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Limits on Injunctive Relief Under the ADA: Rethinking the Standing Rule for Deaf Patients in the Medical Setting

Michael A. Schwartz

LIMITS ON INJUNCTIVE RELIEF UNDER THE ADA: RETHINKING THE STANDING RULE FOR DEAF PATIENTS IN THE MEDICAL SETTING

MICHAEL A. SCHWARTZ*

ABSTRACT

Deaf patients face difficult attitudinal and communication barriers in the medical setting. Although the Americans with Disabilities Act (ADA) entitles them to effective communication via appropriate auxiliary aids, these patients are often frustrated by medical providers who do not understand either their patients' communication needs or the provider's own obligation under the law to provide effective communication. Deaf patients are then challenged by the law of standing that deprives them of their day in court. Because many, if not most, Deaf patients decide to go elsewhere when confronted by a medical provider's refusal to provide auxiliary aids, courts have ruled these patients have presented no case or controversy for adjudication. In this article, Professor Schwartz looks at research data that highlights the difficulties Deaf patients face in the medical setting and the legal paradigm that was established by the ADA to confront and resolve these difficulties. The article then examines how the lack of imminent future injury operates to bar standing where a plaintiff does not return to the provider's office. The article concludes that Deaf patients' intent to return should not be controlling; the lack of accessibility establishes an actual and present injury for these patient-plaintiffs, not a future imminent one, which ought to confer standing. Moreover, the medical provider's refusal ought to establish the likelihood of a continuing refusal in violation of the ADA. Professor Schwartz concludes with a proposal: the allocation of the burden of proof should operate to establish a rebuttable presumption that the defendant's refusal to provide appropriate auxiliary aids represents an ongoing violation of law, which confers standing on the plaintiff regardless of the plaintiff's intention to return to the defendant.

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* Assistant Professor of Law and Director, Disability Rights Clinic, Office of Clinical Legal Education, Syracuse University College of Law (Syracuse, NY).

INTRODUCTION

Deaf patients have a difficult time persuading medical providers to furnish sign language interpreters as an appropriate auxiliary aid in the medical setting.[1] When these patients launch a lawsuit against a provider for injunctive relief under the Americans with Disabilities Act (ADA),[2] their boat runs aground on the shoal of standing.[3] Pursuant to the Supreme Court's reading of Article III's requirement of a "case or controversy,"[4] the federal courts have interpreted standing to bar Deaf plaintiffs from proceeding for an injunction in a number of key cases.[5] This article

1. *See, e.g.*, Loeffler v. Staten Island Univ. Hosp., No. 95 CV 4549 SJ., 2007 WL 805802, at *1, *3 (E.D.N.Y. Feb. 27, 2007); Connors v. W. Orange Healthcare Dist., No. 605CV647ORL31KRS, 2005 WL 1500899, at *1 (M.D. Fla. June 23, 2005); Constance v. State Univ. N.Y. Health Sci. Ctr., 166 F. Supp. 2d 663, 664 (N.D.N.Y. 2001); Majocha v. Turner, 166 F. Supp. 2d 316, 318–19 (W.D. Pa. 2001); Freydel v. N.Y. Hosp., No. 97 Civ. 7926 (SHS), 2000 WL 10264, at *1 (S.D.N.Y. Jan. 4, 2000), *aff'd*, 242 F.3d 365, No. 00-7108, 2000 WL 1836755 (2d Cir. Dec. 13, 2000); Bravin v. Mount Sinai Med. Ctr, 186 F.R.D. 293, 299 (S.D.N.Y. 1999); Davis v. Flexman, 109 F. Supp. 2d 776, 780 (S.D. Ohio, 1999); Falls v. Prince George's Hosp. Ctr., No. Civ. A.97-1545, 1999 WL 33485550, at *1 (D. Md. March 16, 1999); Proctor v. Prince George's Hosp. Ctr., 32 F. Supp. 2d 820, 821 (D. Md. 1998); Naiman v. N.Y. Univ., No. 95 CIV. 6469 (LMM), 1997 WL 249970, at *1 (S.D.N.Y. May 13, 1997); Schroedel v. N.Y. Univ. Med. Ctr., 885 F. Supp. 594, 596 (S.D.N.Y. 1995); People *ex rel.* Vacco v. Mid Hudson Med. Group, 877 F. Supp. 143, 144–45 (S.D.N.Y. 1995); Aikins v. St. Helena Hosp., 843 F. Supp. 1329, 1332 (N.D. Cal. 1994); Mayberry v. Von Valtier, 843 F. Supp. 1160, 1163 (E.D. Mich. 1994). The narratives in these cases involve one or more Deaf people dealing with an inaccessible health care system because a sign language interpreter was unavailable to facilitate communication between the Deaf person (whether a patient or a relative) and medical personnel. The *Mid Hudson* case represented an egregious situation where the medical clinic insisted that the Deaf patient, who was also legally blind, read lips and write notes. *Mid Hudson Med. Group*, 877 F. Supp. at 145.

2. Americans with Disabilities Act of 1990, 42 U.S.C. §§ 12101–12213 (2000).

3. *See Constance*, 166 F. Supp. 2d at 667; *Freydel*, 2000 WL 10264, at *3; *Bravin*, 186 F.R.D. at 299; *Naiman*, 1997 WL 249970, at *5; *Schroedel*, 885 F. Supp. at 599; *Aikins*, 843 F. Supp. at 1333–34. Standing concerns whether "a party has a sufficient stake in an otherwise justiciable controversy to obtain judicial resolution of that controversy." Sierra Club v. Morton, 405 U.S. 727, 731 (1972). In the above-listed cases, the courts generally held that because Deaf plaintiffs would not, or were not able to, return to the medical provider, or because there was little likelihood they would return, there was no case or controversy for resolution. *See* U.S. CONST. art. III, § 2, cl. 1.

4. U.S. CONST. art. III, § 2, cl. 1. To satisfy Article III's demand for a case or controversy that would support judicial intervention, the plaintiff must establish an injury in fact fairly traceable to the defendant's conduct that can be redressed by a court order. Lujan v. Defenders of Wildlife, 504 U.S. 555, 560–61 (1992); Valley Forge Christian Coll. v. Ams. United For Separation of Church and State, Inc., 454 U.S. 464, 471–72 (1982).

5. *See Constance*, 166 F. Supp. 2d at 667; *Freydel*, 2000 WL 10264, at *3–4; *Bravin*, 186 F.R.D. at 299; *Naiman*, 1997 WL 249970, at *5; *Schroedel*, 885 F. Supp. at 599; *Aikins*, 843 F. Supp. at 1333–34. The problem confronting Deaf patient-plaintiffs is that the denial of appropriate auxiliary aids constitutes harm that is completed, and when the plaintiff demands an order to provide the auxiliary aids in the future, the question before the court is whether the plaintiff has shown a sufficient threat—"certainly impending"—of actual injury. Whitmore v. Arkansas, 495 U.S. 149, 158 (1988) ("Each of these cases demonstrates what we have said many times before and reiterate today: Allegations of possible future injury do not satisfy the requirements for Art. III. A threatened injury must be 'certainly impending' to constitute injury in fact.").

constructs an argument for why, when a Deaf plaintiff seeks injunctive relief against a doctor or hospital to compel the provision of a sign language interpreter, standing should be construed liberally to allow the lawsuit to go forward even when the plaintiff will not or is not able to return to the doctor or hospital.[6]

I. THE QUANDARY CONFRONTING DEAF PATIENTS

Despite the fact that up to two million Deaf Americans communicate using American Sign Language (ASL),[7] the overwhelming majority of doctors in America do not sign.[8] There is significant variation in Deaf people's abilities not only in speaking and reading lips, but also in reading and writing English fluently.[9] Most medical personnel know little about Deafness, Deaf culture, and the myriad ways in which Deaf people communicate.[10] Thus, an inaccessible medical office is

6. I choose the convention of capitalizing the word, "Deaf," to underline the political act of naming: to be "Deaf" is to claim membership in a cultural and linguistic minority as opposed to the popular idea of "deafness" as a medical condition. CAROL PADDEN & TOM HUMPHRIES, INSIDE DEAF CULTURE 1 (2005); Steven Barnett, *Cross-Cultural Communication With Patients Who Use American Sign Language*, 34 FAM. MED. 376, 377 (2002) [hereinafter Barnett, *Cross-Cultural Communication*]; Steven Barnett, *Clinical and Cultural Issues in Caring for Deaf People*, 31 FAM. MED. 17, 18 (1999) [hereinafter Barnett, *Clinical and Cultural Issues*]; Todd N. Witte & Anton J. Kuzel, *Elderly Deaf Patients' Health Care Experiences*, 13 J. AM. BOARD FAM. PRAC. 17, 17 (2000). The authors of an important book on Deafness follow this convention throughout the book. HARLAN LANE ET AL., A JOURNEY INTO THE DEAF WORLD, at x (1996).

7. LANE ET AL., *supra* note 6, at 42. Hearing impairment, with a prevalence of 9.35 percent, is the sixth most common "chronic condition" in the "civilian, noninstitutionalized U.S. population." Steven Barnett & Peter Franks, *Health Care Utilization and Adults Who Are Deaf: Relationship with Age at Onset of Deafness*, 37 HEALTH SERV. RES. 103, 103 (2002); JOHN GARY COLLINS, CTRS. FOR DISEASE CONTROL & PREVENTION, VITAL AND HEALTH STATISTICS: PREVALENCE OF SELECTED CHRONIC CONDITIONS: UNITED STATES, 1990–92, at 9–10 (1997), *available at* http://www.cdc.gov/nchs/data/series/sr_10/sr10_194.pdf.

8. Alice Nemon, *Deaf Persons and Their Doctors*, 14 J. REHABILITATION DEAF 19, 19 (1980). There is at least one hearing doctor in Rochester who is fluent in sign language, and while one can find evidence of a medical clinic that highlights its communication accessibility to Deaf patients, *see, e.g.*, Sinai, Deaf Access Program, http://www.sinai.org/services/Deaf-access/deaf-access.asp (last visited Apr. 4, 2008), these are very far and few in between. The literature on communication between a Deaf patient and doctor assumes a signing patient and a non-signing doctor. *See, e.g.*, Steven Barnett, *Communication with Deaf and Hard-of-Hearing People: A Guide for Medical Education*, 77 ACAD. MED. 694, 697 (2002); Annie G. Steinberg et al., *Deaf Women: Experiences and Perceptions of Healthcare System Access*, 11 J. WOMEN'S HEALTH 729, 730–35 (2002).

9. Patricia Golden & Marian Ulrich, *Deaf Patients' Access to Care Depends on Staff Communication*, 52 HOSPITALS 86, 86 (1978); Lisa M. Harmer, *Health Care Delivery and Deaf People: Practice, Problems, and Recommendations for Change*, 4 J. DEAF STUD. & DEAF EDUC. 73, 80–81 (1999) (describing the problems with educating Deaf students in mainstream schools and the resulting levels of education gained); *see also* Michele LaVigne & McCay Vernon, *An Interpreter Isn't Enough: Deafness, Language, and Due Process*, 2003 WIS. L. REV. 843, 851–52 (2003) (explaining the various levels of language proficiency in Deaf culture).

10. Golden & Ulrich, *supra* note 9, at 86.

an ontological reality for many Deaf patients.[11] Because of limited access to health information, many Deaf people are unable to make informed health care decisions for themselves and their families.[12] The major barriers are attitudinal and communication-related.[13]

A. Attitudinal Barriers

The medical setting is a site of power, coloring the relationship between medical personnel and people with disabilities.[14] While this insight is valid for everyone, disabled or not, the disparity is particularly acute for Deaf patients whose expressive and receptive language skills do not conform to the norm of spoken and written English. Accordingly, the doctor's exercise of power and authority over Deaf patients is more hierarchical and unequal than the power exercised over people who are not Deaf: "[The doctor-patient relationship] is an unequal relationship with the professionals holding most of the power. Traditionally professional workers have defined, planned and delivered the services, while disabled people have been passive recipients with little if any opportunity to exercise control."[15]

Attitudes of medical students toward disabled people become more negative as their training proceeds.[16] Many providers are inadequately informed and ill-equipped to understand the "particular constellation of health care needs" of their disabled patients,[17] particularly those who are Deaf or hard-of-hearing.[18] Medical schools offer little or no training in working with Deaf patients.[19]

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11. *See* Harmer, *supra* note 9, at 85.

12. Barnett, *supra* note 8, at 694.

13. *See* Harmer, *supra* note 9, at 90, 93 (explaining that barriers to heath care for Deaf patients include: (1) doctors' attitudes that disabilities are deviations from mainstream that should be corrected if possible; (2) doctors' and Deaf patients' differing frames of reference for situations including health care delivery; (3) that Deaf patients may have different goals and priorities in their health care treatment than the doctor; and (4) that doctors may not understand the communication needs and preferences of Deaf patients).

14. Sally French & John Swain, *The Relationship Between Disabled People and Health and Welfare Professionals*, *in* HANDBOOK OF DISABILITY STUDIES 734, 735–37 (Gary L. Albrecht et al. eds., 2001). Since antiquity, doctors have held themselves out to be healers of humankind, and this has led to an authoritarianism that is deeply embedded in the practice of medicine. JAY KATZ, THE SILENT WORLD OF DOCTOR AND PATIENT, at xl–xlviii, 28 (1984). Pathologizing difference as illness and asserting control over treatment of people with illnesses fueled medicine's rise to power and dominance. Irving Kenneth Zola, *Healthism and Disabling Medicalization*, *in* DISABLING PROFESSIONS 41, 41–42, 51–52 (Ivan Illich et al. eds., 1992).

15. Sally French, *Disabled People and Professional Practice*, *in* ON EQUAL TERMS: WORKING WITH DISABLED PEOPLE 103, 103 (Sally French ed., 1994).

16. Ian Basnett, *Health Care Professionals and Their Attitudes Toward Decisions Affecting Disabled People*, *in* HANDBOOK OF DISABILITY STUDIES, *supra* note 14, at 450, 451–52.

17. Gerben DeJong & Ian Basnett, *Disability and Health Policy: The Role of Markets in the Delivery of Health Services*, *in* HANDBOOK OF DISABILITY STUDIES, *supra* note 14, at 610, 625.

Many physicians are insufficiently prepared to work with Deaf patients whose primary mode of communication is sign language.[20] They often lack the awareness and knowledge to provide effective communication access in their offices, which in turn would enhance their treatment of the Deaf patient.[21] Many physicians hold assumptions, misconceptions, and faulty information about Deaf people and Deafness that impact their delivery of health care to Deaf patients.[22] The problem of attitudinal barriers is of acute concern to Deaf patients and medical personnel, from both a human standpoint and a legal standpoint: health care delivery is compromised if the two parties cannot communicate adequately and effectively.[23] Moreover, a doctor's failure to communicate effectively with a Deaf patient violates federal law.[24]

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18. Harmer, *supra* note 9, at 73.

19. Barnett, *supra* note 8, at 694. Very few medical schools train their students in working with Deaf patients; a bright spot is the University of Rochester School of Medicine where the Deaf Wellness Center offers training on how to work with Deaf patients. *See* University of Rochester Medical Center, Deaf Wellness Center, http://www.urmc.rochester.edu/dwc/index.htm (last visited Apr. 4, 2008). Dr. Robert Q. Pollard of the Deaf Wellness Center has initiated at the University of Rochester School of Medicine "a first-year medical student seminar organized around direct, non-clinical conversation with persons who have disabilities, following the exposure method thought to be most effective in improving beliefs and attitudes about disability." Robert Q. Pollard, Jr., *A Consumer Interview Seminar that Enhances Medical Student Attitudes Toward Persons with Disabilities*, 5 ANNALS BEHAV. SCI. & MED. EDUC. 27, 28 (1998). In addition, the University of Rochester School of Medicine adopted a unique role-reversal exercise called "Deaf Strong Hospital" for first-year medical students where the students were "patients" in a simulated health-care setting and the "health-care professionals" were volunteers from the local Deaf community in Rochester. Julie Richards et al., *Deaf Strong Hospital: An Exercise in Cross-Cultural Communication for First Year Medical Students*, 10 J. U. ROCHESTER MED. CTR. 5, 5 (1999). This exercise "was designed to teach the first-year students about techniques for overcoming communication barriers as well as some of the specific challenges in communicating with Deaf or hard-of-hearing patients." *Id.* Junior doctors in Northern Ireland are now undergoing sign language and cultural awareness training in order to improve their delivery of services to Deaf patients. BBC News, *Doctors Training in Sign Language* (Apr. 3, 2008), http://news.bbc.co.uk/2/hi/uk_news/northern_ireland/4799464.stm.

20. Nemon, *supra* note 8, at 19.

21. *See* Harmer, *supra* note 9, at 93–98; Steinberg et al., *supra* note 8, at 738–40 (explaining how Deaf women's access to healthcare could be improved by educating providers on how to be more effective communicators).

22. Golden & Ulrich, *supra* note 9, at 86; Harmer, *supra* note 9, at 93; *see also* Glenn B. Anderson & Melanie Thornton, *Unresolved Issues in the Provision of Mental Health Services to People Who Are Deaf, in* RESEARCH AND PRACTICE IN DEAFNESS 211, 211–12, 214–16 (Olga M. Welch ed., 1993) (explaining how Deaf individuals may have trouble receiving adequate mental health services because of some mental health professionals' lack of cultural sensitivity).

23. Harmer, *supra* note 9, at 90, 98–101.

24. Barnett, *supra* note 8, at 694; *see also* 42 U.S.C. § 12182(a) (2000) (prohibiting owners and operators of places of public accommodation from discriminating on the basis of disability); 28 C.F.R. § 36.303 (describing the circumstances under which places of public accommodation must provide "auxiliary aids and services," including qualified interpreters).

B. Communication Barriers

As noted, many health care professionals labor under several misconceptions. Many providers think that lip reading is an effective means of communication for every Deaf person; that all Deaf people can read and write English fluently; and that ASL is a manual form of the English language.[25] For many Deaf people, their inability to read and write English fluently impacts their ability to read lips.[26] Deaf patients often confront medical personnel who do not understand their struggle with communication difficulties.[27] When the doctor provides an interpreter, there is a pervasive belief that the interpreter will instantly and perfectly translate the spoken language to ASL or whatever variant of sign language the Deaf person understands.[28] That is often not the case. Interpreters have varying skill, and not every interpreter is the right match for a particular patient in a particular setting.[29]

"Even those [Deaf patients] who are highly literate or well-educated have to struggle in intense, stressful environments like emergency rooms and hospitals to make sense of the information flow; the struggle is much more pronounced for those whose first language is ASL."[30] Even when a doctor realizes there is a communication problem, federal case law is replete with examples of physician resistance to providing an interpreter.[31]

C. Research Data

Fifteen Deaf people spoke about their experiences with medical doctors as part of a qualitative research project exploring the subjective experiences of Deaf

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25. *See* Golden & Ulrich, *supra* note 9, at 86–87; Harmer, *supra* note 9, at 93–96.

26. *See* Harmer, *supra* note 9, at 94.

27. *Id.* at 73, 98.

28. *See* LaVigne & Vernon, *supra* note 9, at 869–70; Annie G. Steinberg et al., *Cultural and Linguistic Barriers to Mental Health Service Access: The Deaf Consumer's Perspective* 155 AM. J. PSYCHIATRY 982, 984 (1998) (explaining that clinicians in the mental health field should not assume that the presence of an interpreter ensures adequate communication).

29. Harmer, *supra* note 9, at 96–98.

30. Michael A. Schwartz, Communication in the Doctor's Office: Deaf Patients Talk About Their Physicians 4–5 (Apr. 10, 2006) (unpublished Ph.D. dissertation, Syracuse University) (on file with author).

31. *See, e.g.*, Gillespie v. Dimensions Health Corp., 369 F. Supp. 2d 636, 637–38 (D. Md. 2005); Majocha v. Turner, 166 F. Supp. 2d 316, 318 (W.D. Pa. 2001); Falls v. Prince George's Hosp. Ctr., No. Civ.A. 97-1545, 1999 WL 33485550, at *3–4 (D. Md. Mar. 16, 1999); People *ex rel.* Vacco v. Mid Hudson Med. Group, 877 F. Supp. 143, 145 (S.D.N.Y. 1995). The ADA bars a place of public accommodation, such as a doctor's office, from imposing a surcharge on the person with a disability for auxiliary aids, 28 C.F.R. § 36.301(c) (2006), and that means the doctor has to absorb the cost of the interpreter, which can run to $80 per visit. Schwartz, *supra* note 30, at 273. Presumably doctors do not like to spend money on something they do not understand or know about, or they do not like to be told what to do within the parameters of their practice.

patients in the medical setting.[32] These fifteen patients were fluent ASL signers with ASL as their primary language, and English as a secondary language.[33] The highest educational achievement for the majority of these patients was high school, and most held working-class jobs.[34] Because Deaf patients communicate differently, that is, they use sign language rather than speech to express themselves and to receive information, the patients reported perceiving a degree of discomfort on the part of their medical providers because of the language difference.[35] The danger is that if there is a communication failure or dysfunction, a doctor may not observe or verify a Deaf patient's symptoms, that doctor may invalidate or ignore the patient's narrative, or, in a worst case scenario, make a life-threatening mistake.[36] Because of the language difference, many Deaf patients reported feelings of frustration, mistrust, and avoidance of health care providers.[37] This led to poor health outcomes.[38]

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32. *See* Schwartz, *supra* note 30, at 1, 56. The research data was developed as part of the author's dissertation study for which he received a Ph.D. in Education at the Cultural Foundations of Education, which is part of the School of Education at Syracuse University. *See* The Center on Human Policy, Law, and Disability Studies, Syracuse University, Michael Schwartz, http://disabilitystudies.syr.edu/who/maschwartz.aspx (last visited on March 18, 2008). Rooted in a social constructivist tradition, *see generally* PETER L. BERGER & THOMAS LUCKMANN, THE SOCIAL CONSTRUCTION OF REALITY: A TREATISE IN THE SOCIOLOGY OF KNOWLEDGE 15, 18 (Anchor Books 1967) (1966), and adopting a grounded theory approach, Kathy Charmaz, *Grounded Theory, in* CONTEMPORARY FIELD RESEARCH: PERSPECTIVES AND FORMULATIONS 335, 335 (Robert M. Emerson, ed., 2d ed., 2001), qualitative research aims for research that "collect[s] descriptive data, people's own words, and people's behavior." STEVEN J. TAYLOR & ROBERT BOGDAN, INTRODUCTION TO QUALITATIVE RESEARCH METHODS: A GUIDEBOOK AND RESOURCE 4 (3d ed. 1998). Qualitative research is fast emerging as a critical tool in shedding light on the lives of people with disabilities, showing the complex interrelationship among physical impairment and societal barriers. Bonnie O'Day & Mary Killeen, *Research on the Lives of Persons with Disabilities: The Emerging Importance of Qualitative Research Methodologies*, 13 J. DISABILITY POL'Y STUD. 9, 11–12 (2002).

33. Schwartz, *supra* note 30, at 56–57, 72.

34. *Id.* at 57–60.

35. *See id.* at 3–4. Sign language is a very visual and kinesthetic language, involving the use of the hands, arms, body, and facial movements, a phenomenon that many non-signing hearing people initially find discomforting because they have never experienced communicating with a signer before. *See* Harmer, *supra* note 9, at 86. It takes a while to get used to it. An apt analogy would be communicating with a person with Tourette's syndrome, characterized by facial and body tics, and in extreme cases, coprolalia—uncontrolled profanity. People without Tourette's syndrome and who have never communicated with a Touretter may feel discomfort in witnessing the behavior, and it takes time to adjust. *See* LOWELL HANDLER, A TOURETTER'S TALE: TWITCH AND SHOUT 2, 221–23 (1998).

36. *See* Nemon, *supra* note 8, at 19–20. In a study exploring the relationship between Deaf patients and their doctors, the patients felt that their doctors failed to make a sincere effort to understand them when the patients described their symptoms. *Id.* Many patients felt they were treated like children and frequently given medication without sufficient information and explanation. *Id.*

37. Schwartz, *supra* note 30, at 292; *see also* Elizabeth Ellen Chilton, *Ensuring Effective Communication: The Duty of Health Care Providers to Supply Sign Language Interpreters for Deaf Patients*, 47 HASTINGS L.J. 871, 873–75 (1996); Steinberg et al., *supra* note 8, at 731. Some doctors and other health care professionals are becoming increasingly concerned with their cultural competence—

Because the vast majority of doctors do not sign, Deaf patients are forced to read and write notes in English. For many of these patients ASL, not English, is their native language, which places them at a disadvantage when communicating with their physician.[39] Patients who do not have a mastery of written English expressed discomfort with expressing themselves in a language in which they were not fluent or literate.[40]

Deaf patients reported that the process of writing notes with the doctor was "time-consuming, incomplete and cursory."[41] The laboriousness involved in writing under time constraints reduced both parties to brief questions and answers, and "question and answer is the customary form of communicative exchange between powerful and powerless, between adult and child."[42] The patients described doctors as hurrying them through the appointment, impatient with the process of paper-and-pen communication.[43] The patients felt disrespected and infantilized, but were worried about annoying or angering the doctor further if they insisted on fuller details.[44] The doctor's reported unwillingness to take the time to write complex ideas and wait for the response echoes Foster's finding that "the overall impression of many [Deaf people] was that hearing people simply didn't have the patience or motivation to work through difficult communication situations."[45] Consequently, Deaf patients often miss important information about their health.[46] Dominant communication practices in the medical setting not only reify and reinforce the power imbalance between patient and doctor; these practices also highlight the importance of providing appropriate auxiliary aids, including sign language

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the ability to empathize with people not like the doctor. Liability is not the sole force driving this concern; the realization that an awareness of another people's culture and beliefs actually assists the doctor in delivery of medical services. This realization is beautifully illustrated in a book about the collision of Hmong culture and American medicine—the doctors see epilepsy in a little girl, while her family regards her as giving expression to a higher spirituality, a spirituality not to be tampered by drugs. *See generally* ANNE FADIMAN, THE SPIRIT CATCHES YOU AND YOU FALL DOWN: A HMONG CHILD, HER AMERICAN DOCTORS, AND THE COLLISION OF TWO CULTURES (1997).

38. *See* Chilton, *supra* note 37, at 873–74; Steinberg et al., *supra* note 8, at 730–31, 738.

39. Golden & Ulrich, *supra* note 9, at 86–88; *see also* Steinberg et al., *supra* note 8, at 730; *Cf.* Harmer, *supra* note 9, at 95–96.

40. Schwartz, *supra* note 30, at 296–97.

41. *Id.* at 296.

42. ANN ARNETT FERGUSON, BAD BOYS: PUBLIC SCHOOLS IN THE MAKING OF BLACK MASCULINITY 13 (4th ed. 2004). In addition, doctors are famous for their unintelligible written scrawls. Lawrence K. Altman, *The Doctor's World: Is Physicians' Penmanship More Hazard Than Joke?*, N.Y. TIMES, March 11, 1986, at C1. To expect some Deaf patients to be able to decipher the scribbling of their physicians is unfair, particularly when it comes to communicating effectively about their health.

43. Schwartz, *supra* note 30, at 297.

44. *Id.*

45. Susan B. Foster, *Communicating Experiences of Death People: An Ethnographic Account*, *in* CULTURAL AND LANGUAGE DIVERSITY AND THE DEAF EXPERIENCE 117, 124 (Ila Parasnis ed., 1996).

46. *Id.* at 129.

interpreters, so that the Deaf patient can enjoy effective communication access, which hopefully will lead to adequate health care.[47]

As an adaptation to the aurally inaccessible environment of the medical setting, many Deaf patients report they are adept at "letting go."[48] If a Deaf patient is feeling healthy or asymptomatic, she is more likely to "let go," or disregard or ignore, an instance of communication difficulty with the doctor or nurse.[49] If a patient misses a word, phrase or sentence on the doctor's lips, or if she does not understand a written word or phrase, she will simply nod as if she understands and agrees.[50] As one patient put it" "If I'm feeling OK, I don't bother to ask for clarification."[51]

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47. Schwartz, *supra* note 30, at 296–97. An argument can be made that this constitutes unjustified disparate treatment based on disability, which violates the ADA. *See* 42 U.S.C. § 12182(b)(1)(A)(ii) (2000) ("It shall be discriminatory to afford an individual or class of individuals, on the basis of a disability or disabilities of such individual or class, directly, or through contractual, licensing, or other arrangements with the opportunity to participate in or benefit from a good, service, facility, privilege, advantage, or accommodation that is not equal to that afforded to other individuals."); 42 U.S.C. § 12182(b)(2)(A)(iii) (2000) (noting it is illegal to fail "to take such steps as may be necessary to ensure that no individual with a disability is excluded, denied services, segregated or otherwise treated differently than other individuals because of the absence of auxiliary aids and services"); 28 C.F.R. § 36.202(a) (2007) ("A public accommodation shall not subject an individual or class of individuals on the basis of a disability or disabilities of such individual class, directly, or through contractual, licensing, or other arrangements, to a denial of the opportunity of the individual or class to participate in or benefit from the goods, services, facilities, privileges, advantages, or accommodations of a place of public accommodation."). According to the Justice Department, "[t]he ADA mandates an equal opportunity to participate in or benefit from the goods and services offered by a place of public accommodation." U.S. Dep't of Justice, ADA Title III Technical Assistance Manual, at III-3.3000, http://www.usdoj.gov/crt/ada/taman3.html#III-3.3000 (last visited Apr. 3, 2008). Of course, not all differential treatment based on disability violates the ADA—the whole point behind the ADA is that there are circumstances where it is permissible, even required, to take disability into consideration when fashioning either reasonable or appropriate accommodations for people with disabilities. *See* 28 C.F.R. § 36.202(c) ("A public accommodation shall not provide . . . on the basis of disability . . . accommodation that is different or separate from that provided to other individuals, *unless such action is necessary to provide the individual or class of individuals with a good, service, facility, privilege, advantage, or accommodation, or other opportunity that is as effective as that provided to others*.") (emphasis added)); MARTHA MINOW, MAKING ALL THE DIFFERENCE: INCLUSION, EXCLUSION, AND AMERICAN LAW 377–78 (1990).

48. Schwartz, *supra* note 30, at 298.

49. *Id.*

50. *Id.* In its guide for law enforcement officers, the Department of Justice states that when an officer comes into contact with people who are Deaf or hard of hearing, the officer "should be careful about misunderstandings in the absence of a qualified interpreter. A nod of the head may be an attempt to appear cooperative in the midst of misunderstanding, rather than consent or a confession of wrongdoing." *See* U.S. Dep't of Justice, Guide for Law Enforcement Officers: When in Contact with People Who Are Deaf or Hard of Hearing, http://www.usdoj.gov/crt/ada/hernandoattd.htm (last visited Apr. 3, 2008).

51. Schwartz, *supra* note 30, at 298–99. "'Letting go,' however, carries within it a kernel of anxiety. The Deaf patient wonders: 'Am I missing something that might come around to bite me in the rear?' There is always that fear that what information the patient is not obtaining by 'letting go' is

But medicine is error-ridden—the process of diagnosing and treating illness is filled with mistakes.[52] Because errors unfold as a series of approximations, doctors must pay continuous attention to the patient's condition.[53] Dialogue permits the doctor to tailor the delivery and content of care to the needs of the individual patient, and this requires vigilance on the part of the doctor.[54] In a setting that is wholly aural and communication-inaccessible for many Deaf patients, forcing Deaf patients to interact with the medical provider without appropriate auxiliary aids—often a sign language interpreter—holds the potential for tragic error.[55]

1. The Experiences of the Fifteen Deaf Patients

This section explores the narratives of the fifteen Deaf patients in this author's study.[56] These stories demonstrate the extent to which communication access for Deaf patients in the medical setting is problematic. For example, when a Deaf patient requests an interpreter, many doctors respond: "No. We will not do it." A classic excuse is, "We can't afford it." Jeff Blye's daughter, Jenny, had serious cavities, and her regular dentist recommended that she see a pediatric specialist. The dentist called the specialist and "gave them all the information about the interpreters, insurance and everything." However, the specialist said he would not provide an interpreter, and despite the entreaties of the Blye's dentist, the specialist stood fast in his refusal.

Calvin Pabst's doctor told him he had no choice but to undergo surgery. As Pabst remembered this visit, "The examining room was a tiny closet-like room with no windows and a sliding door." The doctor led him to believe her word was final,

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exactly the information that is crucial to maintaining one's health." *Id.* at 299. Whenever the patient foregoes following up something he or she does not understand, the fear that something will happen down the road because the patient missed the warning signal is very real. The patient may rationalize what he is doing by saying the odds of that happening are so slight. *Id.* However, this process is unacceptable, particulary given that mistakes made during medical work are commonplace. MARIANNE A. PAGET, THE UNITY OF MISTAKES: A PHENOMENOLOGICAL INTERPRETATION OF MEDICAL WORK 97–98 (1988).

52. PAGET, *supra* note 51, at 97, 100.

53. *Id.* at 124–27.

54. *Id.* at 99–100.

55. The Justice Department acknowledges this much when it says: "It is not difficult to imagine a wide range of communications involving areas such as health, legal matters, and finances that would be sufficiently lengthy or complex to require an interpreter for effective communication." 28 C.F.R. § 36.303 app. B at 715 (2007) (quoting Preamble to Regulation on Nondiscrimination on the Basis of Disability by Public Accommodations and in Commercial Facilities, 56 Fed. Reg. 35,567 (July 26, 1991)).

56. This section is drawn from the author's dissertation study. Schwartz, *supra* note 30, at 141. Until the end of this section, footnotes will identify when a new page of the dissertation begins.

and Pabst felt he was not being given a chance to consider other options or to consult with another doctor.[57] He "wasn't comfortable with her."

a. Abusive Doctor

An interpreter told me that a few years ago he had an opportunity to work with a doctor who was treating a Deaf indigent African-American patient who was on Medicaid. For the entire examination, the doctor complained in front of his patient that he was not making enough money from a Medicaid patient who required the doctor to provide her with an interpreter. The doctor was visibly angry, and the interpreter signed everything he was saying. The patient was extremely distressed.

Emily Lourdes recalled a horrible experience with an elementary school psychologist that colored her feelings about doctors. The psychologist was giving Lourdes a test when Lourdes' hearing aid battery expired:

> It left me floundering. And, you know, you weren't allowed to keep batteries in your pocket. Even today, like you know, they didn't want you to have any aspirin or Tylenol or anything in your pockets. So, you couldn't keep the hearing aid battery in your pocket, so I would have to run to the nurse to get it and I didn't have time, so I was, like, "Ooops, I'm going to have to depend on lip reading." And I thought he asked me, "What kind of . . . what's your favorite animal?," and I answered, "Horses," and all of a sudden he hauled off and smacked me across the face. So hard that my hearing aid flew off my ear and I just took off and I ran to my grandmother's house and hid under a barn. She lived near the school. I was floored and my face blew up and was red. And after that I was afraid of doctors because of that experience.[58]

It turns out that the psychologist had asked Lourdes where milk comes from and hit her because he thought she was being "smart." Lourdes told her father she thought he asked what her favorite animal was. Lourdes was eleven years old, and she thought all doctors were like that school psychologist. Even to this day, she fears that a doctor will get angry, "and it really makes me feel kind of closed in."

b. Careless Doctor

Richard Franklin recalled a communication breakdown with his cardiologist who mistakenly put him down as a carpenter and did not bother to follow up with him.[59] Franklin had been a carpenter in a different state, and when he moved to New York, he became a civil engineer with a state agency; however, his

57. *Id.* at 141–42.

58. *Id.* at 142 (quoting patient Emily Lourdes during an interview with the author where Lourdes described an experience that she had with a school psychologist).

59. *Id.* at 143.

cardiologist assumed he was still a carpenter and wrote that in Franklin's file. This had serious repercussions for Franklin's open heart surgery because the kind of job a patient has plays a determining role in the kind of valve a heart surgeon inserts in a diseased heart. The surgeon had read in Franklin's file that he was a carpenter and based on that, recommended a pig valve, which has a life span of only 20 years as opposed to a lifetime warranty for a mechanical valve.

What was interesting about this incident was the fact that the surgeon gave Franklin his e-mail address and encouraged Franklin to communicate with him in that way. Franklin thought that was "very cool," and when the surgeon recommended the pig valve, Franklin went online to research the difference between the pig and mechanical valves. By prodding the surgeon on why he preferred one valve to the other, Franklin was able to uncover the cardiologist's erroneous information.

Hetty Smith offered another example of a doctor who could have used more care. If Smith's daughter was unavailable, Smith went in anyway:

> One time, it happened that I hurt my shoulder and relied on my daughter—and I wasn't happy about that. So I called my doctor and told him my shoulder hurts, it is important. The doctor said to come in. So I went in at 2:00 p.m. in the afternoon. I told him my shoulder hurt, and the doctor and I wrote notes back and forth. I told him about my problem, and the doctor examined me and took an X-ray. Everything looked normal. I told him I was in pain. So he gave me a pain-killing medicine. The doctor gave me medicine.[60]

However, the medicine, according to Smith, was an antibiotic.[61] The doctor gave her medicine without explaining its purpose. Asked if the doctor explained what the medicine was for, Smith replied: "He told me to take it everyday, every four hours." He did not explain in more detail; he did not tell her the name of the drug or what it was for. Smith recalled that "he just gave it to me and told me how many times a day to take it. He gave it to me for pain, that was it." An antibiotic for pain? One wonders what was in the written communication that would lead a doctor to prescribe an antibiotic for pain.

c. Unresponsive Doctor

Penelope Durst once wrote a letter in advance in which she outlined her expectations and goals for the visit. It was her "attempt to improve communication" with her doctor. The letter expressed Durst's desire "to know what is going on. I would like to know what the test results are . . . . I say [sic] in the letter what I'm

60. *Id.* at 143 (quoting patient Hetty Smith during an interview with the author where Smith described an experience that she had with her doctor).

61. *Id.* at 144.

concerned about and I hope to know about what's going on." However, the doctor did not respond, and Durst felt like she did not have a rapport with her doctor. Durst felt the doctor did not understand why she felt the need to write the letter. So she tried again, telling the doctor:

> You know, this is my personality. I'd really like to know what's going on. I want to have all the information and sometimes it's busy in the office and I thought that maybe this would be a way to improve our communication. You know, I want to know what would be involved. [The letter] was really an attempt at building a relationship.[62]

The doctor responded, "Well, let me know if there is anything else that you want to know." Durst was dissatisfied with that answer.

Durst felt the doctor was infantilizing her because "she didn't really share with me what was going on. She didn't really share with me things that she had discovered and I felt that was important information for me to know. Very specifically what was going on and I felt awkward with her."[63] When Durst asked to see her medical records, the doctor gave her a hard time:

> Oh, well, there's a procedure you have to follow. I said, "Well, okay, there's a procedure, I'm just asking for a copy. I was wondering if I could read [my file]. And the doctor said, "Well, what are you worried about?" And I was, like, "No, I just want to know what my record says, you know."[64]

Durst insisted on being allowed to read her medical file, and the doctor said, "You look like you're worried," and Durst said, "I'm not worried, I just want to read my medical record." Finally the doctor said, "Well, I'll find out who you'll have to talk to so you can have access to your medical records." Durst and her doctor did not have an interpreter. In fact, the hassle over Durst's medical records made her leery about requesting an interpreter: "I'm afraid if I ask for an interpreter, they'll say no. They'll give me a reason like there's no money, or whatever. That I may not be able to fight against [sic]. And they'll say, well you know you can bring an interpreter yourself or you're responsible to pay for it . . . I didn't really want to ask."

Even though Penelope Durst understands that the law requires the doctor to provide an interpreter, she does not want to deal with "the frustration and the hassle of setting the stage for that . . . . it's really difficult to prove discrimination. And you know, I find that they resist as a matter of course. I don't feel like they take responsibility and a lot of them aren't aware of the ADA. It's a little overwhelming

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62. *Id.* (quoting patient Penelope Durst during an interview with the author where Durst described her attempts to improve communications with her doctor).

63. *Id.* at 144–45.

64. *Id.* at 145 (quoting patient Penelope Durst during an interview with the author where Durst described her attempts to review her medical records).

for me. It's a little too much and frustrating for me and they don't get it. So sometimes it's just easier to just go to the doctor, without [the interpreter]."

Penelope Durst's worst experience with a doctor involved one who would not look at her, instead looking to other people for answers. The key to effective communication for Deaf people is eye contact.[65] Often, when a Deaf person speaks with a hearing person and he or she looks down or away, the Deaf person stops talking because without that eye contact, the Deaf person feels he cannot go on talking. Not surprisingly, Durst felt her doctor was not listening to her. Without that eye contact, communication falls apart.

d. Resistant Doctor

When I asked Richard Franklin to contrast his work with private doctors with his experiences in the Monroe infirmary, Franklin grimaced:

> It's interesting. In New Jersey, where I worked, I had hassles with the doctors. Their attitude was [sic] different than the attitudes of doctors here in New York, which has a more diverse population, it's more open, more interaction with different people. In New Jersey, it's different. I had more hassles down there.[66]

Asked to clarify what he meant by "different," Franklin complained that New Jersey doctors almost never provided interpreters. Franklin always "had to struggle with them." The doctors would say they would provide an interpreter, but when Franklin showed up, an interpreter was not there.

> Richard Franklin: "An interpreter? I called for an interpreter." I [would] look at them skeptically, and when I check[ed] with the agency, I find out the agency never got the call. So that way the doctor is playing around.
> Michael A. Schwartz: Does that happen often?
> Richard Franklin: Once in a while. But once a doctor gets to know me, when I go in regularly, they don't do that.

Franklin would go ahead with the visit "many times, many times." Asked how he communicated in these situations, Franklin recalled that it was "tough." However, he has good lip reading, English speaking, and writing skills. Writing notes was always a fall back position for both Franklin and his doctor.

Richard Franklin never had an interpreter with his family doctor until after my interview with him when he decided to ask for one and ran into difficulty.[67] As Franklin recalled:

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65. *Id.* at 145–46.

66. *Id.* at 146 (quoting patient Richard Franklin during an interview with the author where Franklin described the attitudinal differences between doctors in New York and New Jersey).

67. *Id.* at 147.

> "It was a big shock to me. I was floored. Here, all this time I hadn't been using an interpreter and when I make the decision to call one in because of the nature of my problem, I didn't abuse the whole idea of having an interpreter. I never used one. And so here now when I need one, I ask for one, he tells me no. I was shocked. Really!"

Emily Lourdes does not use an interpreter during dental visits. She has been going to the same dentist for many years, "and we write back and forth." She has no problems with her teeth and feels comfortable without an interpreter in the dental office. Asked why she wanted an interpreter with a doctor but not the dentist, Lourdes said: "Well, I haven't used one because the communication is fine. I communicate well with the nurse, the dentists, the dental assistant, the hygienist. If there's anything serious, we write back and forth."

Lourdes is satisfied with that process, but medical doctors are a problem:

> Because they are resistant [sic]. The communication with the doctor is limited because it's a last minute appointment, we don't have much time. Now a medical doctor books many people at once. They book them every five or ten minutes, so there's really a limited time in between patients. They don't have a lot of time to go into any in-depth explanations.[68]

e. Billed for Communication Time

Lourdes raised an interesting issue, one that had not come up with the other respondents—she suspects she is being charged for the extra time it takes the doctor to communicate with her. She noticed several bills reflected a charge for the additional ten minutes; "for example, [in] a regular visit, if you ask a lot of questions and I have to write things down, I'm stealing time from another patient.[69] And they count it as an extended visit." Lourdes objects:

> Extended visit? Instead of a regular visit, hey, if I get the time and there's more time to talk and communicate because they're writing, you know I need to do that and here I am being charged for an extended visit because of the communication. What do you think of that? If I have to talk to the doctor, I feel that's discrimination.[70]

Lourdes's insurance covers the extra time, so she does not say anything to her doctor:

> But they shouldn't do that because a Deaf person needs, or a blind person or a person with handicapped [sic], a mentally retarded person . .

68. *Id.* (quoting patient Emily Lourdes during an interview with the author where Lourdes described communication problems with her doctor).

69. *Id.* at 147–48.

70. *Id.* at 148 (quoting patient Emily Lourdes during an interview with the author where Lourdes discussed an extended visit charge she received from her doctor).

> . how [do] they communicate with them? If they don't feel comfortable, so what happens if it's a minute too long or [ten] minutes more and they're charging the extra for an extended visit because it's gone over?

Lourdes calls doctors "greedy."

f. Doctor Refused to Allow Substitute to Replace ZIG Interpreter

Emily Lourdes had a bad experience with one doctor. She made arrangements for medical tests. It involved a serious health problem, and Lourdes needed to communicate with him during the test. She thus arranged to have an interpreter present for the exam, and Zamboni Interpreter Gigs called to confirm the assignment of an interpreter. However, the day before that medical exam, Zamboni informed Lourdes that the interpreter was unavailable. Lourdes, already in pain and dealing with anxiety over the test, became very upset. She was fearful she would have to put off the test and did not want to "because it would be another six months before I could get an appointment." Lourdes pressed the agency and learned that the interpreter discovered the assignment involved medical interpreting and declined to accept the assignment due to lack of experience in this area of interpreting. Agitated and angry, Lourdes called her contacts in the Deaf community and found someone who would be willing to interpret at the examination.[71] Lourdes then called the doctor, and the doctor said, "No, we only accept interpreters from Zamboni Interpreter Gigs." Incredulous and angry, Lourdes replied, "What!? What do you mean?" The doctor said, "No, we have to work with Zamboni Interpreter Gigs interpreters because we have a contract with Zamboni."

Emily Lourdes asked me for my advice on this problem. After I explained my view, Lourdes recounted how the situation ended:

> Zamboni Interpreter Gigs failed to provide the interpreter, I have someone who is willing, you know, who can sign to me. She's not connected with Zamboni, and she's not under their auspices. So, they said, "Sorry, we have a contract with Zamboni." So I asked this person if she would interpret for me anyway, and then I paid for her. If I go to court and I actually sue these people and get some money, then the interpreter can pay me back. So anyway . . . charging for gas and mileage, she said she would work it out, and I said if there was a court deal, we'll try to work the whole thing out. And I tried . . . I did try one lawyer, but it wasn't successful. I didn't want to get into suing Zamboni Interpreter Gigs.[72]

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71. *Id.* at 148–49.

72. *Id.* at 149 (quoting patient Emily Lourdes during an interview with the author where Lourdes discussed the problems that she faced when trying to bring her interpreter to her doctor's office).

g. Problems with Communication Access

Amanda Blye had a communication breakdown with the doctor because the interpreter was not clear. She was experiencing a high-risk pregnancy, and she wanted to communicate her fears and anxieties about her pregnancy to the doctor. However, Amanda has a tendency to sign very fast, and she fingerspells in a blur. It is not easy to voice for her, and not surprisingly the interpreter had a lot of difficulty in understanding Amanda and voicing properly for her. Luckily for Amanda, she has enough "gumption" to say something, and she informed the doctor she wanted a replacement. The doctor readily agreed, and another interpreter from Zamboni Interpreter Gigs was called in to replace the first interpreter.

As if comprehending written English was not enough of a problem, Deaf patients have to deal with deciphering the doctor's handwriting and understanding its meaning.[73] Having to write notes back and forth with her doctor, Amanda stated, "sometimes I don't understand what [the doctor has] written . . . the doctor notices that, too . . . sometimes I don't understand the way she writes, the handwriting."

A fear of angering the doctor or feeling intrusive into the doctor's time leads to the phenomenon of "letting it go." I had asked Vinnie Brasco if he followed up a word or phrase he did not understand in a written communication from his doctor, and he said, "No. I let it go." I asked him, "Why did you let it go?" He said, "I could sense [the doctor] was in a hurry and I didn't want him to be impatient with me. I didn't want to intrude on his time."

Like many Deaf people, Brasco is keenly tuned into the visual: he could sense from the doctor's body language and facial expression how he was dealing with the writing process. When I asked Brasco what he remembered of the doctor's facial expression while writing notes, Brasco replied, "to me, it looked like he was 'tolerating' me . . . being patient . . . when he would start to show a difference in his body language, like he was getting impatient and wanted to hurry up, then I would feel uncomfortable."

Some of the subjects confessed to a lack of confidence in their ability to express themselves in writing with the doctor. Richard Franklin recalled:

> Well um, okay, if I write a question down and they can't answer it, I assume that they don't understand my question. Not that they don't know the answer. I wonder if they think [sic]. I mean the question is phrased wrong and I think that's interesting, so I tend to drop it. That's why an interpreter is good because the issue of how I'm phrasing the question, how I'm asking it doesn't come in.[74]

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73. *Id.* at 150.

74. *Id.* (quoting patient Richard Franklin during an interview with the author where Franklin described difficulties that he faced when attempting to communicate with his doctor through hand-written notes).

Bea Romanoff pointed out the difficulty she had in pressing her claim against a doctor who would not provide access:

> Sometimes I don't follow up because I get so caught up in the things that I'm doing, and then time passes. I really should, but I didn't follow up in that case. I was intimidated too, I think. And when you do file a complaint, the paperwork for that has so much detail.[75]

Romanoff's English skills were good, so she was able to process and file a complaint against a particular doctor. However, as she realized, writing out a complaint is very difficult for an average Deaf person. Many of Romanoff's clients use ASL as their primary mode of communication, not English, much less spoken English. Romanoff finds she had to assist them with their correspondence:

> Many times I have to help my clients understand what's written in letters to them. That's part of my job, so I'm very familiar with the gaps in their English language usage. They would tell me what they want to say in ASL, and then I have to translate it into English and type it out on forms and things like that. Sometimes things happen, and I don't follow-up with my own life, but I've done that kind of advocating for others.[76]

In addition, a Deaf person may be afraid to ask for an interpreter because he or she does not have good communication skills or is less well-educated. According to Romanoff, "They may not know their rights, the doctor won't see them, or they are sick and they want to get on with being treated."

Hetty Smith's experience with her daughter as an interpreter is an illustration of the danger in using a family member to interpret: lack of clarity, failure to communicate the details of the conversation, leaving the Deaf person out, and simplifying the information ("dumbing down"):

> So I asked my doctor, "Would you mind my daughter interpreting? It wouldn't be often." He said, no, he wouldn't mind. My daughter came with me, and we were together in the doctor's office. You know, my daughter isn't a super interpreter. She's not clear. So she talked with the doctor, talk, talk, talk, and I kept having to say, "What did you say? What did he say?" They talked with each other, and I was left out. I kept asking, "What did you say? What did he say?" She simplified things for me. I wasn't satisfied.[77]

It is striking that Smith felt compelled to ask her doctor if it would be okay for Smith's daughter to mediate as interpreter, and to qualify the request as an

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75. *Id.* at 151 (quoting patient Bea Romanoff during an interview with the author where Romanoff described her reluctance to file complaints against her doctors).

76. *Id.* (quoting patient Bea Romanoff during an interview with the author where Romanoff discusses her attempts to translate correspondence for other Deaf patients).

77. *Id.* at 151–52 (quoting patient Hetty Smith during an interview with the author where Smith discussed utilizing her daughter as an interpreter during a visit with her doctor).

intermittent one. The problem was that the daughter had her own life to live and was not always available. In that event, Smith wrote notes back and forth, but the notes were even less satisfactory:

> Sometimes I'd go in and write back and forth. My daughter is busy, she has other responsibilities, so when she didn't come, the doctor and I would write notes back and forth. The doctor didn't always explain clearly about my health. It was a mess. I wasn't happy.

Even with her daughter as interpreter, Smith had no privacy in her doctor's office:

> I didn't have any privacy, yes. But anyway we didn't go into any depth with the doctor. My daughter would tell me the important things. Blood pressure, that kind of thing. It worked out. The doctor would tell me about my medicine. He would write it down. Then me and my daughter would leave.[78]

II. AN EFFORT TO SOLVE THE PROBLEM: REQUIRING APPROPRIATE AUXILIARY AIDS UNDER THE ADA

In a long overdue effort to address discrimination against people with disabilities, including those who are Deaf or hard-of-hearing, the Americans with Disabilities Act of 1990 (ADA), a pioneering civil rights act for people with disabilities, requires places of public accommodation such as physicians' offices and hospitals to provide effective access for people with disabilities. Effective communication access for Deaf individuals often includes sign language interpreters.[79] According to the ADA, "[n]o individual shall be discriminated against on the basis of disability in the full and equal enjoyment of the goods, services, facilities, privileges, advantages, or accommodations of any place of public accommodation by any person who owns, leases (or leases to), or operates a place of public accommodation."[80]

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78. *Id.* at 152 (quoting patient Hetty Smith during an interview with the author).

79. *See* Americans with Disabilities Act of 1990, Pub. L. No. 101-336, 104 Stat. 327 (1990) (codified as amended at 42 U.S.C. § 12101–12213 (2000)). A doctor's office is included in the twelve categories of public accommodations. 42 U.S.C. § 12181(7)(F); 28 C.F.R. § 36.104 (2007) ("Place of public accommodation means a facility, operated by a private entity, whose operations affect commerce and fall within at least one of the following categories . . . professional office of a health care provider."). To avoid confusion, the author will use the term, "doctor's office," in lieu of "place of public accommodation" or "public accommodation" because the terms are interchangeable, and because the focus of this article is on the doctor's office. *See* 42 U.S.C. § 12181(7)(F). By the same token, by the term, "doctor's office," the author means to include hospitals and medical clinics, both of which are included in the legal definition of a public accommodation. *Id.*; 28 C.F.R. § 36.104.

80. 42 U.S.C. § 12182(a).

The general prohibition against discrimination envisions activities of the following sort: denial of participation,[81] participation in an integrated setting[82] and an opportunity to participate.[83] Two specific prohibitions against discrimination particularly interest Deaf patients: "a failure to make reasonable modifications in policies, practices or procedures,"[84] and "a failure to [provide] auxiliary aids or services."[85] These provisions seek to remove communication barriers and to include and integrate Deaf people into everyday American life.

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81. *Id.* § 12182(b)(1)(A)(i) ("It shall be discriminatory to subject an individual or class of individuals, on the basis of a disability or disabilities of such individual or class, directly, or through contractual, licensing, or other arrangements, to a denial of the opportunity of the individual or class to participate in or benefit from the goods, services, facilities, privileges, advantages, or accommodations of an entity."); *see also* 28 C.F.R. § 36.202(a) ("A public accommodation shall not subject an individual . . . on the basis of disability . . . to a denial of opportunity . . . to participate in or benefit from the goods, services, facilities, privileges, advantages or accommodations of a place of public accommodation.").

82. 42 U.S.C. § 12182(b)(1)(B) ("Goods, services, facilities, privileges, advantages, and accommodations shall be afforded to an individual with a disability in the most integrated setting appropriate to the needs of the individual."); *see also* 28 C.F.R. § 36.203(a) ("A public accommodation shall afford goods, services, facilities, privileges, advantages, and accommodations to an individual with a disability in the most integrated setting appropriate to the needs of the individual.").

83. 42 U.S.C. § 12182(b)(1)(C) ("Notwithstanding the existence of separate or different programs or activities provided in accordance with this section, an individual with a disability shall not be denied the opportunity to participate in such programs and activities that are not separate or different."). *See also* 28 C.F.R. § 36.203(b) ("Notwithstanding the existence of separate or different programs or activities provided in accordance with this subpart, a public accommodation shall not deny an individual with a disability an opportunity to participate in such programs or activities that are not separate or different.").

84. 42 U.S.C. § 12182(b)(2)(A)(ii). *See also* 28 C.F.R. § 36.302(a) ("A public accommodation shall make reasonable modifications in policies, practices, or procedures, when the modifications are necessary to afford goods, services, facilities, privileges, advantages, or accommodations to individuals with disabilities, unless the public accommodation can demonstrate that making the modifications would fundamentally alter the nature of the goods, services, facilities, privileges, advantages, or accommodations."). Similarly, a public accommodation must remove structural communication barriers (permanent signage, alarm systems, sound buffers, walls) if "readily achievable." 42 U.S.C. § 12182(b)(2)(A)(iv); 28 C.F.R. § 36.304(a). However, this obligation is independent of any obligation to provide auxiliary aids and services. 28 C.F.R. § 36.304 app. B at 709 (2006); *see also* 42 U.S.C. § 12182(b)(2)(A)(v).

85. 42 U.S.C. § 12182(b)(2)(A)(iii). The Justice Department regulation echoes the statute:

> A public accommodation shall take those steps that may be necessary to ensure that no individual with a disability is excluded, denied services, segregated or otherwise treated differently than other individuals because of the absence of auxiliary aids and services, unless the public accommodation can demonstrate that taking those steps would fundamentally alter the nature of the goods, services, facilities, privileges, advantages, or accommodations being offered or would result in an undue burden, i.e., significant difficulty or expense.

28 C.F.R. § 36.303(a). The Department's commentary states, "The Department wishes to emphasize that public accommodations must take steps necessary to ensure that an individual with a disability will not be excluded, denied services, segregated or otherwise treated differently from other individuals because of the use of inappropriate or ineffective auxiliary aids." 28 C.F.R. § 36.303 app. B at 708 (2006). "As provided in Section 36.303(f), a public accommodation is not required to provide any particular aid or service that would result either in a fundamental alteration in the nature of the goods, services, facilities,

The key is effective communication access: "A public accommodation shall furnish appropriate auxiliary aids and services where necessary to ensure effective communication with individuals with disabilities."[86] The auxiliary aid requirement is flexible: "A public accommodation may choose among various alternatives as long as the result is effective communication."[87] What constitutes "effective communication" is a question of fact.[88] However, commentary by the Department of Justice states: "It is not difficult to imagine a wide range of communications involving areas such as health, legal matters, and finances that would be

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privileges, advantages, or accommodations offered or in an undue burden." *Id.* at 709. In determining whether an action would impose an undue burden on a public accommodation, the following factors must be considered:

> (1) The nature and cost of the action needed under this part; (2) The overall financial resources of the site or sites involved in the action; the number of persons employed at the site; the effect on expenses and resources; legitimate safety requirements that are necessary for safe operation, including crime prevention measures; or the impact otherwise of the action upon the operation of the site; (3) The geographic separateness, and the administrative or fiscal relationship of the site or sites in question to any parent corporation or entity; (4) If applicable, the overall financial resources of any parent corporation or entity; the overall size of the parent corporation or entity with respect to the number of its employees; the number, type, and location of its facilities; and (5) If applicable, the type of operation or operations of any parent corporation or entity, including the composition, structure, and functions of the workforce of the parent corporation or entity.

28 C.F.R. § 36.104. Most courts addressing the issue of cost "have noted that a reasonable accommodation is both moderate and not unduly burdensome." Bravin v. Mount Sinai Med. Ctr., 186 F.R.D. 293, 305 (S.D.N.Y. 1999) (citing Easley v. Snider, 36 F.3d 297, 305 (3d Cir. 1994); Rothschild v. Grottenthaler, 907 F.2d 286, 293 (2d Cir. 1990).

86. 28 C.F.R. § 36.303(c). As the Department's commentary explains:

> Implicit in this duty to provide auxiliary aids and services is the underlying obligation of a public accommodation to communicate effectively with its customers, clients, patients, or participants who have disabilities affecting hearing, vision, or speech . . . [a]uxiliary aids and services include a wide range of services and devices for ensuring effective communication. Use of the most advanced technology is not required so long as effective communication is ensured.

28 C.F.R. § 36.303 app. B at 706 (2006). Despite the urging of commentators, the Department refused to enumerate the list of possible appropriate accommodations, saying, "[s]uch an attempt would omit new devices that will become available with emerging technology." *Id.*

87. 28 C.F.R. § 36.303 app. B at 707 (2007). For example, a bookstore engaged in a sales transaction would not be required to provide a sign language interpreter because a notepad and pen would be effective under these circumstances. *Id.*

88. *Bravin*, 186 F.R.D. at 302; *see also* Borkowski v. Valley Central Sch. Dist., 63 F.3d 131, 141 (2d Cir. 1995); Mohamed v. Marriott Int'l, Inc., 905 F. Supp. 141, 152 (S.D.N.Y. 1995). For this reason, the issue is not appropriately disposed of on a Rule 12(b)(6) motion to dismiss a complaint. *Bravin*, 186 F.R.D. at 302 (noting that plaintiff's pleading states a claim upon which relief could be granted and concluding that the fact-finder must determine whether Mt. Sinai provided "reasonable and effective" means of communication); *see also* Proctor v. Prince George's Hosp. Ctr., 32 F. Supp. 2d 820, 827–28 (rejecting defendant's motion for summary judgment because courts generally focus on "specific instances during the interaction between the disabled individual and the public accommodation . . . .").

sufficiently lengthy or complex to require an interpreter for effective communication."[89]

Auxiliary aids and services include qualified sign language interpreters or other effective methods of making aurally delivered materials available to individuals with hearing impairments.[90] A qualified sign language interpreter can "interpret effectively, accurately and impartially, both receptively and expressively, using any necessary specialized vocabulary."[91] Public accommodations may not charge Deaf or hard-of-hearing people for an auxiliary aid or service, or for the reasonable modification to a policy, practice or procedure.[92]

Even if the original auxiliary aid or service is deemed too expensive or constitutes a fundamental alteration to the program or service of the public accommodation, the public accommodation is still obligated to provide an alternative auxiliary aid or service that would ensure, to the maximum extent possible, access to the place of public accommodation.[93] The public accommodation does not have to provide the person with a disability with a personal aid or device like a hearing aid or a cane.[94] Likewise, nothing in the law or

89. 28 C.F.R. § 36.303 app. B at 708 (2006).

90. 28 C.F.R. § 36.303(b) ("The term 'auxiliary aids and services' includes—(1) Qualified interpreters, notetakers, computer-aided transcription services, written materials, telephone handset amplifiers, assistive listening devices, assistive listening systems, telephones compatible with hearing aids, closed caption decoders, open and closed captioning, telecommunications devices for Deaf persons (TDDs), videotext displays, or other effective methods of making aurally delivered materials available to individuals with hearing impairments."). Another example of "auxiliary aids and services" is the "[a]cquisition or modification of equipment or devices." *Id.* § 36.303(b)(3).

91. 28 C.F.R. § 36.104 (2007) (defining "qualified interpreter"); *see also* Clarkson v. Coughlin, 898 F. Supp. 1019, 1027 (S.D.N.Y. 1995).

92. 28 C.F.R. § 36.301(c) ("A public accommodation may not impose a surcharge on a particular individual with a disability or any group of individuals with disabilities to cover the costs of measures, such as the provision of auxiliary aids, barrier removal, alternatives to barrier removal, and reasonable modifications in policies, practices, or procedures, that are required to provide that individual or group with the nondiscriminatory treatment required by the Act or this part."). As the Department's commentary points out, "[t]he costs of compliance with the requirements of this section may not be financed by surcharges limited to particular individuals with disabilities or any group of individuals with disabilities." 28 C.F.R. § 36.303 app. B at 716 (2007).

93. 28 C.F.R. § 36.303(f) ("If provision of a particular auxiliary aid or service by a public accommodation would result in a fundamental alteration in the nature of the goods, services, facilities, privileges, advantages, or accommodations being offered or in an undue burden, i.e., significant difficulty or expense, the public accommodation shall provide an alternative auxiliary aid or service, if one exists, that would not result in an alteration or such burden but would nevertheless ensure that, to the maximum extent possible, individuals with disabilities receive the goods, services, facilities, privileges, advantages, or accommodations offered by the public accommodation.").

94. 28 C.F.R. § 36.306 ("Personal Devices and Services. This part does not require a public accommodation to provide its customers, clients, or participants with personal devices, such as wheelchairs; individually prescribed devices, such as prescription eyeglasses or hearing aids; or services of a personal nature including assistance in eating, toileting, or dressing.").

regulations require a person with a disability to accept "an accommodation, aid, service, opportunity, or benefit available" offered by the public accommodation."[95]

In order to establish a *prima facie* case of disability discrimination against a medical provider under Title III of the ADA, the plaintiff must prove three elements: (1) that she has a disability; (2) that defendant's office is a place of public accommodation; and (3) that defendant discriminated against her by engaging in a proscribed activity based on the plaintiff's disability.[96] The plaintiff must show circumstances giving rise to an inference that the denial of the full and equal enjoyment of medical treatment is based on the plaintiff's disability.[97]

Once plaintiff establishes a *prima facie* case, the burden shifts to the defendant to prove that he or she did not discriminate against the plaintiff.[98] The defendant must prove either that the plaintiff was not denied access to the medical provider's office, or that the denial was not unlawful; the burden then shifts back to plaintiff to rebut defendant's reasons as pretext for unlawful discrimination.[99]

Title III provides two mechanisms for enforcement. The first mechanism authorizes a private plaintiff to seek an injunction barring ongoing discrimination

95. 28 C.F.R. § 36.203(c). Under the ADA, a public accommodation is "strongly encourage[d]" to consider a disabled person's choice of an auxiliary aid or service for the purpose of assisting the person in communicating with the public accommodation, but it is not required to give deference to the disabled person's preference. 28 C.F.R. § 36.303 app. B at 707–08 (2006) ("Based upon a careful review of the ADA legislative history, the Department believes that Congress did not intend under Title III to impose upon a public accommodation the requirement that it give primary consideration to the request of the individual with a disability [and] . . . finds that strongly encouraging consultation with persons with disabilities, in lieu of mandating primary consideration of their expressed choice, is consistent with congressional intent.").

96. Mayberry v. Von Valtier, 843 F. Supp. 1160, 1164 (E.D. Mich. 1994). With respect to Deaf patients complaining about the denial of appropriate auxiliary aids in the medical setting, the third element, the nexus between the complained-of activity and the plaintiff's disability, is the crux of much of the litigation under review in this article.

97. *Id.* at 1166. The plaintiff does not need to prove actual discriminatory intent in order to establish the prima facie case. *Id.* (analogizing ADA cases to cases interpreting § 504 of the Rehabilitation Act, 29 U.S.C. § 794 (2000)).

98. *Id.*

99. *Id.* The Court of Appeals for the Fifth Circuit addressed the allocation of the burden of proof in a case involving "reasonable modification" to a brewery company's "no animals" policy at its brewery, which was challenged by a blind tourist who wanted to take the group tour with his guide dog. Johnson v. Gambrinus Co., 116 F.3d 1052, 1056, 1058 (5th Cir. 1997). The brewery offered to provide an employee in lieu of the guide dog. *Id.* at 1056. The Court of Appeals held that plaintiff had the burden of coming forward with proof that a modification to defendant's policy was requested, and that the modification was a reasonable one. *Id.* at 1059. Then the burden shifts to the defendant to show that the requested modification would fundamentally alter the nature of its business. *Id.* Defendant's evidence cannot be of a general nature; it must be specific to the plaintiff's and defendant's circumstances. *Id.* at 1059–60. If the defendant is successful in doing this, the burden then shifts back to the plaintiff to demonstrate pretext. *Mayberry*, 843 F. Supp. at 1166.

based on disability.[100] The private plaintiff cannot obtain injunctive relief for a single past incident of discrimination without a showing that the discrimination is continuing or ongoing.[101] Injunctive relief is the sole remedy for a private plaintiff; compensatory damages are not recoverable in a private civil suit.[102]

The second mechanism authorizes the Attorney General of the United States to investigate and prosecute violations of the ADA when the Attorney General has reasonable cause to believe that a defendant is engaged in a pattern or practice of discrimination, or that the discrimination raises an issue of public importance.[103] Unlike a private plaintiff, the Attorney General may seek injunctive relief for past discriminatory conduct,[104] monetary damages for aggrieved persons,[105] and civil penalties against the defendant of up to $50,000 for a first violation and up to $100,000 for a subsequent violation.[106]

Title III of the ADA allows a disabled person to sue for injunctive relief where the person has "actual notice" that a person or organization covered by Title III does not intend to comply with its provisions: "Nothing in this section shall require a person with a disability to engage in a futile gesture if such person has actual notice that a person or organization covered by this subchapter does not intend to comply with its provisions."[107]

The "actual notice" standard obviates the need for the person to seek access to the place of public accommodation (e.g., the doctor's office or hospital) as a precursor to filing suit.[108]

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100. 42 U.S.C. § 12188(a)(2) (2000); 28 C.F.R. § 36.501. Injunctive relief is available to compel the removal of architectural and communication barriers "that are structural in nature," 42 U.S.C. § 12182(b)(2)(A)(iv), as well as to make new facilities "readily accessible to and usable by individuals with disabilities," *id.* § 12183(a)(1). Additionally, "[w]here appropriate, injunctive relief shall also include requiring the provision of an auxiliary aid or service." *Id.* § 12188(a)(2).

101. DeLil v. El Torito Rests., Inc., No. C 94-3900-CAL, 1997 WL 714866, at *5 (N.D. Cal. June 24, 1997).

102. 42 U.S.C. § 12188(a)(2) (providing for injunctive relief in private suits by affected parties). The Attorney General has the authority to bring a civil action and request compensatory damages on behalf of private parties. 42 U.S.C. § 12188(b) (providing for civil penalties ranging from $50,000 to $100,000 per violation); Jairath v. Dyer, 154 F.3d 1280, 1283 (11th Cir. 1998); Sanchez v. ACAA, 247 F. Supp. 2d 61, 67 (D.P.R. 2003); Riggs v. Cuna Mut. Ins. Soc'y, 171 F. Supp. 2d 1210, 1215 (D. Kan. 2001); Atakpa v. Perimeter Ob-Gyn Assocs., 912 F. Supp. 1566, 1573 (N.D. Ga. 1994); *see also* Ruth Colker, *ADA Title III: A Fragile Compromise*, 21 BERKELEY J. EMP. & LAB. L. 377, 378 (2000).

103. 42 U.S.C. §§ 12188(b)(1)(A)(i), (b)(1)(B).

104. *See id.* § 12188(b)(1)(B)(ii) (authorizing enforcement action when discrimination "raises an issue of general public importance"); *DeLil*, No. C 94-3900-CAL, 1997 WL 714866, at *5 (noting that the Attorney General may bring a civil suit for past discrimination under § 12188(b)(1)(B)).

105. 42 U.S.C. § 12188(b)(2)(B).

106. *Id.* § 12188(b)(2)(C).

107. *Id.* § 12188(a)(1).

108. ANNE MARIE ESTEVEZ & BETH S. JOSEPH, PUBLIC ACCOMMODATIONS UNDER THE AMERICANS WITH DISABILITIES ACT § 14:3(2) (2006).

The ADA's access requirements are backed up by federal regulations issued by the Justice Department.[109] The law establishes the right of a Deaf patient to receive an appropriate auxiliary aid to obtain effective communication access in the medical setting, which often means a sign language interpreter.[110] Furthermore, the law places the financial responsibility for providing such an aid with the medical provider.[111] Yet, when a Deaf patient encounters a recalcitrant provider and seeks a court-ordered injunction forcing the provider to comply with the law, the patient who is unwilling to return to the provider's office runs into a major problem of justiciability: standing.

III. THE LAW OF STANDING

Pursuant to Article III of the United States Constitution, federal courts are constrained to hear only "cases" or "controversies,"[112] and standing to sue (or defend) is an aspect of the case or controversy requirement.[113] Standing examines whether "a party has a sufficient stake in an otherwise justiciable controversy to obtain judicial resolution of that controversy."[114] Standing is more concerned with the party seeking relief than with the issues he or she wishes to raise in the suit.[115] Establishing standing requires a showing of three prongs: injury-in-fact, causation, and redressability.[116] The Supreme Court breaks injury-in-fact into two categories: the type of harm and future injury.[117] The cases involving medical facilities' provision of appropriate auxiliary aids to Deaf patients are mostly within the latter

109. *See* 28 C.F.R. § 36.101 (2007).

110. *See* 42 U.S.C. § 12182(a); 28 C.F.R. § 36.303 (listing the example of auxiliary aids available to Deaf people); *Id.* § 36.104 (explaining that pharmacies, professional offices and hospitals are places of public accommodation).

111. 28 C.F.R. § 36.301(c). Congress stated that the law's purpose was "to provide a clear and comprehensive national mandate for the elimination of discrimination against individuals with disabilities . . . to provide clear, strong, consistent, enforceable standards addressing discrimination against individuals with disabilities . . . and, to invoke the sweep of congressional authority . . . in order to address the major areas of discrimination faced day-to-day by people with disabilities." 42 U.S.C. § 12101(b)(1)–(2), (4). *See also* Elizabeth Keadle Markey, *The ADA's Last Stand?: Standing and the Americans with Disabilities Act*, 71 FORDHAM L. REV. 185, 190 (2002).

112. U.S. CONST. art. III, § 2, cl. 1.

113. Lujan v. Defenders of Wildlife, 504 U.S. 555, 560 (1992) ("One of those landmarks, setting apart the 'Cases' and 'Controversies' that are of the justiciable sort referred to in Article III . . . is the doctrine of standing.").

114. Sierra Club v. Morton, 405 U.S. 727, 731 (1972); *see also* Clinton v. City of New York, 524 U.S. 417, 430 (1998) (finding that a party must have a "personal stake," and suffered an actual injury to have standing).

115. Flast v. Cohen, 392 U.S. 83, 99 (1968).

116. *Lujan*, 504 U.S. at 560–61.

117. Whitmore v. Arkansas, 495 U.S. 149, 155 (1990) (citations omitted).

category: whether the plaintiff has demonstrated sufficient imminence of harm in a future injury to establish standing.[118]

Generally, an allegation of future injury confers standing on a plaintiff if the plaintiff shows "actual or imminent, not 'conjectural' or 'hypothetical'" injury.[119] Proceeding on the theory that a plaintiff does not have to wait to actually suffer the threatened injury before acquiring standing to sue, the Court granted standing to nursing home residents who sued to prevent contemplated transfers to other nursing home facilities;[120] political officeholders who challenged restrictions on candidacy for other state offices without actually defying those restrictions;[121] and, a union that, threatened with prosecution if it engaged in certain conduct, disputed regulations on labor representation elections and consumer publicity.[122]

The Court does not always grant standing to plaintiffs for future injuries. The Court found speculative, for example, a pediatrician's efforts to defend a state's restrictions on abortion on the premise that the restrictions would lead to more paying patients;[123] a group of environmentalists' challenge to the federal government's foreign practices under the Endangered Species Act;[124] and a death row prisoner's efforts to stop the execution of another condemned prisoner who gave up his right to appeal.[125]

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118. *See infra* Part III.A.

119. *Whitmore*, 495 U.S. at 155. The "threatened injury must be 'certainly impending' to constitute an injury in fact." *Id.* at 158 (citations omitted).

120. Blum v. Yaretsky, 457 U.S. 991, 993, 1002 (1982).

121. Clements v. Fashing, 457 U.S. 957, 959, 962 (1982).

122. Babbitt v. United Farm Workers Nat'l Union, 442 U.S. 289, 293, 298–99 (1979).

123. Diamond v. Charles, 476 U.S. 54, 56, 66 (1986).

124. Lujan v. Defenders of Wildlife, 504 U.S. 555, 557–67 (1992). In *Lujan*, environmental groups attacked a regulation promulgated under the Endangered Species Act that restricted the law's effect to the United States or on the high seas. *Id.* at 557–59. The plaintiffs introduced affidavits in an attempt to establish an injury-in-fact. *Id.* at 563. The first affidavit contended that the affiant traveled to Egypt to study the Nile crocodile and intended to return for further study, and the second affidavit contended that the affiant traveled to Sri Lanka to study the natural habitat of that country and intended to return to Sri Lanka, but had no current plans to do so. *Id.* at 563–64. The Court found that plaintiff's affidavits did not establish the injury-in-fact element, stating that "[s]uch 'some day' intentions—without any description of concrete plans, or indeed even any speculation of *when* the some day will be—do not support a finding of the 'actual and imminent' injury that our cases require." *Id.* at 564. What is significant in *Lujan* is the fact that the Court held firm to its jurisprudence that recognized Congress' power to "elevat[e] to the status of legally cognizable injuries concrete, *de facto* injuries that were previously inadequate in law." *Id.* at 578. As one commentator points out, "The opinion in *Lujan*, therefore, does not foreclose the possibility of standing pursuant to a statutory grant." Markey, *supra* note 111, at 195.

125. Whitmore v. Arkansas, 495 U.S. 149, 151 (1990). The prisoner argued that if he won habeas corpus review and a new trial followed by a new death sentence, he wanted to make sure, for purposes of the state court's comparison of his case to other capital cases, that the database included the details of the other condemned prisoner's crime. *Id.* at 156–57.

In *City of Los Angeles v. Lyons*, Adolph Lyons, an African-American resident of Los Angeles,[126] alleged that he was subjected to a police chokehold without provocation or justification during a routine traffic stop, which rendered him unconscious and damaged his throat.[127] Lyons brought suit against the officers involved in the stop and the city of Los Angeles, seeking damages and injunctive relief barring the use of the chokehold except in situations involving the immediate threat of deadly force.[128] The Supreme Court stated that the plaintiff must allege an actual case or controversy that meets Article III's threshold requirement:

> Plaintiff must demonstrate a 'personal stake in the outcome' in order to 'assure that concrete adverseness which sharpens the presentation of issues' necessary for the proper resolution of constitutional questions. Abstract injury is not enough. The plaintiff must show that he 'has sustained or is immediately in danger of sustaining some direct injury' as the result of the challenged official conduct and the injury or threat of injury must be both 'real and immediate,' not 'conjectural' or 'hypothetical.'[129]

While conceding that Lyons had standing to sue for damages based on his past injury at the hands of the police, the Court held, "'[p]ast exposure to illegal conduct does not in itself show a present case or controversy regarding injunctive relief . . . if unaccompanied by any continuing, present adverse effects.'"[130] Lyons could not show that he was in a real and immediate danger of being arrested and choked by the police in the future.[131] Addressing the argument that the denial of standing would hinder a challenge to such police practices, the Court stated, "[t]he legality of the violence to which Lyons claims he was once subjected is at issue in his suit for damages and can be determined there."[132] In short, Adolph Lyons could

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126. 461 U.S. 95, 114 (1983) (Marshall, J., dissenting).

127. *Id.* at 97–98.

128. *Id.*

129. *Id.* at 101–02 (citations omitted).

130. *Id.* at 102 (quoting O'Shea v. Littleton, 414 U.S. 488, 495–96 (1974)).

131. *Id.* at 105. This is quite an odd requirement to impose on a plaintiff: that he or she predict or establish the likelihood of his or her own future criminal conduct. Markey, *supra* note 111, at 194.

132. *Lyons*, 461 U.S. at 111. For an incisive criticism of the *Lyons* reasoning, *see* LAWRENCE H. TRIBE, 1 AMERICAN CONSTITUTIONAL LAW 411–13 (3d ed. 2000). As Professor Tribe points out, *Lyons* "demonstrates the extreme and unprecedented nature of the Court's rejection of completed harm as constituting an 'injury in fact' and of its demand for certainty of future injuries before a party may seek injunctive relief." *Id.* at 411. Tribe points to a number of examples where a lawsuit would have to be dismissed pursuant to the *Lyons* reasoning: "Most ballot access cases seeking prospective relief would have to be dismissed after the election at issue was held since no one could ever prove with near certainty that the candidates would indeed seek access in a future election, would meet all legitimate access requirements, and would be denied access for illegitimate reasons." *Id.* at 411–12 (citation omitted). Cases involving voting rights, abortion, durational residency, and affirmative action would, under *Lyons*, be dismissed because the main event (an election, a pregnancy, living somewhere, or pressing for admission to a program) would have long passed by the time the plaintiff got to court. *See*

not get an injunction to stop future choking, but could get damages for the past harm done by the one incident of choking.

Guided by the Supreme Court's *Lyons* decision, the lower federal courts issued a number of rulings involving Deaf patients in the medical setting. The decisions fall into two categories. The first category holds that Deaf plaintiffs lack standing because they cannot show the threat of imminent future injury despite injury arising out of the past discriminatory practices of a doctor or hospital.[133] The second category holds that Deaf plaintiffs injured by past discriminatory practices have standing because they were able to establish, *inter alia*, that defendants refused to change their policies and/or practices.[134]

A. Standing Denied—No Imminent Future Injury

The actual cases that have produced this discouraging body of law illustrate the recurrent difficulties and obstacles faced by Deaf patients in the medical setting. For example, in *Aikins v. St. Helena Hospital*, the plaintiff's husband suffered a massive heart attack that left him brain-dead.[135] The hospital failed to provide the Deaf plaintiff with interpreters during the crisis, and it was not until the Aikins' daughter, a fluent signer, arrived on the scene four days later that Mrs. Aikins was able to communicate effectively with the doctor overseeing her husband's care.[136] Plaintiff, joined by the California Association of the Deaf, sued the hospital and the

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id. at 411–12. Tribe concludes that the fact that standing did not stop these cases "suggests that *Lyons* must be understood in large part as a decision of substantive law." *Id.* at 412. (citation omitted).

133. Loeffler v. Staten Island Univ. Hosp., No. 95 CV 4549 SJ, 2007 WL 805802, at *1, *9 (E.D.N.Y. Feb. 27, 2007); Connors v. W. Orange Healthcare Dist., No. 605CV647ORL31KRS, 2005 WL 1500899, at *1, *4 (M.D. Fla. June 23, 2005); Constance v. State Univ. of N.Y. Health Sci. Ctr., 166 F. Supp. 2d 663, 664, 667 (N.D.N.Y. 2001); Freydel v. N.Y. Hosp., No. 97 CIV. 7926(SHS), 2000 WL 10264, at *1, *3 (S.D.N.Y. Jan. 4, 2000), *aff'd*, 242 F.3d 365, No. 00-7108, 2000 WL 1836755 (2d Cir. Dec. 13, 2000); Bravin v. Mt. Sinai Med. Ctr., 186 F.R.D. 293, 299 (S.D.N.Y. 1999); Davis v. Flexman, 109 F. Supp. 2d. 776, 780, 784 (S.D. Ohio 1999); Falls v. Prince George's Hosp. Ctr., No. Civ.A. 97-1545, 1999 WL 33485550, at *1, *6 (D. Md. Mar. 16, 1999); Proctor v. Prince George's Hosp. Ctr., 32 F. Supp. 2d 820, 821, 825 (D. Md. 1998); Naiman v. N.Y. Univ., No. 95 CIV. 6469(LMM), 1997 WL 249970, at *1, *5 (S.D.N.Y. May 13, 1997); Schroedel v. N.Y. Univ. Med. Ctr., 885 F. Supp. 594, 596, 599 (S.D.N.Y. 1995); Aikins v. St. Helena Hosp., 843 F. Supp. 1329, 1332–33 (N.D. Cal. 1994).

134. Gillespie v. Dimensions Health Corp., 369 F. Supp. 2d 636, 643–44 (D. Md. 2005) (holding that plaintiffs established standing for injunctive relief when defendant's pattern and practice is to deny interpreters and plaintiffs are likely to seek treatment from defendant in the future); *See* Majocha v. Turner, 166 F. Supp. 2d. 316, 324–25 (W.D. Pa. 2001) ("[W]here a public accommodation in the health care field adheres to its policies of refusing to provide the requested auxiliary aid or has denied treatment altogether to an individual who seeks to receive treatment at the facility, injunctive relief may be available.").

135. 843 F. Supp. at 1331–32.

136. *Id.*

doctor. The defendants sought to dismiss the case, alleging that the plaintiff Association lacked standing.[137]

Citing *City of Los Angeles v. Lyons*, the *Aikins* Court found that the individual plaintiff, Mrs. Aikins, lacked standing because she failed to demonstrate a "real and immediate threat" of future harm required by *Lyons*.[138] The Court stated that, "Mrs. Aikins has shown neither that she is likely to use the hospital in the near future, nor that defendants are likely to discriminate against her when she does use the hospital."[139] The Court found that the California Association of the Deaf also lacked standing to sue because Mrs. Aikins lacked standing.[140]

In *Bravin v. Mount Sinai Medical Center*, Jeff Bravin and his wife, Naomi, a Deaf couple, asked for a sign language interpreter at Lamaze birthing classes at Mt. Sinai Medical Center, contending that without an interpreter, the husband would not be able to understand the classes and would be denied an equal opportunity to benefit from the instruction.[141] The hospital rejected the husband's requests for an interpreter on the ground that he was not the patient.[142] The hospital contended its offer of a text telephone for the hearing impaired (TTY) to the husband was sufficient to meet its obligation under the law and argued that plaintiff could not "premise his claim of intentional discrimination upon his preference for an ASL interpreter over a TTY."[143]

Conceding that the allegations in the complaint were sufficient to demonstrate that, if the Bravins returned to Mt. Sinai, the hospital would fail to provide plaintiffs with effective communication, the Court nonetheless held that plaintiffs failed to establish a "real and immediate" threat of future harm: "The Bravins must show that there is a likelihood that they will require the services of Mt. Sinai in the near future."[144]

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137. *Id.* at 1331. Oddly enough, the defendants conceded that Mrs. Aikens had standing to bring the action against them, but the Court stated that it had an obligation to consider whether the wife had standing because standing "goes to the Court's jurisdiction." *Id.* at 1333 (citing Lujan v. Defenders of Wildlife, 504 U.S. 555 (1992).

138. *Aikins*, 843 F. Supp. at 1333.

139. *Id.* at 1333–34.

140. *Id.* at 1334.

141. 186 F.R.D. 293, 296 (S.D.N.Y. 1999). The hospital agreed to provide an interpreter for the birth itself. *Id.* at 297. Once the baby was born, the hospital transferred him to the neo-natal intensive care unit, where his father again requested an interpreter, and the hospital once again refused on the ground he was not the patient. *Id.*

142. *Id.* at 296.

143. *Id.* at 302.

144. *Id.* at 299. Although Bravin was denied standing for injunctive relief, the Court did find the hospital liable for failing to provide an interpreter for the Lamaze birthing class. *Id.* at 304–05. This was an empty victory because, on the one hand, Bravin had no standing to obtain an injunction, and, on the other hand, the ADA does not contain a provision for damages for individual plaintiffs who have been aggrieved by a defendant's failure to comply with the law. *See* Markey, *supra* note 111, at 200.

Connors v. West Orange Healthcare District involved plaintiffs Jennifer Connors, her husband Robert, and Dawn Borque Rochette, three Deaf residents of Maitland, Florida. Jennifer Connors and Dawn Rochette sought emergency medical attention at the defendant's facility and were denied qualified sign language interpreters.[145] Plaintiffs alleged that due to the lack of interpreters, they were unable to communicate with or understand the defendant's medical personnel, who insisted on writing notes to communicate with the Deaf patients rather than calling for an interpreter.[146] Consequently, plaintiffs alleged that they were deprived of the ability to understand the treatment provided and the procedures performed.[147] In addition, plaintiffs contended they signed forms they did not fully understand, and that the defendant's employees did not explain the risks and benefits of the treatments.[148]

Defendant moved to dismiss the complaint on the ground plaintiffs were not entitled to injunctive relief because they failed to establish an injury-in-fact and a likelihood of future injury.[149] The Court laid out the standard for injunctive relief: an injury-in-fact, a causal connection between the injury and defendant's action, the likelihood or lack thereof of a real and immediate threat of future harm, and the likelihood of redressability by a favorable decision.[150] The plaintiffs lacked standing because they said they would likely not return to defendant unless it was an emergency:

> The Plaintiffs have not alleged that they anticipate returning to receive treatment from the Defendant at any point, whether for ongoing treatment related to their original visits or from some unrelated medical issue. Instead, they base their allegation on the entirely speculative potential of a future medical emergency, and have not alleged that such future medical conditions are likely to, or may possibly, arise.[151]

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145. Connors v. W. Orange Healthcare Dist., No. 605CV647ORL31KRS, 2005 WL 1500899, at *1 (M.D. Fla. June 23, 2005).

146. *Id.* at *1–2.

147. *Id.* at *2.

148. *Id.* Plaintiffs' legal claims included the following: Count 1 contended that defendant violated Title II of the ADA by "(1) failing to maintain policies and procedures to ensure compliance with the ADA; (2) failing to ensure that communications with Plaintiffs were as effective as communications with non-disabled patients; (3) failing to provide auxiliary aids and services; (4) failing to provide notice of the Plaintiffs' rights; and (5) excluding the Plaintiffs from, and denying them the benefits of, services due to their disability." *Id.* at *3. Count 2 focused on Section 504 of the Rehabilitation Act, 29 U.S.C. § 794 (2000), including a contention that defendants "refused to accommodate the Plaintiffs with appropriate auxiliary aids and services." *Id.* Plaintiffs sought a declaratory judgment condemning defendant's practices and policies, injunctive relief, and compensatory damages. *Id.*

149. *Id.* at *3.

150. *Id.* at *4.

151. *Id.* The Court never explained why the possibility of an emergency did not confer standing on the plaintiffs. *See id.* at *1–7.

Because the plaintiffs did not establish the likelihood of returning to the defendant for treatment, the Court held that they failed to establish "a real and immediate threat of future harm" and consequently lacked standing to pursue injunctive relief.[152]

In *Constance v. State University of New York Health Science Center*, the plaintiffs, a Deaf husband and wife, sued the defendant hospital, alleging that the hospital failed to provide them with sign language interpreter services in violation of the ADA and requested injunctive relief.[153] Despite the plaintiffs' contention that they would likely return to the hospital, the Court concluded that "[p]laintiffs' arguments are conclusory and do not have a factual basis."[154] This was because:

> [i]n the past, Mrs. Constance received treatment for cancer at a hospital in Watertown, New York. In fact, she has never utilized the services at Defendant Hospital prior to or since the incident giving rise to this action. It would be speculative to assume that Mrs. Constance will again suffer a medical emergency while in Syracuse and would again be transported to SUNY HSC for treatment. Furthermore, in light of Mrs. Constance's choice to seek treatment for her cancer with her oncologist in Watertown, it is speculative to assume that should her cancer return she would decide to seek treatment at Defendant's facilities.[155]

Because the Constances failed to demonstrate a real and immediate threat of future injury, they lacked standing to pursue injunctive relief.[156]

Similarly, in *Falls v. Prince George's Hospital Center*, the plaintiffs, a hearing mother and her young Deaf daughter, sued Prince George's Hospital Center in Maryland, alleging that it discriminated against the daughter because it failed to provide an interpreter during her nearly one-week-long stay at the hospital.[157] Defendant moved for summary judgment, and the Court granted the motion pursuant to the ADA because the Deaf child lacked standing to sue for injunctive relief:[158]

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152. *Id.* at *4 (citations omitted).

153. 166 F. Supp. 2d 663, 664 (N.D.N.Y. 2001) (citations omitted). The Public Interest Law Firm (now known as the Disability Rights Clinic), a law school clinic at the Syracuse University College of Law, filed this suit. *See id.*; OFFICE OF CLINICAL LEGAL EDUCATION: 2005-2006 ANNUAL REPORT 6, *available at* http://www.law.syr.edu/Pdfs/0OCLE_2005-2006_Annual%20Report.pdf; Syracuse University College of Law, In-house Clinics, http://www.law.syr.edu/academics/clinicaleducation/inhouse_clinics.aspx (last visited March 13, 2008).

154. *Constance*, 166 F. Supp. 2d at 666–67.

155. *Id.* at 667.

156. *Id.*

157. No. Civ.A. 97-1545, 1999 WL 33485550, at *3–5 (D. Md. Mar. 16, 1999). The claims were brought under the ADA, Section 504 of the Rehabilitation Act, 29 U.S.C. § 794 (2000), and Maryland state law (intentional infliction of emotional distress). *Id.* at *1.

158. *Id.* at *1, *5–6.

> [Plaintiff] is unable to establish that she herself faces a real and immediate threat of future harm from Defendant, and not merely a conjectural or hypothetical threat. By now, over two years have passed since [plaintiff] was discharged from PGHC. The present record neither reflects any on-going discrimination by Defendant against [plaintiff], nor that she is likely to return to PGHC in the near future. Indeed, [plaintiff's mother] stated in her deposition that she does not want to use the services of PGHC again, even if [plaintiff] is "near death."[159]

In *Freydel v. New York Hospital*, plaintiff, an elderly Deaf Russian woman, asserted standing on two grounds: she had numerous chronic conditions requiring future medical attention, and her local community hospital was part of a medical network including defendant New York Hospital as a tertiary care center.[160] Plaintiff argued that both grounds meant "that future referrals to New York Hospital for specialized treatment are possible."[161] That was still not enough to confer standing on the elderly plaintiff. Her visit "was a single, fortuitous event that is unlikely to recur;" there were eleven tertiary care centers closer to plaintiff's home than New York Hospital; and plaintiff's primary care physician, was no longer employed by the defendant's cardiac catheterization unit, which "sever[ed] [plaintiff's] previous link with the institution."[162] The Court denied standing:

> One visit to a hospital does not establish that Mrs. Freydel is likely to again find herself seeking treatment at New York Hospital. The relationship between New York Community Hospital (i.e., Mrs. Freydel's community hospital) and defendant New York Hospital is too weak a basis to establish a real or imminent need for her to utilize the defendant hospital in the future. Mrs. Freydel has failed to provide evidence of a likely future encounter between herself and defendant.[163]

In *Loeffler v. Staten Island University Hospital*, the plaintiffs lacked standing because they failed to present "*any* evidence to show that Josephine [was] currently receiving treatment at the Hospital, or that she suffer[ed] from a condition that might require treatment at the Hospital in the future."[164] However, ten years passed between the events leading to the lawsuit and the Court's decision, and in that time the hospital amended its sign language interpreter policies to address the plaintiffs' concerns.[165] Accordingly, even if the plaintiffs had standing to press their petition

159. *Id.* at *6.

160. No. 97 CIV. 7926(SHS), 2000 WL 10264, at *1, *3 (S.D.N.Y. Jan. 4, 2000), *aff'd*, 242 F.3d 365, No. 00-7108, 2000 WL 1836755 (2d Cir. Dec. 13, 2000).

161. *Id.* at *3.

162. *Id.* at *3-4.

163. *Id.* The Court pointed to the fact New York Hospital subsequently amended its policy to provide Deaf patients with an interpreter. *Id.* at *3.

164. No. 95 CV 4549 SJ, 2007 WL 805802, at *9 (E.D.N.Y. Feb. 27, 2007) (emphasis in original).

165. *Id.* at *10.

for injunctive relief, a recurring violation of their rights, should they return to the hospital, appeared unlikely.[166]

In *Naiman v. New York University*, the Court conceded that plaintiff's allegation of four visits to the defendant's hospital was sufficient, for pleading purposes, to demonstrate that, if the plaintiff were to return to defendant's hospital, it would again fail to provide him with effective communication access.[167] However, the Court held it was not sufficient to satisfy plaintiff's burden to demonstrate standing by showing a real or immediate threat that plaintiff "will require the services of [defendant's hospital] in the future."[168] Plaintiff presented no evidence to show that he would require the services of the hospital in the future, but he was given leave to amend the complaint to show likelihood of future visits or be barred from seeking an injunction.[169]

Proctor v. Prince George's Hospital Center involved a Deaf plaintiff injured in a motorcycle accident who faced amputation surgery—despite repeated requests for an interpreter to help facilitate communication about the surgery and its attendant risks, no interpreter was provided until the second surgery.[170] The Court found no standing because there was neither "any on-going discrimination" against plaintiff nor any showing that he was likely to return to the defendant's hospital.[171] Although the hospital amended its policy prior to the plaintiff's stay in order to comply with the Office of Civil Rights of the United States Department of Health and Human Services, the plaintiff alleged that they failed to apply it to him.[172] The plaintiff did not challenge the policy's adequacy and did not demonstrate the existence of any condition that made repeated violations likely if he were to return to the defendant's hospital.[173]

In *Schroedel v. New York University Medical Center*, the Court found that the Deaf plaintiff's statements that she might experience a medical condition in the future warranting emergency room assistance; that she would decide to use defendant's hospital for this condition; and that defendant's hospital would discriminate against her by failing to provide her with effective communication all "amount[ed] to mere speculation."[174] Key in the Court's thinking was the fact that defendant's hospital was "not the nearest medical center to either Schroedel's

166. *Id.*

167. No. 95 CIV. 6469(LMM), 1997 WL 249970, at *5 (S.D.N.Y. May 13, 1997).

168. *Id.*

169. *Id.*

170. 32 F. Supp. 2d 820, 823 (D. Md. 1998). Plaintiff's first two therapy sessions after the surgeries were also not covered by sign language interpreters. *Id.* at 824.

171. *Id.* at 825.

172. *Id.* at 822, 825.

173. *Id.* at 825.

174. 885 F. Supp. 594, 599 (S.D.N.Y. 1995).

residence or place of employment."[175] Also key was the fact that the plaintiff rarely utilized the defendant hospital.[176] Plaintiff could not establish standing by hypothesizing a chain of events "in which the action challenged eventually lead[] to actual injury."[177]

One case took place in a psychological counseling clinic rather than a hospital. *Davis v. Flexman* concerned the alleged failure of the clinic to provide effective communication access to a Deaf couple struggling with marital strife.[178] The record reflected multiple requests on the part of the Deaf couple for sign language interpreter services during counseling sessions, and Defendant Flexman's repeated refusals to provide interpreters.[179] The evidence showed that despite being told about the ADA and apparently being shown a copy of the statute, which he either refused to or failed to read, Flexman continued to drag his feet regarding meeting the communication needs of his patients.[180] Because the evidence demonstrated a genuine issue of material fact with respect to the defendant's deliberate indifference to the Davises' communication needs, the Court denied the defendant's motion for summary judgment on this issue.[181]

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175. *Id.*

176. *Id.* Prior to the incident that led to the litigation, plaintiff had not been to defendant's hospital since 1983, and prior to that time had not been there since 1976. *Id.* In fact, she sought medical assistance on two occasions from a different hospital between 1983 and 1992. *Id.*

177. *Id.* (quoting Northwest Airlines, Inc. v. Fed. Aviation Admin., 795 F.2d 195, 201 (D.C. Cir. 1986)). The Court also rejected Schroedel's argument that her claims fell within the exception to the Article III standing requirement for cases that are deemed "capable of repetition yet evading review." *Id.* (quoting Diotte v. Blum, 585 F. Supp. 887, 895 (N.D.N.Y. 1984)). The Court noted the Supreme Court's ruling limiting the scope of this exception to two kinds of cases: one where the discrimination challenged happened too quickly to be litigated before it stopped, and the other where there was a reasonable expectation that the plaintiff would be subject to the same discrimination again. *Id.* (citing *Diotte*, 585 F. Supp. at 895 (quoting Weinstein v. Bradford, 423 U.S. 147, 149 (1975))). The Court found that "[a] mere physical or theoretical possibility of future injury is not sufficient to satisfy this test." *Id.* at 599–600 (citing Murphy v. Hunt, 455 U.S. 478, 482 (1982)). Commentators have noted that while the Supreme Court's standard for the "capable of repetition yet evading review" exception to the mootness doctrine is stringent, the Court has issued rulings in cases that were moot by the time they reached the Court, the most famous example being *Roe v. Wade*, 410 U.S. 113 (1973). Colker, *supra* note 102, at 396.

178. 109 F. Supp. 2d 776, 780 (S.D. Ohio 1999).

179. *Id.* at 780–81.

180. *Id.* at 781, 791. Continuing to insist that the law imposed no obligation on him, Flexman promised to provide a computer to help the Davises communicate with their therapist, but he never did. *Id.*

181. *Id.* at 791, 808. What is interesting about this case is the Court's tortured interpretation of Ohio's anti-discrimination statute, Ohio Administrative Code Chapter 4112-5, promulgated by the Ohio Civil Rights Commission, which defines unlawful discrimination as the denial by a place of public accommodation, on the basis of disability as "any term, condition, privilege, service or advantage which, upon entrance to such facility, accrues to the public in general." *Id.* at 796–98 (quoting OHIO ADMIN. CODE 4112-5-06(A)(2) (2006)); *see* OHIO ADMIN. CODE 4112-5-01 (2008) (noting that these rules express the Ohio civil rights commission's interpretation of language in Chapter 4112 of the Revised

> However, the Court denied plaintiff standing to sue for injunctive relief:
>
> Neither Julia nor Steven Davis currently visits the Flexman Clinic, and they do not intend to return in the future. In addition, the Davises have no plans to seek counseling from anyone other than [Joanne] Voelkel, and she no longer is affiliated with the Flexman Clinic . . . . Absent some evidence indicating that the Davises are likely to resume marital counseling at the Clinic, [plaintiff] lacks standing to seek injunctive relief.[182]

The courts in these cases analyzed the incidents of discrimination as isolated incidents that had no context, no history, no rhyme or reason other than being just an unfortunate incident that happened to one person at one time, unlikely to occur in the future. The lens that the courts use is myopic: all the judges see is a single plaintiff experiencing one incident of discrimination, and they do not have the slightest inkling that these single incidents are part and parcel of a much larger problem affecting more than just one individual. If the courts had any insight into the experiences of Deaf plaintiffs (and people with other disabilities), they would quickly realize that the single incident of discrimination (denial of effective communication access) indicates an ongoing pattern and practice so systemically engaged in by the medical profession. At least a few judges get it, as the following section shows.

B. Standing Granted—Refusal To Change Policy or Practice

Where there is evidence that the defendants refused to change their policies or practices, courts have been more willing to grant standing to Deaf plaintiffs injured by past discriminatory practices. In *Gillespie v. Dimensions Health Corp.*, the plaintiffs were forced to communicate through written notes and lip reading despite

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Code). Plaintiffs contended that Flexman's failure to provide interpreters violated this section of Ohio law, and the Court rejected this claim. *Davis*, 109 F. Supp. 2d at 796 ("On its face, this regulation states only that a place of public accommodation may not, because of an individual's handicap, deny that person any term, condition, privilege, service, or advantage that is available to the public in general. *In the present case, the Defendants did not deny Julia Davis their counseling services. Rather, she found the services unsatisfactory in the absence of an interpreter.*") (emphasis added)). The Court fails to understand that the absence of an interpreter resulted in the denial of counseling services. Indeed, the Court disregarded or forgot Joanne Voelkel's deposition in which she stated that when plaintiffs brought their own interpreter, at their expense, the presence of the interpreter "had been beneficial." *Id.* at 780–81. This conclusion represents a stunning ignorance of the plaintiffs' communication needs and an inability to understand that opening the door to the clinic without an interpreter served as a barrier as real as a wall or curb for wheelchair users. Substitute "wheelchair user" for the Deaf plaintiff, and you can see the ridiculousness of the Court's logic: The clinic's failure to ramp its entrance door did not deny plaintiff her counseling services. Rather, she found the services unsatisfactory in the absence of a ramp. *Cf. id.* at 796 (analogizing wheelchair users to the Court's tautological argument that Defendants did not deny Plaintiffs their counseling services, but, rather, the services were unsatisfactory in the absence of an interpreter). The services were "unsatisfactory" because the plaintiff could not get in.

182. *Davis*, 109 F. Supp. at 784 (citations to depositions omitted).

repeated requests for a sign language interpreter.[183] The defendant relied on the *Proctor* and *Falls* cases as support for the proposition that the plaintiffs lacked standing to pursue injunctive relief, but the Court distinguished the cases, pointing to the lack of on-going discrimination against the previous plaintiffs, the fact the hospitals in the previous cases amended their policies to include sign language interpreters, and the remote likelihood of plaintiffs returning to the hospitals.[184] By contrast, *Gillespie* involved "multiple plaintiffs, some of whom are alleging multiple violations on multiple occasions."[185] Also, the defendant never provided the plaintiffs with an interpreter despite repeated requests, and "the Video Relay Interpreting (VRI) device the hospital sparingly attempted to utilize was utterly ineffective."[186] The *Gillespie* plaintiffs also alleged in their complaint that they "sought and received, and will likely continue to seek medical treatment" from the defendant's facility, a fact which was buttressed by the proximity of the defendant's facility to the plaintiffs' homes.[187] Finally, the *Gillespie* plaintiffs alleged that they were injured, and would likely continue to be injured, by the defendant's "policies, pattern, and practice."[188] The Court held:

> Given that Plaintiffs have alleged that it is the policy, pattern, and practice of [defendant] to not provide live, in-person, qualified sign interpreters, but rather to resort to occasional and sporadic note-taking, and to a VRI device that its staff is allegedly improperly and inadequately trained on, and which on numerous occasions proved ineffective due to the quality of the picture, it is likely that Plaintiffs will be harmed again if and when, as they allege, they return to [defendant].[189]

Given the allegation of an existing policy that violated the plaintiffs' ADA rights, and buttressed by evidence that the defendant never provided interpreters, the plaintiffs' desire to use the hospital, and the hospital's proximity to plaintiffs'

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183. 369 F. Supp. 2d 636, 637 (D. Md. 2005).

184. *Id.* at 641–42. The Court also discussed the *Constance-Freydel-Schroedel-Naiman* line of cases, finding that plaintiffs in these cases were not able to demonstrate sufficient nexus to the defendant to justify standing. *Id.* at 643–44, 644 n.7.

185. *Id.* at 642.

186. *Id.* In response to plaintiffs' requests for an interpreter, the hospital insisted on providing a Video Relay Interpreting device where a sign language interpreter is at a remote location and, through videoconferencing, the Deaf individual and the interpreter can see each other on a TV screen. *Id.* at 638 n.2. The interpreter voices what the Deaf person is signing, and signs what the hearing people in the room are saying. *Id.* at 638 n.2. The device was not always available to plaintiffs, and the hospital, instead of providing interpreters, "insisted on speaking verbally to Gillespie and Irvine despite the fact that Irvine cannot read lips and Gillespie's ability to read lips was compromised by her medical condition." *Id.* at 638. Interpreters were never provided. *Id.* at 637, 639.

187. *Id.* at 642.

188. *Id.*

189. *Id.* at 643.

homes, the Court found that the *Gillespie* plaintiffs sufficiently demonstrated a real and immediate threat of future injury to support standing to seek injunctive relief.[190]

In *Majocha v. Turner*, the defendants were a group of ear, nose, and throat doctors operating as the Pittsburgh Ear, Nose and Throat Associates, and the plaintiffs were a Deaf man and his infant son who was brought in for treatment of an ear infection.[191] In response to the plaintiff's wife's request for a sign language interpreter for her husband during the consultation, the defendants sent the family a letter, advising them to go elsewhere for their son's treatment.[192] Plaintiffs sought a declaratory judgment, injunctive relief, compensatory and punitive damages, and attorney's fees under the ADA and Section 504 of the Rehabilitation Act, and the defendants moved for summary judgment.[193] The Court held that, although injunctive relief was generally not available for a single instance of refusal to provide auxiliary aids and services to a plaintiff who has not alleged or demonstrated a likelihood of seeking treatment in the future,[194] it may still be available when a physician's office like the defendants' adheres to a policy of refusing to provide the requested auxiliary aid or service, or denies treatment altogether to an individual like the plaintiff.[195] Because the plaintiff had chronic ear infections that were likely to recur "and may require additional surgical procedures," but could not avail himself of the defendant's services because of the defendant's steadfast refusal to provide effective communication, the Court allowed the plaintiff standing to proceed for injunctive relief.[196]

It is difficult to see how the discrimination in *Constance* or *Proctor*, cases where the Deaf plaintiff lost standing, differs from the discrimination in *Majocha*

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190. *Id.* at 645.

191. 166 F. Supp. 2d 316, 318–19 (W.D. Pa. 2001).

192. *Id.* at 318.

193. *Id.* at 319.

194. *Id.* at 324 (citing Aikins v. St. Helena Hosp., 843 F. Supp. 1329, 1333–34 (N.D. Cal.1994) (Aikins I)).

195. *Id.* at 325 (citing Aikins v. St. Helena Hosp., No. C 93-3933 FMS, 1994 WL 794759, at *3–4 (N.D. Cal. Apr. 04, 1994) (Aikins II)). In the follow-up to *Aikins I*, the district court permitted plaintiff to amend her complaint "to allege that she stayed at her mobile home near the defendant hospital several times a year," which made it "reasonably likely that she would seek to use its medical services in the future, and that the hospital engaged in a pattern and practice of denying equal access to the hearing impaired;" *see also* Dudley v. Hannaford Bros. Co., 146 F. Supp. 2d 82, 85 (D. Me. 2001), *aff'd*, 333 F.3d 299 (1st Cir. 2003) (injunction available where defendant refused to revise its discriminatory policies against plaintiff on the basis of his alleged disability; plaintiff is not required to perform a futile act of seeking the services again); Merchant v. Kring, 50 F. Supp. 2d 433, 434–35 (W.D. Pa. 1999) (injunctive relief available where dentist refused treatment of patient and required patient to submit to an HIV test); Mayberry v. Von Valtier, 843 F. Supp. 1160, 1166–67 (E.D. Mich. 1994) (plaintiff may seek injunctive relief under Title III of ADA where doctor refused to treat her because she did not want to provide a sign language interpreter and had not revised her policies).

196. *Majocha*, 166 F. Supp. 2d at 325.

or *Gillespie*, where the Deaf plaintiff won standing. In the former, the courts ruled that the discrimination happened in the past, and that the plaintiff would probably not return to the doctor or hospital.[197] In the latter, the courts found an ongoing practice of discrimination that would likely affect the plaintiff in the future. As the experiences of the fifteen Deaf patients recounted earlier illustrates, denial of an appropriate auxiliary aid made access difficult, if not impossible.[198] What differs in the "game" of standing is how the courts frame the facts. This does not seem to square with the broad mandate of the ADA to combat the kind of discrimination that Deaf patients experience on a daily basis in the medical setting. What is needed is new thinking about an old problem.

IV. RETHINKING STANDING FOR DEAF PATIENTS

The law of standing, as fleshed out in the Supreme Court's decisions and the lower courts' reading of these decisions, poses a problem for the Deaf community. Deaf patients lose standing to sue the medical provider under the ADA because they will not, or are unable to, return to the provider's office. To the courts, there is no case or controversy for resolution if the Deaf patient does not return to the doctor's office or hospital.[199] But why would anyone return to a doctor or hospital that refused or failed to meet his or her most basic communication needs?[200] Indeed, why would the law demand that Deaf patients return to a setting where physicians resisted accommodating their communication needs?[201] Why would the law demand that Deaf patients undergo the frustration of repeated denials and the prospect of ongoing litigation to enforce a recognized right to effective communication? Most importantly, what prevents the law from construing a medical provider's failure or refusal to provide appropriate auxiliary aids as either an actual and present injury or a "certainly impending" injury-in-fact sufficient to support standing?[202]

The problem of access to medical care for Deaf patients is acute. The research demonstrates that many, if not most, of the interviewees encountered physician resistance to accommodating their communication needs.[203] Despite the fact that

197. *See supra* text accompanying notes 154–57, 170–73.

198. *See supra* text accompanying notes 56–78.

199. *See, e.g.*, Hoepfl v. Barlow, 906 F. Supp. 317, 320, 323 (E.D. Va. 1995) (holding that plaintiff did not have standing to sue for injunctive relief under the ADA because plaintiff did not demonstrate a realistic possibility of future discriminatory conduct on the part of defendant that would harm her).

200. *See* Markey, *supra* note 111, at 209 (citing Colker, *supra* note 102, at 398) ("In the context of personal services, it is unlikely that anyone would engage the services of a provider again after the provider had engaged in blatant discrimination, since other providers are usually available.").

201. *Contra* 42 U.S.C. § 12188(a)(1) (2000).

202. *See* Whitmore v. Arkansas, 495 U.S. 149, 158 (1990).

203. Schwartz, *supra* note 30, at 71–130. In addition to the author's research study, other studies on this issue have yielded similar results. *See, e.g.*, Barnett, *Cross-Cultural Communication*, *supra* note 6,

the law entitles Deaf patients to effective communication access in the medical setting, which means they must be given appropriate auxiliary aids such as sign language interpreters free of charge, physician resistance is pervasive. Many doctors either do not understand their legal obligations under the ADA or are not willing to absorb the cost of providing an appropriate auxiliary aid, particularly if it is a sign language interpreter.[204] Yet, the law of standing frustrates many patients who attempt to secure their rights in court. A close reading of the Supreme Court's standing decisions and subsequent case law demonstrates an alternative way of framing the problem so that Deaf patients and patients with other disabilities can retain standing to press their claims under the ADA.

A. Allowing Deaf Patients Standing as an Ongoing Injury Would Be Consistent with the Supreme Court's Lyons *and* Lujan *Decisions*

Allowing a Deaf plaintiff standing, even when that person has no plans to go back to the medical provider, is consistent with the Supreme Court's holdings in *Lyons* and *Lujan*. In *Lyons*, the African-American plaintiff did not have standing because he could not demonstrate the likelihood that he would not only be stopped for a traffic violation, but also subjected to a punitive chokehold without provocation.[205] However, unlike the likelihood of suffering a chokehold, which required that the plaintiff expect repeated police misconduct in response to his future criminal conduct, the likelihood of a recurring and prevalent injury exists where a Deaf patient engaging in lawful conduct encounters a doctor's refusal to provide the patient with appropriate auxiliary aids (usually an interpreter) so that

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at 377 (finding that the overall results of the studies indicate that Deaf people experience difficulty communicating with physicians and have less health knowledge than hearing individuals); Barnett, *Clinical and Cultural Issues*, *supra* note 6, at 21 ("Deaf people frequently report that physicians do not understand them, and they are less likely to try to explain themselves again than are non-English speaking immigrants."); Harmer, *supra* note 9, at 79 (noting that Deaf and hard of hearing individuals have a poorer self-reported health status than the general population); Nemon, *supra* note 8, at 20 ("The primary theme was, predictably, communication."); Steinberg et al., *supra* note 28, at 983 (noting that "participants felt that professionals accept a minimal level of communication with Deaf clients that would never be tolerated with hearing patients").

204. 28 C.F.R. § 36.303 (2007). Sign language interpreters are not cheap. An interpreter certified by the Registry of Interpreters for the Deaf, a national certifying organization of interpreters, can charge up to $70 or $80 an hour with a two-hour minimum. *See, e.g.*, *Judgment Underscores Hospitals' Need to Help Deaf Patients, Families*, HEALTHCARE RISK MGMT. (AHC Media, Atlanta, G.A.), June 1999, *available at* http://www.ahcpub.com/hot_topics/?htid=1&httid=1417 (stating that in New York a sign language interpreter charges approximately $70 for two hours); Schwartz, *supra* note 30, at 273. It is generally higher in the major cities of the United States and lower in suburban and rural areas. However, the yardstick for measuring the reasonableness of the interpreter's fee is not what the doctor charges for the visit, but rather, the doctor's annual income. 28 C.F.R. § 36.104 (2007) (defining the reasonableness standards of "readily achievable" and "undue burden" as considering "the overall financial resources of the site or sites involved in the action.").

205. City of Los Angeles v. Lyons, 461 U.S. 95, 108 (1983).

the patient has effective communication access.[206] The Deaf patient will encounter the communication barrier every time he or she attempts to visit the medical practice and the practice adheres steadfastly to its refusal to provide interpreters.[207] Further, as the late Professor Adam Milani noted, "every other person with the same disability will also encounter that barrier."[208]

The Court's decision in *Lujan* can also be distinguished. In that case, the plaintiffs were traveling to foreign lands to study the environment, and their affidavits indicated an intent to return "some day" without specifying a return date.[209] The Court said, "[s]uch 'some day' intentions—without any description of concrete plans, or indeed even any speculation of *when* the some day will be—do not support a finding of the 'actual or imminent' injury that our cases require."[210] On the contrary, a Deaf plaintiff does not contend that he or she will some day return to a distant land, but rather the neighborhood doctor's office or hospital when an appropriate auxiliary aid becomes available.[211] When a medical provider makes it known that he or she is communication accessible to Deaf patients on an ongoing basis, these patients will likely return.[212]

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206. Colker, *supra* note 102, at 397. Recall the Justice Department's admonition: "It is not difficult to imagine a wide range of communications involving areas such as health, legal matters, and finances that would be sufficiently lengthy or complex to require an interpreter for effective communication." 28 C.F.R. § 36.303 app. B at 715 (2007).

207. It flies in the face of human experience, common sense and logic to expect that a medical provider would change course voluntarily and willingly once he or she refused to provide an interpreter. Deaf patients interviewed in the author's dissertation study recounted numerous efforts, to no avail, to convince the provider to change his or her mind about the initial refusal to provide an interpreter. Schwartz, *supra* note 30, at 129–33.

208. Adam A. Milani, *Wheelchair Users Who Lack "Standing": Another Procedural Threshold Blocking Enforcement of Titles II and III of the ADA*, 39 WAKE FOREST L. REV. 69, 113 (2004). Discrimination against a discrete or insular group of people based on a shared characteristic like deafness enables the Attorney General of the United States to bring suit to stop the discriminatory behavior. 42 U.S.C. § 12188(b)(1)(B) (2000).

209. Lujan v. Defenders of Wildlife, 504 U.S. 555, 563–64 (1992).

210. *Id.* at 564.

211. *See* Milani, *supra* note 208, at 114 ("Unlike *Lujan*, plaintiffs in *most* ADA actions are not alleging that they might some day return to a far off land. They are stating that they will go to restaurants, stores, and health care providers near their homes when the accessibility problems are corrected or discriminatory policies are changed."); *see, e.g.*, Clark v. McDonald's Corp., 213 F.R.D. 198, 229 (D.N.J. 2003) (holding that a wheelchair user had standing when he stated that he would return if the defendant removed architectural barriers to the premises); Disabled in Action v. Trump Int'l Hotel & Tower, No. 01 Civ. 5518(MBM), 2003 WL 1751785, at *8–9 (Apr. 2, 2003 S.D.N.Y.) (wheelchair-using plaintiffs stated, we "are not the type of 'some day' intentions rejected in [*Lujan*]," and the Court granted them standing to pursue an action to compel a restaurant to provide a wheelchair lift).

212. Professor Cass Sunstein criticizes the *Lujan* decision as "a form of *Lochner*-style substantive due process." Cass R. Sunstein, *What's Standing After Lujan? Of Citizen Suits, "Injuries," and Article III*, 91 MICH. L. REV. 163, 236 (1992). Professor Sunstein argues that "an injury in fact is neither a necessary nor a sufficient condition for standing . . . . It assumes that there can be a factual inquiry into 'injury' independent of evaluation and of legal conventions. There can be no such law-free inquiry." *Id.*

B. *The Denial of an Interpreter Should be Construed as an Actual and Present Injury*

A plaintiff with a disability bringing an action to compel accessibility should not be required to demonstrate the imminence of a future injury because he or she has an actual and present injury—the barrier to entry to a place of public accommodation.[213] Thus, according to Professor Milani, *Lujan's* requirement of "imminence" is "unnecessary to the extent [the plaintiff] seeks injunctive relief to remedy today's 'actual harm,' or 'continuing, present adverse effects' from his past exposure to [the defendant's] allegedly illegal conduct."[214]

Furthermore, the ADA explicitly states, "[n]othing in this section shall require a person with a disability to engage in a futile gesture if such person has actual notice that a person or organization covered by this subchapter does not intend to comply with its provisions."[215] This provision allows a plaintiff who knows of a barrier to a place of public accommodation to avoid making a futile gesture of trying to gain access "because the injury continues for as long as they are deterred from patronizing a public accommodation due to the discriminatory conditions which continue to persist at the establishment."[216] Deaf people draw on local knowledge; i.e., the community's pool of information regarding the larger world, including doctors and the law.[217] For instance, some patients ask around in the Deaf community to find a doctor that is sensitive or aware of the needs of Deaf patients. Some patients go to Deaf clubs and meetings of Deaf people to learn more about laws that impact the medical setting. The Deaf community shares a sense of culture through ASL, which constitutes a continuum of language ranging from traditional sign language to Signed English.[218] It is through this culture that Deaf patients learn who is providing effective communication access and who is not.[219]

According to Professor Sunstein, "[d]espite the holding of *Lujan*, Congress should be permitted to grant standing to citizens." *Id.* Sunstein's argument attacks the requirement of injury-in-fact as not being rooted in the Constitution, common law, and history, and asserts that as long as Congress grants a statutory right, a plaintiff within the scope of that right has an interest that supports standing. *Id.*

213. *See* Milani, *supra* note 208, at 117–18.

214. *Id.* (citations omitted).

215. 42 U.S.C. § 12188(a)(1) (2000); *see* 28 C.F.R. § 36.501 (2007) (clarifying that the subchapter referred to in the statute is Title III of the ADA); Pickern v. Holiday Quality Foods, Inc., 293 F.3d 1133, 1136 (9th Cir. 2002) (applying this provision of Title III of the ADA).

216. Milani, *supra* note 208, at 118 (citing *Pickern*, 293 F.3d at 1136–37).

217. Schwartz, *supra* note 30, at 300.

218. *See* Susan Mather & Robert Mather, *Court Interpreting for Signing Jurors: Just Transmitting or Interpreting?*, *in* LANGUAGE AND THE LAW IN DEAF COMMUNITIES 60, 67–68 (2003).

219. Schwartz, *supra* note 30, at 300 ("In addition to sign language, there are traditions, rituals, and other indicia of community that give expression to a feeling of identity with the Deaf World—a sense of 'us' versus 'them,' the latter being the hearing world. This sense of "us v. them" is heightened in the doctor's office where doctors hold traditional views of Deaf people's competence—the inability to speak equals incompetence, and the ability to sign, too, equals incompetence. This sense of alienation is

Even if the plaintiff does not plan to return, "courts should be 'reluctant to embrace a rule of standing that would allow an alleged wrongdoer to evade the court's jurisdiction so long as he does not injure the same person twice.'"[220] When a doctor rejects a Deaf patient's request for an appropriate auxiliary aid, such as a sign language interpreter, the law should interpret the rejection as actual notice the doctor does not intend to comply with the ADA. Otherwise, to demand proof of the likelihood of a future violation "would create a standard far more demanding than that contemplated by the Congressional objectives that influenced the ADA."[221]

Indeed, the refusal to change policies regarding the provision of auxiliary aids or services to people with disabilities is, by its nature, an "ongoing and not isolated" violation.[222] A plaintiff with a disability should have standing to seek injunctive relief because the refusal constitutes evidence that discrimination is an on-going problem and is likely to recur in the future.[223] For example, spurred by the complaint of a Deaf patient that a large medical practice operating in three counties refused to provide effective communication access (i.e., sign language interpreters) to patients, investigators for the Civil Rights Bureau of the New York State Attorney General's Office telephoned the clinic on two separate occasions.[224] The office placed calls two weeks apart, and each call confirmed what the Deaf patients told the Attorney General's Office: the clinic refused to provide interpreters to Deaf patients who needed the accommodation.[225] When a place of public accommodation employs a policy of discrimination, one refusal ought to establish the likelihood of a future denial of aids or services, i.e., the likelihood of a future injury.[226]

Another consideration in favor of allowing standing concerns the availability of monetary damages for an injury. In *Lyons*, the Court emphasized that denial of standing to pursue injunctive relief did not mean that the African-American plaintiff would be out of luck—he would still be allowed to pursue damages for the

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only reinforced when doctors use outdated terminology to refer to their patients: 'Deaf and dumb' or 'Deaf mute.'").

220. Milani, *supra* note 208, at 119 (quoting Indep. Living Res. v. Or. Arena Corp., 982 F. Supp. 698, 762 (D. Ore. 1997)).

221. Dudley v. Hannaford Bros., 333 F.3d 299, 307 (1st Cir. 2003).

222. Milani, *supra* note 208, at 113.

223. *Id.* at 119.

224. People *ex rel.* Vacco v. Mid Hudson Med. Group, 877 F. Supp. 143, 145 (S.D.N.Y. 1995).

225. *Id.* What happened in the *Mid Hudson* case was not unusual. Research by the author shows that Deaf patients experienced repeated refusals by their physicians to provide interpreters to their patients. Schwartz, *supra* note 30, at 128–34. Many of these patients received refusals on a number of occasions before leaving the practice and going elsewhere. *Id.* at 128. Many federal cases are replete with the stories of Deaf patients who struggled against ongoing refusals to provide interpreters. *See* cases cited *supra* note 1.

226. *See* Milani, *supra* note 208, at 119.

pain and suffering from the illegal chokehold.[227] That is not the case with Title III of the ADA. Injunctive relief generally is the only remedy for plaintiffs alleging discrimination based on disability.[228] Damages are not available under Title III,[229] and are available under Title II only if the plaintiff can prove intentional discrimination.[230] This is fundamentally unfair to Deaf plaintiffs. A rule preventing plaintiffs with disabilities from claiming damages to remedy an ADA violation while simultaneously depriving them of the ability to obtain injunctive relief is hardly an expression of Congressional intent that "civil rights laws [rely] heavily on private enforcement."[231]

C. *The Justice Department Has Its Limitations as an Enforcement Mechanism*

Reliance on private enforcement of disability rights law is even more critical, given the Justice Department's limited ability or desire to fully enforce the ADA. *Trafficante v. Metropolitan Life Insurance*, a housing discrimination case brought under Section 810(a) of the Civil Rights Act of 1968, teaches us that the Justice Department has limited authority and resources to enforce compliance with the law.[232] In that case, the Supreme Court concluded that the Civil Rights Act of 1968 required "a generous construction which gives standing to sue to all in the same housing unit who are injured by racial discrimination . . . ."[233] In coming to this conclusion, the Court took notice of the Justice Department's limited staff for

227. City of Los Angeles v. Lyons, 461 U.S. 95, 111 (1983). "[W]ithholding injunctive relief does not mean that the 'federal law will exercise no deterrent effect in these circumstances.'" *Id.* at 112–23 (quoting O'Shea v. Littleton, 414 U.S. 488, 503 (1974)).

228. Americans with Disabilities Act of 1990, 42 U.S.C. § 12188(a)(2) (2000) (remedies are limited to injunctive relief, including a court order "requiring the provision of an auxiliary aid or service, modification of a policy, or provision of alternative methods . . . .").

229. *Id.* § 12188(a).

230. *Id.* § 12133 (adopting the "remedies, procedures, and rights set forth in section 505 of the Rehabilitation Act of 1973 (29 U.S.C. 794(a)"). A few courts have held that the "deliberate indifference" standard is the appropriate yardstick for determining the existence of intentional discrimination. *See, e.g.*, Garcia v. State Univ. of N.Y. Health Scis. Ctr., 280 F.3d 98, 115 (2d Cir. 2001); Duvall v. County of Kitsap, 260 F.3d 1124, 1138 (9th Cir. 2001). For an extended discussion of the difficulty in proving "intentional discrimination," see Milani, *supra* note 208, at 115–17.

231. STAFF OF H. COMM. ON EDUC. & LABOR, 101ST CONG., REPORT ON AMERICANS WITH DISABILITIES ACT 1485 (Comm. Print 1991) (statement of Howard Wolf, Partner, Fulbright & Jaworski); *see also* Milani, *supra* note 208, at 117.

232. 409 U.S. 205, 206, 210–11 (1972). It appears that the Department of Justice places greater emphasis on education rather than litigation. *See* Note, *The Americans with Disabilities Act of 1990: An Analysis of Title III and Applicable Case Law*, 29 SUFFOLK U. L. REV. 1117, 1141 (1995) ("[S]ettlement agreements with the Department of Justice have resulted in many of the accomplishments of Title III. Commentators reason that initial litigation has been sparse because the government has placed a greater emphasis on education").

233. *Trafficante*, 409 U.S. at 212.

enforcing the statute and the concurrent importance of private plaintiffs bringing these cases.[234] As Professor Milani noted:

> The statutory language in ADA Title III is remarkably similar to the language in the Civil Rights Act of 1968, and the Department of Justice has only limited staff to enforce not only it, but also Title II and section 504. Accordingly, courts should likewise give it a broad construction in determining standing.[235]

The Justice Department's civil rights enforcement suffers from several problems. First, its Disability Rights Section in the Civil Rights Division has a large agenda on its plate—not only is it responsible for enforcement of Titles II and III of the ADA, but also Sections 504 and 508 of the Rehabilitation Act of 1973, the Small Business Regulatory Enforcement Fairness Act, and Executive Order 12250.[236] Yet, as Professor Milani noted, "a recent report from the U.S. Commission on Civil Rights found that the Disability Rights Section initiated 701 investigations in fiscal year 2002, down 181 from fiscal year 2001, and filed twenty-eight cases, down from thirty-seven."[237] More troubling, in its 1996 review of the Justice Department's Civil Rights Division, the United States Commission on Civil Rights found a lack of support from the Justice Department's Office of Justice Programs (OJP) for civil rights enforcement.[238] The Commission found that civil rights was not a focus or a priority at the agency as the OJP organizational

234. *Id.* at 211.

235. Milani, *supra* note 208, at 107.

236. *See* U.S. Dep't of Justice, Civil Rights Div., A Guide to Disability Rights Laws (Sept. 2005), *available at* http://www.ada.gov/cguide.pdf; U.S. Dep't of Justice, Civil Rights Div., Disability Rights Section Home Page, http://www.usdoj.gov/crt/drs/drshome.htm (follow "Enforcement" hyperlink) (last visited Mar. 2, 2008). In 1980, President Carter signed Executive Order 12250, which provided for the consistent and effective implementation of various laws prohibiting discriminatory practices on the basis of race, color, national origin, sex, disability, or religion in programs and activities receiving federal financial assistance. Exec. Order No. 12,250, 45 Fed. Reg. 72,995 (Nov. 4, 1980). The responsibility for implementing this Executive Order was placed with the Attorney General, who in turn assigned this responsibility, except for the authority to approve regulations, to the Assistant Attorney General for Civil Rights. U.S. Dep't of Justice, Civil Rights Div., Coordination & Review Section, Overview of Executive Order 12250, http://www.usdoj.gov/crt/cor/12250.htm (last visited Mar. 2, 2008). *See generally* Colker, *supra* note 102, at 403–04 (reviewing the settlements obtained by the Department of Justice and stating, "[w]hile the DOJ settlements appear to be effective, they are few in number.").

237. Milani, *supra* note 208, at 107 (citing Shannon McCaffrey, *Civil Rights Division Backs Away from Its Initial Activism*, PHILA. INQUIRER, Nov. 23, 2003, at A08).

238. 2 U.S. COMM'N ON CIVIL RIGHTS, TEN YEAR CHECK-UP: HAVE FEDERAL AGENCIES RESPONDED TO CIVIL RIGHTS RECOMMENDATIONS? 16 (2002), *available at* http://www.law.umaryland.edu/marshall/usccr/documents/tenyrchekupvol2.pdf. As the Commission reports, "[t]he Department remains the largest federal civil rights agency with additional responsibilities in civil rights enforcement and coordination since the 1996 report. Civil rights is a priority as evidenced by the placement of the Civil Rights Division within the Department. However, with so many statutes to enforce and ever-evolving civil rights issues, effectively carrying out all its responsibilities remains a serious challenge for the Department." *Id.* at 12.

structure minimized the Office for Civil Rights' (OCR) authority and hindered OCR's ability to fulfill its external civil rights responsibilities.[239] In 2002, the Commission found the situation to be the status quo.[240]

Furthermore, the statutory language of the ADA constricts the Attorney General's power to sue on behalf of Deaf plaintiffs. Title III allows the Attorney General to bring suit only in limited circumstances: against "(i) any person or group of persons is engaged in a *pattern or practice* of discrimination under this subchapter; or (ii) any person or group of persons [that] has been discriminated against under this subchapter and *such discrimination raises an issue of general public importance.*"[241] As the Supreme Court noted in *Trafficante v. Metropolitan Life Insurance*, the "pattern or practice" language limits what the Attorney General can do,[242] and frequent litigation over this power ensued with a number of courts dismissing the action when it found the Attorney General failed to show a pattern or practice of discrimination.[243] Quite aptly, the Court in *Trafficante* noted that given "the enormity of the task of assuring [accessibility for disabled people] . . . the role of the Attorney General in the matter [is] minimal, [so] the main generating force must be private suits . . . ."[244]

A similar problem arises with the State Attorney General's ability to enforce the ADA. In *People* ex rel. *Vacco v. Mid Hudson Medical Center*, a case of first impression, the United States District Court for the Southern District of New York ruled that the State of New York, in the person of its Attorney General, had *parens patriae* standing to sue a medical clinic when the clinic refused to provide Deaf patients with sign language interpreters in violation of the ADA.[245] Such standing required an examination of whether New York was more than a nominal party to the suit and had a quasi-sovereign interest in pursuing the litigation; whether the complainants affected by the defendant's conduct represented a substantial segment of the state's population; and whether the individual complainant could get complete relief in an individual lawsuit.[246] The line of *parens patriae* standing

239. U.S. COMM'N ON CIVIL RIGHTS, FEDERAL TITLE VI ENFORCEMENT TO ENSURE NONDISCRIMINATION IN FEDERALLY ASSISTED PROGRAMS 480, 490–91, 494 (1996).

240. *Id.* at ix. According to Colker, "the broad coverage of ADA Title III came at a price . . . . In return for a broad list of covered entities, civil rights advocates agreed to a limited set of remedies under ADA Title III." Colker, *supra* note 102, at 377–78. Stating that "it is wrong to blame the Justice Department" for the problems with Title III ADA enforcement, Colker argues, "[e]nforcement problems with Title III exist because of the limited relief available under the statute, coupled with courts' narrow interpretations of that relief provision." *Id.* at 381.

241. Americans with Disabilities Act of 1990, 42 U.S.C. § 12188(b)(1)(B) (2000) (emphasis added).

242. 409 U.S. 205, 210–11 (1972).

243. Milani, *supra* note 208, at 106 (citations omitted).

244. 409 U.S. at 211.

245. 877 F. Supp. 143, 149 (S.D.N.Y. 1995). The case was not appealed and remains good law in the district.

246. *Id.* at 146–49.

cases relied on by the District Court in the *Mid Hudson* case compels the State Attorney General to restrict its cases to those that not only involve a pattern and practice of discrimination involving a substantial state interest, but also those that affect a discrete class of state residents.[247]

In addition, the *Mid Hudson* case is instructive in the ways of political orientation and power. The suit was brought under a Democratic Attorney General, G. Oliver Koppell,[248] who made it clear to this author that he wanted the Civil Rights Bureau to take a very aggressive stand against those who violated the ADA and other civil rights statutes. Koppel approved the lawsuit against the medical clinic, including demands for $200,000 in compensatory damages and a five-year monitoring plan.[249] However, while the suit was pending, Koppel lost the Democratic primary,[250] and Dennis Vacco, the Republican candidate, won the general election.[251] Vacco, who verbalized very different ideas about civil rights, ordered the Civil Rights Bureau's settlement offer of $200,000 to be drastically reduced to $25,000 and the five-year monitoring plan slashed to two years.[252] In the

247. *Id.* at 146–48. *See, e.g.*, Alfred L. Snapp & Son, Inc. v. Puerto Rico, 458 U.S. 592, 607 (1982) (noting that the state "must express a quasi-sovereign interest" in protecting the health and well-being of its residents or in preventing discriminatory denial of "rightful status" in *parens patriae* actions); *see also* People *ex rel.* Abrams v. 11 Cornwell Co., 695 F.2d 34, 38–40 (2d Cir. 1982) (New York had standing to sue in *parens patriae* for violations of 42 U.S.C. § 1985 on behalf of the mentally disabled), *modified on other grounds*, 718 F.2d 22, 24 (1983) (en banc)); Pennsylvania v. Porter, 659 F.2d 306, 310, 314–19 (3d Cir.1981) (State had *parens patriae* standing to sue under 42 U.S.C. § 1983 on behalf of victims of police misconduct); People *ex rel.* Abrams v. Operation Rescue Nat'l, No. 92 CIV. 4884(RJW), 1993 WL 405433, at *1–2 (S.D.N.Y. Oct. 1, 1993) (New York "has *parens patriae* standing to redress conspiratorial civil rights violations directed against its citizens" by seeking an injunction under 42 U.S.C. § 1985(3) to prohibit extremists from accosting Govenor Clinton during the 1992 Dem. Nat'l Convention); Support Ministries for Persons with AIDS, Inc. v. Village of Waterford, 799 F. Supp. 272, 279 (N.D.N.Y. 1992) (New York had standing to sue in *parens patriae* for persons with AIDS under the Fair Housing Act). In each of these cases the statute under which the attorneys general sued did not specifically grant them standing. As an Assistant Attorney General in the Civil Rights Bureau of the New York State Department of Law, the first question the author always had to ask when considering a civil rights complaint, including those brought under the ADA, was whether the complained-of conduct constituted a pervasive pattern or practice of discrimination that affected a broad class of New York residents, and whether the defendant was large enough to affect that class of people.

248. *Mid Hudson*, 877 F. Supp. at 144. The author was the Assistant Attorney General who brought the action and argued against defendant's motion to dismiss for lack of standing. *See id.*, 877 F. Supp. at 144 (listing Michael A. Schwartz as one of the Assistant Attorneys General who brought suit against Mid Hudson).

249. *See* Complaint at 7–10, People *ex rel.* Koppell v. Mid Hudson Med. Group, 877 F. Supp. 143, 145 (S.D.N.Y. 1995) (No. 94 Civ. 4688) (requesting claims for relief).

250. Francis X. Clines, *The 1994 Campaign: Attorney General; After Hard Race, Burstein Plunges Into Attacks on Republican Rival*, N.Y. TIMES, Sept. 15, 1994, at B6. Attorney General Koppell lost the September 1994 primary. The Court decided *Mid Hudson* in February 1995. 877 F. Supp. at 143.

251. Maria Newman, *The 1994 Elections: New York State Attorney General; Vacco Comes From Behind To Win Against Burstein*, N.Y. TIMES, Nov. 9, 1994, at B9.

252. Consent Judgment at 12, People *ex rel.* Vaco v. Mid Hudson Medical Group, 877 F. Supp. 143, 145 (S.D.N.Y. 1995) (No. 94 Civ. 4588).

years since 1995, when the case settled by consent decree, the New York State Attorney General has brought very few lawsuits on behalf of people with disabilities, let alone Deaf patients in the medical setting.[253]

D. The Courts Should Adopt an Allocation of Burden Analysis that Requires a Defendant to Rebut a Presumption of Standing for Plaintiff

This article proposes a resolution of the question of standing that allows people with disabilities their day in court without requiring an intent to return to the offending facility in order to qualify for standing.[254] Instead of focusing on whether a past incident of discrimination is likely to recur in the future, the courts can turn to an old mechanism very familiar to them: the allocation of the burden of proof. When a plaintiff with a disability files a complaint in federal court, alleging that a defendant violated Title III of the ADA by failing or refusing to provide an appropriate auxiliary aid or service, the allocation of the burden of proof requires the plaintiff to bear the initial burden of establishing the elements of his or her claim.[255] Once the plaintiff has done so, the burden shifts to the defendant to demonstrate a lawful basis for its actions.[256]

Something else should happen at this juncture. A presumption should immediately arise that the defendant's failure or refusal to provide an appropriate auxiliary aid or service indicates an on-going violation of the ADA's mandate for effective communication access.[257] In other words, the failure or refusal to provide

253. A search of the New York State Attorney General's Office website uncovered only two actions against medical providers on behalf of Deaf patients. Both actions were settled by consent decrees in 2000. Press Release, Office of the N.Y. State Att'y Gen., Spitzer Announces Agreement with Upstate Physician's Practice to Provide Sign Language Interpreters for Deaf Patients (June 21, 2000), http://www.oag.state.ny.us/press/2000/jun/jun21b_00.html (last visited Mar. 3, 2008); Press Release, Office of the N.Y. State Att'y Gen., Agreement Provides Hospital Interpreters for Deaf: Spitzer Seeks Compliance with Americans with Disabilities Act (May 2, 2000), http://www.oag.state.ny.us/press/2000/may/may02a_00.html (last visited Mar. 3, 2008).

254. Elizabeth Markey proposes a two-part standard for standing: first, "courts should focus on defendant's conduct and the likelihood that, were plaintiff to return, he or she would again face discrimination." Markey, *supra* note 111, at 211. Whether the plaintiff would return or not would take a secondary role in the analysis of real and imminent future harm. *Id.* The second part of the standard would have "courts . . . consider[ing] the plaintiff's relationship with the defendant, and to this end should take into account the type of relationship, the length of the relationship, and the frequency of plaintiff's visits to the public accommodation." *Id.* Thus, the inquiry into standing would be on a case-by-case basis, first examining the defendant's conduct, and if it appears that the alleged discrimination is an on-going occurrence, examining the relationship between the parties to determine if standing is appropriate *Id.* Markey's proposal admittedly still allows judges to impose on plaintiffs with disabilities the heavy burden of demonstrating a likelihood of returning to the public accommodation. *Id.* at 212. It still allows a court to deprive a plaintiff of standing if the plaintiff does not show intent to return. *Id.*

255. *See, e.g.*, Mayberry v. Von Valtier, 843 F. Supp. 1160, 1166 (E.D. Mich. 1994).

256. *Id.*

257. *See* FED. R. EVID. 301 ("Presumptions in General in Civil Actions and Proceedings. In all civil actions and proceedings not otherwise provided for by Act of Congress or by these rules, a presumption

what was necessary for effective communication did not just happen in isolation or at random; the defendant's failure or refusal should be placed in a historical context of communication inaccessibility. For decades, the medical setting as well as countless other venues of public accommodations have been virtually incommunicado for Deaf people.[258] Indeed, for the courts such as the court in *Constance* to be oblivious or neglectful of this history only compounds the harm that the ADA attempts to address.[259]

Once the plaintiff established that no appropriate auxiliary aids were made available, the defendant would have to assert an affirmative defense such as a fundamental alteration of services, a safety issue, or an undue financial burden; or, in the alternative, demonstrate that the violation has abated and the defendant is in compliance with the law.[260] The burden would then shift back to plaintiff to show pretext. Such a presumption would be limited in scope and purpose—it would simply require the defendant to either offer a legitimate explanation or show the problem has been fixed. The burden of persuading the fact-finder that the defendant violated the law still remains on the plaintiff.[261]

The equities of justice support the imposition of a presumption of standing. As the Advisory Committee Notes to the Federal Rules of Evidence observes about presumptions:

> The same considerations of fairness, policy, and probability which dictate the allocation of the burden of the various elements of a case as between the prima facie case of a plaintiff and affirmative defenses also

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imposes on the party against whom it is directed the burden of going forward with evidence to rebut or meet the presumption, but does not shift to such party the burden of proof in the sense of the risk of nonpersuasion, which remains throughout the trial upon the party on whom it was originally cast.").

258. *See generally* Harmer, *supra* note 9, at 74; LaVigne & Vernon, *supra* note 9, at 847–48.

259. *See* Constance v. State Univ. of N.Y. Health Sci. Ctr., 166 F. Supp. 2d 663, 667 (N.D.N.Y. 2001); Davis v. Flexman, 109 F. Supp. 2d 776, 784 (S.D. Ohio 1999) (noting that none of the evidence before the Court suggests that the plaintiff faces a real and immediate threat of future discrimination).

260. 42 U.S.C. § 12182(b)(2)(A) (2000). It would be quite rare, if not unlikely, that the provision of sign language interpreters or even CART technology would work a fundamental alteration to the services or programs of a medical provider, or would impose a financial burden. *See, e.g.*, N.J. Office of the Att'y Gen., Division on Civil Rights, Ensuring Open and Effective Communication in Hospitals for Persons Who are Deaf or Hard of Hearing Fact Sheet, *available at* http://www.nj.gov/lps/dcr/downloads/dcr_hospital-fact-sheet.pdf (suggesting that sign language interpreters and CART technology are reasonable accommodations for Deaf and hard of hearing people). It would be even rarer to successfully demonstrate that the auxiliary aid posed a problem of safety to plaintiff, defendant or others.

261. *See* FED R. EVID. 301; JACK B. WEINSTEIN & MARGARET A. BERGER, WEINSTEIN'S EVIDENCE MANUAL § 5.02 (2007) (clarifying the distinction between burdens of production and burdens of proof in civil cases). Rule 301 adopts the Thayer, or "bursting bubble," approach to presumptions. Nunley v. City of Los Angeles, 52 F.3d 792, 796 (9th Cir. 1995) (citations omitted). The "bursting bubble" characterizes what happens if a defendant offers evidence to rebut the presumption: the presumption disappears, although the evidence presented in support of the presumption remains. *E.g.*, Retail Serv., Inc. v. Freebies Publ'g, 364 F.3d 535, 542–43 (4th Cir. 2004).

> underlie the creation of presumptions. Those considerations are not satisfied by giving a lesser effect to presumptions.[262]

First, the focus is on the defendant's conduct rather than the plaintiff's intent to return. The problem of communication inaccessibility has been well-recorded,[263] and the courts should not employ an analysis that enables defendants to evade their responsibilities under the law because the plaintiff does not want to, or cannot, return to the defendant's office. Permitting such an evasion defeats the intentions of the statute.

Presuming the existence of a future recurrence based on a single past incident of discrimination advances the policy goals of the ADA, one of which is to eliminate discrimination in places of public accommodation.[264] Whether or not the plaintiff intends to return is immaterial. Such an approach is consistent with the goals of the ADA and in line with Congress's determination "to provide a clear and comprehensive national mandate for the elimination of discrimination against individuals with disabilities."[265]

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262. FED.R. EVID. 301 advisory committee's note.

263. *See* Schwartz, *supra* note 30, at 149–58; cases cited *supra* note 1.

264. *See* 42 U.S.C. § 12102(b) (2000) ("It is the purpose of [the ADA] (1) to provide a clear and comprehensive national mandate for the elimination of discrimination against individuals with disabilities; (2) to provide clear, strong, consistent, enforceable standards addressing discrimination against individuals with disabilities; (3) to ensure that the Federal Government plays a central role in enforcing the standards established [by the ADA] on behalf of individuals with disabilities; and (4) to invoke the sweep of congressional authority . . . to address the major areas of discrimination faced day-to-day by people with disabilities.").

265. *Id.* § 12101(b)(1). Professor Colker takes a different approach. She proposes that "Congress should enhance DOJ enforcement authority to increase compliance with Title III," and that "not only do states need to enhance the relief available under their statutes, but they need to revisit the scope of protection generally provided under state law in the area of disability discrimination." Colker, *supra* note 102, at 411. To attain uniform enforcement of disability discrimination law, Colker argues, "we should move toward a compensatory damage scheme under ADA Title III, borrowing from the damages scheme available under the [Fair Housing Act]." *Id.* This would require businesses that violate the ADA prior to the lawsuit to pay compensatory damages based on the number of years not in compliance. *Id.* at 411–12. This ought to serve as a cash incentive for American businesses to enter into compliance since it would be more cost effective to do so than to be liable for accruing costs for remaining in violation of the law. *Id.* However, Colker's proposal would involve a legislative amendment, a risky business given the current climate in the United States with respect to disability rights. *See* Mary Johnson, *Before Its Time: Public Perception of Disability Rights, the Americans with Disabilities Act, and the Future of Access and Accommodation*, 23 WASH. U. J.L. & POL'Y 121, 124–29 (2007). Johnson's main point is that American society does not understand the rationale and goals of the ADA, a statute that was enacted without public awareness and debate, unlike the Civil Rights Act of 1964, which followed decades, even centuries of hatred and violence against Black Americans. *Id.* at 121. To Johnson, "critics of the ADA have successfully cast people who use the law as malcontents who hurt the rest of us. And many Americans have fallen for the argument that there are 'disabled people' and 'the rest of us'—the former divided into the truly disabled (read: deserving but few) and the fakers." *Id.* at 149. As Johnson and Colker outline, there was a Herculean struggle by the drafters of the ADA to surmount considerable opposition to the ADA. *See id.* at 129–37; Colker *supra* note 102, at 383–85. There has been a great deal

Finally, medical providers have the resources, knowledge, and power to make changes to their behavior that will bring them into compliance with the law's clear mandates that have been in place for over fifteen years. These providers have had ample time to bring their policies and practices into compliance with the law, and they should not benefit from an analysis that shifts the focus from their behavior to the intentions of the patients.

In short, a basic set of facts—the absence of appropriate auxiliary aids and services—should give rise to a rebuttable presumption—namely, the absence of appropriate auxiliary aids reflects an on-going problem of accessibility that should and could underwrite a Deaf plaintiff-patient's standing to press a claim under the ADA. The burden is then on the medical provider to assert a legitimate reason, explanation or defense; or otherwise prove that the policy has been changed. The policy promoted by such a presumption is the efficient enforcement of an important civil rights law on behalf of a discrete group that has historically experienced discrimination. Moreover, the medical provider has superior access to the evidence and is in a position to enunciate a defense—whatever that defense may be—to the accusation of communication inaccessibility.

There is nothing revolutionary in the law about this proposition. Take a letter that has been regularly addressed and mailed—it is presumed that the addressee received it. If a vehicle is lawfully stopped and struck in the rear by a second vehicle, it is presumed the driver of the second vehicle was negligent.[266] An employee driving the employer's vehicle is presumed to be acting within the scope of employment if he is in an accident.[267] Goods delivered to a bailee in good condition, if damaged, were presumably damaged because of the bailee's negligence.[268] Similarly, goods damaged during transit by several carriers were presumed damaged by the last carrier.[269] It makes sense from a policy point of view—the addressee, the second driver, the employee, the bailee, and the last carrier, respectively, are all actors with superior knowledge or who have easier access to the evidence.[270]

If someone dies violently from external means, the presumption is that the death was accidental and not the result of suicide.[271] Or someone who has been

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of vocal opposition and criticism of the ADA in the national media and proposing a legislative redrafting of the ADA to strengthen it should be carefully considered. *See* Johnson, *supra*, at 129–37.

266. GRAHAM C. LILLY, PRINCIPLES OF EVIDENCE 394 (4th ed. 2006). The existence of the basic fact pattern can be established in a number of ways: pleadings, discovery, a stipulation, trial evidence, or judicial notice. *Id.* at 394 n.7.

267. *Id.* at 395.

268. *Id.*

269. *Id.*

270. *Id.*

271. *Id.*

absent for seven years without explanation or any communication with family or friends, and their inquiries turn up nothing—it is presumed the absentee is dead.[272] The policy promoted by these presumptions favors the settlement of estates.[273] The operation of these listed presumptions has a function—to compel the party with the best knowledge or best access to the proof to come forward, or to promote the efficient operation of law—and these are the goals accomplished by the presumption of standing for the plaintiff in a Title III claim against a medical provider.

The presumption simply allows the Deaf patient-plaintiff the ability to press on with his or her claim. It shifts the burden of production, not the burden of persuasion. The plaintiff still must prove all the elements of the case. It does not guarantee victory in the courtroom. The presumption of standing will support the Congressional vision articulated in the ADA and restore Deaf patients' trust in the legal system.

CONCLUSION

One might wonder: if Deaf patients do not want to return to a medical provider's office because they received a refusal of an appropriate accommodation, what is the purpose of an injunctive remedy? Wouldn't damages be more effective? The point of easing the standing bar by decoupling it from the patient's intention and placing the presumption of an ongoing pattern or practice on the medical provider is to effectuate the aims of the ADA. By contrast, a rigid reading of the standing rule shields the medical provider as he or she discriminates against Deaf patients.[274] Moreover, if Deaf patients were aware that the burden would be on the provider to explain why an accommodation was refused, more patients might feel emboldened to do one of two things: either return to the practice, or press the claim in order to force compliance for future patients.

Case law underscores the necessity for a statute like the ADA to protect Deaf patients from discrimination and unequal treatment in the offices of a health care provider.[275] The doctrine of standing must be reevaluated in light of what we now know about the experiences of Deaf patients in the medical setting and the ongoing nature of the doctor's refusal to accommodate them. The narratives of Deaf people demonstrate a lack of knowledge on the part of some medical personnel about Deafness and about appropriate behavior toward Deaf people.[276] The narratives of

272. *Id.*

273. *Id.*

274. *See* Markey, *supra* note 111, at 201–02.

275. *See* cases cited *supra* note 1.

276. *See supra* text accompanying notes 56–77.

Deaf patients provide powerful evidence that the denial of interpreter services, a completed harm under the ADA, constitutes an injury-in-fact.[277]

The communication-inaccessible milieu of the medical setting, as described by these patients, establishes a certainty of future injuries sufficient to warrant injunctive relief regardless of the patients' intention to return.[278] Yet, in the meantime, resistance to paying for appropriate auxiliary aids injures a whole society "when people with disabilities are excluded from public accommodations and governmental facilities and services . . . [because] non-disabled members of society are deprived of the benefits of interacting with people with disabilities."[279] A law may not be able to guarantee what a culture will not give,[280] but it ought to lead the way.

277. *See* cases cited *supra* note 1.

278. *See supra* Part I.C.

279. Milani, *supra* note 208, at 104.

280. Johnson, *supra* note265, at 145–48.