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*This investigative report has been redacted; removing all facts and analysis relating to the no reasonable grounds finding.

INVESTIGATIVE REPORT

VHRC Case PA16-0016

Complainant: Julie Hay

Respondent: University of Vermont Medical Center

Charge: Public Accommodations Discrimination: Disability

Summary of Complaint

Julie Hay, a Deaf person, alleges that she was discriminated against when she was denied a live interpreter while being treated for chest pains at the University of Vermont Medical Center (UVMC). The remote interpreter provided to her by the University of Vermont Medical Center was inadequate and did not provide her effective communication.[1]

Summary of Response

[Deleted]. Respondent states that a remote interpreter was used during Ms. Hay's care at UVMC which provided her effective communication. Respondent denied discrimination occurred.[2]

Preliminary Recommendations

This investigation makes a preliminary recommendation that the VHRC find that there are **reasonable grounds** to believe that The University of Vermont Medical Center discriminated

[1] Complaint.
[2] Response.

against Julie Hay on the basis of her disability and violated the VFHPAA, codified at 9 V.S.A. §4502.

Documents

Complaint

Response

Complainant's Reply to Response

Respondent's written reply to Requests for Information (RFI).

VHRC Agreement between George Lareau and Fletcher Allen, May 10, 2011

Draft Policy: American Sign Language and Interpretation Services (2012)

[Deleted]

UVMC Interpreter Policies (ASL and Language), effective July 2015 and current Policies

UVMC's Contract with Stratus (Stratus Video Agreement for Services)

Records of Technical Problems with Stratus

[Deleted]

[Deleted]

UVMC Medical Records for Julie Hay

Emails from UVMC employees

[Deleted]

Interviews[3]

Julie Hay[4] (through ASL Interpreter Joan Pellerin)	June 13 & 14, 2016
Laurie Hay, Complainant's sister	August 26, 2016
Tara Pacy, Nursing Director UVMC Director of Emergency Care, Access and Patient Transition.	October 19, 2016

[3] The initial request for interviews with hospital employees was made in early August and it required several months to coordinate and finalize dates due to the demanding schedules of nurses and doctors. This investigation was unable to interview Ms. Hay's mother, Betty Hay, as she unexpectedly passed away prior to the commencement of this investigation.

[4] Ms. Hay submitted an affidavit through her attorney, Barb Prine, Esq., subsequent to her interview with this investigator. Although the affidavit is part of the VHRC investigative file, it was not considered because Respondent did not have the opportunity to submit the same. Ms. Prine was invited to provide a brief to this investigation but she declined.

Sara Roberts, M.D. UVMC Resident Doctor	October 19, 2016
Susan Onderwyzer, Manager UVMC Case Management and Social Work Department	October 19, 2016
Michael Wehner, UVMC Manager, Telemedicine Interview & Demonstration of Stratus IPAD Device	October 19, 2016 & March 20, 2017
Lynette Reep, UVMC Interpreter Coordinator & ASL Interpreter	December 8, 2016
Heather Wright, D.O. UVMC Post-Graduate Year Training 2[5]	December 8, 2016
Imran Alkhalil, M.D. UVMC Cardiology Fellow	December 8, 2016
Harold Dauerman, M.D. UVMC Professor of Medicine and Director of Cardiovascular Services	December 8, 2016
Marc Tischler, M.D. UVMC Attending Cardiology Physician and Director of Ultrasound Cardiovascular Laboratory	December 8, 2016
Mehdi Rambod, M.D. UVMC Cardiology Fellow	December 8, 2016
[Deleted]	January 31, 2017
[Deleted]	January 31, 2017
[Deleted]	January 31, 2017
[Deleted]	January 31, 2017
Michayla Warren, R.N. UVMC Cardiology[6]	February 3, 2017
[Deleted]	February 6, 2017

[5] At the time of the allegations in the complaint, Ms. Wright was Post-Graduate Year Training 1.
[6] At the time of the allegations in the complaint, Nurse Warren was R.N. in the Cardiology Department but is currently in the Emergency Department.

James Rodger, Complainant's son[7] February 16, 2017

Keri Darling, Director March 13, 2017
Deaf Vermonters Advocacy Services

Facts

The Complainant: Julie Hay

Julie Hay is 51 years old and was born Deaf after her mother was infected with the German measles during pregnancy. Ms. Hay attended the Austine School for the Deaf and graduated in 1984 and then pursued a clerical certificate from a one year vocational program in Minnesota. Ms. Hay worked sporadically for a few years but has been on Social Security Disability Insurance (SSDI) since 1990. Although Ms. Hay occasionally uses written notes to communicate with others, the communication is limited to a few words because she reads and writes only in rudimentary English; American Sign Language (ASL) is her first and primary language. Ms. Hay does not rely on lip reading as a form of communication as it is very difficult skill to acquire; ever-changing and highly dependent on familiarity with the speaker. Most of the time, Ms. Hay moves about in obscurity, avoiding the people around her because of the communication barrier. Where she is expected to participate in a lengthy conversation such as a medical appointment, Ms. Hay always requests and requires a live community interpreter.[8]

In addition to being deaf, Ms. Hay has Schizophrenia with psychotic breaks, Hypertension, Anxiety and Parkinson's.[9] And Ms. Hay has a propensity for migraines, has a Thyroid condition and suffers from on-going abdominal pain.[10] Also, Ms. Hay has had degenerative eye problems that have impacted her vision.[11] Due to these health conditions, Ms. Hay regularly sees doctors and specialists and takes a long list of medications. Although she resides on her own, Ms. Hay

[7] The Interview with Mr. Rodgers was conducted through Instant Messenger on Facebook as a telephone and in person interview was not possible.
[8] Interview with Julie Hay.
[9] UVMC medical records (TeleTracking).
[10] Interview with Julie Hay.
[11] Id., Interview with James Rodger.

receives regular support from Washington County Mental Health with transportation and groceries.[12]

Julie Hay at [Deleted]

On or around 6 p.m. on July 15, 2015, while at home, Ms. Hay sensed chest pains and dizziness and called 911 using her video phone. The Emergency Medical Technicians (EMTs) from the Montpelier Ambulance Service used written notes to communicate with Ms. Hay before transporting her [Deleted].[13]

[Deleted]

Enroute to UVMC via the ambulance, Ms. Hay experienced an increased heart rate which the EMTs identified as a Ventricular Tachycardia (V-tach), potentially cardiac arrest.[14] The EMT gave Ms. Hay Lidocaine IV and Amioderone IV with no effect. The EMT performed a cardioversion, a medical procedure used to restore normal heart by sending electronic shocks to Ms. Hay's heart using electrodes. This successfully returned Ms. Hay's heart rate to normal.[15]

Julie Hay at University of Vermont Medical Center

Dr. Sarah Roberts, a resident in Cardiology, who was on a 24 hour shift that evening recalled being fairly busy; having already admitted eight patients to Cardiology.[16] She was notified by Dr. Mehdi Rambod, the Cardiology fellow, that a 50-year-old patient was enroute to the UVMC ED with NSTEMI (a shorthand medical term for non-ST segment elevation myocardial infarction; also known as a heart attack) who had some complications in the ambulance during transfer. Dr. Roberts was also notified that Ms. Hay was Deaf.[17]

Ms. Hay arrived in the ED at UVMC on or around midnight.[18] Dr. Mario Trabulsy, the ED doctor noted his observations:

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[12] Interview with Julie Hay.
[13] Montpelier Ambulance Service records.
[14] Id.
[15] [deleted].
[16] Interview with Dr. Sarah Roberts.
[17] Id.
[18] UVMC Medical Records, Patient Admission Agreement.

she feels a pinching sensation in her heart. She notes her ankles don't feel right. She has an associated headache, which was worse earlier, but is improving currently. Her chest pain is also improving, with her worst chest pain at 4/10. Her CP is currently at 2/10. She notes she was congested yesterday. The history is provided by the patient and medical records. The history is limited by a language barrier (Deaf). A language interpreter was used.[19]

Dr. Roberts arrived in the ED almost immediately after Ms. Hay arrived as the ED nurses and doctor were still present. Dr. Roberts stated that she did not see any family members.[20] Dr. Roberts interviewed Ms. Hay using a remote interpreter which was already in the room. Dr. Roberts remembered Ms. Hay being very upset; the environment was overwhelming, she had just had a heart attack and she was Deaf and had difficulty communicating, saying, "it was admittedly somewhat an unusual and somewhat challenging experience and I'm sure stressful for her."[21] It was difficult for Dr. Roberts to obtain a clear fluid story from Ms. Hay so she asked several closed-ended questions that allowed Ms. Hay to respond more clearly. Dr. Roberts felt that she was able to receive the information necessary for diagnosis and treatment but noted that additional history from Ms. Hay would have to be obtained in the morning.[22] Most of the information Dr. Roberts received that evening came from the EMTs or ED nurses, and not Ms. Hay directly.[23] Dr. Roberts could not recall Ms. Hay requesting a community interpreter but she was certain that she never asked Ms. Hay if she wanted a community interpreter. Dr. Roberts did not know who the interpreter coordinator was at the hospital.[24] Dr. Roberts also stated that she didn't believe communication was as effective as it could have been, had Ms. Hay not been Deaf.[25] She believed that having a community interpreter would have helped Ms. Hay calm down and therefore assist in the communication.[26]Dr. Marc Tischler, Ms. Hay's assigned physician, also interviewed and examined Ms. Hay with Dr. Rambod and agreed with the history, physical examination and assessment.[27] Dr. Tischler recalled seeing Ms. Hay in the ED and seeing the Stratus device being used in the ED but stated that he specifically remembered not

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[19] UVMC Medical Records.
[20] Interview with Dr. Sarah Roberts.
[21] Interview with Dr. Sarah Roberts, email from Dr. Roberts to Erika Smart, Esq.
[22] Interview with Dr. Sarah Roberts, UVMC Medical records.
[23] Interview with Dr. Sarah Roberts.
[24] Id.
[25] Id.
[26] Id.
[27] Id.

using the remote interpreter himself. Ms. Hay was able to provide a little information about the ambulance ride but most of the information was obtained from her records and the EMTs.[28]

An hour after being admitted to the ED, Ms. Hay was admitted to Cardiology. Conflicting medical records show that she was admitted under "serious condition" with an approximate stay of two nights and admitted under "fair condition" with a pain level of 2/10. [29] Ms. Hay was roomed in McClure 5 located in UVMC's main building.[30] Dr. Roberts ordered a Left Heart Cardiac Catheterization at 1:42 a.m. on July 16th but this order was discontinued by Dr. Rambod at 4:37 a.m. and re-ordered for later in the day after an examination and conclusion that catheterization could wait unless Ms. Hay showed symptoms that would warrant earlier intervention or diagnostic testing. The results of the EKG test done at 12:45 a.m. showed Ms. Hay had normal sinus rhythm with normal access and intervals.[31] The case and plan was presented to and discussed with the supervising attending physician, Dr. Kevin Carey, by telephone.[32]

Ms. Hay was on routine hourly observation and her evening nurse was Nurse Dong Zhang. [33] Nurse Zhang noted in the medical records that the information regarding the Echocardiogram, Cardiac Catheterization and Serial Blood Tests were provided at 1:58 a.m. on July 16th.[34] And according to UVMC medical records, Ms. Hay signed the cardiac catheterization consent form at 1:58 a.m. although there is no time next to her signature on the consent form.[35] There is some confusion as to who was charged with educating Ms. Hay about these procedures. Nurse Zhang appeared to have this obligation per patient education medical records.[36] On the other hand, it is Dr. Rambod's signature that appears on the consent form with the time of 12:58 a.m. The consent form originally had Dr. Kevin Carey's name listed as the physician but Dr. Carey's name was crossed out and replaced with "RAMBOD." Dr. Rambod denied having made this change to the form and said that the UVMC staff who marked this change was most likely the

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[28] Interview with Dr. Marc Tischler.
[29] UVMC medical records, Notes by Dr. Trabusly.
[30] Id.
[31] UVMC Medical Records.
[32] Id.
[33] Id.
[34] Id.
[35] Id., UVMC Cardiology Consent Form.
[36] Medical Records, patient education. 7/16/2015 at 1:58 a.m.

person who obtained informed consent from Ms. Hay for the catheterization procedure since informed consent can sometimes be obtained in two phases and he did not recall specifically obtaining informed consent.[37] Dr. Rambod stated that it is typically the responsibility of a doctor to obtain informed consent and not a nurse or trainee and that the norm for Dr. Rambod is to obtain informed consent from patients directly.[38]

UVMC adopted guidelines on patient education regarding the relevant medical procedures and treatment. The guidelines say:

> *Give the patient written information on Cardiac Catheterization. Define Cardiac Catheterization. Explain why the catheterization is needed, the preparation for, process of and recovery from the procedure. Explain the dye used during the catheterization may make the patient feel hot, get a headache, or feel sick to the stomach. Encourage the patient tell the doctor/nurse he/she has: 1) chest pain or discomfort, 2. Nausea, 3) bleeding from the area where the catheter was.*
>
> *Serial blood tests: Explain the patient will be having limited blood tests that will help diagnose if there has been any damage to the heart muscle.*
>
> *Echocardiogram: Give the patient written any pertinent information about Echocardiogram. Explain the reason for the testing, preparation for the test, how the test is performed, and how long the test will take.*

Dr. Rambod said an explanation on cardiac catheterization would typically take a few minutes, depending on the patient's questions and concerns. Dr. Rambod typically begins with an overview of the procedure and then discusses the risks and benefits, then provides further explanation and answers questions. Dr. Rambod would describe cardiac catheterization to a patient as:

> *Based on the information that we have, one diagnostic and treatment option is cardiac catheterization. For that, we make a little hole in your arm or leg, 2-3 millimeters. We send a catheter through the arm, plastic tubes. We inject a contrast dye to pass through the vessels, to see how the vessels look like to see if there's any blockage causing heart attack or* ---inaudible---. *Depending on what we find, we decide what to do. There are three possibilities. If we find nothing, no significant blockage, we stop right there and then. If we find multiple blockages, or blocking* ---inaudible ---*we may ask surgeons to come by and see if bypass surgery is an option, and if we find blockages that we can alter with a stent, we go ahead and do so right then. The procedure has about 1% chance of complications, and that includes minor ones to major ones. Minor ones, sometimes some*

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[37] Id.

[38] UVMC Cardiology Consent Form, Interview with Dr. Mehdi Rambod.

pain, nerve damage, small infections, bleeding, Major ones include major infections or bleeding, heart attack, kidney disease, stroke and death. The reason I say kidney disease is because the contrast dye that we inject sometimes is toxic to the kidneys or sometimes it impairs function of the kidneys specially for people who have kidney disease to begin with or other risk factors of kidney disease. In terms of heart attack because we're sending devices to the heart, it may cause or some damage to the vessel that we need to treat that right there and then. Because of that, you have to ---inaudible--*allowing other doctors to resuscitate you if something happens. During procedure, you'll be exposed to x-ray radiation because we're using x-ray cameras. That has some side-effects related to x-ray, very very few things. Damage to the skin for example or very* –inaudible – sounds like "little --*complications of x-ray radiation. We use sedative medication and relaxing medicine. It's not general anesthesia, most of the time. You may react and we can adjust the dose.* To calm the patient, Dr. Rambod might ask: *Have you ever had colonoscopy? Similar medication to that if you've had that experience before, it's the same medication.* If a patient looks particularly concerns, Dr. Rambod might add: *The difficult part for you will be the time of getting access to your arm and leg because of injecting needle or injecting medicine. There are no pain receptors in the vessel. You don't feel anything moving in your body to your heart. That part you don't feel.*[39]

The consent form identifies the name of the procedure, lists the associated risks and the possible treatment in the event of complications, the possible length of time in the hospital and a waiver of any "do not resuscitate orders." However, the consent form does not describe the procedure itself, the risks associated with the dye, x-ray radiation and sedation.[40] Furthermore, the consent form requires that the UVMC staff person charged with explaining the procedure answer all of the patient's questions and verify that the patient is adequately informed.[41] Nurse Zhang admitted that he did not use a remote interpreter during the course of his care for Ms. Hay and a remote interpreter device was not in Ms. Hay's room.[42] Dr. Rambod did not recall obtaining informed consent nor using a remote interpreter.[43] Although Dr. Tischler and Dr. Rambod examined Ms. Hay in the ED, Dr. Tischler specifically said it was not his responsibility to obtain informed consent and he had no recollection in this regards. Stratus records show that a remote interpreter was not used after the initial 18 minutes in the ED.[44]

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[39] Dr. Mehdi Rambod was infected with a cold and was wearing a mask on the day of the interview and at a few points during the recording, his voice was muffled or inaudible, as indicated. Interview with Dr. Rambod.
[40] UVMC Cardiology Consent Form.
[41] Id.
[42] Interview with Dong Zhang.
[43] Interview with Dr. Mehdi Rambod.
[44] Stratus Billing records show that the device in the ED was turned on from 11:52 p.m. – 12:10 a.m. and then not again until the next evening at 11:46 p.m.

Ms. Hay recalled learning that there would be an "operation" and that something was going to go down her throat, something was going into her arm, and she would have to wear a mask.[45] This investigation finds it difficult to believe that Ms. Hay received the same or similar information as other non-disabled patients through the use of hand-written notes and/or by reading the consent form because Ms. Hay's written English skills were rudimentary and the consent form was void of important information that is typically provided orally to patients.[46] Furthermore, Ms. Hay said she was not afforded the opportunity to seek more information or ask clarification questions.

Medical records show that Ms. Hay experienced no events overnight, no palpitations or pressure. However, Ms. Hay reported vaginal bleeding, an unusual and concerning occurrence since Ms. Hay was post-menopausal. Ms. Hay attempted to write, "Why? Period?" to which the nurse replied by writing on a piece of paper, "I don't know." [47]

Nurse Zhang was replaced by Nurse Michayla Warren in the morning, who had no recall of Ms. Hay as a patient.[48] Medical records are absent of any indication that Nurse Warren reviewed any of the forthcoming procedures with Ms. Hay and no interpreter was provided during all of Ms. Warren's shift.[49] Ms. Hay said that when she questioned the medications she was receiving through her IV, a daytime nurse wrote on a piece of paper "clot" which she interpreted to mean she had a blood clot. Ms. Hay was concerned that doctors and nurses did not have accurate and updated lists of her many medications and allergies because this was not her home hospital and she was now receiving several new and unknown medications.[50] Ms. Hay said some of the medication she received caused her to have nightmares and frightened her.[51]

Ms. Hay said that she was seen by Dr. Wright in the morning on July 16th but communication was limited, short with no details or explanations.[52] Dr. Wright said she used a remote interpreter to speak with Ms. Hay and that she believed communication was effective.[53] Dr.

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[45] Interview with Julie Hay.
[46] Id., Interview with [deleted].
[47] Id.
[48] Interview with Michayla Warren.
[49] Stratus Records.
[50] [Deleted]; Interview with Julie Hay.
[51] Interview with Julie Hay.
[52] Id.
[53] Interview with Dr. Heather Wright.

Tischler also saw Ms. Hay in the mornings and a couple of times afterwards. He did not recall seeing the Stratus device being used after seeing it in the ED. Dr. Tischler stated that he and others used a white board or family members to communicate with Ms. Hay. He never asked Ms. Hay if she wanted an interpreter.[54]

Dr. Roberts ordered an Echocardiogram (ECG) test that was completed at 9:15 a.m. on July 16th. The ECG tests generally revealed Ms. Hay's heart to be functioning normally although some findings suggested "diastolic dysfunction" which meant some abnormalities could not be entirely ruled out.[55] The study was limited however, as a result of Ms. Hay's inability to communicate. Notes in the medical records show that "the study was technically limited due to poor patient compliance and patient inability to follow directions." [56] The tests were completed and Ms. Hay appeared to have tolerated the procedure well without complications.[57]

On the 16th, Ms. Hay's mother Betty Hay, her sister Laurie Hay and her son James Rodger visited her at UVMC. Also at that time, Karen Robin from UVMC Case Management visited Ms. Hay in her room. Medical records indicate that case management and medical staff was supposed to work together to resolve any communication barriers.[58] Ms. Robin's notes indicate that case management met with Ms. Hay, her mother and sister at bedside and Ms. Hay's mother, Betty Hay was used to sign. No professional interpreter, neither remote nor live, was used for this meeting.[59]

Almost fifteen hours after arriving in the ED, Ms. Hay went to the Catheterization Lab at 2:29 p.m. where she was seen by Dr. Harold Dauerman, Dr. Imran Alkhalil and Dr. Sreedivya Chava.[60] Ms. Hay was extremely nervous about what she understood to be an "operation" and began crying. Someone used a cell phone to text the message, "relax."[61] Ms. Hay said two men came over and held her arms and then tied them down.[62] According to medical records, Ms. Hay

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[54] Interview with Dr. Marc Tischler.
[55] UVMC Medical Records, ECG Echo Results.
[56] Id.
[57] Id.
[58] Id.
[59] UVMC Medical Records-Flowsheet data.
[60] UVMC Medical Records.
[61] Interview with Julie Hay.
[62] Id.

was provided pre-op instructions and Ms. Hay acknowledged understanding of the impending procedure. However, Dr. Dauerman admitted that there was a barrier to communication and that informed consent would have been obtained by a different doctor and prior to arriving in the lab.[63] In the control room, Ms. Hay was sedated via general anesthesia, unusual for the circumstances according to Dr. Rambod. After a baseline ECG was recorded and her skin was prepared for puncture, a catheter was advanced into the left coronary vessel, several images were obtained and the catheters were removed.[64] The catheter was inserted at 3:16 p.m. and removed by 3:20 p.m. According to lab records, Ms. Hay was provided post-op instructions at 3:31 p.m.[65]

Although the medical records indicate that the attending physician, Dr. Dauerman, explained the findings, therapies, complications and treatment plan to the patient and obtained the patient's consent and that all family members and patient support persons who were present at the conclusion of the procedure were informed of the results, Dr. Dauerman specifically noted that communication was limited due to patient's hearing disability.[66] Dr. Dauerman could not recall if Ms. Hay had any family members present. During the investigative interview, Dr. Dauerman stated that he typically reviews the results of the procedure with the patient and family members, although this most likely did not happen because there had been no interpreter present.[67] Generally, communication with patients in the Catheterization Lab is limited anyway because patients are recovering from sedation.

In his letter to Dr. Tischler, Dr. Dauerman said Ms. Hay had tolerated the procedure well although she was under anesthesia and had not required any interventions. The cardiac catheterization revealed normal with no severe irregularities. Ms. Hay had mild coronary artery disease. Further work up was required because there was no obvious etiology for her current NSTEMI or VTach.[68] Dr. Dauerman recommended medical therapy and/or counseling, possibly further diagnostic testing.[69]

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[63] Interview with Dr. Harold Dauerman.
[64] UVMC Medical Records – Imaging results.
[65] Id.
[66] Id.
[67] Interview with Dr. Harold Dauerman.
[68] Id – notes from Dr. Harold Dauerman to Dr. Marc Tischler.
[69] UVMC Medical Records – Cath results.

Dr. Tischler concluded that the presumed VTach during the transport to UVMC was in fact not a true VTach but Sinus Rhythm with Artifact (something mimicking an arrhythmia that is in fact not heart-made but possibly the result of an outside electrical interference, poor contact or machine malfunction). The plan was for Ms. Hay to continue prior medications. No further intervention was necessary and while Ms. Hay remained on telemetry (monitoring of vital signs) no other events occurred prior to discharge from the hospital.[70]

At 2:10 a.m. on 7/17/2015, Ms. Hay removed her telemetry. Nurses tried to put the telemetry back on her but she refused.[71] Nurses and Doctors were notified of Ms. Hay's rejection of the telemetry but were not clear as to her reasoning.[72] Dr. Wright saw Ms. Hay the morning after and noted that Ms. Hay refused medication overnight. Dr. Wright's notes indicate that Ms. Hay refused medication because it caused her pain and made her feel congested. Nurse Zhang's notes from the evening show that Ms. Hay mentioned that the "blue pill" made her unable to breath.[73] Medical notes also show that Ms. Hay called out "can't breathe" but her oxygen level appeared to be normal and she did not show any respiratory distress.[74]

At 5:50 a.m., Ms. Hay refused blood draw for labs and declined to have the nurse hang up a new bag of Amiodarone for the infusion.[75] At 6:03 a.m., Ms. Hay told the nurse she wanted "off" the drip. The nurse turned off the pump and disconnected the infusion from the IV.[76]

Ms. Hay said the reason she declined medication and removed her telemetry was because she had become so increasingly frustrated and upset about the complete lack of communication from UVMC nurses and doctors; having been there since the evening of July 15th without any notice and information about her medical status.[77] When the remote interpreter was used, the interpreter was unfamiliar with medical terms and finger-spelled words without providing further explanation or information.[78] As a result, Ms. Hay was prepared and had every intention of

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[70] Dr. Marc Tischler's notes, UVMC medical records.
[71] UVMC Medical Records.,
[72] Id., Interview with Dr. Marc Tischler.
[73] UVMC Medical Records notes by Nurse Dong Zhang.
[74] UVMC Medical Records, notes by Paul Wood.
[75] UVMC Medical Records.
[76] Id.
[77] Interview with Julie Hay.
[78] Id.

leaving the hospital prior to discharge. Ms. Hay was visibly upset in recalling her experience at UVMC.

Ms. Hay was discharged on July 17th at 7:16 p.m. from McClure by Nurse Warren and Dr. Wright. Nurse Warren recalled nothing of the day and Dr. Wright said she reviewed the discharge instructions and medications with patient and her husband and that she received prescriptions, medication sheets, and discharge instructions via ASL interpreter. The written discharge instructions were specific and detailed; summarizing her hospitalization, the catheterization procedure, a list of new medications, changes to current medications and a recommendation that she stop one medication altogether.[79] Dr. Wright said that the discharge documents are not intended for the patient but for her providing doctors. However, Ms. Hay was instructed to follow-up with her provider and get her potassium re-checked in 3-10 days with a primary care physician.[80] Ms. Hay signed the discharge documents but did not date the form. Ms. Hay said she was not married and does not know who the hospital assumed was her "husband."

None of the hand-written notes used to communicate with Ms. Hay at UVMC were preserved and therefore, could not be produced to this investigation.

Stratus

[Deleted]...The Stratus IPAD devices are lighter and could be hand-held or mounted on an adjustable stand and, thus, are more user-friendly. Stratus is a significant improvement over DeafTalk but it is not without its share of technical problems which include login and password problems and most frequently, connection issues.[81]

The cost of implementing Stratus [Deleted] included a one-time fee of $1250 training/installation fee, an annual fee of $8700 for equipment and stand-by capacity, and a monthly cost of using ASL interpreters at $2.99 per minute (1-400 minutes) compared to a Spanish Interpreter usage cost of $1.67 per minute (1-400).[82] [Deleted]

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[79] UVMC Discharge Instructions.
[80] UVMC Medical Records – Discharge Summary signed by Dr. Heather Wright and reviewed by Dr. Marc Tischler.
[81] UVMC Records of Stratus IT calls.
[82] UVMC contract with Stratus, Respondent's response to request for information.

UVMC has a list of contracted certified sign language interpreters who are paid $55 an hour for a minimum of two hours, plus portal to portal travel time at the hourly rate.[83] Outside of normal business hours, UVMC pays an additional $10 per hour above the hourly rate.[84] UVMC recently hired an Interpreter Coordinator who is also an ASL sign-language interpreter for the hospital.

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At UVMC, the Stratus IPAD was used in the ED, according to Dr. Roberts, Dr. Tischler and Dr. Trabulsy's medical notes. Dr. Wright said she used the Stratus device that was in Ms. Hay's room to communicate with her on the morning of July 16th and July 17th and during discharge which she estimated to be 30-40 minutes.[85] Nurse Zhang who saw Ms. Hay every hour for two nights, said there was no Stratus IPAD device in Ms. Hay's room and that he did not use the Stratus device to communicate with Ms. Hay.[86] Nurse Warren also said she used the IPAD device but recalled nothing else of Ms. Hay or her hospitalization. Ms. Hay recalled the Stratus IPAD device being used but could not clearly articulate the specific details of how and when it was used although she was adamant that communication through the IPAD was not effective.[87]

Michael Wehner, UVMC's Manager of Telemedicine, states that Stratus billing records are accurate and reliable and capture every time a device is used.[88] The billing records identify the device by number, the username associated with the device and the start and end time for each session and the service provided (i.e. Cantonese, Arabic, ASL, etc.). The usernames for Stratus devices are Managers or Supervisors in various departments and not the name of each nurse or doctor who signs onto Stratus. Additionally, the records do not identify the patients associated with the device.[89]

Stratus records show that some devices were used for ASL interpretation on July 16th and July 17th. However, not every device could have been used for Ms. Hay as some of them were permanently held in distant locations from UVMC's main building where Ms. Hay remained

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[83] Id.
[84] Id.
[85] Interview with Dr. Heather Wright.
[86] Interview with Dong Zhang.
[87] Interview with Julie Hay.
[88] Interview with Michael Wehner. This investigation also called Mr. Wehner to confirm the Stratus records twice prior to this report.
[89] Stratus records, Emails from Michael Wehner, Interview with Michael Wehner.

during her hospitalization and one device was non-clinical and therefore not used for patients.[90] Respondent admits that this investigation could reasonably conclude that the only two devices that could be linked to Ms. Hay were assigned to Patient Support Services and the ED, respectively.[91]

On July 15, 2015 at 11:52 p.m., the device assigned to the ED was turned on for 18 minutes, corroborating Dr. Robert's statement, Dr. Tischler's statement, Dr. Trabulsky's notes and Ms. Hay's recollection of her admission into UVMC. Stratus records also show that the same ED device was turned on for seven minutes the next evening at 11:46 p.m. However, Ms. Hay was no longer in the ED as she had already been moved to McClure 5, the prior evening. Furthermore, the ED device typically remains in the ED for emergencies. Even if this device had been borrowed to communicate with Ms. Hay for seven minutes, the medical notes are not clear as to what would have been the purpose of the communication at 11:46 p.m., since the Echocardiogram and Cardiac Catheterization were completed by this time.

The Patient Support Services device was turned on for two minutes from 6:13 a.m. to 6:15 a.m. on July 16, 2015 and again from 6:02 a.m. to 6:04 a.m. on July 17th.[92] Although, Mr. Wehner stated that this short time frame most likely reflects the device being turned on, the remote interpreter coming on screen to wait before the device was turned off again,[93]the Stratus record does corroborate Dr. Wright's recollection of using the device each morning she visited Ms. Hay. However, the records also support Ms. Hay's recollection that the communication with Dr. Wright was short and limited in nature. Despite Dr. Wright's recollection that she used a remote interpreter for Ms. Hay's discharge which she estimated to be at least 30 minutes, Stratus records show no remote interpreter was provided on the 17th.

Because the recollections of witnesses are subject to the passage of time, competing demands on attention and the interests of those involved, this investigation finds that the most credible evidence of Stratus device usage during Ms. Hay's hospitalization is the Stratus billing records,

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[90] One device was assigned to UHC Reg/Lab and was located in a separate detached building, blocks away from the hospital's main building; another device was assigned to Berlin Dialysis and lastly, a non-clinical device assigned to Environmental Services was used only for training and not patients. Email from Michael Wehner to Erika Smart in response to Request for Information and Interviews with Michael Wehner.

[91] Email from Erika Smart, 4/11/2017; Interview with Michael Wehner.

[92] Id., Stratus records.

[93] Interview with Michael Wehner.

which Respondent agrees are credible and reliable. As a result, it is concluded that Respondent provided no remote or community interpreter for Ms. Hay at UVMC but for the first 18 minutes in the UVMC Emergency Department and the four minutes (two minutes each day) by Dr. Wright.

Did Julie Hay Request a Community Interpreter?

Ms. Hay stated that throughout her care at UVMC, she tried to request a community interpreter but that this request went unheeded by nurses and doctors.

Ms. Hay's son, James Rodger said that he visited his mother at UVMC on July 16th and 17th and on both days, he requested a community interpreter for his mother.[94] He remembered Ms. Hay telling him that she persistently requested a community interpreter, was denied and was in a state of distress.[95] Mr. Rodger indicated that his grandmother, Betty Hay (now deceased) also requested a community interpreter for Ms. Hay but this request was also denied.[96] Mr. Rodger said that because his mother is Deaf with a mental health diagnosis and has vision issues, the Stratus IPAD device was not sufficient to effectuate communication. Mr. Rodger stated that the lack of communication she received at the hospital resulted in Ms. Hay later having a mental breakdown and fostered a distrust of the medical community.[97]

Laurie Hay, Ms. Hay's sister, said that she observed Ms. Hay being upset, confused and frustrated during her visit on July 16th and recalled Ms. Hay asking a nurse for a community interpreter to which the nurse wrote on a piece of paper, "This is the best we could do right now."

Although doctors and nurses did not recall Ms. Hay making a request for a community interpreter, this must be viewed in light of the fact that many of them did not recall the specific circumstances of this case altogether. During the investigative interview, Dr. Wright believed that she may have asked Ms. Hay if she wanted a community interpreter but then later recanted this statement after reviewing an earlier email in which she wrote, "I never asked her if she

[94] Interview with James Rodger.;
[95] Id.
[96] Id.
[97] Id.

wanted a live interpreter."[98] Dr. Wright also said she used a remote interpreter to communicate with Ms. Hay during the discharge but this was unsupported by Stratus records. The aforementioned statements by Ms. Hay, Ms. Laurie Hay and Mr. Rodger, coupled with [Deleted] statements that Ms. Hay routinely objected to using remote interpreters and requested community interpreters in the past are most credible. Furthermore, [Deleted] said, "Ms. Hayes [sic] has expressed to us in the past that she does not like using the technology."[99] These statements support a reasonable conclusion that Ms. Hay did request a community interpreter at UVMC. Despite having been seen by numerous doctors and nurses, no one attempted to secure a community interpreter for Ms. Hay at any point or at the very least, notified the UVMC interpreter coordinator or her evening substitutes that Ms. Hay was Deaf and present in the hospital.[100]

UVMC Employees and Their Knowledge of ASL Interpretation

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Until Interpreter Coordinator Lynette Reep was hired at UVMC, it also did not maintain a list of trainings regarding the use of ASL interpreters, Video Remote Services, Video Relay Services.[101] The Stratus trainings offered to hospital employees were neither systematic nor targeted. Some departments requested training and received them while other departments were contacted.

All of the doctors stated that although they have used the Stratus device on prior occasions for language interpretation, it is typically the responsibility of the nurses to set up the device for utilization. But for a few, most [Deleted] and UVMC doctors and nurses, irrespective of their years of experience, were unable to identify the Interpreter Coordinator at their hospital, had not read or could not recall having ever read the ASL Interpreter Policies. Some hospital staff were

[98] Interview with Dr. Heather Wright, Email from Dr. Heather Wright to Erika Smart. Esq.
[99] Email from Laurell Hubbel, MSW ACM to Erika Smart, Esq.
[100] Emails from Erika Smart, 12/13/2016, 12/19/2016: Tim Stamatis, nighttime social worker who staffs ED, and Mary Gordon, Case Management Department staff assistant, and Katy Wallace, nighttime social worker, all have no record of a request for a community interpreter, Interview with Lynette Reep.
[101] Id.

unsure of where they would even find the interpreter policy while others said, they could probably find it on the hospitals' intranet if they wanted to read it.

[Deleted]

The competencies of UVMC employees were not provided to this investigation. However, based on the statements of hospital employees, it's not likely that these competencies on effective communication were any more detailed or specific, if they existed at all.

Overall, UVMC employees demonstrated a surface-level understanding of Deaf patients and Deaf culture.

The Difference Between a Community and Remote Interpreter

Ms. Hay stated that the communication she received from the remote interpreter was inadequate and not effective because the remote interpreter was unfamiliar with certain medical words and had to finger spell these words to Ms. Hay who had no clearer understanding of the words, herself.[102]

UVMC's contract with Stratus places all responsibility for the training, instruction, and certification of Stratus ASL interpreters on Stratus.[103] Although UVMC has the ability to conduct an annual audit through a Healthcare auditing entity to verify the qualifications of the ASL interpreters,[104] Respondent provided no evidence they've ever conducted an audit in this regard. Similarly, UVMC relies on the criteria set by Vermont Interpreter Referral Services for the community interpreters that are utilized at each facility, which include national certification by the Registry of Interpreters for the Deaf (RID) and adherence to the Code of Professional Conduct.[105]

UVMC's Interpreter Coordinator, Lynette Reep, hired in February 2015, stated that she has had a conversation with the Stratus employee responsible for training but has not followed up further.[106] Ms. Reep also said that as the interpreter coordinator, she has had the occasion to

[102] Interview with Julie Hay.
[103] Stratus Contract with UVMC.
[104] Id.
[105] Response to request for information.
[106] Interview with Lynette Reep.

resolve problems with interpreters and that most of the concerns about remote interpreters have been related to technology and not competency. Ms. Reep stated that the local ASL interpreters are all nationally credentialed, very experienced, have worked in the field at least 10 years and have a lot of experience in medical settings although there is no current medical certification for any ASL interpreters.[107]

Prior to becoming UVMC's Interpreter Coordinator, Ms. Reep was self-employed for thirty years as an ASL sign language interpreter in Burlington. Ms. Reep says that to ensure effective communication, she has often asked patients to provide information back to her or asked the provider for clarification. [108]Ms. Reep is of the belief that the hospital should strive to be patient-centered when deciding between community versus remote interpreters. Ms. Reep stated that the Deaf community generally did not favor using remote interpreters for a number of reasons including technology limitations.[109] Because of Vermont's size and culture, Deaf patients are familiar with all of the ASL interpreters and prefer to use someone they know and trust. Local accents and knowledge is also appreciated by Deaf people. American Sign Language is also uniquely different from spoken language in that it is three dimensional; the subtleties of language and information can be lost on a flat screen.[110] Other times when a community interpreter might be preferable is when a patient is in pain, cannot move or has vision impairment or is both Deaf and from a different ethnic background than the provider.[111] Developmental disorders and mental health issues coupled with being Deaf might also be a basis for using community interpreters.[112]

Tara Pacy, UVMC's Nursing Director and Director of Emergency Care, Access and Patient Transition said which modality is utilized depends on patient preference, if the patient is DeafBlind, has Visual or Hearing impairments or mental health issues.[113] Along the same lines, Susan Onderwyzer, UVMC's Manager for Case Management and Social Work Department says that patient choice is most important.[114] In certain circumstances, a community interpreter is

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[107] Id.
[108] Id.
[109] Id.
[110] Id.
[111] Id.
[112] Id.
[113] Interview with Tara Pacy.
[114] Interview with Susan Onderwyzer.

preferable to a remote interpreter such as a surgical consultation or conveying a very important health diagnosis or in deliveries.[115] However, there are occasions where a remote interpreter is preferable such as brief interactions and check-ins and when the patient is known to the provider.[116] Additionally, a remote interpreter should be used when use of a community interpreter is contra-indicated, i.e. communicable diseases or surgery suites. Ms. Onderwyzer believes that for the majority of patients who are Deaf, in-person interpreters are used. Although it's not regular practice, community interpreters have also been utilized in the evenings.[117]

Most of the doctors and nurses interviewed did not have a preference to use one modality over the other and were not aware of any hospital-wide policy that Stratus should be preferred over community interpreters as a matter of cost-savings. However, doctors and nurses were not knowledgeable about community interpreters and why one modality would be preferable to another. Ms. Pacy also stated that she was not cognizant of any cost issues as a consideration for choosing remote vs. community interpreters.[118] Contrarily, a plain reading of UVMC's interpreter policies suggests a preference to use remote interpreters over community interpreters in that it first identifies the circumstances for using a telephonic or video remote interpreter and then identifies *"Limited Circumstances in Which In-Person Interpreter Services May be Used."*[119] UVMC has revised its interpreter policy but even its most recently adopted interpreter policy suggests that in-person interpreters may be requested by patients only when feasible and that such requests had to be made in advance.[120] Ms. Reep stated that before she was hired as the Interpreter Coordinator, the hospital had a policy to use Stratus over community interpreters and that this was the modality being offered to patients.[121] Ms. Reep did want to clarify that the hospital was willing and was using community interpreters but that it really did require some education and justification to offer both modalities to patients from the beginning.[122] The need

[115] Id.
[116] Id.
[117] Id.
[118] Interview with Tara Pacy.
[119] UVMC Interpreter Policy, 2015.
[120] UVMC Interpreter Policy, 2017.
[121] Interview with Lynette Reep.
[122] Id.

for these types of conversations is on-going at the hospital as some managers continue to have a bias in favor of using Stratus over community interpreters.[123]

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This investigation reached out to Keri Darling, Director of Deaf Vermonters Advocacy Services for the last 17 years, for some knowledge and expertise in this area. As Director, Ms. Darling provides advocacy, education and training in addition to creating policies and supervising staff.[124] Ms. Darling said that a community interpreter offers a lot more than what a remote interpreter can offer to a Deaf client. Community interpreters know the local dialects and accents and regional signs. Community interpreters know the names of communities and locations. There are no concerns with technology, with sound or signal dropping. When interpreting particularly complex information, a community interpreter can move around, use body language and has the freedom of space to convey information and guarantee communication is effective.[125] Ms. Darling confirmed what Ms. Reep said about ASL being three dimensional and how communication can be hindered by a flat screen.[126] Additionally, community interpreters are known to clients; their nuances, styles and body language and tools. Ms. Darling distinguishes the terms "certified" versus "qualified." Although an ASL interpreter might meet the criteria for certification as an ASL interpreter, he/she may not necessarily be qualified to interpret in a specific situation, specially a medical clinic or hospital.[127] To demonstrate this, Ms. Darling discussed the use of a Deaf ASL Interpreter who has a unique ability to communicate culture and information that a Non-Deaf ASL interpreter alone could not. For example, when a patient's English is limited, the doctor would speak to the Non-Deaf ASL interpreter who would then sign to the Deaf ASL interpreter who then ultimately interprets to the Deaf patient.[128] Ms. Darling also said that whenever a client has a secondary disability or multiple diagnosis such as a developmental or mental diagnosis, it is especially important to use

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[123] Id.
[124] Interview with Keri Darling.
[125] Id.
[126] Id.
[127] Id.
[128] Id.

a community interpreter.[129] Lastly, there is a lack of standardization across the different states for ASL interpreters that does not exist for local community interpreters.[130]

UVMC's Interpreter Policies

The case at present is not the first nor only complaint UVMC has received on failure to provide effective communication to its Deaf patients. In 2011, UVMC (then known as Fletcher Allen Health Clinic) entered into an agreement with George Lareau, a Deaf Person who filed a complaint with the Vermont Human Rights Commission.[131] In addition to paying Mr. Lareau $6000, UVMC agreed to:

1. Develop a written policy regarding sign language interpretation
2. Develop the written policy with input from the community including the Disability Law Project at Vermont Legal Aid, the Vermont Department of Disabilities, Aging and Independent Living, a Deaf Advocacy Organization, and a representative from the Vermont Registry of Interpreters for the Deaf.
3. Implement a training program for hospital staff on their sign language interpretation policy including Emergency Room staff, All charge nurses; and any staff who have a patient who is Deaf or Hard of Hearing and have requested the VRI equipment.
4. Train new employees as part of new employee orientation.

A model policy was developed with UVMC which included the following language:

> *"When possible, the preference of the deaf individual as to their preferred method of effective communication should be considered when determining whether to use live or VRI/VRS Interpretation. The determination of whether to use live or VRI/VRS interpretation will vary in accordance with the nature, length, and complexity if the communication involved, and the context in which the communication is taking place."*[132]

UVMC's governing interpreter policy at the time of the allegations in the complaint, did <u>not</u> include the aforementioned model policy language and thus, UVMC never adopted patient preference as part of its policy.

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[129] Id.
[130] Id.
[131] Settlement Agreement between George Lareau and Fletcher Allen Health Clinic.
[132] Draft Policy.

The draft policy identifies the circumstances supporting utilization of a live interpreter:

1. *The individual has secondary disability, such as low vision or a developmental disability (low IQ)*
2. *The individual has a psychiatric disability, or is receiving mental health treatment;*
3. *The individual is on medication that impairs attention or is fatigued, or intoxicated;*
4. *The individual is receiving an eye-exam or physical therapy session;*
5. *The individual is receiving complex information about his/her diagnosis and potential treatments;*
6. *The individual is a child;*
7. *The individual is receiving information of a sensitive nature (bad news);*
8. *The individual is in a physical position or has an injury that makes it difficult for them to see the screen;*
9. *The individual is having difficulty paying attention to the communication because of pain or discomfort;*
10. *The individual needs interpretation in a variety of hospital settings, that is, moving around the hospital for various tests/procedures*

UVMC's governing interpreter policy at the time,, adopted almost all of the above draft language except when *the individual is receiving information of a sensitive nature (bad news)*, under the heading: Limited Circumstances in Which In-Person Interpreter Services May be Used.[133] Based on UVMC's policy, Ms. Hay should have been considered for a live community interpreter because she had met at least five of the above-identified reasons: Ms. Hay had limited vision, a psychiatric condition, was receiving complex information about her diagnosis and treatment and complained of chest pain and discomfort and was fatigued.

Interpreter Coordinator Lynette Reep said that her familiarity with Ms. Hay in other settings led her to believe that Ms. Hay was what she considered "grass-roots Deaf;" someone who was monolingual (zero to limited experience with English) and that an interpreter for Ms. Hay would probably have to be very adept at ASL interpretation.[134]

UVMC's most recently adopted interpreter policy, February 2016-February 2018, removed all of the reasons to consider a live interpreter altogether in lieu of a short paragraph that states, "*when feasible (emphasis in original) individuals who prefer in-person interpreters should contact the hospital directly before leaving home or while en route to the Emergency Department to enable*

[133] UVMC Interpreter Policy, 2015.
[134] Interview with Lynette Reep.

staff to try and provide coverage." In short, UVMC placed the burden on the patient to directly contact the hospital, in advance, for a live interpreter.

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Ms. Reep said that in most cases, a patient knows which modality works best for effective communication.[135] In answering the larger question about what changes could be implemented at the hospital to ensure patients received effective communication, Ms. Reep identified training for everyone, at orientation and annually. Ms. Reep also said that she would have wanted to be notified by the ED through a text or called the next day. Ideally, if there was a mechanism for her to receive automatic email notification whenever someone with ASL interpreter needs was in the hospital, she could follow up during the day. Ms. Reep said, "I can't be of help if I don't know the patient is here."[136]

Analysis

Section I of the report sets forth the legal framework governing disability discrimination in a place of public accommodation and identifies the elements of a prima facie case of discrimination. Section II examines UVMC's failure to provide an interpreter for Ms. Hay between July 15-17, 2015 under the legal framework and identifies the available defenses. Section III examines [Deleted].

I. Legal Framework

The Vermont Fair Housing and Public Accommodations Act (VFHPAA), 9 V.S.A § 4502 states:

> (c) No individual with a disability shall be excluded from participation in or be denied the benefit of the services, facilities, goods, privileges, advantages, benefits, or accommodations, or be subjected to discrimination by any place of public accommodation on the basis of his or her disability.

The VFHPAA sets forth nine separate ways in which discrimination may occur, but a plaintiff need only make a showing under one of these provisions. This report examines the two most relevant VFHPAA subparts: 9 V.S.A. §4502 (c) subparts (1) and (6):

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[135] Interview with Lynette Reep.
[136] Id.

> (1) A public accommodation shall provide an individual with a disability the opportunity to participate in its services, facilities, privileges, advantages, benefits, and accommodations. It is discriminatory to offer an individual an unequal opportunity or separate benefit; however it is permissible to provide a separate benefit if that benefit is necessary to provide an individual or class of individuals an opportunity that is as effective as that provided to others.
>
> (6) A public accommodation shall take whatever steps 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 on the public accommodation.

Vermont's Public Accommodations Statute, VFHPAA, defines "Auxiliary aids and services" as:

> Qualified interpreters, notetakers, computer aided transcription services, written materials, telephone handset amplifiers, assistive listening devices and systems, hearing aid compatible telephones, closed caption decoders, open and closed captioning telecommunications devices for deaf persons, videotext displays or other effective methods of making aurally delivered materials available to individuals with hearing impairments.[137]

The burden is on Julie Hay to establish a prima facie case of public accommodations discrimination but this burden is a "relatively light" one as the Second Circuit Court of Appeals has held that the burden of establishing a prima facie case under the ADA is not onerous.[138] To establish a prima facie case of public accommodations discrimination under the VFHPAA, Ms. Hay must show:

1) She is a person with a disability;
2) UVMC is a place of public accommodation;
3) Ms. Hay was offered an unequal opportunity to participate in Respondent's services, facilities, privileges, advantages, benefits *because of* her disability;

OR

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[137] 9 V.S.A. §4500 (7)(A).

[138] *Kennedy v. Dresser Rand Co.*, 193 F.3d 120, 122 (2nd Cir. 1999); see also *Dean v. Univ. at Buffalo School of Medicine, et. al.*, 804 F.3d 178, 189 (2nd Cir. 2015).

Respondent failed to take whatever steps may be necessary to ensure that Ms. Hay is not excluded, denied services, segregated, or otherwise treated differently *because of* the absence of auxiliary aids and services.

The legal standards, duties and requirements set forth under VFHPAA are to be construed consistently with The Americans with Disabilities Act (ADA).[139] Thus, in addition to looking at Vermont law, we also look to federal interpretations of that statute in determining whether complainant has met her burden.[140] Under the principles of deference established in *Chevron U.S.A. Inc. v. Natural Resources Defense Council, Inc.*,[141] courts give controlling weight to agency interpretations.[142] According to the Department of Justice's regulations and guidelines on effective communication, the ultimate decision as to what measures to take and the burden to furnish the auxiliary aids and services rests with the public accommodation. However, the public accommodation must ensure that the method chosen results in effective communication.[143] The public accommodation is strongly encouraged to consult with the person with a disability in determining the appropriate aid or service.[144] The nature, length, complexity, and context of the communication along with the person's normal method(s) of communication are considered.[145]

The purpose of effective communication rules is to ensure that the individual with the disability can receive and convey information.[146] As a result, in assessing the effectiveness of communication, one must also consider the systems of sign language (the most common systems of sign language are American Sign Language and signed English.) as individuals who use a particular system may not communicate effectively through an interpreter who uses another system.[147] The ADA uses the term "qualified" not "certified;" it is not whether the interpreter has been certified by a licensing body but whether the interpreter is one "who is able to interpret

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[139] 9 VSA § 4500 (a) and ADA, 42 U.S.C. §12101 et. seq.
[140] *Id.* See also, *State v. G.S. Blodgett Co.*, 163 Vt. 175, 180 (1995); *Hodgdon v. Mt. Mansfield Co.*, 160 Vt. 150, 165, (1992).
[141] 467 U.S. 837 (1984)
[142] Courts give controlling weigh to agency interpretations unless they are arbitrary, capricious, or manifestly contrary to the statute. *K.M. v. Tustin Unified School District and D.H. v. Poway Unified School District*, 725 F.3d 1088 (9th Cir., 2013) *citing Armstrong v. Schwarzenegger*, 622 F.3rd. 1058, 1065 (9th Cir., 2010).
[143] 28 CFR 36.303, Department of Justice Guidelines on Effective Communication, January 31, 2014.
[144] Id.
[145] Id.
[146] Id.
[147] ADA Technical Assistance, Effective Communication III-4.3000 Auxiliary aids.

effectively, accurately and impartially, both receptively and expressively, using any necessary specialized vocabulary."[148] Thus, a certified interpreter may not meet this standard in all situations.[149]

The law prohibits the use of family members and friends as interpreters as these people often lack impartiality and specialized vocabulary needed to interpret effectively and accurately.[150] The only two exceptions are:

> (1) In an emergency involving an imminent threat to the safety or welfare of an individual or the public where there is no interpreter available; or
>
> (2) Where the individual with a disability specifically requests that the accompanying adult interpret or facilitate communication, the accompanying adult agrees to provide such assistance, and reliance on that adult for such assistance is appropriate under the circumstances.

When a public accommodation relies on the use of a remote interpreter device such as Stratus and DeafTalk, it must ensure that it provides:

> (1) Real-time, full-motion video and audio over a dedicated high-speed, wide-bandwidth video connection or wireless connection that delivers high-quality video images that do not produce lags, choppy, blurry, or grainy images, or irregular pauses in communication;
>
> (2) A sharply delineated image that is large enough to display the interpreter's face, arms, hands, and fingers, and the participating individual's face, arms, hands, and fingers, regardless of his or her body position;
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> (3) A clear, audible transmission of voices; and
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> (4) Adequate training to users of the technology and other involved individuals so that they may quickly and efficiently set up and operate the device. [151]

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[148] Id.
[149] Id.
[150] Department of Justice Guidelines on Effective Communication, January 31, 2014.
[151] 28 CFR 30.03 Auxiliary Aids and Services (f).

II. Ms. Hay's Prima Facie Case Against UVMC

A. Ms. Hay is a person with a disability and Respondent is a Place of Public Accommodations.

The first two prongs of the prima facie case are presumably not in dispute as neither party has ever raised Ms. Hay's disability or Respondent's status as an issue.

The VFHPAA defines "disability" as a physical or mental impairment which limits one or more major life activities; a history or record of such an impairment; or being regarded as having such an impairment.[152] Ms. Hay is Deaf, has a medical diagnosis of mental illness and has low vision. Ms. Hay receives disability benefits and support from the Washington County Mental Health.[153] Ms. Hay and Respondent agree that Ms. Hay is Deaf and uses American Sign Language to communicate.[154]

The VFHPAA defines a place of public accommodation as any school, restaurant, store, establishment or other facility at which services, facilities, goods, privileges, advantages, benefits or accommodations are offered to the general public. Hospitals have been traditionally considered places of public accommodations under Title III of the Americans with Disabilities Act, VFHPAA's federal equivalent.

B. The Caselaw on Effective Communication

Whether a patient in a hospital received effective communication is highly dependent on the specific facts of each case. Vermont's only case on effective communication involves a Deaf arrestee who claimed police did not reasonably accommodate his disability when officers communicated orally and used written notes. The court held that although no sign language interpreter was provided, because the plaintiff could effectively lip read and answer questions, communication was effective.[155]

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[152] 9 V.S.A. §4500.
[153] UVMC Medical Records and [Deleted].
[154] Complaint, Response.
[155] *Ryan v. Vermont State Police*, 667 F. Supp. 2d 378 (D. Vt. 2009).

In the Second Circuit, the Court found that plaintiff was entitled to a sign language interpreter under the law when the plaintiff, an elderly Deaf patient whose primary language was Russian, suffered from a heart attack, was hospitalized for seven days, requested an interpreter and hospital staff failed to follow their own policies.[156] Plaintiff's claim for compensatory damages was ultimately denied due to failure to meet the higher bar of "deliberate indifference."[157] The standard for "deliberate indifference" is when a policymaker acts with deliberate indifference to the likelihood that the patient's rights will be or have been violated.[158] As for the plaintiff's injunctive relief claims, the court held that plaintiff could not show that there is a "real and immediate threat of repeated injury" and not just past exposure to illegal conduct."[159] In a different matter, plaintiff's claim of discrimination survived summary judgment when the Court found that a jury could reasonably find deliberate indifference when a Deaf patient made multiple requests for an interpreter, the hospital used minor children to act as interpreters when they could not understand many of the medical terms and one doctor laughed off requests for interpreters. [160] In a different case when an interpreter was not provided on separate occasions and the defendant argued that it had nonetheless provided effective medical care, the Court rejected Defendant hospital's argument, stating that it had missed the point as the question was whether plaintiff could effectively communicate and meaningfully participate in their medical care, not whether their medical care and treatment was effective.[161]

Effective communication depends on "the nature, significance, and complexity of the involved treatment."[162] Situations that involve surgery, diagnosis or more complex treatment may require an interpreter.[163] Courts may be reluctant to hold that every time an auxiliary aid is denied, it

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[156] *Freydel v. New York Hosp.*, 242 F. 3d 365 (2d Cir. 2000)
[157] Id.
[158] Id. at 365, *citing Barlett v. New York State Board of Law Examiners*, 156 F.3d 321, 331 (2nd Cir. 1998)
[159] Id at 365.
[160] *Loeffler v. Staten Island Univ. Hosp.*, 582 F.3d 268 (2d Cir. 2009)
[161] *Nalman v. New York Univ.*, No. 95 CIV 6469 (LMM), 1997 WL 2499770, at *1 (S.D.N.Y. May 13, 1997) *citing Alkins v. St. Helena Hosp.*, 843 F.Supp. 1329, 1338 (N.D.Cal.1994) recognizing that adequate medical treatment is not a defense to claim that defendant failed to provide effective communication under the RA.
[162] *Liese v. Indian River County Hospital District, 701* F.3d. 334, 342 (11th Cir. 2012), 28 CFR 36.303, Department of Justice Guidelines on Effective Communication, January 31, 2014.
[163] *Berry-Mayes for Estate of Berry v. New York Health and Hospitals Corp.*, United States District Court, S.D. New York, September 19, 2016 (Slip copy 2016, WL 8461191*7).

would equate to discrimination under the ADA.[164] Similarly, the ADA and regulations do not require that a sign-language interpreter be provided for every interaction with a hearing-impaired patient.[165]

A live ASL interpreter was considered necessary for a Deaf patient to understand a complex procedure such as gallbladder surgery when the Deaf patient did not understand through lip-reading, notes or pantomiming and had requested an interpreter and did not receive one.[166] In a different case, the court found that the failure to provide a live ASL interpreter was not discrimination under the ADA. In that case, the patient who had to undergo an emergency catheterization typically used hand-written notes to communicate and had received an interpreter for eight hours of his hospitalization.[167] Likewise, when a plaintiff failed to request an interpreter, rejected the interpreter that was offered, or the purpose for the hospitalization was relatively minor, Courts have found no violation.[168] On the other hand, when a defendant argued that a plaintiff did not have a right to *any* accommodation, the Court concluded that effective communication could not have been achieved since there was no accommodation provided. However, the right to an accommodation did not equate to the right to an interpreter.[169]

In sum, effective communication is determined by a fact-intensive inquiry into the nature, length, complexity and context of the communication and considers the person's normal methods of communication. Courts have been sympathetic to plaintiff's effective communication claims against hospitals when the plaintiff was hospitalized for longer periods of time, as opposed to several separate visits or a limited encounter and when the procedures or medical interventions were particularly complex or invasive. Lastly, if a plaintiff could not lip-read or had limited English skills, plaintiffs were also more successful in their claims.

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[164] *Liese* at 343.
[165] *Berry-Mayes for Estate of Berry* at 6.
[166] *Liese at* 343–44
[167] *Martin v. Halifax Healthcare Systems, Inc.* 621 Fed.Appx.594, 602 (11th Cir. 2015).
[168] Id.
[169] *Bravin v. Mount Sinai Medical Center*, 58 F. Supp. 2d 269, 374 (1999).

C. Ms. Hay did not receive effective communication at UVMC.

When Ms. Hay met with Karen Robin from UVMC's Case Management, no ASL interpreter was used nor ordered. Ms. Robin used Ms. Hay's family members to interpret as did Dr. Tischler who said he used family members and a white board to communicate with Ms. Hay. The Department of Justice's regulations and guidelines specifically say that family members should only be used in the event of an emergency or at the request of the patient.

For Ms. Hay's entire hospitalization, UVMC provided a remote interpreter for a total of 22 minutes.[170] When a hospital uses technology, it must ensure that its devices are technologically sound and it must provide adequate training to users of the technology.[171] UVMC has very little knowledge of the certifications and qualifications of remote ASL interpreters as they have never conducted an audit of Stratus. UVMC's records show that Stratus often had connection problems, rendering the devices useless from time to time. Although many hospital employees have been trained to use the device, there was no organizational strategy to train UVMC employees. Some of the doctors at UVMC did not know how to set up the device for communication.

Whether it's a community or remote interpreter or hand-written notes, the hospital must ensure that the auxiliary aids and services they choose provide effective communication. Remote ASL interpreters are at a disadvantage in providing effective communication as they are essentially bound by the screen, having no freedom of space to use the room or their body language to emphasize complex medical terminology and processes. Furthermore, language and communication may be lost through a screen since ASL is a dynamic three-dimensional system of communication. Additionally, remote interpreters do not have local knowledge that the Deaf community considers important when receiving and expressing information. All of these considerations along with the fact that Vermont's community interpreters are well-known by the Deaf community and provide a high level of trust and ease that is not easily achieved by remote

[170] Interview with Dr. Roberts, Medical notes by Dr. Trabulsy and Stratus Records.
[171] 28 CFR 30.03 Auxiliary Aids and Services (f)

interpreters, call into question whether effective communication was achieved for the 22 minutes the remote interpreter was used.

Ms. Hay said that she did not receive effective communication and that the remote interpreter was unfamiliar with some medical terms and used fingerspelling to communicate. Ms. Hay further said that the remote interpreter did not provide details and there was no opportunity to ask clarification questions. Dr. Roberts resorted to close-ended questions and requested additional history be obtained from Ms. Hay at a later time and said that most of her information came from sources other than Ms. Hay.[172] Dr. Roberts also stated that she didn't believe communication was as effective as it could have been, had Ms. Hay not been Deaf.[173]

It must be noted that Ms. Hay has never argued that medical services in the ED should have been delayed for a community interpreter to arrive but here, UVMC made no effort to request or secure a community interpreter. This investigation draws no conclusion as to the hospital's use of remote interpreters as a whole, since this will highly depend on the circumstances of each case. In this case, however, effective communication was not achieved in the 22 minutes Ms. Hay used the remote interpreter. Ms. Hay could not fully express herself and did not fully receive information about her medical condition. Although doctors were able to obtain some information from Ms. Hay, most of the information relied upon in assessing her condition and creating her treatment plan came from other sources.

This investigation recognizes that the lens through which Ms. Hay viewed her experiences was very different from those of her providers. Ms. Hay's English was rudimentary and limited and she could not read lips. Ms. Reep described Ms. Hay as "monolingual" and [Deleted] said that using hand-written notes to communicate with Ms. Hay was not always effective as Ms. Hay's writing was basic and her spelling was sometimes incorrect. Ms. Hay believed she was having a heart attack before arriving[Deleted], was rushed to the hospital in an ambulance, was transferred to a new hospital and both she and the EMT believed she was experiencing another heart attack enroute. From July 15th through July 17th, she received new medications whose purposes and side-effects were explained through hand-written notes or never explained at all. Dr. Rambod's detailed explanation of a cardiac catheterization procedure could not have been effectively

[172] Id.
[173] Id.

communicated to Ms. Hay through the use of hand-written notes or an incomplete consent form, considering the complexity, level of detail and seriousness of the procedure. Ms. Hay was not afforded the same explanation and opportunity to seek information or ask questions before undergoing an invasive and costly diagnostic treatment; opportunities that are made available to non-disabled patients and opportunities that could have been provided to Ms. Hay through the use of a qualified interpreter. Ms. Hay's knowledge of the cardiac catheterization was basic and incorrect.

Other evidence that Ms. Hay never received effective communication include Ms. Hay asking a nurse "Why? Period?" to which the nurse replied by writing on a piece of paper, "I don't know." And when she asked another nurse about her medications and she received the answer "clot" which she interpreted to mean she had a blood clot and not that the medication was to prevent blood clots. Notes in the medical records show that echocardiogram was "limited due to poor patient compliance and patient inability to follow directions."[174] Ms. Hay was so stressed about the catheterization procedure that general anesthesia, atypical of the procedure, was used and a doctor had to use his phone to text "relax." Dr. Dauerman's notes confirm that communication was limited due to patient's hearing disability.[175]

Despite there being a window of 15 hours, none of the many UVMC's staff who saw and treated Ms. Hay notified Lynette Reep that Ms. Hay was in the hospital, was Deaf, and would be undergoing an invasive procedure because none of them even knew who the UVMC's interpreter coordinator was. In fact, most of them had never even read the hospital's interpreter policy because UVMC had no organized training for their employees. It was clear that UVMC had a preference to offer Stratus to Deaf patients and did very little to encourage understanding or acceptance that there were multiple modalities that could be offered to a patient.

Perhaps the most important fact that sets Ms. Hay's case apart from most, if not all, of the cases across the circuits is that Ms. Hay is not just Deaf but she also has a mental illness that was

[174] UVMC Medical Records, ECG/Echo Results.
[175] Id.

clearly identified in her medical records. UVMC was on notice that communication through a remote interpreter or hand-written notes could be compromised and thus, not effective.

This investigation finds that UVMC failed to take whatever steps necessary to ensure that Ms. Hay would not otherwise be treated differently because of the absence of auxiliary aids and services. It also finds that Ms. Hay did not receive the same services, benefits and treatment as non-disabled patients because of her disability. This investigation need not conclude that discrimination was based on animus or ill-will. At most, a private individual seeking monetary damages under the ADA must show Defendant acted with *deliberate indifference*.

It's not clear that the deliberate indifference standard is applicable to a private plaintiff seeking monetary relief under VFHPAA. Although the legal standards set forth under VFHPAA are to be construed consistently with the ADA, the law specifically states "except those provisions relating to remedies."[176] Additionally, Courts may not impose this standard upon public entities such as the Department of Justice or the Vermont Human Rights Commission who bring claims in the public's interest and seek monetary relief on behalf of complainants. The question before this investigation and the Vermont Human Rights Commission is whether any provisions of the VFHPAA have been violated and not necessarily if and what type relief is available to Ms. Hay under the statute. Lastly, a plaintiff need not show deliberate indifference if they are seeking injunctive or declaratory relief.[177]

D. Defenses

Ms. Hay makes no allegations about the quality of the medical care or treatment she received at UVMC and any argument that she received effective medical care or treatment is "missing the point" as the courts have held. Ms. Hay argues that because communication was not effective,

[176] 9 VSA § 4500 (a) and ADA, 42 U.S.C. §12101 et. seq.

[177] An ADA plaintiff establishes such a real and immediate threat if "he intends to return to a noncompliant place of public accommodation where he will likely suffer repeated injury." *Chapman v. Pier 1 Imports, 631 F. 3d 939, 948 (9th Cir. 2011) citing Fortyune v. American Multi-Cinema Inc., 364 F. 3d 1075, 1082 (9th Cir. 1075) at 1082* (holding that plaintiff who suffered discrimination only once was likely to suffer repeat injury where he returned to place of public accommodation often and discrimination was pursuant to written policy); and *Pickern v. Holiday Quality Foods, Inc.,* 293 F. 3d 1133, 1138 (9th Cir. 2002).

she was denied the opportunity afforded to non-disabled patients, to meaningfully participate in her own medical care.

The statute allows UVMC to raise only two defenses: That providing a qualified interpreter for Ms. Hay would "fundamentally alter the nature of the goods, services, facilities, privileges, advantages or accommodations" or result in an "undue burden" on UVMC. [178] Undue burden is defined as significant difficulty or expense. Courts will consider the economic conditions on the resources available to an entity: the nature and cost of the aid or service relative to their size, overall financial resources, and overall expenses. In general, where a hospital has greater resources, it is expected to do more to ensure effective communication than one with fewer resources. Even the size, expenses and resources of a parent company will be considered.

Respondent has never raised the argument that providing a community interpreter for Ms. Hay during her hospitalization would create an "undue burden" or "fundamental alteration" of its program or policies. And it would be difficult to raise that argument now considering that it hired a full-time interpreter coordinator who has over 30 years of experience as an ASL interpreter, and was available and willing to provide qualified interpreter services to Ms. Hay. Furthermore, it's not clear that providing a community interpreter to explain critical and complex medical procedures would create an undue hardship or fundamental alteration since UVMC hospital is the second largest employer in the State of Vermont. As a result, this investigation finds that UVMC has no defenses to Ms. Hay's prima facie case.

III. [Deleted]

[178] 9 V.S.A. §4500 (c)(5)(6).

Conclusion

This investigative report recommends that the VHRC find that there are **reasonable grounds** to believe that The University of Vermont Medical Center discriminated against Julie Hay on the basis of her disability and violated the VFHPAA, codified at 9 V.S.A. §4502.

Bor R. Yang, Administrative Law Examiner

6-1-2017
Date

Approved by:

Karen Richards, Executive Director
& Legal Counsel

6-1-2017
Date

STATE OF VERMONT
HUMAN RIGHTS COMMISSION

Julie Hay, Complainant	)	
v.	)	VHRC Complaint No. PA16-0016
University of Vermont Medical Center; and Central Vermont Medical Center, Respondents	)	

FINAL DETERMINATION

Pursuant to 9 V.S.A. 4554, the Vermont Human Rights Commission enters the following Order:

1. The following vote was taken on a motion to find that there are reasonable grounds to believe that the University of Vermont Medical Center, the Respondents, illegally discriminated against Julie Hay, the Complainant, in violation of Vermont's Fair Housing and Public Accommodations Act.

Mary Marzec-Gerrior, Chair	For ✓	Against __	Absent__	Recused __
Nathan Besio	For ✓	Against __	Absent __	Recused __
Mary Brodsky	For ✓	Against __	Absent __	Recused __
Donald Vickers	For ✓	Against __	Absent __	Recused __
Dawn Ellis	For ✓	Against __	Absent __	Recused __

Entry: ✓ Reasonable Grounds ___ Motion failed

Dated at Montpelier, Vermont, this 25th, day of May 2017.

BY: VERMONT HUMAN RIGHTS COMMISSION

Mary Marzec-Gerdor, Chair

Nathan Besio

Mary Brodsky

Donald Vickers

Dawn Ellis