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# INACCESSIBLE MEDICAL EQUIPMENT: A BARRIER TO ROUTINE MEDICAL CARE FOR PERSONS WITH MOBILITY IMPAIRMENTS AND A CIVIL RIGHTS ISSUE

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More than twenty years after the passage of the Americans With Disabilities Act of 1990 (ADA) and forty years after the passage of Section 504 of the Rehabilitation Act of 1973 (Section 504), a recent study of physicians' offices in five major metropolitan areas reveals that patients with mobility impairment are being turned away in disturbingly high numbers. This trend is due to physical barriers to routine medical care posed by inaccessible medical and diagnostic equipment, such as examining tables, rather than by building accessibility. The results indicate that there is a continuing need for education of health care providers and patients, as well as enforcement of these laws by the government and by consumers of health care.

Researchers at the Center for Quality of Care Research at Baystate Medical Center in Springfield, Massachusetts, telephoned 256 specialty medical and surgical practices seeking an appointment for a fictional, obese wheelchair user, who could not self-transfer to an examining table.[1] Of this number, 22% reported that the patient could not be seen because, in most instances, they were unable to transfer the patient from a wheelchair to the examination table (18%) and to a lesser extent because the building where the practice was located was inaccessible for people in wheelchairs (4%).[2] Practices in eight medical subspecialties, such as endocrinology,

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[1] Tara Lagu et al., *Access to Subspecialty Care for Patients With Mobility Impairment: A Survey*, 158 ANN. INTERN. MED. 441–443 (2013).

[2] *Id.* at 443–44.

gynecology and orthopedic surgery, were tested. Of these subspecialties, gynecologists had the highest rate of inaccessible practices, with 44% of the gynecological offices called informing the tester that she needed to go elsewhere, usually because the provider lacked a table that could be raised and lowered, or a lift to transfer the patient out of a wheelchair.[3]

Inaccessible medical equipment has an impact on the timeliness and quality of care provided to people with mobility impairments. A study by Dr. Lisa I. Iezzoni, a Professor of Medicine at the Harvard Medical School, found that mobility-impaired patients with breast cancer, when confronted with inaccessible equipment, experienced delays in receipt of treatment and physician failure to perform a proper examination. In a follow up study, Iezzoni reported that mobility limitations affected the diagnosis and treatment decisions for women with early-stage breast cancer.[4]

## I. TURNING A PATIENT AWAY BECAUSE THE MEDICAL PRACTICE LACKS ACCESSIBLE EQUIPMENT VIOLATES FEDERAL CIVIL RIGHT LAWS

Medical practices are covered by Title III of the ADA as places of public accommodation and, to the extent practitioners accept Medicare and Medicaid reimbursement, also by Section 504 as entities that receive federal financial assistance.[5] Thus, they operate under the general mandate of the ADA to provide persons with disabilities "full and equal access to their health care services and facilities."[6] This means that a medical practice must: (1) not deny an individual the opportunity to participate in its services on the basis of a disability, (2) remove barriers to health services and facilities in existing facilities where it is "readily achievable" to do so, and (3) make reasonable modifications to its policies, practices, and procedures when necessary to make health care services fully available to people with disabilities, unless the modification would fundamentally alter the nature of their services.[7] These requirements apply irrespective of when the office was built or whether there have been alterations which would trigger the new construction standards.[8]

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[3] *Id.*

[4] Lisa I. Iezzoni, Kerry Kilbridge & Elyse R. Park, *Physical Access Barriers to Care for Diagnosis and Treatment of Breast Cancer Among Women with Mobility Impairments*, 37 ONCOL. NURS. F., 711–17 (2010). Iezzoni L. I., Park E. R., Kilbridge K. L**.,** *Implications of Mobility Impairment On the Diagnosis and Treatment of Breast Cancer*, 20 J. WOMEN'S HEALTH 45–52 (2011).

[5] Pub. Health and Welfare, 42 U.S.C. § 12181(7)(F); 29 U.S.C. § 794(a).

[6] 42 U.S.C. § 12182(a).

[7] 42 U.S.C. §§ 12182 (b)(1)(A)(i), (b)(2)(A)(iv) and (b)(2)(A)(ii).

[8] The new construction standards do not currently cover medical equipment such as examining tables. However, in July 2010, the DOJ issued a notice of proposed rulemaking

Guidance from U.S. Department of Justice (DOJ) and U.S. Department of Health and Human Services (HHS) makes clear that a medical practitioner generally may not turn away a patient who would otherwise be served because the practice does not have accessible medical equipment. The patient must be examined as the doctor would examine any patient, regardless of disability. This means that if the examination were to require that a person lie down, an accessible exam table, stretcher, gurney, or patient lift may be necessary, as well as staff trained to help the patient make the transfer.[9]

This guidance reflects the DOJ's view that the provision of accessible medical equipment and trained staff is "readily achievable" for most doctors' offices. In the two settlement agreements reached between the DOJ and medical practitioners, an adjustable examining table was required as a part of the settlement.[10] The cost of the accessible equipment needed, the overall financial resources of the medical provider, the number of persons to be trained and their impact upon the operation of the facility are all factors to be considered in determining what is "readily achievable."[11] However, the bald claim of "unable to purchase an adjustable table because of budget constraints" should not be accepted on its face.[12] The United States Access Board found in a recent study that the manufacturer's suggested retail price for an adjustable height treatment tables ranged from

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in which it announced that, although the obligation has always existed under the ADA for covered entities to provide accessible medical equipment, it was considering amending its regulations implementing Title III of the ADA to include specific standards for the design and use of accessible equipment that is not fixed or built into a facility in order to ensure that medical services are accessible to people with disabilities. *See* Nondiscrimination on the Basis of Disability by State and Local Governments and Places of Public Accommodation; Equipment and Furniture, 75 Fed. Reg. 43452 (July 26, 2010) (to be codified at 28 C.F.R. pt. 35, 36). The DOJ stated it would consider adopting the standards issued by the Access Board, which are now pending. Proposed Accessibility Standards for Medical Diagnostic Equipment (proposed February 8, 2012 and pending), *available at* http://www.access-board.gov/attachments/article/664/nprm.pdf.

[9] U.S. DEPARTMENT OF JUSTICE & U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, AMERICANS WITH DISABILITIES ACT: ACCESS TO MEDICAL CARE FOR INDIVIDUALS WITH MOBILITY DISABILITIES 2 (July 2010), *available a*t http://www.ada.gov/medcare_mobility_ta/medcare_ta.pdf.

[10] United States v. Exodus Women's Ctr., Inc., Dept. of Justice, Complaint No. 202-17M-214, (settled Mar. 26, 2005), *available at* http://www.justice.gov/crt/foia/readingroom/frequent_requests/ada_settlements/fl/fl_3.pdf (a medical office providing obstetrics and gynecology services); United States v. Dr. Robila Ashfaq, Dept. of Justice, Complaint No. 202-12C-264, 1 (settled Dec. 29, 2005), *available at* http://www.ada.gov/drashfaq.htm.

[11] 42 U.S.C. § 12181(9).

[12] Settlement Agreement in *United States v Dr. Robila Ashfag*, *supra*, at 1.

$1,500 to $2,400.[13] While not insignificant, the cost is clearly within the budget of most medical practices.[14] And tax credits for small businesses, i.e., businesses whose gross receipts did not exceed $1 million in the preceding year, are available to offset expenses incurred in complying with the ADA.[15]

## II. PATIENTS TURNED AWAY FROM MEDICAL PRACTICES BECAUSE OF THE LACK OF ACCESSIBLE EQUIPMENT OR TRAINED STAFF ARE NOT ASSERTING RIGHTS PROTECTED BY THE CIVIL RIGHT LAWS

Medical practices are covered by Title III of the ADA as places of The DOJ's Disability Rights Section (DRS) has been the major player in enforcing the ADA in the provision of medical care. Private actions are brought but they are relatively small in number.[16] DRS enforces the ADA through complaints filed in federal court, out-of-court settlements of actions it initiates as a result of consumer complaints it receives, and by the mediation of consumer complaints through an alternative dispute resolution process.

In this context, enforcement of the civil rights laws begins with an awareness of the right to receive equal medical services. For people with mobility impairment, this right means not only access into and out of the doctor's office, but also access to the examination room and to medical equipment used in the examination, such as exam tables and chairs, scales, and radiologic equipment, as well as trained staff. The challenge for disability advocates and lawyers is to help in this education process by spreading the word about the application of the ADA and Section 504 to these features as well. This could be as simple as making educational publications from the DOJ available in your offices,[17] by conducting your own outreach to interested groups, or by making access to medical services and facilities a topic at annual gatherings and professional conferences.

Enforcement also begins with a willingness to assert those protections. When confronted with a barrier that their health care provider will not remedy, a person with a disability must be willing to file a complaint with the DOJ or initiate a private legal action. This can be difficult. According to

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[13] Access Board Proposed Accessibility Standards *supra* at 44.

[14] Access to Subspecialty Care for Patients With Mobility Impairment, *supra* at 445.

[15] 26 U.S.C. § 44.

[16] Private settlements available at http://thebarrierfreehealthcareinitiative.org.

[17] *Access To Medical Care For Individuals With Mobility Disabilities*, a publication of the Department of Justice, may be downloaded from www.ada.gov and additional copies may be obtained from the ADA Information Line at 800-514-0301 (voice) or 800-514-0383 (TTY).

Dr. Iezzoni, "[t]his demand imposes huge burdens on persons with disabilities, especially when they feel most vulnerable—when they are sick, seek the goodwill of their clinicians, and need access to medical services*now* (i.e. not once the facilities are finally renovated)." Moreover, "some persons may believe it is their own fault, not the provider's, when they cannot climb unaided onto a high examining table . . . ."[18] Where legal advocacy is warranted, advocates should be mindful of the client's need for support throughout process.

A client's understanding of the alternative means for enforcement is also useful. A private lawsuit may be directly filed for injunctive relief. An individual complaint may also be filed with the DRS, which may take the complaint for possible direct litigation.[19] The formality of a courtroom is not the only alternative, however. The DRS may refer a complainant to its ADA mediation program for possible resolution, and the client can request mediation as well.[20] Mediation is informal, does not require the participation of an attorney, and is oriented to helping the parties find a mutually satisfactory solution. If mediation is not successful, the complainant may still pursue a private lawsuit.

In conclusion, those with mobility impairments face a greater barrier in accessing medical care at doctor's offices, particularly for gynecological services, in transferring from the wheelchair to the examining table rather than in accessing the office itself. Advocates and lawyers have a role to play in improving the consumers' awareness of the rights afforded by the ADA and Section 504 to accessible medical equipment, and, where appropriate, in helping them to exercise those rights.

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[18] LISA I. IEZZONI & BONNIE L. O'DAY, MORE THAN RAMPS: A GUIDE TO IMPROVING HEALTH CARE QUALITY AND ACCESS FOR PEOPLE WITH DISABILITIES 231 (2006).

[19] Aggrieved individuals or the Attorney General may enforce the ADA. 42 U.S.C. § 12188. Private parties may utilize the remedies and procedures made available by the Civil Rights Act of 1964. § 12188(a)(1). In particular, they may obtain injunctive relief including "an order to alter facilities to make such facilities readily accessible to and usable by individuals with disabilities." § 12188(a)(2). In suits brought by the Attorney General, courts may grant both equitable relief and monetary damages. § 12188(b)(2). Monetary damages are not available in private suits under Title III of the ADA, *Wander v. Kaus,* 304 F.3d 856, 858 (9th Cir.2002), but the ADA gives courts the discretion to award attorney's fees to prevailing parties. 42 U.S.C. § 12205.

[20] Detailed instructions on filing a complaint with the Department of Justice available at http://www.ada.gov/fact_on_complaint.htm.