. 2012)
Including subsequent DOJ retaliation claim vs MD in the case.)
2. Martin v. Halifax Healthcare Systems, Inc., (U.S. Dist. Ct. (Middle District of Florida (Orlando), 2014) No.6:2012cv01268 – Document 101.
3. Silva v. Baptist Hospital of Miami, Inc., --- F.3d ---- (2017) WL 1830158
4. Settlement Agreement Between the United States of America and Franciscan St. James Health (2014)

Note: There are 13 appellate courts that sit below the U.S. Supreme Court. They are called the U.S. Courts of Appeals. The United States Court of Appeals for the Eleventh Judicial Circuit has jurisdiction over federal cases originating in the states of Alabama, Florida and Georgia. The circuit includes nine district courts with each state divided into Northern, Middle and Southern Districts.

Liese v. Indian River Cty. Hosp. Dist. (11th Circuit, 2012)

Liese v. Indian River Cty. Hosp. Dist, 11th Circuit, 2012

- **Facts:** Susan and James Liese both suffer from severe hearing impairments. (One deaf, one hard of hearing.) Plaintiffs brought this suit against Indian River Memorial Hospital (IRMH) on grounds of discrimination/ineffective communication.
- **Laws Involved:** Plaintiffs brought this lawsuit alleging unlawful discrimination under Section 504 of the Rehabilitation Act of 1973.
- **Posture:** Plaintiffs challenged the district court's order granting summary judgement in favor of defendant IRMH.
- **Issues:** 1) Did IRMH intentionally discriminate against plaintiffs under Section 504 of the Rehabilitation Act?; 2) Were the actions of doctors and nurses employed by IRMH attributable to the Hospital for purposes of liability?
- **Result:** The 11th Circuit reversed the district court and held for plaintiffs on both questions (actions of doctors/nurses were attributable to Hospital for purposes of liability and these actions constituted intentional discrimination). Remanded to district court for determination of plaintiffs' compensatory damages.

Liese v. IRMH (2012) – District Court Decision & Holdings

- 1. District Court granted summary judgement to defendant hospital on all claims.** It found that plaintiffs could not establish the required element of discriminatory intent where the hospital had a policy in place regarding communication barriers with deaf and hard of hearing individuals and conducted employee training on the issue. While IRMH may have been negligent, negligent conduct was not sufficient to establish liability under Section 504 of the Rehabilitation Act of 1973.
- 2. The 11th Circuit reversed, holding that IRMH had violated plaintiff's rights to effective communication under Section 504** by failing to provide “appropriate auxiliary aids” in violation of the RA and 45 C.F.R. 84.52(d)(1). The court noted that the determination of appropriate auxiliary aids was “inherently fact-intensive” and therefore not appropriate for S/J.
- 3. The 11th Circuit held that “the simple failure to provide an [ASL] interpreter upon request” did not violate plaintiffs rights under the RA.** “Construing the regulations in this manner” the court said, “would substitute “demanded” auxiliary aid for “necessary” auxiliary aid.” (Implication: provider has ultimate right to decide approp. auxiliary aid.)

Liese v. IRMH (2012) – 11th Circuit Decision/Holdings

4. According to the 11th Circuit, **“the proper inquiry is whether the auxiliary aid that a hospital provided to its hearing-impaired patient gave that patient an equal opportunity to benefit from the hospital’s treatment.”**
5. “Whether a particular aid is effective in affording a patient an equal opportunity to benefit from medical treatment largely depends on context, including principally, the nature, significance, and complexity of the treatment.”
6. The 11th Circuit concluded that, in the context of emergency surgery, “the hospital’s use of written notes, body gestures, and lipreading was ineffective in ensuring that a hearing-impaired patient received an equal opportunity to benefit from the hospital’s treatment.”
7. Similarly, the 11th Circuit concluded that the hospital’s use of lipreading, written notes and pantomiming was insufficient to assure that plaintiff understood the risks of the medical tests, general anesthesia and the risks associated with emergency laparoscopic surgery.

Liese v. IRMH (2012) – 11th Circuit Decision/Holdings

8. The final legal issue in the case was whether the actions of IRMH's medical personnel could be attributed to the Hospital so that the Hospital could be said to have acted with "deliberate indifference".
9. The 11th Circuit held that IRMH doctors' actions could be attributed to the hospital because they had complete discretion about whether to provide the Liese's with an interpreter or other auxiliary aid. Further, because they had supervisory authority, doctors could override nurse's decisions not to provide an auxiliary aid.
10. The Court specifically faulted IRMH's language access policy and training programs for giving doctors and nurses no guidance or recommendation as to when doctors or nurses should use auxiliary aids. The training on MARTTI dealt with how to use MARTTI not when to use it.

Liese v. IRMH (2012) – 11th Circuit Decision/Holdings

11. Having found that the doctor's actions were attributable to the hospital, the 11th Circuit concluded that the Hospital acted with deliberate indifference where a Dr. Perry: a) knew that Liese's ability to read lips was limited and that she had requested an interpreter on several occasions. Despite that knowledge, he ignored her requests, "laughed at her and made exaggerated facial movements."; b) Dr. Perry had the authority to remedy the failure to provide an interpreter; and c) his knowledge of Liese's need for an interpreter and his deliberate refusal to provide one "satisfied the deliberate indifference standard."
12. Nevertheless, IRMH argued that it should not be liable for Dr. Perry's actions because it had a policy on effective communication with deaf and hard of hearing patients.
13. The 11th Circuit found this argument "unconvincing" because IRMH's policies "did not provide any guidelines or recommendations about when or whether the Hospital staff should provide auxiliary aids." Instead, "IRMH delegated complete discretion to its staff."

Aftermath: DOJ ADA Retaliation Claim vs. Dr. Brown

1. The 11th Circuit decided the Liese case v IRMH on November 13, 2012. Subsequently, on July 29, 2013, the U.S. Department of Justice filed a lawsuit against one of the doctors (Hal Brown) involved in the case.
2. According to the Justice Department's complaint, the doctor and medical practice terminated Mr. and Mrs. Liese as patients because the couple pursued ADA claims against a hospital for not providing effective communication during an emergency surgery.
3. Upon learning of the Liese's lawsuit against the hospital, Dr. Brown, who was the Liese's primary doctor, terminated them as patients.
4. According to Jocelyn Samuels, then Acting Assistant General for DOJ's Civil Rights Division, "A person cannot be terminated as a patient because he or she asserts the right [under the ADA] to effective communication at a hospital."
5. The ADA makes it unlawful to "coerce, intimidate, threaten or interfere with any individual exercising rights protected by the ADA."

Martin v. Halifax Healthcare Systems (U.S. District Court, Middle Florida, 2014)

Martin v. Halifax Healthcare Systems, US Dist. Ct., 2014

- **Facts:** All three Plaintiffs are completely deaf, and the primary mode of communication for each of them is American Sign Language. All three (separately) had dealings with Halifax Hospital Medical Center (“Halifax Hospital”), a hospital in Volusia County, Florida. All three contend that the Defendants failed to provide live sign language interpreters during at least some portions of their stay.
- **Laws Involved:** Plaintiffs brought this lawsuit alleging unlawful discrimination in violation of Title III of the Americans With Disabilities Act, Section 504 of the Rehabilitation Act of 1973, Title II of the Americans With Disabilities Act, and the Florida Civil Rights Act.
- **Result:** the U.S. District Court of Middle Florida granted summary judgment for defendant hospital on all claims. A party is entitled to summary judgment when the party can show that there is no genuine issue as to any material fact. Fed.R.Civ.P. 56(c).

Martin v. Halifax Healthcare (2014) – Key Facts

1. Each Plaintiff requested that Halifax Hospital provide a live ASL interpreter to assist their communication with hospital staff.
2. Plaintiff Martin, who was brought in for treatment of a minor head injury, was never provided a live interpreter.
3. Plaintiff Gervarzes, whose pregnant daughter was at Halifax Hospital to deliver her baby, was provided an interpreter on some occasions but testified that “[o]n many occasions, no interpreter was present”.
4. Plaintiff D’Ambrosio was brought into the emergency room in the throes of a serious heart attack. D’Ambrosio was provided with an interpreter on some occasions, but on others – including when D’Ambrosio first arrived, and had to undergo an emergency cardiac catheterization – no interpreter was present.
5. On those occasions when no interpreter was present, hospital personnel communicated with the Plaintiffs by other means, including written notes, gestures, and in some instances “Lifelinks,” a video relay interpreting service.

Martin v. Halifax Healthcare (2014) – Holdings

1. The Plaintiffs argued that “anything aside from an ASL interpreter was inappropriate for treatment or a hospitalization involving complicated medical procedures and terminology.”
2. In response, the U.S. District Court for Middle Florida stated that: “the Plaintiffs have not cited, and this Court has not uncovered, any precedent obligating a hospital to provide a live ASL interpreter on every occasion when medical personnel wish to communicate with a deaf person.”
3. According to the court: “Plaintiffs have not provided any evidence ... that any of them was excluded from participating in any service, program, or activity, or denied the benefits thereof, or discriminated against.”
4. “For instance”, the court said, “there is no evidence that the alternative methods of communication employed by Halifax Hospital were insufficient to allow any Plaintiff to understand their circumstances and treatment as well as they would have understood them if a live ASL interpreter had been utilized. Similarly, there was no testimony or other evidence that any Plaintiff would have reached a different decision about treatment options or reached a more beneficial result if the medical providers had only communicated via a live ASL interpreter.”

Martin v. Halifax Healthcare (2014) – Comments

1. Legal commentators were quick to contend that the decision in this case stands for the proposition that a “hospital does not have to provide a live interpreter for a deaf patient in the throes of a serious heart attack where other effective means of communication were provided.” Seyfarth Shaw article posted on the firm’s website on April 21, 2014.
2. On the one hand, the ruling appears to comport with ADA regulations stating that a covered entity is not required to provide an individual’s requested auxiliary aid or service so long as the accommodation that is provided results in effective communication that is timely and protects the privacy and independence of the individual with a disability.
3. On the other hand, the ruling seems inconsistent with the view commonly expressed in many other 11th Circuit cases that context matters when deciding upon an appropriate means of accommodation. As the 11th Circuit would later state in *Silva*, “the type of auxiliary aid necessary to ensure effective communication [should include] the nature, length, and complexity of the communication involved and the context in which the communication is taking place.”

Martin v. Halifax Healthcare (2014) – Comments

4. It is important to remember that this case was decided by a U.S. District Court and does not carry the weight of an 11th Circuit decision.
5. It is likely that this case was wrongly decided. In Silva, (a 2017 11th Circuit case), the court stated that “effective communication claims often presents questions of fact [that should] preclude summary judgement. (citing Liese v. Indian River Cty. Hosp. Dist.) As a result, the Martin court was probably wrong to grant summary judgment to defendants in this case without further exploration of whether the accommodations which the hospital offered were effective in communicating with plaintiff in the emergency medical circumstances surrounding his heart attack.
6. The 11th Circuit may have signaled the limited influence of this case by never mentioning it in its later, more comprehensive ruling in Silva which involved similar legal issues.
7. Finally, any reading of Martin could not fail to recognize how clumsily it was pled and argued by plaintiffs’ counsel who failed to demonstrate that defendants (1) received federal financial assistance or (2) jointly owned, operated, or financed Halifax Hospital.

Silva v. Baptist Memorial Hospital of Miami (11th Circuit, 2017)

Silva v. Baptist Hospital of Miami, 11th Circuit, May 8, 2017

- **Facts:** Plaintiffs were two profoundly deaf individuals who presented at Defendants' hospitals on multiple occasions but allegedly could not communicate effectively with hospital staff because the auxiliary aids or services offered (including VRI) failed to establish "effective communication."
- **Laws Involved:** Plaintiffs brought this lawsuit alleging unlawful discrimination under Title III of the ADA and Section 504 of the Rehabilitation Act of 1973.
- **Posture of Case:** District Court awarded summary judgment to Baptist Hospital for three reasons: 1) plaintiffs lacked Article III standing because they did not show that they were likely to return to the hospitals in the future; 2) plaintiffs failed to show that communication difficulties resulted in actual adverse medical consequences and 3) plaintiffs ineffective communication claim was foreclosed where evidence showed that plaintiffs communicated their chief medical complaint and understood their treatment plan and discharge instructions.
- **Result:** the 11th Circuit reversed on all three issues. Remanded back to District Court for a decision on damages. (Plaintiffs required to show that hospital was deliberately indifferent to their needs in failing to ensure effective communication.)

Silva v. Baptist Hospital of Miami (2017) – Key Facts

1. Plaintiffs are deaf and communicate primarily in American Sign Language (ASL).
2. Defendants are two hospitals and their parent organization, Baptist Health.
3. Plaintiffs visited Defendant's hospitals numerous times. They requested live, on-site ASL interpreters for most visits, but Defendants chose to rely primarily on Video Remote Interpreting (VRI) or family members as interpreters.
4. The VRI machines routinely suffered from technical difficulties that either prevented the device from being turned on, or otherwise resulted in unclear image quality, thereby disrupting the message being visually communicated on the screen. When the VRI machine malfunctioned or was unavailable, hospital staff would often rely on family-member companions for interpretive assistance or exchange hand-written notes with Plaintiffs. Sometimes, an on-site ASL interpreter was provided.

Silva v. Baptist Hospital of Miami (2017) – Holdings

- 1. Plaintiffs Have Standing for Injunctive Relief Under the ADA.** The district court held that Plaintiffs lacked Article III standing since “it is merely speculative that Plaintiffs will return to Defendant’s hospitals and that the VRI technology will continue to malfunction in the future.” The 11th Circuit disagreed holding that plaintiffs were likely to return to Defendant’s hospitals because of the location of their doctors, the fact that Defendants had all of their medical records and history, the hospitals’ proximity to Plaintiff’s home and the substantial history of prior care and treatment at Defendant’s hospitals. The court also noted that Plaintiffs had “visited Defendant’s facilities dozens of times in the years preceding this lawsuit and Plaintiff Silva had recurring health issues which made future visits likely”. Further, the court noted that “Plaintiffs routinely experienced problems with the VRI devices not working at all or failing to transmit a clear screen image.” Consequently, there was “good reason to believe that [VRI problems] will continue to happen at Defendant’s facilities when Plaintiffs do return.”

Silva v. Baptist Hospital of Miami (2017) – Holdings

2. **Proper Inquiry Is Whether Hospitals Established Effective Communication, Not Whether Plaintiffs Suffered Adverse Medical Consequences.**
 - A. The district court relied on Plaintiff's failure to prove that any communication difficulties resulted in a misdiagnosis, incorrect treatment, or other adverse medical consequences.
 - B. The 11th Circuit concluded that these were not the appropriate tests for evaluating effective communication claims. Instead, "the correct standard examines whether the deaf patient experienced an impairment in his or her ability to communicate medically relevant information with hospital staff."
 - C. According to the 11th Circuit, "The ADA and RA focus not on quality of care or the ultimate treatment outcomes, but on the equal opportunity to participate in obtaining and utilizing services."
 - D. The 11th Circuit relied on McCullum v. Orlando Reg' Medical Center (11th Cir. 2014) and Liese v. Indian River Cty Hosp. Dist. (11th Cir. 2012) to support its holdings.

Silva v. Baptist Hospital of Miami (2017) – Holdings

3. **Providers, Not Patients, Have Ultimate Decision-Making Authority to Determine the Appropriate Form of Accommodation.**
 - A. According to the 11th Circuit, “deaf patients are [not] entitled to an on-site interpreter every time they ask for it.”
 - B. “If effective communication under the circumstances is achievable with something less than an on-site interpreter, then the hospital is well within its ADA and RA obligations to rely on other alternatives.”
 - C. **“Indeed, the implementing regulations clarify that “the ultimate decision as to what measures to take rests with the hospital”** citing 28 C.F.R. 36.303(c)(1)(ii)
 - D. In a footnote, the 11th Circuit stated: **“We stress again that ... [t]he hospital ultimately gets to decide, after consulting with the patient, what auxiliary aid to provide. But whatever communication aid the hospital chooses to offer, the hospital must ensure effective communication with the patient.”**

Silva v. Baptist Hospital (2017) – Other Key Points

4. **Effective Communication Claims Regarding the Effectiveness of Auxiliary Aids Are Fact-Intensive & Inappropriate for Summary Judgment.**
5. **This case is instructive for its multiple examples of ineffective communication. For example, it was ineffective communication to:**
 - A. Conduct tests, perform procedures and prescribe medication for a Deaf and Hard of Hearing patient (whose preferred method of communication was ASL) while attempting to communicate with her using friends and family (none of whom were fluent in ASL).
 - B. Communicate with a Deaf and Hard of Hearing patient through written notes and gestures where plaintiff testified that she was “unable to understand most of what was being communicated through these means.”
 - C. Require a Deaf and Hard of Hearing patient to sign medical forms without having a qualified medical interpreter present to explain the informed consent forms and recommended medications.
 - D. Require the patient to wait a long time (over an hour) for an interpreter to arrive without any way to communicate with medical personnel in the meantime.

Silva v. Baptist Hospital (2017) – Other Key Points

5. **This case is instructive for its multiple examples of ineffective communication. For example, it was ineffective communication to:**
 - E. Fail to provide another form of communication during a prenatal exam (that was unable to detect any fetal movement) where VRI failed and no further effort was made to communicate with the patient.
 - F. Fail to provide another form of communication between a Deaf patient and hospital staff where the VRI technology either failed to function, had a bad connection, would freeze or where there was a substantial lag time in communication and/or poor image quality.
 - G. Fail to document the use (date/time/personnel) of VRI.
 - H. Fail to provide a qualified ASL interpreter to a Deaf companion of a patient (his father) who suffered a heart attack and was forced to undergo emergency surgery. The hospital relied on a family member instead.

Silva v. Baptist Hospital (2017) – Other Key Points

5. This case is instructive for its multiple examples of ineffective communication. For example, it was ineffective communication to:
 - I. Rely on a Deaf patient's father and wife to communicate with him during two separate situations where he was in a hospital ED suffering "excruciating pain from kidney stones" and "pain from a broken rib".
 - J. Fail to provide patient's Deaf son with a qualified ASL interpreter in a hospital ED where his father was suffering a severe heart attack. Instead, the hospital relied on the patient's niece (a family member herself) who was "crying and grieving" in ways that made her "emotionally compromised to act as an interpreter."
 - K. Fail to cure defects in hospital staff's knowledge of how to plug in or operate a VRI machine.

Silva v. Baptist Hospital (2017) – Other Key Points

6. Other Key Legal Points.

- A. **To be a proper defendant under the ADA or the RA, one does not have to be a direct-service provider.** Defendants argued that all claims against Baptist Health were improper because it is the parent organization to the two hospitals involved in the case and because it was not, itself, a medical facility that treated the plaintiffs. The 11th Circuit disagreed stating: “There is no rule that a covered entity under the ADA or RA must be the direct service-provider – in fact the ADA addresses itself to those who own, lease, or operate a place of public accommodation.” (citing 42 U.S.C. 12182(a).
- B. **Neither the ADA nor the RA provides a statute of limitations.** Consequently, courts must apply the “most analogous state statute of limitations – typically that used for personal injury actions.
- C. **To obtain compensatory damages, plaintiffs must prove that Defendants exhibited deliberate indifference.** Specifically, plaintiff must show that defendant knew that harm to a federally protected right was substantially likely and failed to act on that likelihood.”

Silva v. Baptist Hospital (2017) – Other Key Points

6. Other Key Legal Points.

- D. Hospitals and physicians may pay a big price for failing to document their attempts to provide “effective communication”. In this case, the hospital failed to document its attempted use of VRI on multiple occasions. The plaintiffs’ detailed notes of the hospital’s repeated failure to provide effective communication were better than the hospital’s own records.
- E. Providers should be cautious about what they document in the patient’s medical record. In this case, a clinical report from the attending M.D. noted that the patient’s deafness “limited” the medical evaluation. The district court dismissed this evidence but the 11th Circuit took it as an admission and as direct evidence of ineffective communication.
- F. A reasonable jury could have concluded that a Deaf patient acted reasonably in refusing VRI as an auxiliary aid where, on numerous past occasions, the device either had not worked or the “screen images were corrupted or unclear.”

U.S. v. Franciscan St. James Health Settlement Decree (2014)

U.S. v. Franciscan St. James Health – Settlement Decree (2014)

- **Facts:** Complainant is deaf and communicates primarily through sign language. She was admitted as a patient at the Chicago Heights hospital in September 2011. (St. James owns a number of Chicago hospitals including Chicago Heights.) During her four day stay, she received numerous tests and was seen by various doctors. Complainant alleged that, on multiple occasions, she requested, but was not provided, a sign language interpreter so she could communicate with Chicago Heights' medical personnel about her condition.
- **Laws Involved:** This matter was initiated by a complaint filed with the United States DOJ against St. James, alleging violations of Title III of the Americans with Disabilities Act (ADA). 42 U.S.C. §§ 12181-12189, and its implementing regulation, 28 C.F.R. Part 36. Specifically, the Complainant, alleged that St James failed to provide sign language interpretive services when necessary to ensure effective communication.
- **Result:** The US Department of Justice investigated and determined that St. James denied the Complainant appropriate auxiliary aids and services necessary for effective communication during her treatment at Chicago Heights. St. James disputed the DOJ findings but agreed to pay \$70,000 in compensatory damages and agreed to implement the required changes detailed in the 16-page settlement decree.

Settlement Terms: U.S. v. Franciscan St. James Health – (2014)

Under the settlement agreement, St James will ensure that its hospitals:

- Provide auxiliary aids and services, including sign language interpreters, to people who are deaf or hard-of-hearing, within prescribed time frames and free of charge;
- Designate an ADA Administrator;
- Utilize their grievance resolution systems to investigate disputes regarding effective communication with deaf and hard of hearing patients;
- Post notices of their effective communication policy;
- Train hospital personnel on the effective communication requirements of the ADA;
- File compliance reports with the Department of Justice; and
- Pay damages in the amount of \$70,000.00 to the complainant.

Exhibit A: Model Communication Assessment Form

We ask this information so we can communicate effectively with Patients and/or Companions. All communication aids and services are provided FREE OF CHARGE. If you need further assistance, please ask your nurse or other Hospital Personnel.

Date:

Name of Patient or Companion:

Nature of Disability:

- Deaf
- Hard of Hearing
- Other: _____

Relationship to Patient:

- Self
- Family member
- Friend
- Other: _____

Exhibit A: Model Communication Assessment Form

Does the person with a disability want an onsite professional sign language or oral interpreter?

Yes. Choose one (free of charge):

- American Sign Language (ASL)
- Signed English
- Oral interpreter
- Other. Explain:-----

No.

Which of the following would be helpful for the person with a disability? (free of charge)

- TTY/DD (text telephone)
- Assistive listening device (sound amplifier)
- Qualified note-takers
- Writing back and forth
- Other. Explain:-----

Exhibit A: Model Communication Assessment Form

If the person with a disability, or the Patient who the person with a disability is with, is ADMITTED to the hospital, which of the following should be provided in the patient room?

- Video remote interpreting
- Telephone handset amplifier
- Telephone compatible with hearing aid
- TTY/DD
- Flasher for incoming calls
- Paper and pen for writing notes
- Other. Explain:-----

Any questions?

Please call (voice), _____ (TTY), or visit us during normal business hours. We are located in room _____

A man with short dark hair, wearing a white lab coat over a light blue shirt and a yellow patterned tie, is looking directly at the camera. To his right is a laptop screen displaying the 'INDEMAND Interpreting' logo, which includes a yellow diamond icon. The background is a blurred blue and white.

Q&A

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Thank You!