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The Americans with Disabilities Act means more than providing wheelchair ramps wider doorways. It's about attitude. Is your office ADA-compliant?

By Christine A. Hinz

It didn't take an act of Congress for Sharon Kawai, MD, to modify her practice to accommodate the disabled. Long before the Americans with Disabilities Act (ADA) was signed into law in 1990, she knew how important it was for every patient to be able to navigate her office and have access to her services.

Kawai didn't arrive at this juncture just because she thought a federal law eventually would mandate her to assist physically and otherwise challenged individuals—which the ADA has ultimately directed doctors to do. She did it because she knows from personal experience just how difficult it is for those individuals to maneuver around offices and be treated fairly.

Kawai has spina bifida, a condition that has never deterred this plucky practitioner from getting her own needs met or, for that matter, taking care of those of her patients. As a medical director of rehabilitation, she doesn't need the ADA to ensure that every disabled patient at St. Jude Medical Center in Fullerton, California, gets the necessary services or is treated with respect. It's a mindset born of experience.

"I think we people with disabilities want compassion. We want to be treated as equals. Even though we may be paralyzed from the waist down or need an interpreter to hear and translate, we want to be treated with dignity."

What the Law Requires

While no law can legislate that kind of attitude in doctors, the ADA calls for every practice and health entity to at least address equal treatment and opportunity—including medical care—to its disabled patients. To be protected, individuals must be substantially limited in their ability to perform major life activities such as seeing, speaking, hearing, walking, working, or learning.

But what do you need to do to be in compliance with the ADA and what constitutes an undue burden?

Remember first that the law applies to your roles as both an employer and health-care provider. It covers the people you would hire and the patients you would treat by ensuring that your physical facility is accessible and your

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Accommodation

Rebecca N. Gaughan, MD, left, hires sign language interpreters like Cathy Cochran, right, of Deaf Services, regularly in her Olathe, Kansas otolaryngology practice to communicate effectively with her patients.

PHOTOS/DAN WHITE

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policies don't discriminate.

But the ADA is more than about widening your doorways and installing ramps for the wheelchair-bound. The same law that guarantees rights and opportunities to individuals who can't walk protects those who have hearing and visual impairments and mental or chronic conditions such as alcoholism, drug addiction, cancer, and HIV.

This law ensures—by threat of financial penalties or possible lawsuits—that you don't reject a candidate from getting and holding a job or a patient from obtaining your services just because that person has a current or past disability.

Also, while it's specific in its purpose, it's wide in the latitude it gives doctors. You don't have to institute any accommodations that seem "unreasonable" because of their financial or operational effects on your practice. But you must do those things that are deemed "reasonable," even if you have to eat the cost in your overhead and recalibrate your thinking or policies.

For instance, it maybe unreasonable to remodel your entire office including an elevator but very reasonable to outfit one examination room with a high-low table that accommodates wheelchair patients. It maybe unreasonable to have every pamphlet and piece of paper in Braille but reasonable to have your office staff read materials to visually handicapped persons or provide videotapes that have excellent audio.

"You really can't say that a set number of dollars is reasonable or unreasonable," says Daniel L. Icenogle, MD-JD, and a Verona, Wisconsin, family physician. "Every time you're looking at a change, you should also consider other issues. Does the accommodation impact your ability to perform? Does it interfere with other employees? There aren't any real set rules. It's all very much subject to interpretation."

Leveling the playing field

Yet, the size of your practice can determine what you have to do. If you have a staff of 15 or more, you're subject to the ADA's provisions concerning employment. That is, you must make sure that hiring policies don't shut out disabled persons, even though you don't have to give them preferential treatment either.

Sharon Kawai, MD, knows from personal experience how important it is for disabled individuals to be treated with dignity. She made her practice accessible to the disabled long before the ADA mandated to do so.

For instance, while you can't ask if someone has a disability or how severe it might be, you can pursue some questions to ensure that your applicant can perform job-related functions. If, for example, this person has a known psychological disability, you may ask how he (or she) can function effectively in the workplace by getting along with co-workers.

You also can't use pre-employment medical examinations as a tool to screen candidates. In fact, you can only request a physical once you've extended a job offer—and only if you require such exams of everyone.

Similarly, you can't deny employment to someone who has a history of cancer or heart disease or is a recovering alcoholic or rehabilitated drug abuser. But you can require individuals to submit to testing for illegal substances before and during their employment. And if they test positive, you're not required under this law to accommodate them.

You're also not obliged to hire someone if you have to bring a second person on board to cover the tasks he or she can't do because of a disability. But you do have to consider reasonable ways to assist that same individual if he or she fulfills the requirements and is the best candidate.

Reasonable measures to assist an individual may include restructuring jobs, tape-recording notes, or modifying work schedules and equipment. There are a number of ways to assist an employee without breaking the bank or alienating others in whom you've also invested.

If your secretary's disability requires medication that causes drowsiness in the morning, you might create a flex-time policy and work around it. If your new file clerk is hearing impaired, you could provide a sign language interpreter for training and any other special programs or office gatherings. For day-to-day communication, encourage (and pay for) another employee to learn sign or install a video display terminal so everyone can exchange messages.

"This law isn't meant to cause any fundamental alteration in a particular job or the workplace environment as a whole," says Wendy Wilkinson, the project director of Houston's Southwest Disability and Business Technical Assistance Center, one of 10 federally-funded agencies that provide assistance with the ADA. "It's about leveling the playing field."

Meeting patients needs

When it comes to patients, however, the ADA doesn't level the field according to practice size. You can't deny medical services to any disabled person, including those with HIV or hepatitis, unless those services are outside your specialty or pose a direct health and safety threat that can't be reduced by modifying your policies, practices, or procedures.

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Ways to Accommodate

Here are common sense tips that will put you in good stead with your patients—and the Americans with Disabilities Act.

✔ **AVOID POLICIES** that might inadvertently screen disabled patients. For instance, if you require identification for payment by check, don't limit your office staff in accepting only driver's licenses. Your visually and physically impaired patients will thank you for it.

✔ **BE CAREFUL DURING THE HIRING PROCESS** with your questioning of candidates. Never presume that someone who has an impairment is necessarily disabled or not qualified for the job. An impairment must substantially limit an individual in major life activities to make him or her disabled under this law. Just gather the facts as best you can, be open to the possibilities, and then make your choice.

✔ **INTEGRATE YOUR DISABLED PATIENTS** into both your schedule and other practice-sponsored classes or activities. Don't reserve specific appointment times—e.g. Saturday mornings or around lunch—for people who fall under the ADA. Such segregation flies in the face of the law and makes you vulnerable to its penalties.

✔ **EVALUATE YOUR OFFICE** for any architectural barriers. If you're not sure what needs to be changed, have a consulting firm review the inside and outside environments to make suggestions about ramps, curb cuts, wide doorways, and larger bathroom stalls. As a first step, get rid of your shag carpet and install a floor covering that allows wheelchairs to move.

✔ **ASK PATIENTS** for suggestions. They can tell you in a flash what changes or additions would make their visit more fruitful—an adjustable-height examination table, platform scale, staff members to help them. And keep the dialogue going constantly. The same applies to disabled employees. Find out their suggestions before implementing your own solutions. ■

Threat to safety is determined by using current medical knowledge and objective evidence to weigh the nature, severity, and duration of a risk along with the potential for injury and possibility that it can be mitigated with reasonable modifications.

In other words, you may "fire" a patient who is consistently abusive to you or your employees or fails to follow your advice. Yet you can't dismiss or refuse an individual who has a medical condition that makes you uncomfortable but can be treated safely with precautions.

You can't just change the venue of your services and think that you're covered, either. In Bragdon vs. Abbott, the US Supreme Court found a dentist in violation of the ADA because he wouldn't fill the cavity of a patient with HIV unless she agreed to be treated at a local hospital.

She sued, ultimately winning when the dentist failed to show that the condition posed a significant threat to either him or his staff. The court reasoned that by following universal precautions, he could safely treat this patient in his office.

"The argument was that there is a risk involved in treating these patients and the risk would be that the professional would be infected," says Ellen Grabois, JD, LLM, an assistant professor in physical medicine and rehabilitation at Baylor College of Medicine and a member of its Center for Research on Women with Disabilities.

"But the court said 'No.' This isn't true. There are established guidelines and if you follow them you should not be infected by any HIV-positive patient; therefore you can't deny treatment in your office to that patient."

On an entirely different front, you don't have to provide interpreters to people who can't speak English. But you do have to consider qualified signers (preferably those who know American Sign Language and are skilled with medical terms) for those who are hard-of-hearing or deaf.

Under the law, you have the latitude to decide which conversations necessitate an interpreter, even though some would argue that it's just good medical practice to use them at every juncture. Patients requiring these services cannot be assessed a surcharge for this service.

"The law says that you have to provide effective communication," says Rebecca Gaughan, MD, an Olathe, Kansas otolaryngologist, and a member of the Kansas Commission for the Deaf and Hard of Hearing. "But the problem is that most physicians don't know what effective communication to the deaf and hard of hearing is because they don't understand sign language.

"They think that if you just write notes to deaf people, they'll understand English. But only 12 percent of them understand English well. They understand American Sign language, which is a language all its own."

Gaughan has the luxury of close proximity to a school for the deaf so she can

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have an interpreter on site in 10 minutes. She uses five to 10 signers each month, reserving them for when she needs to orient a new patient, diagnose a problem, explain surgery, or get consent for a procedure. She passes when it's just a follow-up appointment and the patient agrees that he (or she) doesn't need someone there.

But it's not so easy for doctors in other parts of her state where interpreters are simply not available. If hiring a signer becomes an undue burden—for any reason—you're in compliance if you use auxiliary aides such as videotext displays and assisted listening devices, which are acceptable under the law.

You aren't required, however, to install telecommunication (TDD or TTY) devices unless your telephone is used by deaf patients on more than an incidental basis. (You are required to provide such devices for hearing and speech impaired employees unless you have an equally effective alternative such as TDD software and a modem for use with a computer.) But, you're not obligated to offer personal hearing devices anymore than you're required to have Braille available for the visually impaired.

That said, however, you still want the clearest communication possible, especially when the discussion turns to more complicated matters—family health history, chronic illness, cancer treatment, surgery, or the symptoms of a heart attack or stroke.

As some doctors and their patients have discovered, the results can be serious, if not deadly, when the exchange goes haywire. Gaughan cites the hearing impaired patient who ended up in the emergency room with high blood pressure and symptoms of a stroke. When an interpreter finally intervened, doctors learned that she had stopped her blood pressure medicine because she misunderstood her doctor's original orders, which weren't communicated in sign.

Not every situation has such deadly potential. With a signer on board, Gaughan finds it much easier just to reassure patients that the poking and prodding she's doing with a scope has a purpose and that the diagnosis isn't lethal. For instance, if one of her deaf patients complains of a cold, she could miss the real purpose of the visit—fear that the hoarseness is cancer—if she just relied on exchanging notes.

"If I didn't have an interpreter, I wouldn't know the patient's fears or concerns because I'd never get that out by writing notes back and forth," she says. "If that person came in to find out if they had cancer and I didn't answer that question, they'd walk out, still not feeling good about themselves."

The bottom line: attitude

While your ultimate goal may be to make your patient feel good, there are dollars-and-cents reasons to comply with the ADA. For instance, when one 19-member New York medical practice refused all interpreter services to the 10 hearing impaired among its 50,000 patients, the state attorney general took issue.

The doctors thought that note-writing and lip-reading, regardless of the nature of the visit, put them in compliance with the ADA. But New York's highest lawyer, on behalf of all hearing-impaired people, sued for both compensatory damages and civil penalties. To avoid trial, the physicians eventually settled for an undisclosed amount.

You can put yourself in the same kind of financial jeopardy with similar missteps involving this law. For failing to provide access to your patient, you could be subject to penalties from both the government and that individual. A federal court may force you to make changes in your operations and still award non-punitive damages and civil penalties of up to $50,000 for the first violation and $100,000 for each subsequent one.

Similarly, if the issue is employment, the courts could force you to hire, reinstate, or promote this person, restoring benefits or providing back or front pay. You may also be asked to pay punitive and compensatory damages if the discrimination was intentional.

On a brighter note, if you comply with the ADA you're eligible for several different federal tax credits.

Under its Disabled Access Tax Credit, the Internal Revenue Service (IRS) allows a tax credit of up to 50 percent (maximum $5,000) of any reasonable expenditures (up to $10,250) to remove architectural barriers or modify or acquire equipment and services to accommodate the disabled. A second provision allows a $15,000 tax deduction for architectural changes.

Similarly, the Work Opportunity Tax Credit gives employers of businesses with 30 or less staffers a credit of 35 percent of the first $6,000 of a new employee's initial year's wages.

But while the federal government is tempting you with incentives, underwriting any accommodation can be a winner in more than dollars. When Icenogle's clinic hired its first disabled employee recently, he and his colleagues decided to install an automatic door to the lounge to accommodate this person's wheelchair. At first glance the cost for such a renovation might have seemed excessive, especially since it would be to assist just one employee.

But administrators took a broader view. They thought the change would benefit everyone, including future disabled employees and current staffers who might be temporarily incapacitated. Seeing the bigger picture made the expense all the more

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reasonable.

You may have the same experience. By accommodating a disability, you might be assisting able-bodied people as well. But more important, you'll be encouraging contented employees and compliant patients like Kawai, whose office and institution provide the accommodations called for under the ADA.

Unfortunately, she doesn't find the same among her own physicians or colleagues who haven't discovered the value of adjustable exam tables, carpet-free floors, wider bathroom stalls, and lower counters that restore dignity to patients.

"Do we need the law? Definitely. We have to get people thinking," she says. "But the actual initiation and implementation of this law comes from the heart. It's a one-on-one revolution that has to happen within every person." ■

Chris Hinz is a Wisconsin-based freelance writer.