

Legal Briefings

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The ADA in the Healthcare Setting

The unique nature of the healthcare setting may impact how the ADA is applied. In this brief, we will examine how the ADA impacts healthcare employees and employers under Title I, and how it impacts patients and healthcare service providers under Title III (and Title II)². Under Title I, the main ADA issues involve the provision of reasonable accommodations to qualified employees and situations where an employee may pose a direct threat to the health or safety of the employee or others, (generally patients). Under Title III, the main issue involves when a healthcare provider must provide a reasonable accommodation or modification for a patient absent undue burden. This may include utilizing a sign language interpreter to provide communication access or modifying policies to provide access for a service animal. In addition, there may be issues regarding legal standing. Recent and pending U.S. Department of Justice Regulations (DOJ) will also be discussed.

I. ADA Title I - Reasonable Accommodations for Qualified Employees

A. Reasonable Accommodations under the ADA in General³

Under Title I of the ADA, prohibited discrimination includes “not making reasonable accommodations to the known physical or mental limitations of an otherwise qualified individual with a disability” absent undue hardship⁴, defined as “an action requiring significant difficulty or expense.”⁵ An employee must show that they are able to perform the essential functions of their position with or without a reasonable accommodation. An employer’s duty to provide a reasonable accommodation is a “fundamental statutory requirement because of the nature of discrimination faced by individuals with disabilities.”⁶ ADA regulations, promulgated by the Equal Employment Opportunity Commission (EEOC), define reasonable accommodations as:



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Modifications or adjustments to the work environment, or to the manner or circumstances under which the position ... is customarily performed, that enable a qualified individual with a disability to perform the essential functions of that position ... or ... enjoy equal benefits and privileges of employment...⁷

The ADA provides a non-exhaustive list of reasonable accommodations that “may include”:

[J]ob restructuring, part-time or modified work schedules, reassignment 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.⁸

Any of these accommodations may be required for an employee in the healthcare setting.⁹

The reasonable accommodation process generally begins with a request for a reasonable accommodation. Any statement by an employee, or someone speaking on behalf of the employee, that lets an employer know that an adjustment or change at work is needed for a reason related to a medical condition is considered a request for a reasonable accommodation under the ADA.¹⁰ The request need not be in writing.¹¹ The request for a reasonable accommodation

triggers the employer’s duty to engage in an informal, interactive process with the employee to determine an appropriate reasonable accommodation.¹² Specific accommodations do not need to be identified by the employee although it is usually best if specific accommodations can be recommended. The employer should give “primary consideration” to the employee’s preferred accommodation although employers are not obligated to provide the requested accommodation as long as an “effective” reasonable accommodation is provided.¹³

B. Healthcare Cases Finding for the Employer

The cases discussed below demonstrate that courts appear more inclined to protect the reasonable accommodation rights of nurses and general technicians as opposed to doctors and surgical technicians, as all but one of the researched cases found in favor of the employer when involving reasonable accommodations for doctors and surgical technicians.¹⁴ This is likely due to the courts’ perception of the relative importance of the services provided by doctors and surgical technicians and the perception that there is less room for job modifications. It should also be pointed out that reasonable accommodations may reduce the risk of harm if properly implemented.

In *Griffin v. Prince William Health System*,¹⁵ a Registered Nurse’s (RN) doctor informed the nurse’s supervisors that she had back problems resulting in a 25-pound lifting limit. The only reasonable accommodation proposed was having

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other nurses help her, which amounted to creating a new position.¹⁶ The court found that lifting 40 pounds was an essential function of the job. The court also noted that one essential function was to respond to emergencies, such as patients falling/fainting, and that Ms. Griffin would not have been able to perform in these situations.¹⁷

In *Stafne v. Unicare Homes*,¹⁸ a nurse with rheumatoid arthritis was greatly limited in her ability to walk. Her doctors stated that she needed a “totally sedentary sit-down job” and was qualified for “seated work only.” Ms. Stafne sought the accommodation of using a motorized scooter called an Amigo on the job. The court affirmed a jury verdict in favor of the defendant, because it found her unqualified to perform her job’s essential functions. Ms. Stafne failed to establish that she could perform job functions such as pushing other people in wheelchairs while using an Amigo or in performing the Heimlich maneuver.¹⁹

In *Rask v. Fresenius Medical Care North America*, a kidney dialysis technician with clinical depression sought a reasonable accommodation due to adverse side effects from the medication used to treat her condition.²⁰ The technician worked two days per week and had a poor attendance history. After being terminated from her job, she filed suit claiming that she should have been provided with a reasonable accommodation under the ADA. The court further found that there was no duty to accommodate Ms. Rask, as she never sufficiently requested a reasonable accommodation.²¹ Ms. Rask had let her employer know that she was “having

problems” with her medication and that she might “miss a day here and there because of it.” The court held that even if Ms. Rask had advised her employer that she had depression and suggested “what a reasonable accommodation might be, no reasonable person could find that Ms. Rask ‘specifically identif[ied]’ her ‘resulting limitations.’²²

In *Rask*, the court put the “initial burden ... primarily upon the employee ... to specifically identify the disability and resulting limitations, and to suggest the reasonable accommodations.”²³ This holding was based on the fact that the ADA requires that employers make reasonable accommodations “to the known physical or mental limitations” of an individual with a disability.²⁴ The court stated, “Where, as here, ‘the disability, resulting limitations, and necessary reasonable accommodations, are not open, obvious, and apparent to the employer, as is often the case when mental disabilities are involved, the initial burden rests primarily upon the employee ... to specifically identify the disability and resulting limitations, and to suggest the reasonable accommodations.’²⁵

The accommodation sought by Rask was the ability to have sudden, unscheduled absences to manage the adverse reaction to her medications.²⁶ The court held that the employee was not qualified as she was unable to perform the essential job function of regular and reliable attendance with or without a reasonable accommodation. The court specifically referenced the importance of regular and reliable attendance when caring for “seriously ill patients.” While the

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technician might personally benefit were the accommodation granted, it would not assist her in performing her job. Therefore, the accommodation request was deemed unreasonable.²⁷

In the case of *Dickerson v. Peake*,²⁸ *et. al.*, the court ruled that a hospital was not required to accommodate a staff nurse's multiple chemical sensitivity to a "growing list of substances" as clinical areas would expose her to these and she offered no accommodation that would avoid all exposure. The nurse asserted that she would have allergic reactions due to floor wax..., chemical products, cleaning products, chemical solvents, scents and odors, fumes of any kind, volatile compounds, molds, rubbing alcohol, and ammonia.²⁹ The court found Dickerson's situation "both unusual and lamentable," but ruled against Dickerson as she "has not identified any position where she could avoid these substances and still perform the essential functions of a Staff Nurse."³⁰

In the case of *Robertson v. Neuromedical Ctr.*,³¹ the court found that no reasonable accommodation was possible for doctor with ADHD who was not able to handle paperwork as this was an essential function of being doctor. The court held that the hospital was not required to hire an administrative assistant for him, and even then, the doctor would have to interpret test results and complete patient charts. The doctor had already made mistakes in patients' charts and dispensing medication. Therefore, the court concluded that the doctor posed a "direct threat," that could not be reduced by a reasonable accommodation, especially as he stated that it was only a

matter of time before he seriously hurt someone.³²

Similarly, in *Stopka v. Med. Univ. of South Carolina*,³³ a doctor with a brain injury read slowly. He requested a scanner that would read paperwork aloud. The hospital looked into it, but found that it would only work for typed information, not handwriting. As most information at the hospital was handwritten, the court granted the employer's motion for summary judgment finding that the requested accommodation would not be effective as it would not significantly improve performance. Hiring an additional person to do the reading was not required under the ADA.³⁴

There are several older reasonable accommodation cases involving doctors and surgical technicians living with HIV, all finding for the employer. However, it is possible that as courts now generally better understand protections now available for people living with HIV, future cases will find in favor of doctors living with HIV. It should be noted that there are some cases where healthcare workers living with HIV were able to proceed with harassment claims.³⁶

C. Healthcare Cases Finding for the Employee

The one case where the court found in favor of a doctor who was denied a reasonable accommodation was actually brought under Title III as it involved an independent contractor, but as the plaintiff worked at the healthcare provider; it is being included in this section. In that case, *Branson v. West*,³⁷ an Illinois district court

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held that a Veterans Administration (VA) hospital violated the federal Rehabilitation Act when it refused to permit its employee, a physician with a spinal chord injury, use of a service dog while at work. The physician, who acquired paraplegia following a horseback riding accident, used the service dog primarily to pull her manual wheelchair so she would not overuse her upper extremities. The physician rejected the hospital's suggestion that she use a motorized wheelchair instead as she thought it would limit her independence. The hospital was unable to demonstrate any an undue burden or threat to health or safety because it already permitted seeing-eye dogs in its facility and other VA hospitals allowed individuals with disabilities to be accompanied by their service animals except where a significant health risk existed or the animal's behavior became disruptive. The court ordered the hospital to allow the physician use of her service dog. The court also ordered that the hospital refrain from attempting to minimize the presence of the dog unless a qualified medical professional determined with specificity the reason the dog would pose a threat to health or safety in the hospital that a human would not pose.³⁸

In contrast to the *Stafne* case discussed above, a court ruled for a nurse with significant restrictions in the case of *Sydnor v. Fairfax County Virginia*.³⁹ In *Sydnor*, a public health nurse had multiple chronic conditions including fibromyalgia, inflammatory arthritis, and back conditions.⁴⁰ After exhausting her leave under the Family Medical Leave Act (FMLA), the nurse still had 20-pound lifting limit, could only stand/walk for 20 minutes

each hour, and was generally limited in her ambulation. She was terminated because lifting was part of the job description, and because administrators were worried about her ability to respond to emergencies. However, defendant offered no evidence to support its position and one doctor's note had said plaintiff could perform her duties with a lightweight wheelchair. For example, defendant stated that plaintiff would be unable to help a seated patient who fainted, but the plaintiff explained that she could "put the patient on the exam table instead of a chair before giving him or her the shot."⁴¹ As the court found no contradictory evidence, it denied defendant's motion for summary judgment.

In the case of *Enica v. Principi*,⁴² plaintiff was an RN of Psychiatry at the Veterans Administration (VA). As a child she was diagnosed with poliomyelitis and now has significant arthritis in her right knee, ankylosis in her right ankle, and one leg that is shorter than the other. She had limitations in walking and was often told that her duties would be modified so that she would not have to walk as much. She was also told that she would not be required to participate in the physical aspect of any crisis intervention, but these accommodations were never fully implemented. The Court held that the VA might have failed to provide Enica with reasonable accommodations for two reasons: 1) Because of evidence that the VA did not actually implement the accommodations it agreed to provide; 2) Because the VA failed to provide a reasonable response once it became clear that the provided accommodations were insufficient. The court denied the VA's motion for summary judgment and allowed

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Enica to proceed with her claim.⁴³

In *Wright v. Hosp. Auth. of Houston County*,⁴⁴ an RN with significant severe hearing loss was placed on leave and subjected to fitness for duty tests after a communication breakdown on the job. It was determined that the communication breakdown was not her fault, but the employer also discovered other communication issues as plaintiff's hearing limitations had increased over time. The nurse challenged those tests as discriminatory, but the court agreed with the employer that there was a legitimate "business necessity" to perform the tests due to a potential direct threat to patient safety if the nurse was unable to hear or communicate, especially in emergency situations. However, the court denied defendant's motion for summary judgment, disputing defendant's assertion that "good hearing acuity" was an essential function simply because it's in job description. As defendant did not specify the specific functions that would be implicated, plaintiff's reasonable accommodation claim was able to proceed. Plaintiff was provided with a pager, but also sought accommodations such as telephone amplifiers, a TTY, a text telephone, a visual alarm, and a sign language interpreter for meetings.⁴⁵

II. ADA Title I: What Constitutes a Direct Threat Under the ADA in the Healthcare Setting?

A. The Foundations of Direct Threat in General: The Rehabilitation Act and the *Arline* Decision

Generally, the foundations of the ADA's direct threat provisions can be found in the U.S. Supreme Court's decision in *School Board of Nassau County v. Arline*, 480 U.S. 273 (1987). In *Arline*, a teacher with tuberculosis was terminated from her elementary-school teaching position.⁴⁶ Subsequently, she brought suit, alleging that her termination violated Section 504 of the Rehabilitation Act which prohibits discrimination by federal funding recipients.⁴⁷ After finding that an individual with a contagious disease is covered by Section 504, the Court ruled that the school district must make an individualized assessment to determine whether, despite her disability, the teacher was qualified:

The fact that *some* persons who have contagious diseases may pose a serious health threat to others under certain circumstances does not justify excluding from the coverage of the Act all persons with actual or perceived contagious diseases. Such exclusion would mean that those accused of being contagious would never have the opportunity to have their condition evaluated in light of medical evidence and a determination made as to whether they were "otherwise qualified." Rather, they would be vulnerable to discrimination on the basis of mythology—precisely the type of injury Congress sought to prevent.⁴⁸

To determine whether Arline was qualified, the Court stated that the district court would need to conduct an individual inquiry to balance "protecting handicapped individuals from

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deprivations based on prejudice, stereotypes, or unfounded fear, while giving appropriate weight to such legitimate concerns of grantees as avoiding exposing others to significant health and safety risks.”⁴⁹ The Court directed the district court to consider four factors: (1) the nature of the risk, (2) the duration of the risk, (3) the severity of the risk, and (4) the probability of the risk and likelihood of the harm.⁵⁰ The Supreme Court’s analysis in *Arline* has been incorporated into the ADA’s direct threat provisions, as can be seen in the ADA’s text, the EEOC’s regulations, and federal court cases focusing on direct threat.

The “Defenses” section of the ADA Statute provides that, under certain conditions, covered employers may impose qualification standards that establish specific requirements for positions. Specifically, Section 12113(a) provides:

It may be a defense to a charge of discrimination . . . that an alleged application of qualification standards, tests, or selection criteria that screen out or tend to screen out or otherwise deny a job or benefit to an individual with a disability has been shown to be job-related and consistent with business necessity, and such performance cannot be accomplished by reasonable accommodation . . .⁵¹

Section 12113(b) continues that “[t]he term ‘qualification standards’ may include a requirement that an individual shall not pose a direct threat to the health

or safety of other individuals in the workplace.”⁵² The ADA defines direct threat to mean “a significant risk to the health or safety of others that cannot be reduced by reasonable accommodation.”⁵³

The EEOC regulations state that to prove direct threat not only requires a “significant risk,” but also requires that there be “substantial harm.”⁵⁴ So, if there is a “significant risk” that a person with epilepsy will have a seizure at work, but it cannot be shown that the seizure would cause “substantial harm,” under the EEOC’s regulation, that person would not be deemed a “direct threat.” The EEOC regulations also state that if the threat can be “reduced” by a reasonable accommodation so that the person is no longer a significant risk of substantial harm, then there is no direct threat.⁵⁵

Additionally, the EEOC regulations set forth the standard for whether an individual is a direct threat. Under the regulations, a decision whether an individual presents a direct threat must be based on a particularized inquiry. Such a determination must be based on “an individualized assessment of the individual’s present ability to safely perform the essential functions of the job” which itself must be based on “a reasonable medical judgment that relies on the most current medical knowledge and/or on the best available objective evidence.”⁵⁶ The assessment should consider four factors: (1) the duration of the risk; (2) the nature and severity of the potential harm; (3) the likelihood that the potential harm will occur; and (4) the imminence of the potential harm.⁵⁷ These are essentially the same four factors

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articulated by the Supreme Court in the *Arline* case discussed above.

The EEOC's Interpretative Guidance to 29 C.F.R. § 1630.2(r) emphasizes the "case by case" determination of whether an employee poses a direct threat.⁵⁸ According to the EEOC:

The employer should identify the specific risk posed by the individual. For individuals with mental or emotional disabilities, the employer must identify the specific behavior on the part of the individual that would pose the direct threat. For individuals with physical disabilities, the employer must identify the aspect of the disability that would pose the direct threat. The employer should then consider the four factors listed in part 1630.⁵⁹

The Interpretative Guidance also states that the "determination must be based on individualized factual data, using the factors discussed above, rather than on stereotypic or patronizing assumptions and must consider potential reasonable accommodations."⁶⁰

In the healthcare setting, direct threat issues almost always concern the safety of patients. Thus, the court's analysis usually turns on the specific patient-care responsibilities of the employee.

B. Healthcare Cases Finding for the Employer

In *Johnson v. Shawnee County Bd. Of County Commissioners*,⁶¹ plaintiff RN had a history of fibromyalgia and seizures that were controlled by medication. When her seizures began increasing, her employer placed her on medical leave until she obtained a doctor's opinion showing she would not be a threat to patient safety or herself. The court granted summary judgment to the employer on plaintiff's ADA termination claim, finding that plaintiff posed a "direct threat" to patients as she regularly "spaces out" for 10-15 seconds at a time without warning. The seizures made it unsafe for her to perform her job duties of "handling emergency situations; triage; administering injections with needles; drawing blood samples with needles; and sorting and administering medications to be taken by the patients."⁶² It was also noted that plaintiff worked in a detention facility, requiring that the nursing staff "be alert and able to exercise professional judgment."⁶³

A hospital RN with alcoholism, PTSD, and depression resulting from being the victim of a crime was terminated for consuming alcohol in violation of a Last Chance Agreement in the case of *Nicholson v. West Penn Allegheny Health System*.⁶⁴ Her job duties included "handling incoming patient calls, scheduling procedures, monitoring test results, and calling in prescriptions to pharmacies." She also assisted patients with chemotherapy instructions and performed certain injections. Supervisors raised patient safety concerns with her related to her drinking. During a PTSD-related medical leave, she signed a Last Chance Agreement, stating that she could

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be immediately terminated for consuming any alcohol, even outside work. She broke this agreement, consumed alcohol outside of work, telephoning a co-worker while under the influence. As a result, her employment was terminated. The court held that the reasons for her termination were not pretext as her alcohol consumption made her a direct threat to patients.⁶⁵

Similarly, in *Altman, M.D. v. New York City Health & Hospitals Corp.*, 903 F.Supp. 503 (S.D.N.Y. 1995)⁶⁶, a hospital's Chief of Medicine was suspended due to being visibly drunk while treating a patient. He was told he would have to get treatment "if there was any possibility of him returning," but after he did get treatment, the hospital chose not to reinstate him due to patient safety concerns. The court agreed his alcoholism posed a direct threat. Despite three months of recovery, the extreme risks to patients – he was in charge of 70 ICU patients – from undetected relapse were too great.⁶⁷

In *Wright v. Hosp. Auth. of Houston County*, discussed above, an RN with significant severe hearing loss was placed on leave and subjected to fitness for duty tests after a communication breakdown on the job. The nurse challenged those tests as discriminatory, but the court agreed with employer that there was a legitimate "business necessity" to perform the tests due to a potential direct threat to patient safety if the nurse was unable to hear or communicate, especially in emergency situations. However, the court denied defendant's motion for summary judgment

on the reasonable accommodation issue as explained above.⁶⁹

A medical resident with Asperger's Syndrome was terminated due to poor performance in *Jakubowski v. The Christ Hospital, Inc.*⁷⁰ The resident had a history of poor performance and reviews, largely relating to poor communication including, "poor organizational skills, skipped standard procedures in his examinations, and performed procedures incorrectly."⁷¹ Although no patients were ever harmed by plaintiff, in one instance, "Jakubowski wrote an unclear order for medication for a patient that, if interpreted and administered literally, would have killed the patient."⁷² The Sixth Circuit Court of Appeals held the resident was not qualified because his poor communication, especially with clients, and poor performance constituted a direct threat to patients.⁷³

The performance of a hospital medical resident was also at issue in the case of *Stopka v. Med. Univ. of South Carolina*.⁷⁴ During medical school, plaintiff suffered a head injury that impaired his vision, caused acquired dyslexia, and slowed his reading by 4-5 times. The hospital eventually allowed him to see only 2-3 patients instead of 10-15 expected of other residents, and to spend 45-50 minutes per patient instead of 15. Nevertheless, plaintiff's performance continued to deteriorate as he was "unable to retrieve the basic medical knowledge he should have gained in medical school;" was "functioning at a level below a third-year medical student ...;" had "extreme difficulty in memory and retention of learning;" "has extreme

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difficulty in making decisions ...; failed to even discuss or disclose when he was unsure of what to do about a situation...; and ... 'doesn't know how severe his detriment is' ...[seeming] to be in denial of the seriousness of the issue."⁷⁵ As a result, his employment was terminated. The court upheld the termination, finding his significantly impaired cognitive abilities were a direct threat to patient safety, relying on the unanimous opinion of doctors who had evaluated the Plaintiff.⁷⁶

In *Robertson v. Neuromedical Ctr.*,⁷⁷ a neurologist with ADHD was terminated due to his inability to perform the administrative portion of job. The court held the doctor was a direct threat to patient safety as he made mistakes in charts and dispensing medicine. The court further noted that, "Most significantly, Robertson voiced his own concerns about his ability to take care of patients, stating that it was only a matter of time before he seriously hurt someone."⁷⁸

As noted in the section on Reasonable Accommodation issues, courts uniformly find for employers in situations where health care providers have HIV although some pro-employee decisions may come down in the future as these cases are fairly old. In these older cases, the courts generally focused on the severity and nature of the harm, even if the risk of harm might not be significant. For example, in the most recent case found, *Waddell v. Valley Forge Dental Associates, Inc.*,⁷⁹ a dental hygienist living with HIV was told that he can no longer work as a hygienist and was offered a desk job paying half as much. When he rejected those accommodations, the

plaintiff was terminated. The court granted summary judgment to defendant using this broad standard: "[W]hen transmitting a disease inevitably entails death [Ed. Note: the court just assumed this about HIV, in 2001], the evidence supports a finding of 'significant risk' if it shows both (1) that a certain event can occur and (2) that according to reliable medical opinion the event can transmit the disease." (emphasis in original). The court specified that no evidence of any incidents of transmission ever are needed – so the risk can be both infinitesimal and hypothetical.⁸⁰

C. Healthcare Cases Finding for the Employee

In a direct threat case involving an administrative supervisor at a hospital, *French v. Providence Everett Med. Ctr.*,⁸¹ the plaintiff had muscular dystrophy and used arm braces and a scooter. She started falling 2-4 times per week at work, and based on this, the hospital placed her on medical leave, and eventually fired her. The hospital argued that plaintiff posed a direct threat to patient safety due to her inability to respond quickly to "codes," as she had to document the process. The court rejected this argument as plaintiff did not provide patient care during codes, but rather documented and analyzed the process. In addition, the defendant did not raise the inability to respond to codes when terminating the plaintiff. For this and other reasons, the court denied defendant summary judgment on ADA claims.⁸²

In *EEOC v. Midwest Division-RMC, LLC*,⁸³ a secretary in the cardiac telemetry

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unit had decreasing vision. Her patient-care duties including responding to call lights, inputting patient information, sorting medication, and transporting bodily fluids. The court denied the defendant's summary judgment motion on reasonable accommodation, because there was some adaptive equipment that should have been attempted for a trial period to determine if it worked before defendant constructively discharged plaintiff due to the perceived direct threat. Even though plaintiff's vision could impair her ability to safely sort medications and transport bodily fluids, the court found a question of fact as to any safety risk could be eliminated or reduced by a reasonable accommodation.⁸⁴

In a case involving narcotic use of Percocet due to back pain, *Griel v. Franklin Med Ctr.*,⁸⁵ a nurse who had once been terminated for diverting narcotics had completed a five-year addiction recovery program and regularly attended AA meetings. However, she was cited by the hospital for multiple alleged deviations from protocol regarding administration of narcotics to patients, e.g. not obtaining signatures for "wasting" surplus narcotics and failing to record morphine that was administered in her nurse's notes.⁸⁶ She was tested multiple times, and was never found to be taking drugs. She was nevertheless terminated for these deviations from protocol. The court denied summary judgment to defendant, because plaintiff's own experts said she did not deviate from protocol standards as defendant alleged. In addition, none of plaintiff's patients had been harmed while under her care.⁸⁷

As the cases above indicate, courts

seem to be more receptive to employer arguments in cases where it is alleged that a doctor poses a direct threat to patient safety. However, a court did find for the plaintiff doctor in the case of *Haas v. Wyoming Valley Health Care Sys.*⁸⁸ Plaintiff, a hospital surgeon with Schizotypal Personality Disorder experienced a "hypomanic" episode during his first surgery, a total knee replacement. The effects of the episode were disputed, defendant claiming that Dr. Haas "could not remember the names of surgical instruments and was unable to perform the surgery without assistance." On the other hand, Plaintiff asserted that he was "thinking clearly and knew what he was doing, but that he was simply more jovial than usual on this day."⁸⁹ Nevertheless, plaintiff thereafter went on voluntary leave and was admitted to a psychiatric hospital. Later, despite two psychiatric opinions that plaintiff should be reinstated without restriction, the hospital only offered to let him back if he agreed to retain a surgeon to supervise his surgeries. Plaintiff said he tried to find one, but this was impossible. The court reviewed the direct threat issue under Title III as plaintiff was an independent contractor. Using the *Arline* factors, the court determined that at summary judgment, there were genuine issues of fact as to whether the risk to patient safety posed by Plaintiff was significant compared to that posed by average surgeon.⁹⁰

In a failure to hire case, *Rojek v. Catholic Charities of Jackson, Inc.*,⁹¹ plaintiff was a social worker who was denied an interview for an open clinical therapist position with an outpatient

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mental health agency due to her blindness, as the hiring managers admitted. The hiring managers argued that her blindness posed a direct threat to clients, because therapists need to be able to pick up visual cues of abuse and neglect in clients. Plaintiff said she had 26 years of experience picking up non-visual cues. The court found genuine issue of fact on this and denied summary judgment, since the agency had no experience with blind therapists and was basing its judgments on stereotypes of what they could or could not do. The court found that the employer's arguments that the applicant could not be reasonably accommodated were also based on stereotypes and misperceptions and not facts as the applicant was never even interviewed.⁹²

Employer misperceptions were also involved in the case of *McCann v. City of Eugene*,⁹³ involving a firefighter and EMT with a pacemaker due to heart problems. Her physician released her without limitations, but the City was concerned about interference with radio transmissions, and made her undergo a treadmill test with the radio running, which she passed easily, and was put back on duty. The Plaintiff challenged the test as it caused her anxiety, sleeplessness, and other problems. Part of the City's argument was that she would pose a direct threat to the safety of herself and others if she had heart attack while responding to an emergency call. The court found disputed issues of fact as to whether the City had a reasonable basis for believing there would be radio interference problems, and denied Defendant's summary judgment.⁹⁵

III. ADA Title III (and Title II) Healthcare Issues: In General

Under Title III of the ADA, hospitals and the professional offices of health care providers are places of public accommodation.⁹⁶ While hospitals or professional offices of health care providers are clearly subject to the ADA, individual doctors also might be liable when they act as operators of their offices.⁹⁷ Doctors who practice in hospitals are liable under Title III where "(a) he or she is in a position of authority; (b) within the ambit of this authority he or she has both the power and discretion to perform potentially discriminatory acts; and (c) the discriminatory acts are the result of the exercise of the individual's own discretion, as opposed to the implementation of institutional policy or the mandates of superiors."⁹⁸

This brief will discuss ADA requirements in terms of Title III, but it is important to note that ADA issues regarding access for the public are similar under Title II and Title III, the main difference being that Title II entities only need to provide program access, not necessarily access to each individual existing facility. Generally, the main issue under Titles II and III involve situations where a healthcare provider must provide a reasonable accommodation or modification for a patient absent undue burden. This may include utilizing a sign language interpreter to provide communication access, modifying policies to provide access for a service animal. In addition, there may be issues regarding legal standing. This section will begin by

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referencing proposed U.S. Department of Justice Regulations (DOJ) regarding accessible medical equipment.

A. Pending DOJ Regulations on Accessible Medical Equipment

On July 26, 2010, DOJ issued "Proposed Rules on Nondiscrimination on the basis of Disability by State and Local Governments and Places of Public Accommodations; Equipment and Furniture," found at 75 Fed. Reg. 43452. Public comments were due by January 24, 2011. The proposed regulations contained the following sections:

- i. Medical Examination and Treatment Tables and Chairs
- ii. Accessible Scales
- iii. Radiological Diagnostic Equipment
- iv. Lifts
- v. Infusion Pumps
- vi. Rehabilitation Equipment
- vii. Ancillary Equipment
- viii. Hospital Beds and Gurneys
- ix. Medical Equipment Questions

Also in July 2010, DOJ issued a fact sheet in collaboration with the U.S. Department of Health and Human Services, Office of Civil Rights (HHS/OCR) titled, "Access To Medical Care For Individuals With Mobility Disabilities," found at: http://www.ada.gov/medcare_mobility_ta/medcare_ta.htm

This document applies the existing ADA Accessibility Guidelines (ADAAG) to medical facilities and states that:

- Both Title II and Title III of the ADA and Section 504 require that

medical care providers provide individuals with disabilities:

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

Cases decided under the existing regulations in the healthcare setting involve the following specific issues under Title II and Title III of the ADA: legal standing, direct threat issues affecting people living with HIV, providing effective communication for people who are deaf or hard of hearing, and modifying policies to permit access for service animals. We will start with a brief discussion of legal standing.⁹⁶

IV. ADA Title III: Legal Standing Issues in the Healthcare Setting

Article III limits federal court jurisdiction to cases or controversies.⁹⁷ Courts have fleshed out this constitutional phrase and interpreted it as requiring that all cases be justiciable, requiring that every plaintiff have legal standing to bring a claim before federal court. Standing is a

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doctrine stemming from both constitutional and prudential roots, which ensures that the proper plaintiff is bringing the claim before the court by requiring that the plaintiff have a personalized stake in the outcome.⁹⁸ It requires the plaintiff to demonstrate three components.⁹⁹ First, the plaintiff must suffer a personalized and concrete injury-in-fact of a legally cognizable interest.¹⁰⁰ Second, the injury must be fairly traceable to the defendant's conduct. Finally, it must be likely, as opposed to speculative, that the injury be redressable through a favorable court decision.¹⁰¹

The standing analysis impacts Title III cases in two significant ways. First, the Supreme Court's recent standing precedent has led courts to inquire whether a plaintiff is likely to be specifically harmed in the future by an inaccessible place of public accommodation in order to find standing for a plaintiff to seek injunctive relief under Title III. Second, the standing analysis has been used to address the concern for allegedly vexatious or frivolous litigation brought under Title III. This document will only discuss the first issue as it specifically relates to the healthcare setting.

A. Healthcare Standing Case Finding for the Healthcare Provider

The case of *McInnis-Misenor v. Maine Medical Center*¹⁰² involved a woman with rheumatoid arthritis who uses

a wheelchair. She was planning on having a child although she was not yet pregnant. She brought suit claiming that the hospital nearest to her was in violation of the ADA as the rooms in the after-birth recovery area were not wheelchair accessible. The court determined that she did not have standing as the case was not ripe. The court acknowledged that it was a close case but held that the dispute was too theoretical to establish federal jurisdiction. This was due to the many contingencies that may prevent a controversy from occurring: she may not become pregnant, it is uncertain when it will happen, she may not choose to go to that hospital to give birth, there may be complications in her delivery which would prevent her from going to the after-birth recovery room (which is what happened the last time she gave birth). The court also stated that failing to act would not impose a hardship on plaintiff as she could wait until she's pregnant before bringing a lawsuit (the magistrate judge felt certain they could resolve the dispute before she gave birth.)¹⁰³

In *Chambers v. Melmed*, the Tenth Circuit dismissed a case for lack of standing when a woman brought a suit to challenge a clinic's denial of insemination treatments because she was blind.¹⁰⁴ The plaintiff could not show a likelihood of future harm because she had moved and the doctor had stopped offering artificial insemination services.¹⁰⁵

B. Healthcare Standing Case Finding for the Patient

In *Rose v. Cahee*,¹⁰⁶ a prisoner was denied surgery because she had HIV. However, she was released from prison

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after bringing suit and lived 80 miles away from the clinic that refused to treat her due to her HIV status while she was in prison. Nevertheless, the court held that she had standing to sue even if it was unlikely that she would return to the clinic as the court examined the standing issue in the context of her standing at the time she filed the suit. At that time, she was still incarcerated and would have been taken back to that clinic if she needed treatment. Therefore, she had legal standing and her lawsuit was able to proceed.¹⁰⁷

A man with a heart condition who is deaf was found to have standing in the case of *Benavides v. Laredo Medical Center*.¹⁰⁸ Mr. Benavides was taken to Laredo Medical Center “because of severe coughing and a fluttering hear” and was admitted for five days.¹⁰⁹ Upon arrival, he requested a sign-language interpreter, but this was not provided. Instead, two nurses attempted to communicate with him through written notes, one in English and one in Spanish. Mr. Benavides alleged that written notes were not effective “due to the complexity of the information, [...his] limited reading capacity,” and the fact that he did not understand Spanish. He claimed that decision about his condition and treatment were made while he was “completely unaware of what was happening to him.” The court examined the following factors: plaintiff’s proximity to the hospital, the number of prior visits, whether his medical condition would likely require attention in the future, and whether the defendant hospital has changed its policy so as to accommodate the plaintiff in the future; and determined that plaintiff had standing to bring suit. The court also held that

plaintiff’s claim for monetary damages under Section 504 could proceed.¹¹⁰

V. ADA Title III – HIV Issues in the Healthcare Setting

In the first ADA case decided by the U.S. Supreme Court, *Bragdon v. Abbott*,¹¹¹ the Court held that a dentist’s refusal to treat a patient due to her positive HIV status violated the ADA. The Court analyzed the case using the direct threat analysis described above and found that the dentist’s decision to refuse treatment was not objectively reasonable even though the dentist claimed to be an expert acting on a good faith belief of a significant risk of harm as no outside evidence was offered by the dentist.

In another case involving a person living with HIV, *Doe v. Division of Youth and Family Services*,¹¹² the plaintiff gave birth at Capital Health System and alleged a refusal to administer treatment and confidentiality violations as the medical provider disclosed her HIV status to family members and the police. In fact, the hospital set up an emergency guardianship over the newly born child and contacted the police to prevent the mother from leaving the hospital with her child. The child was then administered AZT without the mother’s permission even though it was eventually discovered that the baby was not HIV positive.¹¹³ The court held that these actions by the medical provider sufficiently alleged ADA (and Rehabilitation Act) violations as the ADA “proscribes the denial of an opportunity to participate in services on an

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equal basis with nondisabled individuals” and that the medical provider violated the ADA by refusing to administer plaintiff’s pain medication orally while she gave birth. However, the court found that there was no individual liability for medical staff.¹¹⁴

VI. ADA Title III: Communication Issues in the Healthcare Setting

There are many cases and DOJ settlements that uphold the rights of individuals who are deaf or hard of hearing to have a sign language interpreter present or to have another means of effective communication provided. The cases and DOJ settlements also establish that family members of patients should not be used to ensure effective communication. Due to technological advances, it is now easier to provide interpreters than it was several years ago due to advances such as video relay services and Deaf Talk, a remote sign language interpreter service provided through video-conferencing equipment.

A. Healthcare Communication Case Finding for the Healthcare Provider

In *Constance v. State of New York Health Science Center at Syracuse*,¹¹⁵ a hospital tried unsuccessfully to secure an ASL interpreter for an emergency room patient and her husband who were both deaf. As the hospital made a good faith attempt to obtain an interpreter, the court held that it did not violate the ADA or Rehabilitation Act. [Ed. Note: Given the advances in technology allowing for remote interpreters, the case may be

decided differently today.] In addition, the plaintiff was not entitled to injunctive relief as she did not plan to return to the hospital.¹¹⁶

B. Healthcare Standing Cases Finding for the Patient

In *Loeffler v. Staten Island University Hosp.*,¹¹⁷ a hospital refused to provide an interpreter to a heart-surgery patient and his wife, both of whom were deaf. Instead, the hospital used the plaintiffs’ minor children who were thirteen and seventeen years-old, to interpret. Plaintiffs began requesting interpreters weeks before Mr. Loeffler was to be admitted for a right carotid endarterectomy, a procedure designed to prevent a stroke. These requests, and their numerous requests for interpreters after admission, were denied.¹¹⁸ The facts are as follows:

After the surgery, Dr. Sithian brought Bobby into the Recovery Room to interpret for his father, and told Bobby that the surgery had gone well. Bobby again asked about an interpreter, explaining to Dr. Sithian that he did not “feel comfortable doing this and ... [did not] understand some of the terms.” Dr. Sithian assured Bobby that he was “doing just fine.” According to Bobby, Dr. Sithian “patted me on the back, and laughed it off like usual.”

Soon after the surgery, Robert suffered a stroke. He grabbed his ankle and writhed in pain. Bobby alerted a nearby nurse, who responded with indifference and opined that “that was how deaf

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people communicate.” Bobby disagreed, and she responded, “what do you know, you’re a kid.” Bobby raised a disturbance for two to five minutes until Dr. Sithian came back.

After removing Bobby from Robert’s bedside and caring for Robert, Dr. Sithian told Josephine (through Bobby) that Robert had suffered a stroke and needed another operation. According to Bobby, interpreting was “amazingly overwhelming” and he had trouble because he did not “know what a stroke was.”

Before Henderson, [a patient representative at the hospital], left for the weekend, she advised a “charge nurse” that, if Robert was not discharged the following day (as expected), the charge nurse should call an ASL interpreter. Henderson gave the nurse the two telephone numbers that had not been disconnected. Henderson was unaware of Robert’s stroke; the charge nurse never tried calling any interpreter that afternoon or evening.

That night, Kristy, [aged seventeen], stayed overnight in the Critical Care Unit (“CCU”), in order to translate for her parents. ... Bobby... testified that he was traumatized and apparently felt responsible for failing to help his father.¹¹⁹

For two weeks after surgery, the children continued to serve as interpreters, staying out of school so they could be available. Both children claim to have “suffered depression as a result of their father’s stroke, and the role they performed in relaying medical information.”¹²⁰ When the hospital’s patient representative asked if an interpreter was being provided, a nurse stated that one was. At that point, the family filed a lawsuit and the hospital began to provide an interpreter.¹²¹

The district court granted summary judgment to the hospital, but this was reversed by the appellate court which held that the hospital may have acted with “deliberate indifference” when it denied family requests for an interpreter and TTY despite a hospital policy stating, “When a physician, nurse or other professional staff member determines an interpreter is needed, and when in the opinion of the *patient*, effective communication cannot be established without an interpreter,” an interpreter should be provided.¹²² The court held that money damages may be available under the Rehabilitation Act and that the children, who had to interpret, also had a Rehabilitation Act claim. A negligence claim against the doctor was also able to proceed.¹²³

In another case, *Majocho v. Turner*,¹²⁴ a parent who was deaf sought an interpreter when discussing treatment with an ENT specialist regarding his infant son, was told that the no interpreter would be provided. When the parent stated that note writing would not be effective, he was told that the child’s appointment would be cancelled. The parent was allowed to proceed with his ADA claim despite the

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doctor's claim that "note taking" was listed as an example of an acceptable auxiliary aid. The court noted that the ADA required "effective communication" which may not have been provided in this case. However, the claim of the hearing mother and the claim for punitive damages were dismissed by the court.¹²⁵

DOJ has entered into many settlements with health care providers that are available at <http://www.ada.gov/settlemt.htm>. Generally, the following relief is agreed to by the healthcare provider:

- Provide appropriate auxiliary aids free of charge, including sign language interpreters, within a specific time of being requested (generally 48 hours except for emergencies);
- Having staff trained on how to set-up and operate Video Remote Interpreting services for dealing with emergencies;
- Training personnel on use of auxiliary aids to ensure effective implementation of policies;
- Prohibiting the use of family members or other unqualified people to interpret;
- Developing effective complaint resolution mechanisms;
- Requiring up-to-date lists of interpreters and methods for obtaining interpreters or other auxiliary aids;
- Giving notice to the community and the hospital's personnel regarding their policy on the provision of

auxiliary aids;

- Posting policies at the facility;
- Providing captioned television and videos;
- Paying monetary damages and fines;
- Reporting to DOJ for monitoring¹²⁶ purposes.¹²⁶

VII. ADA Title III: Service Animal Issues in the Healthcare Setting

Access for service animals in healthcare facilities has been an ongoing issue for individuals and healthcare providers. Generally, service animals should be given the "broadest feasible access" to avoid separation.¹²⁸ Service animals may be required to perform the following tasks:

- Pulling a wheelchair;
- Assisting an individual during a seizure;
- Alerting individuals to the presence of allergens;
- Retrieving items such as medicine or the telephone;
- Providing physical support and assistance with balance and stability to individuals with mobility disabilities; and
- Helping persons with psychiatric and neurological disabilities by preventing or interrupting impulsive or destructive behaviors.¹²⁹

A. Healthcare Service Animal Cases

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Finding for the Healthcare Provider

In *Roe v. Providence Health System-Oregon*,¹³⁰ a hospital patient used a service dog with a “putrid odor” that resulted in patient transfers as the dog’s size and growling response made it difficult for staff to treat patients and a handler was not always available. The court noted that the dog may have had an infection as well. The hospital offered a compromise by requesting that patient close her door when the dog was present and offered to provide a HEPA filter, but the patient refused this offer. Therefore, the court held that the animal posed a direct threat and dismissed Plaintiff’s case, enjoining her from bringing any service animal to the hospital if she returned. The Court noted that the hospital had a history of accommodating service

In a case involving a service animal without a “putrid odor,” *Smith v. Moorman*,¹³¹ a veteran who used a service animal as he was hard of hearing filed a *pro-se* lawsuit when the Veterans Administration Medical Center (VA) would not allow his service animal to accompany him during a hospitalization. Instead, the VA placed the dog in a kennel at its own expense. The Sixth Circuit Court of Appeals held that the VA did not discriminate based on disability under the ADA by refusing the veteran’s request to keep his dog with him during the veteran’s hospitalization. Without much elaboration, the Sixth Circuit found that the record showed Smith received medical treatment, so he was therefore not excluded from receiving services. The court also found, without explanation, that his disability played no part in the Medical Center’s decision to prohibit the dog from

staying with him.

B. Healthcare Service Animal Cases Finding for the Patient

In the case of *Sheely v. MRI Radiology Network, P.A.*,¹³² a woman who was blind and used a service animal brought her minor son to MRI Radiology Network for an MRI. She was not permitted to accompany her son and was forced to wait in waiting room due to policy that animals not allowed past waiting room due to space concerns, safety issues, and the need to keep metal objects out of the magnetic area. Nine months after a lawsuit was filed, MRN changed its policy requiring that service animals be allowed in, except for a few specific exceptions.¹³³ MRN then moved for summary judgment, based on mootness. The court denied the motion stating that, “Our binding precedent says that ‘voluntary cessation of offensive conduct will only moot litigation if it is clear that the defendant has not changed course simply to deprive the court of jurisdiction.’”¹³⁴ In this case, the court held that defendant has a high burden to establish that the challenged conduct cannot reasonably be expected to start up again. It is not enough for defendant to simply say that it does not intend to start that behavior again. The court found for the plaintiff as it could not “say with any degree of confidence, let alone with absolute clarity,” that defendant would not engage in the same conduct in the future.¹³⁵

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VIII. ADA Title III: Other Settlements Related to Healthcare Access

At the beginning of 2012, the U.S. Department of Health and Human Services Office of Civil Rights (OCR) entered into a settlement in a service animal case arising under Section 504 of the Rehabilitation Act.¹³⁶ The case involved a person with a lumbar and spinal disability who requires a service animal to assist him in a number of daily functions, including carrying and picking up items and helping to stabilize his walking. The complainant was denied admission to St. Edward Mercy Medical Center, being told that was told his service animal was not a “seeing eye dog” and that he needed to provide vaccination records or tags verifying the health of the animal. After an investigation, OCR found that Mercy’s policies and procedures regarding access to service animals inappropriately excluded service animals already being used by qualified individuals with disabilities other than vision impairment.

There are several DOJ settlements involving other Title III issues in healthcare services. In *U.S. v. Ashfaq*,¹³⁷ a woman in a wheelchair had difficulty getting onto examination table for yearly checkup. She requested that Dr. Ashfaq purchase a lift or adjustable table. Dr. Ashfaq said she would no longer provide medical care to the patient and was unable to readily purchase either a lift or adjustable table due to budget constraints. Under the settlement, Dr. Ashfaq agreed to:

1. Purchase one adjustable exam table;
2. Adopt a non-discrimination policy and post it in her office;

3. When scheduling an appointment, Dr. Ashfaq's staff will ask the patient if he or she will need any special assistance, modification of policy, or auxiliary aid or service at the examination because of a disability;
4. Attend a training session on the requirements of Title III of the ADA with her staff;
5. Pay damages to the complainant of \$1,000;
6. Report to DOJ to ensure compliance.

In a case involving access for plasma donors with sensory impairments, DOJ entered into a wide ranging agreement with Bio-Medics providing that Bio-Medics adopt, post, and train staff regarding policies that require, in part:¹³⁸

1. Having staff work with an individual one-on-one to make sure they are acclimated to, and comfortable in, the facility;
2. Deferring to donor preferences for reasonable accommodations;
3. Providing detailed visual descriptions for individuals who are blind or who have visual impairments;
4. Utilizing sign language interpreters or other auxiliary aids to fully explain documents to people who are deaf or hard of hearing – the method for providing effective communication is spelled out in detail.

Settlements have also been achieved by private parties utilizing structured negotiations. Structured

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Negotiations are a collaborative and solution-driven advocacy and dispute resolution method conducted without litigation. The method is collaborative, focuses on solutions and seeks a win-win resolution to issues of accessibility. For over fifteen years, Lainey Feingold, a private attorney in California has used Structured Negotiations to increase accessibility, including access to technology and information. In recent years, she and other attorneys have used Structured Negotiations to achieve systemic solutions regarding accessibility at healthcare providers across the country, including agreements with the University of California San Francisco Medical Center, Massachusetts General Hospital, and Brigham & Women's Hospital in Boston. In these cases, agreements were reached through Structured Negotiations that resulted in comprehensive plans to improve access by removing physical and programmatic barriers and through the acquisition of accessible medical equipment for people with disabilities.

Also, Structured Negotiations have been used in recognition of the growing importance of accessible health care information to people with visual impairments. Through Structured Negotiations, the American Cancer Society (ACS) has agreed to design and generate its website in accordance to well accepted web accessibility standards. ACS has also agreed to undertake a pilot program for making its print materials available in alternative formats including Braille, Large Print, audio and electronic formats. For more information about Structured Negotiations and the agreements referenced in this brief go to: www.lflegal.com/category/settlements/accessible-health-care-settlements

A group of disability rights lawyers and advocates has announced the creation of The Barrier Free Healthcare Initiative, a collaborative effort to support legal and policy initiatives aimed at eliminating the physical and programmatic barriers that people with disabilities face in obtaining healthcare. For more information on this new initiative go to: www.thebarrierfreehealthcareinitiative.org.

A non-profit organization, Disability Rights Advocates (DRA), has entered into several settlements with healthcare providers in cases filed under state and federal law. DRA notes that, "The delivery of health related services is in crisis for people with disabilities, who are more likely to be uninsured, receive second-class health care even if they are insured, and pay more for their health care, insurance and benefits than people without disabilities." More information about these important settlements can be found at: http://www.drlegal.org/cases/health_insurance/index.php. Of particular importance is the case of *Metzler v. Kaiser* in March 2011. The DRA press release notes that, "Studies have shown that women with severe disabilities get half as many mammograms and pap smears as women without disabilities. Although accessible mammography equipment exists, very few providers use them."

IX. Conclusion

Due to the importance of healthcare, especially with the passage of

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recent healthcare legislation, individuals and healthcare providers need to be aware of the protections and requirements of the ADA.

Notes

1. This legal brief was written by Barry C. Taylor, Legal Advocacy Director, Alan M. Goldstein, Senior Attorney, and Volunteer Attorneys Matthew Teaman and Aaron Lawee, with Equip for Equality, the Illinois Protection and Advocacy Agency (P&A). Equip for Equality is providing this information under a sub-contract with Great Lakes ADA Center.

2. The Title III and Title II analyses are similar except for Title II requiring program access, which may not require that each facility be accessible (although no cases were found that discuss this issue). Due to the importance of healthcare services, it is likely that the program access requirement will not relieve an individual facility of its ADA or Rehabilitation Act obligations.

3. This legal brief is not intended to be an in-depth discussion on the legal requirements regarding reasonable accommodation; nor will it provide a full discussion of many important ADA terms and concepts, such as the definitions of “disability,” “qualified,” “undue hardship,” “fundamental alteration,” “interactive process,” appropriate “medical inquiries,” “direct threat,” and “essential functions.” For additional information on these topics, please see *EEOC Enforcement Guidance on Reasonable Accommodation and Undue Hardship*, No. 915.002 (October 22, 2002), www.eeoc.gov/policy/docs/accommodation.html; *EEOC Enforcement Guidance on Disability-Related Inquiries and Medical Examinations of Employees Under the Americans with Disabilities Act (ADA)*, No. 915.002 (July 27, 2000), www.eeoc.gov/policy/docs/guidance-inquiries.html; 42 U.S.C. §§ 2102(2), 12111(8); 29 C.F.R. §1630.2(g)-

(n); 29 C.F.R. pt. 1630 app. §§ 1630.2(g)-(n).

4. 42 U.S.C. §12112(b)(5)(A).

5. 42 U.S.C. §12111(10)(A).

6. See *EEOC Enforcement Guidance on Reasonable Accommodation*, *supra*, Questions 1 and 2.

7. 29 C.F.R. § 1630.2(o)(1)(ii), (iii).

8. 42 U.S.C. § 12111(9)(B); 29 C.F.R. § 1630.2(o).

9. See *EEOC Enforcement Guidance on Reasonable Accommodation and Undue Hardship*, *supra*. See also e.g., *U.S. Airways, Inc. v. Barnett*, 535 U.S. 391 (2002) (modifying workplace policies); *Garcia-Ayala v. Lederle Parenterals, Inc.*, 212 F.3d 638, 646 (1st Cir. 2000) (leave); *Carr v. Reno*, 23 F.3d 525, 530, (D.D.C. 1994) (work at home).

10. See *EEOC Enforcement Guidance on Reasonable Accommodation*, *supra*, Questions 1 and 2.

11. *Id.* at Question 3.

12. *Id.* at Question 1; 29 C.F.R. § 1630.2(o)(3).

13. *EEOC Enforcement Guidance on Reasonable Accommodation*, *supra*, Question 35; See also, 29 C.F.R. pt. 1630 app. §1630.9.

14. See below, *Branson v. West*, (not reported) 1999 WL 1129598 (N.D. Ill. Dec. 3, 1999), amended memorandum opinion and order at 1999 WL 1186420 (N.D. Ill. 1999).

15. *Griffin v. Prince William Health System*, 2011 WL 1597508 (E.D. Va. Apr. 26, 2011).

16. *Id.* at 4.

17. See also, *Ingerson v. Healthsouth Corp.*, 139 F.3d 912 (10th Cir. 1998) (an RN with a 20-pound lifting restriction was not able to perform the essential functions of moving patients from beds to wheelchair to commode or helping patients in an emergency).

18. *Stafne v. Unicare Homes*, 266 F.3d 771 (8th Cir. 2001).

19. *Id.* at 774-775.

20. *Rask v. Fresenius Medical Care North America*, 509 F.3d 456 (8th Cir. 2007).

21. *Id.* at 469-470.

22. *Id.* at 470-471. (Internal citation and emphasis in original omitted).

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23. *Id.* (internal quotation marks, original emphasis and citation omitted).
24. 42 U.S.C. §12112(b)(5)(A).
25. *Rask*, 2007 WL 4258620 at 2 (internal quotation marks, original emphasis and citation omitted).
26. *Rask v. Fresenius Medical Care North America*, 2007 WL 4258620, 1 (8th Cir. 2007).
27. *Rask*, 2007 WL 4258620 at 1-2.
28. *Rask Dickerson v. Peake, et. al.*, 2011 WL 1258138 (D. M.D. Ga. Mar. 31, 2011).
29. *Id.* at 13.
30. *Id.* at 14.
31. *Id.* at 674.
32. *Robertson v. Neuromedical Ctr.*, 983 F.Supp. 669 (M.D. La. Oct. 10, 1997).
33. *Stopka v. Med. Univ. of South Carolina*, 2007 WL 2022188 (D.S.C. July 11, 2007).
34. *Id.* at 13-14.
35. See, e.g., *Doe v. Univ. of Md. Med. Sys. Corp., et al.*, 50 F.3d 1261 (4th Cir. 1995) (wearing two pairs of gloves, making stitches with only one hand, using blunt-tipped, solid-bore needles would always involve “some measure of risk”); *Mauro v. Borgess Med. Ctr.*, 886 F.Supp. 1349 (W.D. Mich. 1995) (eliminating direct manual contact from a surgical technician's job would require adding another person to surgical team); *Bradley v. Univ. of Texas M.D. Anderson Cancer Ctr.*, 3 F.3d 922 (5th Cir. 1993)(surgical technician living with HIV must be able to be in the operative field, which plaintiff could not do).
36. See, e.g., *Flowers v. Southern Regional Physician Services Inc.*, 247 F.3d 229 (5th Cir. 2001).
37. *Branson v. West*, (not reported) 1999 WL 1129598 (N.D. Ill. Dec. 3, 1999), amended memorandum opinion and order at 1999 WL 1186420 (N.D. Ill. 1999).
38. *Id.* at *14.
39. *Sydnor v. Fairfax County, Va.*, 2011 WL 836948 (E.D. Va. Mar. 3, 2011).
40. *Id.* at 1-2.
41. *Id.* at 8.
42. *Enica v. Principi*, 544 F.3d 328 (1st Cir. 2008).
43. *Id.* at 337-339.
44. *Wright v. Hosp. Auth. of Houston County*, 2009 WL 274148 (M.D. Ga. Feb. 3, 2009).
45. *Id.* at 8-10.
46. *School Bd. of Nassau County v. Arline*, 480 U.S. 273, 276 (1987).
47. *Id.*
48. *Arline*, 480 U.S. at 280–86, 285.
49. *Id.* at 287.
50. *Id.* at 288.
51. *Id.* § 12113(a).
52. *Id.* § 12113(b)
53. 42 U.S.C. § 12111(3)
54. 29 C.F.R. § 1630.2(r).
55. *Id.*
56. *Id.*; See also EEOC Interpretive Guidance, *supra* note 20 (“Such consideration must rely on objective, factual evidence—not on subjective perceptions, irrational fears, patronizing attitudes, or stereotypes—about the nature or effect of a particular disability, or of disability generally.”).
57. 29 C.F.R. § 1630.2(r).
58. EEOC Interpretive Guidance, *supra* note 20.
59. *Id.*
60. *Id.*
61. *Johnson v. Shawnee County Bd. Of County Commissioners*, 2003 WL 21305402 (D. Kan. May 28, 2003), *aff'd* 2004 WL 1260305 (10th Cir. 2004).
62. *Id.* at 3, 8-9.
63. *Id.* at 3.
64. *Nicholson v. West Penn Allegheny Health System*, 2007 WL 3120275 (W.D. Pa. Oct. 23, 2007).
65. *Id.* at 10.
66. *Altman, M.D. v. New York City Health & Hospitals Corp.*, 903 F.Supp. 503 (S.D.N.Y. 1995).
67. *Id.* at 508-510. See also, *Judice, M.D. v. Hosp. Serv. Dist. No. 1*, 919 F.Supp. 978 (E.D. La., Mar. 13, 1996); *Dovenmuehler v. St. Cloud*

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Hospital, 509 F.3d 435 (8th Cir. 2007)(Illegal conduct of stealing prescription medications is not protected); *Bekker v. Humana Health Plan, Inc.*, 229 F.3d 662, 672 (7th Cir. 2000) (Termination of Dr. for treating patients while under the influence of alcohol was proper).

68. *Wright v. Hosp. Auth. of Houston County*, 2009 WL 274148 (M.D. Ga. Feb. 3, 2009).

69. *Id.* at 8-10.

70. *Jakubowski v. The Christ Hospital, Inc.*, 627 F.3d 195 (6th Cir. 2011).

71. *Id.* at 198.

72. *Id.*

73. *Id.* at 203.

74. *Stopka v. Med. Univ. of South Carolina*, 2007 WL 2022188 (D.S.C. July 11, 2007).

75. *Id.* at 8.

76. *Id.* at 12-13.

77. *Robertson v. Neuromedical Ctr.*, 983 F.Supp. 669 (M.D. La. Oct. 10, 1997).

78. *Id.* at 674.

79. *Waddell v. Valley Forge Dental Associates, Inc.*, 276 F.3d 1275 (11th Cir. 2001).

80. *Id.* at 1280-82. See also, *Mauro v. Borgess Med. Ctr.*, 886 F.Supp. 1349 (W.D. Mich. 1995) (aff'd 137 F.3d 398 (6th Cir. 1998) (involving an operating room surgical technician); *Doe v. Univ. of Md. Med. Sys. Corp., et al.*, 50 F.3d 1261 (4th Cir. 1995)(involving a neurosurgical resident who acquired HIV when stuck with a needle while operating); *Bradley v. Univ. of Texas M.D. Anderson Cancer Ctr.*, 3 F.3d 922 (5th Cir. 1993)(involving a surgical assistant living with HIV); *M.D. v. Mercy Health Corp. of Southeastern Pa.*, 887 F.Supp. 765 (E.D. Pa. 1994)(involving an orthopedic surgeon living with HIV). *But see, Flowers v. Southern Regional Physician Services Inc.*, 247 F.3d 229 (5th Cir. 2001), where the court found in favor of a medical assistant living with HIV. The case did not involve a direct threat defense but instead, claims of harassment, hostile work environment, and wrongful discharge. Prior to her supervisor learning of her HIV status, the plaintiff in *Flowers* was only required to submit to one random

drug test. However, after her supervisor learned of her HIV status, *Flowers* was subjected to four random drug tests in a one week period. In addition, her performance was rated a 38 out of 40 prior to her condition being learned, but she was written up one month after her employer learned her HIV status. She was also called a "bitch" and was placed on probationary status before being discharged. The court upheld the jury award in favor of plaintiff on the wrongful discharge claim but did vacate the jury's award of damages prior to her discharge as there was an insufficient injury to meet the high standard for harassment prior to her wrongful discharge.

81. *French v. Providence Everett Med. Ctr.*, 2008 WL 4186538 (W.D. Wash. Sept. 8, 2008).

82. *Nicholson v. West Penn Allegheny Health System*, 2007 WL 3120275 (W.D. Pa. Oct. 23, 2007).

83. *EEOC v. Midwest Division-RMC, LLC*, 2006 WL 2164618 (W.D. Mo., July 31, 2006).

84. *Id.* at 4-6.

85. *Griel v. Franklin Med Ctr.*, 71 F.Supp.2d 1 (D. Mass. Nov. 23, 1999).

86. *Id.* at 5-6.

87. *Id.* at 5-6.

88. *Haas v. Wyoming Valley Health Care Sys.*, 465 F.Supp.2d 429 (M.D. Pa. Dec. 6, 2006).

89. *Id.* at 430.

90. *Id.* at 437.

91. *Rojek v. Catholic Charities of Jackson, Inc.*, 2010 WL 2232240 (E.D. Mich. May 27, 2010).

92. *Id.* at 12-14.

93. *McCann v. City of Eugene*, 2011 WL 2490739 (D. Or. June 21, 2011).

94. *Id.* at 8-9.

95. *Id.*

96. For more general information on Title III issues, please see the Great Lakes ADA Center Legal Brief titled, "Hot Topics in ADA Title III Litigation," available at: http://www.adagreatlakes.org/Publications/Legal_Briefs/BriefNo011_Title3Litigation.pdf.

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97. *Lujan v. Defenders of Wildlife*, 504 U.S. 555, 559 (1992).
98. *Id.*
99. *Id.* at 560.
100. *Id.*
101. *Id.* at 561.
102. *McInnis-Misenor v. Maine Medical Center*, 319 F.3d 63 (1st Cir. 2003).
103. *Id.* at 72-73. While not technically a standing case, see also, *McElroy v. Patient Selection Committee of Nebraska Medical Center*, Not Reported in F.Supp.2d, 2007 WL 4180695 (D.Neb., Nov. 21, 2007) (The ADA and Section 504 of the Rehabilitation Act do not cover medical treatment decisions where a medical center denied to provide a kidney transplant to an individual due to his significant mental illness which would negatively impact his chances for a successful transplant).
104. 141 Fed.Appx. 718, 720 (10th Cir. 2005).
105. *Id.*
106. *Rose v. Cahee*, 727 F.Supp.2d 728 (E.D.Wis. 2010).
107. *Id.* at 741.
108. *Benavides v. Laredo Medical Center* Not Reported in F.Supp.2d, 2009 WL 1755004 (S.D.Tex., June 18, 2009).
109. *Id.* at *1.
110. *Id.* at *4-*6. Note: This case also contains summaries of a number of other standing cases. Compare *Benavides* with *Falls v. PG Hosp. Ctr.*, Civ. No. A-97-1545, 1999 WL 33485550, (D.Md. March 16, 1999) (no standing where plaintiff vowed to never go back to the hospital again and the hospital did have a policy in place to provide an interpreter in the future).
111. *Bragdon v. Abbott*, 524 U.S. 624 (1998).
112. *Doe v. Division of Youth and Family Services*, 148 F.Supp.2d 462 (D.N.J. 2001).
113. *Id.* at 472-73.
114. *Id.* at 486-88.
115. *Constance v. State of New York Health Science Center at Syracuse*, 166 F.Supp.2d 663 (N.D. N.Y. 2001).
116. *Id.* at 668.
117. *Loeffler v. Staten Island University Hosp.*, 582 F.3d 268 (2nd Cir. 2009).
118. *Id.* at 271-272.
119. *Id.* at 272-273.
120. *Id.* at 273.
121. Mr. Loeffler died while the case was pending.
122. *Id.* at 271.
123. *Id.* at 277.
124. *Majocho v. Turner*, 166 F.Supp.2d 316 (W.D. Pa. 2001).
125. *Id.* at 324-325. See also, *Posner v. Adventist Healthcare, Inc.*, unpublished, 2010 WL 2640118 (D.Md. June 25, 2010) ("There is no *per se* rule that sign language interpreters are necessary in hospital settings as the test is case-specific.).
126. See, e.g., *US v. Cheshire Medical Center, Keene Health Alliance, and Dartmouth-Hitchcock Clinic*, available at: http://www.ada.gov/cheshire_cd.htm (October 7, 2011).
127. For extensive general information on service animals under the recent DOJ Regulations, please see the Great Lakes ADA Center Legal Brief titled, *Service Animals Under the ADA*, available at: http://www.adagreatlakes.org/Publications/Legal_Briefs/BriefNo015ServiceAnimals.pdf (November 2010).
128. See, 28 C.F.R. pt. 36 App. B; DOJ Comments at *Nondiscrimination on the Basis of Disability by Public Accommodations and in Commercial Facilities*, 28 CFR Part 36 at page 56272.
129. See Comments to 28 CFR Part 36 at Page 56266.
130. *Roe v. Providence Health System-Oregon*, 655 F. Supp. 2d 1164 (D. Oregon 2009).
131. *Smith v. Moorman*, 2002 WL 31182451 (6th Cir. Sept. 20, 2002).
132. *Sheely v. MRI Radiology Network, P.A.*, 505 F.3d 1173 (11th Cir., 2007).
133. *Id.* at 1181.
134. *Id.* at 1187-88.