Executive Summary

The Americans with Disabilities Act (ADA) applies to public and private hospitals in the United States. Many hospitals have struggled to understand what the ADA requires of them with respect to deaf patients and their families. Recognizing the importance of effective communication to quality health care, the U.S. Department of Justice has developed a model program for hospital compliance with the ADA as it concerns deaf individuals. The program requires hospitals to provide:

- availability of sign language interpreting services, both on-demand with video interpreting services and on-call with live interpreters,
- aids and services such as text telephone (TTY/TDD) availability similar to voice phone availability for hearing individuals,
- policies, procedures and intake forms to provide a communication assessment upon entry by a deaf patient or family member,
- a complaint resolution/grievance procedure regarding all of the above, and
- training of hospital personnel to accommodate the needs and preferences of deaf patients and family members.

This whitepaper provides additional detail on the applicability of the ADA to hospitals and other health care facilities, and the efforts by the Department of Justice to clarify the ADA’s requirements relative to deaf individuals.

A continuously evolving legal landscape makes it a challenge for even the most astute hospital administrators to stay on top of all the legal and compliance obligations they face. One area where this is especially true is in the field of non-discrimination and accessibility for the disabled. In this area, a particular challenge for health care providers has been the rapid evolution in recent years of requirements surrounding the unique communication needs of deaf patients and their family members under the Americans with Disabilities Act (ADA). This paper addresses those requirements, with goal of enabling health care facility administrators to determine whether any action may be required to bring their facilities into compliance with the ADA.

**Hospitals are Subject to the ADA**

The Americans with Disabilities Act of 1990 (ADA) is a Federal civil rights law that protects individuals with disabilities. It is intended to prohibit discrimination in a broad range of contexts, including

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1 Title II of the ADA covers government owned or operated hospitals, while Title II governs private entities.
employment, state and local government services, and equal access to “places of public accommodations,” among other things.

Hospitals in the United States are considered “places of public accommodation” and are subject to the requirements of the ADA, regardless of whether they are public or private. In fact, the ADA covers “all hospital programs and services, including emergency room care, inpatient and outpatient services, surgery, clinic services, educational classes, even cafeteria and gift shop services.”

**“Effective Communication” Must Be Facilitated for Deaf Patients and Family Members**

One of the most important elements in providing equal health care access under the ADA for the deaf is “effective communication” – i.e., assuring that deaf individuals have access to any aural communications that ordinarily would be part of any hospital service, program or activity that is as clear, complete, interactive and expressive as communications ordinarily are with hearing patients. In essence, wherever patients (or their family members) who are deaf interact with any of its staff members, a hospital is required under the ADA to provide effective communication. Effective communication is essential to ensure that a deaf individual has an equal opportunity to receive the full benefit of a hospital service, program, or activity.

Because quality health care is impossible to deliver without effective communication between patient and provider, the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) also has adopted similar requirements for hospital accreditation. Without effective communication, patients are denied the fundamental right of involvement in care decisions, and care givers are denied accurate assessment and treatment information.

Effective communication for deaf individuals usually requires the provision of “auxiliary aids and services.” Consequently, the ADA requires a hospital to implement policies, practices and procedures enabling it to provide necessary “auxiliary aids and services.”

**Hospitals Are Required to Provide Certain Identified Auxiliary Aids and Services**

While most hospital administrators now understand that the ADA requires them to provide some method of communication to interact with individuals who are deaf, many are unaware of which aids or services have been required by the Act, the courts, and the U.S. Department of Justice, which is charged with enforcement.

Among the required aids and services, qualified sign language interpreting services are given particular importance by the deaf community and the Department of Justice as essential for effective communication between caregivers and deaf patients (as well as deaf family members of hearing patients). Because it is so important, the Attorney General of the United States has made it a priority for the Department of Justice to demonstrate clearly the obligation of health care providers to facilitate and provide sign language interpreting.

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4 U.S. Dept. of Health and Human Services, Office for Civil Rights Fact Sheet, “Effective Communication for Persons Who Are Deaf or Hard-of-Hearing.”
6 28 C.F.R. § 36.303(c)
This conscious effort by the Department of Justice has resulted in a significant number of federal lawsuits successfully pursued against hospitals for failure to provide auxiliary aids and services necessary for effective communication. Of 114 reported ADA enforcement cases undertaken by the Department of Justice in recent years, the largest number (sixty-five) involved the provision of auxiliary aids and services required to ensure effective communication for individuals who are deaf. In most cases, health care providers were not providing live or remote video enabled sign language interpreters, text telephones (TTYs) or other communication devices.  

One product of that enforcement effort was a “model consent decree” that has been followed by virtually every federal court since its publication (as well as state courts and enforcement agencies). As explained by the Attorney General, the model Consent Decree “included detailed provisions for the implementation and administration of a program to ensure effective communication with persons with hearing disabilities.”

According to the Attorney General, the Department of Justice program requires the following of hospitals:

“[1] to provide both on-site interpreters and interpreters appearing through video interpreting services where necessary for effective communication; [2] to provide other auxiliary aids and services as necessary [including TTY/TDD telephone capabilities]; [3] to modify medical and intake forms to ensure that once a deaf or hard-of-hearing patient or family member enters the hospital, the hospital makes a communication assessment and, if necessary, a reassessment of the patient or family member; [4] to maintain a complaint resolution/grievance procedure regarding the provision of auxiliary aids and services; [5] and to train hospital personnel to accommodate the communication needs and preferences of deaf or hard-of-hearing patients and family members.”

**Common Misconceptions (Small Deaf Populations/Cost Concerns Do Not Excuse Compliance)**

In the past, many health care providers were content to rely on methods of communication such as reliance on family members or friends to provide sign language interpreting, lip-reading and passing of written messages between the parties (either in the form of handwritten notes, or sometimes via electronic devices). These approaches pose a variety of problems. Family members, friends or even hospital staff with some proficiency in American Sign Language typically do not meet the ADA’s requirement that interpreters be “qualified” to interpret in medical settings. As a result, “The Department also made clear that, except in very limited instances, medical providers should not ask family members or other representatives to interpret for a person who is deaf or hard of hearing because of potential emotional involvement, considerations of confidentiality, and limited interpreting skills.”

Other common justifications given by hospital administrators before the ADA for relying on methods that the Department of Justice and the court have since determined to be unacceptable include the small size of the deaf population the hospital believed it serve, or the infrequency of deaf patient visits. But, the ADA does not recognize those factors and health care providers believing they could escape ADA requirements on these bases have learned otherwise in courtrooms across the country. In fact, in one recent case, after a

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9 Id. at page 28.
10 Addressing video interpreting services in detail, the Attorney General explained, new technologies may allow health care providers to engage qualified sign language interpreters from remote locations “more quickly, economically, and efficiently 24 hours a day.” Id. at page 27.
11 Id. at page 28.
12 Id.
three week trial a $400,000 verdict was entered against a physician who had not previously had any deaf patients who required “auxiliary aids and services” such as a sign language interpreter, providing a stark demonstration that one need not serve a large deaf population or see deaf patients frequently to be subject to ADA requirements to provide for effective communication.

Under the ADA, a hospital may decline to make the kinds of accommodations required under the Department of Justice program only if it can demonstrate that providing those auxiliary aids or services would “fundamentally alter” the nature of services provided, or would constitute an “undue burden or expense.”

“Undue burden” is defined as a significant difficulty or expense when considered in light of a variety of factors, including the nature and cost of the auxiliary aid or service and the overall financial and other resources of the provider. This has proven to be an extremely high hurdle for providers to clear in the arena of health care services. For example, in the Gerena case referenced above, the defendant was single physician with resources far more limited than virtually any hospital. He argued that providing the auxiliary aids and services required by a deaf patient posed an “undue financial burden.” The court found that the cost of interpreting services in that case did not pose an “undue burden,” even though those costs would have exceeded the total cost of the medical treatment.

At this time, there appear to be no published cases in which the kinds of auxiliary aids and services detailed in the Department of Justice’s program were found to constitute an undue burden on even a small hospital. Hospital administrators would be well advised to view taking such a position as a high-risk approach. Similarly, there are no known cases in which a hospital facility was allowed to escape ADA requirements on the basis that accommodating a deaf patient’s communication needs fundamentally altered the nature of medical care services. To the contrary, since participation and consent are hallmarks of quality health care, failure to provide aids and services necessary to facilitate communication is inherently inconsistent in itself with the nature of the services provided by hospitals.

**Summary and Recommendations – Proactive Compliance is Least Expensive, Most Effective**

The days of hospital facilities dealing with deaf patients on an ad hoc or “make due” basis are over. What once was “good enough” in the eyes of many health care executives, administrators and providers clearly is no longer “good enough” under the Americans with Disabilities Act. The ADA was designed to prevent exactly such approaches because they result in medical care that is less effective and lower quality than that received by hearing individuals. Indeed, hearing individuals on the whole would not accept health care services and programs as historically experienced by deaf individuals.

Federal regulators, the Attorney General and the Department of Justice as a whole have made it clear that they will interpret and enforce the ADA as it relates to hospitals with an eye toward equal participation and quality of care. They should be expected to continue to give little regard to historical custom and practice, or perceived inconvenience or cost in the context of the overall operations of even small hospitals.

The ADA, and the federal regulations implementing it, require that hospitals “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.”

Concerning individuals who are deaf or hard-of-hearing in particular, the ADA requires that policies,

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13 See Irma Gerena v. Robert Fogari, MD., Hudson County Superior Court, NJ (October 9, 2008).
14 28 C.F.R. § 36.104.
15 28 C.F.R. § 36.303(c).
practices and procedures ensure that a hospital is equipped to provide “auxiliary aids and services” necessary for “effective communication.”

A hospital without policies, practices and procedures implementing the program described in the Department of Justice’s model consent decree remain exposed to a variety of risks. Legal action by individuals and/or the federal government can be expensive, and as the defendant learned in the Gerena case, they can be excluded from malpractice insurance coverage. Even when non-compliance is discovered that does not lead to formal legal action, the reputational damage can be significant, and hospital accreditation can be at risk.

Hospitals that proactively evaluate their own ADA compliance and take action on their own initiative to ensure that they have appropriate programs in place typically are able to maintain control of the compliance process. A proper self-evaluation and a reasonably defensible ADA plan on file can not only secure control of the process, but as a result can control costs which otherwise can mushroom quickly. Without a plan, a lawsuit or formal complaint can place the compliance process in the hands of courts or enforcement agencies, leaving the hospital with little budgetary control.

Most importantly, though, ADA compliance is the right thing to do. Most facilities want to accommodate the needs of all individuals regardless of disability. Unfortunately, the ADA’s confusing and ambiguous language and the variety of regulations and published lawsuits make it difficult to understand what is required. The resulting temptation is to take a wait-and-see approach and handle problems as they arise. Unfortunately, this approach means that those who are too embarrassed or unwilling to ask for accommodation are often left out, unable to fully participate in programs, services and activities with others. The quality of care they receive suffers – something no provider wants to see. Now, in the wake of very clear guidance from the U.S. Department of Justice, wait-and-see is no longer a responsible strategy.

16 28 C.F.R. § 36.303(c)