Litch's Law Log

What is the Dentist's Legal Responsibility for Parents or Guardians with Hearing Impairments or Limited English Proficiency?

Answers to these "thorny patient treatment questions" are addressed in questions 152, 153, and 154 of the ADA's publication *Frequently Asked Legal Questions: A Guide for Dentists and the Dental Team*.[1] Like many legal questions, these cannot be answered with a simple yes or no. That's why you hear lawyers use the phrase "arguably" so often.

For the patient, or in the case of pediatric dentistry the parent or guardian, the main legal issue about a **hearing impairment** is that it is a protected disability under the Americans with Disabilities Act. This, of course, triggers certain legal requirements. Under the disabilities act, a dental office is a place of public accommodation that cannot discriminate and must also supply "auxiliary aids and services"—such as sign language interpreters—unless this would cause an "undue burden."

This means that in many cases the dental office has to hire and pay for an interpreter. Several factors must be considered. An interpreter is needed if necessary to achieve "effective communication" with the patient/parent/legal guardian. In some cases exchanging notes may suffice. The answer may also vary by type of treatment (simple vs. more complex). Informed consent must be considered, since the pediatric dentist must ensure that the parent/guardian has given informed consent for the treatment of their child (see the AAPD's new clinical guideline on informed consent at: *http://www.aapd.org/media/Policies_Guidelines/G_Informed%20Consent.pdf).*

The National Association of the Deaf advises patients: "It is best to contact your doctor/health care provider directly and tell them, prior to your appointment, that you need an interpreter." *(http://www.nad.org/infocenter/infotogo/legal/doctors/html)*

Of course, the thorniest question is, who pays? If necessary for effective communications, the dentist must pay the cost of the interpreter and cannot pass the cost along to the patient's family. But the dentist can select the interpreter through local resources, such as disability support groups. **Note, however, that the dentist cannot insist that patients use friends or family to interpret.** Most dental offices will not be able to use the "undue burden" argument as the measure is the overall financial picture of the practice. Dental offices do qualify for a tax credit of 50 percent of the cost of interpreter services between $250 and $10,250 expended annually.

There is a different answer to the **limited English proficiency** scenario. **There is no federal law requiring a dentist to provide foreign language interpreters. However, this MAY be required for dentists participating in Medicaid.** State law must also be reviewed. Of course, the dentist, as noted above, must always be cognizant of obtaining proper informed consent.

The Office of Civil Rights (OCR) for the U.S. Department of Health and Human Services has stated that if a health care provider treats Medicaid-eligible patients, foreign language assistance should be provided at no cost to the health care provider's entire limited English proficient population![2] The guidance arguably exceeds federal regulatory authority. The American Medical Association has also expressed concerns about the financial and administrative burdens that the "LEP guidelines" impose on physician practices. The ADA disagrees with OCR that dentists are even covered by this requirement. ADA House of Delegates Resolution 56 passed in 2005 addresses the issue in some detail.

ADA Council on Government Affairs Resolution 56 H—Limited English Proficiency

> **Resolved,** that the Association work with the appropriate federal agencies, advocacy groups, trade associations, and other stakeholders to ensure that accommodating the language needs of English-limited patients is recognized as a shared responsibility, which cannot be fairly visited upon any one segment of a community, and be it further
>
> **Resolved,** that the Association support appropriate legislation and initiatives that would enhance the ability of individuals of limited English proficiency to effectively communicate in English with their dentist and the dental office staff, and be it further
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> **Resolved,** that the Association oppose federal legislative and regulatory efforts that would unreasonably add to the administrative, financial, or legal liability of providing dental services to limited English proficient patients, such as being required to provide interpreters on demand as a condition of treating patients receiving

state and/or federal benefits, and be it further

Resolved, that constituent and component dental societies be encouraged to support state, local, and private sector efforts to address the language needs of English-limited patients, and be it further

Resolved, that dental and allied dental programs be encouraged to educate students about the challenges associated with treating patients of limited English proficiency.

The LEP guidelines apply a four-factor test to determine provider responsibility for LEP services:

1) number or proportion of LEP patients in the eligible population (i.e. scope and type of provider's practice and demographics of geographical area in which patients reside);
2) frequency with which LEP patients come into contact with the provider's services (which will obviously be much different for a solo or partnership practice versus a hospital or other institutional facility);
3) nature and importance of provider's services (the more important the service, the more likely language assistance will be required, especially where delay or denial of services could be life-threatening); and
4) availability of resources and costs (small providers with more limited budgets are not expected to provide the same level of language services as larger providers with larger budgets). Note that providers must document they have explored the most cost-effective means of delivering LEP services before deciding to limit services due to resource concerns.

After applying this four-factor test, if a provider determines that language assistance is required, he or she should develop a plan for implementation. The DHHS Revised Guidance[2] in fact provides five steps for designing a written LEP plan. I

Services can be provided by oral interpretation and written translation. OCR notes that in some cases it may be appropriate for a provider to refer a patient to another provider where the patient may receive better language access. Note however, similar to the "family member" rule with regard to the hearing-impaired, OCR guidance indicates that while a patient should have the option of using his family member rather than an independent interpreter or bilingual staff, the provider **may not require** that a patient (or family) provide his or her own interpreter.

For further information, please contact Deputy Executive Director and General Counsel C. Scott Litch at (312) 337-2169 or *slitch@aapd.org*.

[1]Note: If you wish to order this ADA publication, go to the ADA's Product Catalogue at www.ada.org. You will need to login as an ADA member to access this particular product. The ADA member cost is $125.

[2]See Revised Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons, 68 Fed. Reg. 47311 (Sept. 30, 2003). The PDF of this document is available at: http://www.hhs.gov/ocr/lep/lep_guidance080403.pdf.

UPDATES in BRIEF

- A study of the Community-Oriented Dental Education Program for senior dental school students at the University of Medicine and Dentistry of New Jersey concluded that community-based dental educational programs can be at least as effective as intramural (dental school-based) educational experiences in providing students with a sound clinical education. See *Castro JE, Bolger D, Feldman CA. Clinical competence of graduates of community-based and traditional curricula. J Dent Educ 2005; 69 (12): 1324-1331.*
- Few Ohio general dentists (8 percent) recommended a first dental visit by age one, and only 34 percent treated children 0 through 2 (although they were somewhat more likely to treat Head Start children) according to a recent study published in the Journal of the American Dental Association: *Siegal MD, Marx M. Ohio dental care providers' treatment of young children, 2002. JADA 2005; 136: 1583-1591.* **This study also found that pediatric dentists in Ohio are three times more likely than general dentists to treat patients enrolled in Medicaid.**
- The ADA recently released the report *2004 Survey of Legal Provisions for Delegating Intraoral Functions to Dental Assistants and Dental Hygienists.* Thirty-nine jurisdictions completed the survey, which reports results for functions such as polishing coronal surfaces of teeth, monitoring nitrous oxide analgesia, applying pit and fissure sealants, applying fluoride varnishes and carving amalgam restorations. A copy of the full report is available from the ADA Survey Center at (800) 621-8099.