

DISABILITY, EQUIPMENT BARRIERS, AND WOMEN’S HEALTH: USING THE
ADA TO PROVIDE MEANINGFUL ACCESS

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INTRODUCTION

My primary physician and several specialists I respect all practice at a major university medical center fairly close to my home. Recently, though, when I requested a gynecology referral there, I was told that I would not be seen unless I could bring my own assistants to help me get on the examining table. This is a huge world-renowned hospital. This is the era of [the] ADA. Still I am treated as though I don't belong with the other women who seek services in OB/GYN unless I can make my disability issues go away. This news makes me weary. I know it means once again that I can't simply pursue what I need as an ordinary citizen. I can't be just a woman who needs a pelvic exam; I must be a trailblazer.¹

It is well-known that people with disabilities face multiple barriers to adequate health care, including lower average incomes,² disproportionate poverty,³ and issues with insurance coverage.⁴ This article focuses on a more fundamental barrier—one that has not been discussed in the legal

1. Narrative of a woman with post-polio syndrome who uses a power wheelchair. June Isaacson Kailes, *The Patient's Perspective on Access to Medical Equipment*, in *MEDICAL INSTRUMENTATION: ACCESSIBILITY AND USABILITY CONSIDERATIONS* 3, 5 (Jack M. Winters & Molly Follette Story eds., 2007). For related webcast and presentation materials, see Independent Living Research Utilization, Just Hop Up, Look Here, Read This, Listen Up, Don't Breathe & Stay Still! Access to Medical Equipment – Where Are We?, Presented by June Isaacson Kailes (Jan. 4, 2007), at www.ilru.org/html/training/webcasts/archive/2007/01-04-JK.html (last visited Feb. 6, 2009).

2. THE HENRY J. KAISER FAMILY FOUND., HEALTH CARE FOR AMERICANS WITH DISABILITIES (2004), available at www.kff.org/medicaid/upload/Health-Care-and-the-Elections-Health-Care-for-Americans-With-Disabilities-pdf.pdf (last visited Feb. 6, 2009) (“Relative to the general population, those with disabilities have lower incomes and are far less likely to be employed.”).

3. ERIKA STEINMETZ, U.S. CENSUS BUREAU, CURRENT POPULATION REPORTS, AMERICANS WITH DISABILITIES: 2002 HOUSEHOLD ECONOMIC STUDIES 3 (2006), available at www.census.gov/prod/2006pubs/p70-107.pdf (last visited Feb. 6, 2009) (“The poverty rate for people 25 to 64 with no disability was 7.7 percent; the rate was 11.2 percent for people with a nonsevere disability and 25.9 percent for people with a severe disability.”); JANICE BLANCHARD & SUSAN HOSEK, RAND HEALTH, WHITE PAPER: FINANCING HEALTH CARE FOR WOMEN WITH DISABILITIES, at x (2003), available at www.rand.org/pubs/white_papers/2005/WP139.pdf (last visited Feb. 6, 2009) [hereinafter BLANCHARD & HOSEK, FINANCING HEALTH CARE] (Based on 2000 U.S. Census data, “[m]ore women with disabilities than without disabilities live in poverty, with incomes below the mean for both women without disabilities and men with disabilities. Many also belong to ethnic or minority groups that are traditionally underserved by the health care system.”).

4. For an analysis of sources of health care coverage for people with disabilities, see KRISTINA HANSON ET AL., THE HENRY J. KAISER FAMILY FOUND., UNDERSTANDING THE HEALTH-CARE NEEDS AND EXPERIENCES OF PEOPLE WITH DISABILITIES: FINDINGS FROM A 2003 SURVEY 9, 10 exhibit 9 (2003) [hereinafter HANSON ET AL., UNDERSTANDING THE HEALTH-CARE NEEDS].

literature—inaccessible medical equipment and its effect on the delivery of women's health care⁵ to millions of women with disabilities.⁶

Stories like the one above are commonplace in the disability community, yet are seldom heard outside of it. The problem of physical barriers to the delivery of health care for people with disabilities is a surprisingly under-examined subject. Early writing after the passage of the Americans with Disabilities Act (ADA),⁷ primarily in the medical literature, noted lack of access as a problem,⁸ but predicted or appeared to assume that the ADA's requirement of removal of architectural barriers where readily achievable would quickly remedy the problem.⁹ Most legal scholars since then have focused on the problems of the role of disability in medical decision-making and insurance coverage.¹⁰

5. There is no single definition of "women's health." Traditionally, women's health has been defined in terms of childbirth and reproductive health. See, e.g., TINA SHAW, NAT'L CONF. ST. LEGISLATURES, WOMEN'S HEALTH: AN EMERGING DEFINITION (2008), at www.ncsl.org/programs/health/forum/womenshealth.htm (last visited Feb. 6, 2009). Modern, more inclusive definitions of women's health include issues of gender-specific medicine. *Id.* For the purposes of this article, I am using the narrower definition because it most relates to the theme of the symposium, "Disability, Reproduction and Parenting."

6. There is no reliable estimate of the number of women who experience mobility disabilities. According to recent Census data, nearly twelve million Americans experience some form of mobility disability, requiring the use of a wheelchair, cane, crutches, or walker. STEINMETZ, *supra* note 3, at 3. There is evidence that more women experience mobility disabilities than men. See Mitchell P. LaPlante, Demographics of Wheeled Mobility Device Users 9 (Oct. 7, 2003) (paper presented at the conference on Space Required for Wheeled Mobility on file with author). If women make up the same proportionate share or are proportionately overrepresented in this category of disability as in disabilities generally, that would mean there are approximately 6.6 million women with mobility disabilities. See H. STEPHEN KAYE ET AL., U.S. DEP'T OF EDUC., NAT'L INST. ON DISABILITY & REHABILITATION RES., MOBILITY DEVICE USE IN THE UNITED STATES 8-9 (2000).

7. 42 U.S.C. §§ 12101-12213 (2000).

8. Around the time of the passage of the ADA, there was note in the medical literature that physicians' offices were not accessible to people with mobility disabilities. See Ellen W. Grabois & Margaret A. Nosek, *The Americans with Disabilities Act and Medical Providers: Ten Years After Passage of the Act*, 29 POL'Y STUD. J. 682, 686-87 (2001) (reviewing literature, and specifically noting equipment access as an issue for women seeking care in obstetrician-gynecologists' offices).

9. See, e.g., Wendy E. Parmet, *Discrimination and Disability: The Challenges of the ADA*, 18 J.L. MED. & ETHICS 331, 333, 335, 337, 339 (1990); Mary Crossley, *Becoming Visible: The ADA's Impact on Health Care for Persons with Disabilities*, 52 ALA. L. REV. 51, 51 (2000).

10. See, e.g., Paul K. Longmore, *Medical Decision Making and People with Disabilities: A Clash of Cultures*, 23 J.L. MED. & ETHICS 82, 82 (1995); Mary A. Crossley, *Medical Futility and Disability Discrimination*, 81 IOWA L. REV. 179, 180 (1995); Maxwell J. Mehlman et al., *When Do Health Care Decisions Discriminate Against Persons with Disabilities?*, 22 J. HEALTH POL. POL'Y & L. 1385, 1395, 1393 (1997); Sharona Hoffman, *AIDS Caps, Contraceptive Coverage, and the Law: An Analysis of the Federal Anti-Discrimination Statutes' Applicability to*

Although the Rehabilitation Act¹¹ and the ADA require that health care programs, institutions, and offices be accessible, few actually are: over fifteen years after the passage of the ADA, women with mobility impairments cannot get on examination tables, cannot be weighed, and cannot use mammography equipment. This pervasive and unequal treatment has serious consequences for the health and well-being of millions of women.

The continuing failure to ameliorate this seemingly simple problem points to larger questions. What does it mean to have a disability? And how does the answer to that question inform our understanding of the social, political, and economic consequences of disability?¹² Even a cursory review of law and practice in this area reveals a deep conflict in our understanding of disability and the justness of its social, political, and economic consequences. I have explored these questions elsewhere, arguing that disability is under-theorized, and offering an alternative model of disability in the context of employment discrimination claims under Title I of the ADA.¹³ These same questions are present here in a different context. What does it mean to be a woman with a disability? And what if anything should we do to ameliorate disparities in access to health care for women with disabilities? This article seeks a solution to the problem of inaccessible medical equipment informed by these larger questions.

Part I establishes the scope of the problem through a review of the medical literature and the first national survey of women with disabilities on their experiences with women's health care. Disturbingly, the literature reveals significant equipment-related barriers to women's health care for women with mobility disabilities. Part II provides an overview of disability-based civil rights law, specifically the Rehabilitation Act and the ADA, and the requirements regarding equal access to health care programs and services. Part III explores possible explanations for the discrepancy between the requirements of the law and the experience of women with disabilities. The section first addresses possible objections to enforcement of the duty to acquire accessible equipment, including claims that there is no consensus

Health Insurance, 23 CARDOZO L. REV. 1315, 1316 (2002); Elizabeth A. Pendo, *The Politics of Infertility: Recognizing Coverage Exclusions as Discrimination*, 11 CONN. INS. L.J. 293, 294-95 (2005).

11. 29 U.S.C. §§ 701-796 (1988).

12. These questions were inspired by a series of questions posed by Paul K. Longmore in the introduction to his book *Why I Burned My Book and Other Essays on Disability*. PAUL K. LONGMORE, *WHY I BURNED MY BOOK AND OTHER ESSAYS ON DISABILITY* 1-15 (2003).

13. Elizabeth A. Pendo, *Disability, Doctors and Dollars: Distinguishing the Three Faces of Reasonable Accommodation*, 35 U.C. DAVIS L. REV. 1175, 1177-78 (2002); Elizabeth A. Pendo, *Substantially Limited Justice? The Possibilities and Limits of a New Rawlsian Analysis of Disability-Based Discrimination*, 77 ST. JOHN'S L. REV. 225, 228 (2003) [hereinafter Pendo, *Substantially Limited Justice?*].

on the definition of accessible equipment, that accessible equipment is not available, and that accessible equipment is not necessary because patients can be lifted onto existing equipment. It then argues that the continuing stigmatization of sexuality, reproduction, and parenting in connection with women with disabilities plays a key role in the continuing invisibility of the problem among people without disabilities, including physicians. Finally, Part IV discusses ways to increase equitable access to women's health care for women with disabilities in light of the physical and societal barriers identified above, and suggests addressing the responsibility of states to ensure meaningful access to the Medicaid program for women with disabilities as a promising place to start.

I. THE PROBLEM OF INACCESSIBLE MEDICAL EQUIPMENT

In addition to the barriers noted above, people with disabilities also "receive less appropriate health care and education when compared to those without disabilities . . .",¹⁴ and are less likely to receive primary preventative health care services than people without disabilities.¹⁵ A 2004 poll conducted by the National Organization on Disability in connection with Harris Interactive, a polling company, found that eighteen percent of people with disabilities reported going without needed care in the past year, as compared to seven percent of people without disabilities.¹⁶ Similarly, a national survey of people with disabilities conducted by the Kaiser Family Foundation in 2003 found that "[l]ess than half of all female respondents reported having a mammogram in the past year and only about a third of all men reported having a prostate exam over the same period."¹⁷

Little attention has been paid to the health status of women with disabilities¹⁸ and access to women's health services.¹⁹ All women, including

14. Peter Blanck et al., *Employment of People with Disabilities: Twenty-Five Years Back and Ahead*, 25 L. & INEQUALITY 323, 325 (2007) (citing Harris survey, *infra* note 16).

15. Thilo Kroll et al., *Barriers and Strategies Affecting the Utilisation of Primary Preventive Services for People with Physical Disabilities: A Qualitative Inquiry*, 14 HEALTH & SOC. CARE IN THE COMMUNITY 284, 285 (2006).

16. KRISTINA HANSON, NAT'L ORG. ON DISABILITY, DETAILED RESULTS FROM THE 2004 N.O.D./HARRIS SURVEY OF AMERICANS WITH DISABILITIES 10 (2004), available at www.nod.org/Resources/harris2004/harris2004_data.pdf (last visited Feb. 6, 2009). Similarly, a smaller 2002 survey in Los Angeles County indicated that 22% of responders with physical or sensory disabilities reported difficulty accessing a health care provider's office because of the physical layout of location of the property and 12.9% reported unfair treatment at a provider's office because of a disability. Ctrs. for Disease Control & Prevention, *Environmental Barriers to Health Care Among Persons with Disabilities – Los Angeles County, California, 2002-2003*, 55 MORBIDITY & MORTALITY WKLY. REP. 1300, 1301-02 (2006).

17. KRISTINA HANSON ET AL., UNDERSTANDING THE HEALTH-CARE NEEDS, *supra* note 4, at 9.

18. In keeping with the theme of the Symposium, this Article focuses on women's health care as it related to sexuality, reproduction, and parenting. This is not to minimize the

women with disabilities, require routine women's health care, such as regular gynecological examinations and mammograms. Unfortunately, the available evidence shows that women with disabilities are receiving unequal and in many cases inadequate care. For example, a 1998 study by the Centers for Disease Control and Prevention found that adult women with functional limitations were less likely to receive breast and cervical cancer screenings within the recommended time frame than women without disabilities.²⁰ Studies conducted in 1999, 2000, 2001, and 2003 made similar findings.²¹

Emerging research reveals that inaccessible medical equipment is a fundamental barrier to basic women's health care services.²² These were the findings of the first national survey of women with disabilities on their experiences with women's health and gynecological care and conducted in the years immediately following passage of the ADA by the Center for

equipment and other barriers experienced by men with disabilities. See, e.g., Kristi L. Kirschner et al., *Structural Impairments that Limit Access to Health Care for Patients with Disabilities*, 297 JAMA 1121, 1121 (2007).

19. *Id.* ("Although no direct evidence currently exists about the population prevalence of these problems nationwide, increasing numbers of legal cases, small studies, and circumstantial evidence point to widespread access barriers for patients with disabilities within US health care settings."); Rosemary B. Hughes, *Achieving Effective Health Promotion for Women with Disabilities*, 29 FAM. CMTY. HEALTH (SUPPLEMENT 1) 44S, 44S (2005) (noting that "[f]ew of randomized, controlled research studies have been conducted on health promotion for women with disabilities[]" and calling for study); M.A. Nosek et al., *National Study of Women with Physical Disabilities: Final Report*, 19 SEXUALITY & DISABILITY 5, 39 (2001) [hereinafter Nosek et al., *CROWD Study*]; see also JUDY PANKO REIS ET AL., *IT TAKES MORE THAN RAMPS TO SOLVE THE CRISIS OF HEALTHCARE FOR PEOPLE WITH DISABILITIES* 7 (2004), available at www.tworldwide.com/events/hhs/041206/PPT/RIC_whitepaperfinal82704.pdf (last visited Feb. 6, 2009) (examining the extent to which people with disabilities experience problems and barriers receiving health care, and why).

20. Ctrs. for Disease Control & Prevention, *Use of Cervical and Breast Cancer Screening Among Women with and Without Functional Limitations – United States, 1994-1995*, 47 MORBIDITY & MORTALITY WKLY. REP. 853, 853, 855 (1998) [hereinafter CDC, *Use of Cervical and Breast Cancer Screening*].

21. See Leighton Chan et al., *Do Medicare Patients with Disabilities Receive Preventive Services? A Population-Based Study*, 80 ARCHIVES PHYSICAL MED. & REHABILITATION 642 *passim* (1999); Lisa I. Iezzoni et al., *Mobility Impairments and Use of Screening and Preventive Services*, 90 AM. J. PUB. HEALTH 955 *passim* (2000); Lisa I. Iezzoni et al., *Use of Screening and Preventive Services Among Women with Disabilities*, 16 AM. J. MED. QUALITY 135 *passim* (2001); HANSON ET AL., *UNDERSTANDING THE HEALTH-CARE NEEDS*, *supra* note 4, at 9.

22. BLANCHARD & HOSEK, *FINANCING HEALTH CARE*, *supra* note 3, at 8; Kailes, *The Patient's Perspective on Access to Medical Equipment*, *supra* note 1, at 4.

Research on Women with Disabilities (the "CROWD Study").²³ Since the CROWD Study, other surveys have found similar results.²⁴

To be clear, the barrier at issue here is to care, not coverage.²⁵ Indeed, most women with disabilities are covered by some type of health insurance.²⁶ According to the Kaiser Family Foundation, in 2003 fifty percent of women with disabilities had coverage through the Medicaid program,²⁷ twenty-five percent through the Medicare program,²⁸ and

23. Nosek et al., *CROWD Study*, *supra* note 19, at 5 (analyzing research conducted at the Center for Research on Women with Disabilities from 1992 to 1996).

24. For example, "[a] 2005 survey of approximately 400 Californians with disabilities found exam tables were inaccessible to 69% of wheelchair users, and 46% of cane, crutch, and walker users." Kailes, *The Patient's Perspective on Access to Medical Equipment*, *supra* note 1, at 8 (citing ALEXIUS MARKWALDER, *DISABILITY RIGHTS ADVOCATES, A CALL TO ACTION: A GUIDE FOR MANAGED CARE PLANS SERVING CALIFORNIANS WITH DISABILITIES 22-23* (2005)). Of respondents using wheelchairs, "60% had difficulty being weighed. . . . 45% had difficulty using x-ray equipment, such as mammography [machines]. 43% had difficulty using exam chairs. . . . 33% of all people with mobility disabilities experienced barriers accessing examination rooms." *Id.* In a survey by the Rehabilitation Engineering Research Center on Accessible Medical Instrumentation (RERC-AMI), of 408 people "with a variety of disabilities" surveyed nationwide, respondents "ranked examination tables, radiology equipment, exercise and rehabilitation equipment, and weight scales as the top four categories of medical devices that were most difficult to use." *Id.*

25. See HANSON ET AL., *UNDERSTANDING THE HEALTH-CARE NEEDS*, *supra* note 4, at 9, 12-15 (summarizing access and cost barriers to care for both insured and uninsured respondents).

26. BLANCHARD & HOSEK, *FINANCING HEALTH CARE*, *supra* note 3, at xi. According to Census data, of people with non-severe disabilities between 25 to 64 years old, 76.3% were covered by private or military health insurance. STEINMETZ, *supra* note 3, at 8 & fig.4. People with a severe disability (a category which includes people using a wheelchair, a cane, crutches or a walker) were most likely to be covered by government-provided health insurance (45.9%). *Id.*

27. Medicaid is a program funded jointly by the federal and state governments that provides health insurance benefits for a broad range of basic health services to the poorest and most vulnerable Americans. THE HENRY J. KAISER FAMILY FOUND., *THE MEDICAID PROGRAM AT A GLANCE* (2007), available at www.kff.org/medicaid/upload/7235-02.pdf (last visited Feb. 6, 2009). To qualify for Medicaid, an individual must meet financial criteria and be a member of one of the eligible categories, including low-income children, pregnant women, the elderly, people with total and permanent disabilities, and some parents. See generally Ctrs. for Medicare & Medicaid Servs., *Medicaid Eligibility: Are You Eligible?*, at www.cms.hhs.gov/medicaideligibility/02_areyoueligible_.asp (last visited Feb. 6, 2009). According to the Centers for Medicare and Medicaid Services, Medicaid covered twenty-seven million children, fourteen million adults, six million seniors, and eight million persons with disabilities in 2003. THE HENRY J. KAISER FAMILY FOUND., *THE MEDICAID PROGRAM AT A GLANCE*, *supra*; see also THE HENRY J. KAISER FAMILY FOUND., *ISSUE BRIEF: MEDICAID'S ROLE FOR WOMEN* (2007), available at www.kff.org/womenshealth/upload/Medicaid-s-Role-for-Women.pdf (last visited Feb. 6, 2009).

28. Medicare is a federal program that provides health insurance benefits to forty-five million Americans over the age of sixty-five who have paid payroll taxes for at least ten years,

nineteen percent had private coverage.²⁹ In addition, the types of basic women's health care services described here—screenings such as mammograms, routine pelvic examinations (including Pap tests), and weight measurement as part of a regular physical examination or pre-natal visit—are generally covered under the Medicaid program³⁰ and most private insurance plans.³¹

Accordingly, this section establishes the scope of the problem of inaccessible medical equipment through a survey of the medical literature as well as the CROWD Study—all of which reveal significant equipment-related barriers to care.

A. Examination Tables and Pelvic Exams

A pelvic exam is considered routine care for adult or sexually active women. The exam includes manual examination of the uterus, vagina, ovaries, fallopian tubes, bladder and rectum, and use of a speculum to visually examine the upper portion of the vagina and cervix.³² A Pap test is

people with disabilities who have received Social Security Disability Income Benefits, and people with end-stage renal disease. See generally 42 U.S.C. § 1395c (2000); Ctrs. for Medicare & Medicaid Servs., Medicare Program – General Information: Overview, at www.cms.hhs.gov/MedicareGenInfo/ (last visited Feb. 6, 2009); THE HENRY J. KAISER FAMILY FOUND., FACT SHEET: MEDICARE AT A GLANCE (2008), available at http://www.kff.org/medicare/upload/1066_11.pdf (last visited Feb. 6, 2009).

29. THE HENRY J. KAISER FAMILY FOUND., FACT SHEET: MEDICARE AT A GLANCE, *supra* note 27; see also HANSON ET AL., UNDERSTANDING THE HEALTH-CARE NEEDS, *supra* note 4, at 9 (finding that ninety-five percent of responders had some type of coverage, including Medicaid (forty-four percent, including fourteen percent with both Medicaid and Medicare), Medicare (forty-three percent, including the same fourteen percent with both Medicaid and Medicare) and private coverage (thirty-three percent)).

30. Medicaid covers diagnostic, screening, preventive, and rehabilitative services, a broad set of categories that would include pelvic examinations and mammograms. 42 C.F.R. § 440.130(a)-(c) (2007). It also covers “family planning services and supplies,” which are matched at a higher rate, although it is left to the states to define the scope, amount and duration of these benefits. See THE HENRY J. KAISER FAMILY FOUND., FACT SHEET: COVERAGE OF GYNECOLOGICAL CARE AND CONTRACEPTIVES (2000), at www.kff.org/womenshealth/loader.cfm?url=/commonspot/security/getfile.cfm&pageID=13347 (last visited Feb. 6, 2009).

31. Most private health insurance plans cover access to obstetricians or gynecologists and allow direct access without a referral. THE HENRY J. KAISER FAMILY FOUND., FACT SHEET: COVERAGE OF GYNECOLOGICAL CARE AND CONTRACEPTIVES, *supra* note 30. See also CLARK C. HAVIGHURST, HEALTH CARE CHOICES: PRIVATE CONTRACTS AS INSTRUMENTS OF HEALTH REFORM 125 (1995) (noting that most private health insurance plans and contracts in the United States cover a broad range of treatments and services, provided such treatments and services are both “medically necessary” and non-experimental).

32. See, e.g., NAT'L CANCER INST., FACT SHEET - THE PAP TEST: QUESTIONS AND ANSWERS 1 (2007), available at www.cancer.gov/images/Documents/6e8424db-12f5-4b8a-b160-e8d010fd6026/Fs5_16.pdf (last visited Feb. 6, 2009).

also performed, so that cervical cells can be examined for conditions such as cancer or other abnormalities that may lead to cancer of the cervix.³³ Exams are performed while a woman lies on an examination table with her feet elevated so that the physician has the necessary visual and physical access for the exam, including proper insertion of the speculum for visual examination of and collection of cells from the cervix.³⁴

According to the National Institutes of Health, generally women between the ages of eighteen and thirty-nine should have a pelvic exam and a Pap test every one to two years to check for cervical cancer, and women over the age of forty should have a yearly pelvic exam and Pap test.³⁵ However, the medical literature reveals that women with disabilities in general are less likely to receive pelvic exams within the recommended guidelines than women without disabilities.³⁶ Women with mobility impairments in particular receive significantly fewer screening and preventative services, including pelvic examinations and Pap tests.³⁷ For example, a study of the Medicare population published in 1999 reported that women with significant limitations in activities of daily living were fifty-seven percent less likely to have reported a Pap test, and fifty-six percent less likely to have reported a mammogram than women without such limitations.³⁸ After controlling for

33. *Id.*

34. *Id.* at 2.

35. These recommendations are not limited to sexually active women, although it is recommended that sexually active women have additional screening for certain sexually transmitted infections. See generally, U.S. Nat'l Libr. of Med., MedlinePlus, Medical Encyclopedia: Physical Exam Frequency, at www.nlm.nih.gov/medlineplus/print/ency/article/002125.htm (last visited Feb. 6, 2009) (hereinafter MedlinePlus, Physical Exam Frequency).

36. BLANCHARD & HOSEK, FINANCING HEALTH CARE, *supra* note 3, at 6; Margaret A. Nosek, *Overcoming the Odds: The Health of Women with Physical Disabilities in the United States*, 81 ARCHIVES PHYSICAL MED. & REHABILITATION 135, 136 (2000) [hereinafter Nosek, *Overcoming the Odds*]; see also CDC, *Use of Cervical and Breast Cancer Screening*, *supra* note 20 (reporting the results of a 1994 study by the Centers for Disease Control, which found that "women with function limitations (FLs) were less likely than women without FLs to have had a Pap test within the previous 3 years, and women aged ≥ 65 years with three or more FLs were less likely to have ever had a mammogram compared with similarly aged women with no limitations.").

37. Nosek, *Overcoming the Odds*, *supra* note 36, at 136; lezzoni et al., *supra* note 21, at 957. Several studies have identified similar disparities. "Women who are unable to stand 10 minutes or climb 10 stairs are far less likely to have received a Pap smear in the last three years (63.3% compared to 81.4%), and also less likely to have received a mammogram in the last two years (45.3% compared to 63.5%)." DISABILITY RIGHTS EDUCATION & DEFENSE FUND, DISABILITY HEALTHCARE ACCESS BRIEF 4 (2007), available at www.dredf.org/healthcare/Access_Brief.pdf (last visited Feb. 6, 2009). See also CDC, *Use of Cervical and Breast Cancer Screening*, *supra* note 20, at 853.

38. See Chan et al., *supra* note 21, at 644.

other factors, that study concluded that disability is a significant and independent risk factor for not receiving Pap tests and mammograms.³⁹

While there could be more than one reason for this disparity, the CROWD Study found that inaccessible medical equipment was a major barrier—"[a]mong the women with disabilities who did not have regular pelvic exams, the most frequently selected reason was difficulty getting onto the exam table."⁴⁰ Other studies have made similar findings.⁴¹ As one woman explained, "Pap smear, I don't get that. Gynecologist, no, don't do that. Mainly because the tables are inaccessible and the doctors' offices are too."⁴²

A standard, non-adjustable examination table is generally too high for a safe self or assisted transfer from a wheelchair to the table surface. Tables that adjust to wheelchair height—typically between fifteen and eighteen inches from the floor—can make this transfer safer and more comfortable. Once on the examination table, a woman with a mobility disability may need hand-rails and adjustable foot rests in order to stay safety on the

39. *Id.* at 645.

40. Nosek et al., *CROWD Study*, *supra* note 19, at 36 (noting that "[a]mong the women with disabilities who did not have regular pelvic exams, the most frequently selected reason was difficulty getting onto the exam table (37%), followed by being too busy (31%), and inability to find a doctor who suited them (29%).").

41. Nosek, *Overcoming the Odds*, *supra* note 36 (stating that the primary reason "older women with more severe disabilities were the least likely to receive regular pap tests . . . was their difficulty getting onto the exam table . . . Among the top three reasons given by women with physical disabilities over 40 for not having mammograms was being unable to get into the required position, and because no doctor recommended having one."); see also Kroll et al., *supra* note 15, at 288; Mari-Lynn Drainoni et al., *Cross-Disability Experiences of Barriers to Health-Care Access*, 17 J. DISABILITY POL'Y STUD. 101, 103 (2006) (noting that "[t]he literature also documents a number of additional structural barriers unique to persons with disabilities. Physical barriers include insufficient space for wheelchairs and a lack of accessible medical screening equipment essential for early diagnosis of serious diseases, such as breast and cervical cancer." (internal citations omitted)). A more recent review of the literature also notes accessibility as a major issue. One study found that, "[i]n the area of gynecological health of the [study] participants . . . women with physical disabilities, particularly those with severe impairments, were not receiving the same quality of care as their able-bodied counterparts. It was more difficult for women with physical disabilities to receive information about birth control options that would be safe and effective in light of the special considerations related to their disability. Although the participants with physical disabilities intended to have regular pelvic examinations, they were discouraged by the inaccessibility of physicians' offices." Grabojs & Nosek, *supra* note 8, at 686 (reviewing literature).

42. Margaret A. Nosek et al., *The Meaning of Health for Women with Physical Disabilities: A Qualitative Analysis*, 27 FAM. COMMUNITY HEALTH 6, 16 (2004) [hereinafter Nosek et al., *The Meaning of Health*].

table.⁴³ When a woman cannot safely get or stay on an examination table, a physician cannot perform an appropriate examination. The inability to safely access examination tables can result in the delay or denial of treatment, with serious results. For example,

“[w]hen a wheelchair user began to have irregular vaginal spotting, she tried to ignore it. She had not had a pelvic exam for a number of years because she wasn't able to find a facility where she could get on the examination table. When she finally did find such a facility, after much searching, she was diagnosed with endometrial cancer. Had accessible exam tables been in routine use in gynecological clinics and offices, this woman might have been diagnosed and treated earlier.”⁴⁴

B. Scales and Weight Measurement

Weight measurement is important to overall health, and is generally included in a gynecological examination.⁴⁵ Weight gain and obesity can be linked to reproductive and hormonal problems, as well as cardiovascular disease, high blood pressure, diabetes, and cancer, and weight loss can be a sign of conditions such as infection, depression, and cancer.⁴⁶ Accurate weight measurement is also important to establish medication dosages.⁴⁷

However, people with mobility disabilities are not being weighed due to the lack of wheelchair accessible scales.⁴⁸ In a national survey of people with disabilities, sixty percent of the respondents who used wheelchairs reported problems being weighed due to lack of an accessible scale.⁴⁹ Similar evidence exists for women with disabilities.⁵⁰ This inability to be properly weighed is especially problematic in light of data that suggests that

43. See generally Sandra L. Welner et al., *Practical Considerations in the Performance of Physical Examinations on Women with Disabilities*, 54 *OBSTETRICAL & GYNECOLOGICAL SURVEY* 457 (1999).

44. JUNE ISAACSON KAILES ET AL., *CTR. FOR DISABILITIES ISSUES AND THE HEALTH PROFESSIONS, THE IMPORTANCE OF ACCESSIBLE EXAMINATION TABLES, CHAIRS AND WEIGHT SCALES 3* (2008), at <http://www.cdihp.org/products.html> (follow “Importance of Accessible Examination Tables, Chairs and Weight Scales” PDF hyperlink under “Accessible Health Care Briefs” heading) (last visited Feb. 6, 2009).

45. MCKINLEY HEALTH CENTER, UNIVERSITY OF ILLINOIS AT URBANA-CHAMPAIGN, *THE GYNECOLOGICAL EXAM* (2005), available at www.mckinley.uiuc.edu/handouts/pdfs/gynelological_exam.pdf (last visited Feb. 6, 2009).

46. KAILES ET AL., *supra* note 44, at 14-15.

47. Russell H. Jenkins & Allen J. Vaida, *Simple Strategies to Avoid Medication Errors*, 14 *FAM. PRAC. MGMT.* 41, 42 (2007) (“Having accurate patient information [such as weight and height] is the first priority in medication safety, as it guides physicians to choose the appropriate medication, dose, route and frequency.”).

48. See, e.g., Kroll et al., *supra* note 15, at 288.

49. Kailes, *The Patient's Perspective on Access to Medical Equipment*, *supra* note 1, at 8.

50. Nosek et al., *The Meaning of Health*, *supra* note 42, at 15.

women with disabilities have higher rates of obesity than women in the general population.⁵¹

Barriers to weight measurement are also problematic for pregnant women, as monitoring weight gain is an important aspect of basic prenatal care.⁵² Indeed, the failure to weigh a pregnant woman with a disability may be related to the overall lack of accommodation of disability in connection with pregnancy and delivery care.⁵³ As one mother explained, “[c]ould you believe that all through my pregnancy so far they don’t know how much weight I’ve gained, because they don’t have a wheelchair or sitting scale or nothing. They don’t monitor my weight at all.”⁵⁴

C. Mammography Machines and Breast Health

According to the National Institutes of Health, women over the age of forty should have a screening mammogram every one to two years, depending on risk factors for breast cancer.⁵⁵ A screening mammogram is an x-ray of each breast, and is used to detect changes such as tumors and calcium deposits that may indicate cancer.⁵⁶ The screening is used to detect changes that are too small to be felt during a self-exam or a manual exam by a physician.⁵⁷ In general, a woman stands in front of an x-ray machine,

51. See, e.g., Evette Weil et al., *Obesity Among Adults with Disabling Conditions*, 288 JAMA 1265 *passim* (2002) (finding that obesity is more prevalent in adults with disabilities than the general population); Allison A. Brown & Carol J. Gill, *Women with Developmental Disabilities: Health and Aging*, 2 CURRENT WOMEN’S HEALTH REPS. 219, 219-20 (2002). “National Health Interview Survey [NHIS] data from 2002 indicate that 21.4 percent of women aged 18 and over are obese CROWD data show that 47.6 percent of a convenience sample of women with physical disabilities report having a BMI of 30 or greater. Another study that used NHIS data for women with functional limitations found that 43.2 percent of women with three or more limitations were obese.” CTR. FOR RESEARCH ON WOMEN WITH DISABILITIES, BAYLOR COLLEGE OF MED., HEALTH DISPARITIES BETWEEN WOMEN WITH PHYSICAL DISABILITIES AND WOMEN IN THE GENERAL POPULATION, at www.bcm.edu/crowd/?PMID=1331 (last visited Feb. 6, 2009) (citing studies).

52. See NAT’L WOMEN’S HEALTH INFO. CTR., *PRENATAL CARE: FREQUENTLY ASKED QUESTIONS 3-4* (2006), available at www.womenshealth.gov/faq/prenatal.pdf (last visited Feb. 6, 2009).

53. According to the CROWD Study, more than one-third of women with disabilities reported “difficultly finding a physician who was willing or able to manage their pregnancy”, and “[m]ore than half of women with spinal cord injury had this problem.” Nosek et al., *CROWD Study*, *supra* note 19, at 38-39. Over half of the women surveyed “reported that the hospital could not accommodate their disability-related needs when they gave birth.” *Id.*

54. *Id.* at 22.

55. See generally MedlinePlus, *Physical Exam Frequency*, *supra* note 35.

56. See, e.g., NAT’L CANCER INST., *FACT SHEET - SCREENING MAMMOGRAMS: QUESTIONS AND ANSWERS*, at <http://www.cancer.gov/cancertopics/factsheet/Detection> (follow “Screening Mammograms: Questions and Answers” hyperlink) (last visited Feb. 6, 2009).

57. *Id.*

and the technician places her breast between two plates.⁵⁸ The plates press against the breast to make it flat, generating a more accurate image, and the woman must remain still while the image is taken.⁵⁹

Women with disabilities have less access to breast health services than other groups of women. One study found that women without disabilities receive mammograms eleven percent more frequently than women with physical disabilities.⁶⁰ According to the CROWD Study, among women with disabilities who were at least forty years of age and had not had a mammogram within the past two years, "the most frequently given reason was [the] inability to get into the required position."⁶¹ Inaccessible mammography equipment has also been noted as barrier to breast exams in other studies.⁶²

Breast examination by a health care provider is particularly important in circumstances where a woman's disability limits her ability to perform self-examinations.⁶³ Even if self-examination and examination in the doctor's office are performed, women with disabilities, like all women, still need mammograms within recommended guidelines, as illustrated by the following narrative:

During a routine physical, Lois's doctor suggested it was time for her to get a baseline mammogram. When she called her hospital to arrange it and mentioned that she was paraplegic, they asked Lois if she could stand. Lois said no, she used a wheelchair. "Then we can't do it," they said. When Lois called her doctor's office to ask for guidance, she discovered her doctor had just been taken in to have heart surgery. Because the breast exam in that doctor's office revealed no problem, Lois decided to wait. Later, she had to be hospitalized for treatment of a decubitus ulcer. During the pre-surgical exam, a lump was discovered in her breast. Under doctor's orders, a mammogram was performed in the same hospital that refused to serve her before. Sadly, the lump, already palpable in size, was malignant and

58. See generally U.S. Nat'l Libr. of Med., MedlinePlus, Mammography, at www.nlm.nih.gov/medlineplus/mammography.html (last visited Feb. 6, 2009).

59. *Id.*

60. Kailes, *The Patient's Perspective on Access to Medical Equipment*, *supra* note 1, at 6.

61. Nosek et al., *CROWD Study*, *supra* note 19, at 36.

62. Kailes, *The Patient's Perspective on Access to Medical Equipment*, *supra* note 1, at 6 ("Even if women with disabilities schedule mammograms or clinical breast exams, many cannot receive either service when they arrive because of inaccessible health care facilities and medical equipment.").

63. See, e.g., Nosek et al., *The Meaning of Health*, *supra* note 42, at 16-17 ("[f]ree [study] participants with extensive functional limitations had had mastectomies and spoke of difficulties in doing breast self-exams.").

she had a mastectomy. Had her cancer been diagnosed earlier, her treatment options may have been different.⁶⁴

As these stories and studies indicate, widespread and systematic lack of access to appropriate medical care leads to serious consequences for the health and well-being of millions of women. As stated by Disability Policy Consultant June Isaacson Kailes, “[w]hen health care providers are unable to get an accurate weight or perform an appropriate examination because patients cannot use a traditional scale or cannot get onto or are not assisted in getting onto diagnostic, therapeutic, or procedural equipment, then patients may receive unequal health care.”⁶⁵ Without appropriate examinations and tests, women may be undiagnosed or misdiagnosed, and miss the benefit of early detection and treatment. Indeed, there is evidence that women with physical disabilities are at a higher risk for delayed diagnosis of breast and cervical cancer.⁶⁶

Barriers to appropriate health care can also heighten a sense of “stigmatization, disenfranchisement, and demoralization.”⁶⁷ One researcher reported that people with disabilities feel defeated by the experience of a continual health care “hassle factor,” what she conceptualized as the “‘Four F’ experiences—frustration, fatigue, fear and failure.”⁶⁸ This resonates with other findings that “lack of access to health care may cause individuals to withdraw and isolate themselves from society and loved ones.”⁶⁹

II. LEGAL GUARANTEES OF EQUAL ACCESS

Evidence that inaccessible equipment is a barrier to adequate women’s health care for women with disabilities is deeply troubling. Also troubling is the knowledge that the problem persists nearly twenty years after the passage of the ADA. The legislative history of the ADA amply demonstrates significant and persistent discrimination against people with disabilities in a

64. Kailes, *The Patient’s Perspective on Access to Medical Equipment*, *supra* note 1, at 7 (citing WOMEN WITH PHYSICAL DISABILITIES: ACHIEVING AND MAINTAINING HEALTH AND WELL-BEING (D.M. Krotoski et al. eds., 1996)).

65. *Id.* at 6.

66. See, e.g., Margaret A. Nosek & Carol A. Howland, *Breast and Cervical Cancer Screening Among Women with Physical Disabilities*, 78 ARCHIVES PHYSICAL & MED. REHABILITATION (SUPPLEMENT 5) S-39, S-39, S-40 (1997).

67. Kirschner et al., *supra* note 18; U.S. DEP’T OF HEALTH & HUMAN SERVS., THE SURGEON GENERAL’S CALL TO ACTION TO IMPROVE THE HEALTH AND WELLNESS OF PERSONS WITH DISABILITIES 18 (2005).

68. Kailes, *The Patient’s Perspective on Access to Medical Equipment*, *supra* note 1, at 5.

69. *Id.* at 6.

variety of areas, including the provision of health care.⁷⁰ Concern for the nondiscriminatory provision of health care services is also evident from the many health care related examples in the regulations and technical assistance manual.⁷¹

70. 42 U.S.C. § 12101(a)(3) (2000); see also Crossley, *supra* note 9, at 51 n.3 (collecting citations from legislative history).

71. See, e.g., Nondiscrimination on the Basis of Disability in State and Local Government Services, 56 Fed. Reg. 35,694, 35,700 (July 26, 1991) (Department of Justice guidelines specifying that mobile health screening units are within the definition of "facility" in 28 C.F.R. § 35.104 (2008) ("Definitions."); *id.* at 35,706 (clarifying the grounds upon which a health care facility may refuse treatment to an individual illegally using drugs under 28 C.F.R. § 35.131 (2008) ("Illegal use of drugs."), noting that "[f]or example, a health care facility that specializes in a particular type of treatment, such as the care of burn victims, is not required to provide drug rehabilitation services, but it cannot refuse to treat a[n] individual's burns on the grounds that the individual is illegally using drugs."). See also 28 C.F.R. pt. 36 app. B 695 (2007) (indicating that while the definition of "public place of accommodation" does not include a private home, "if a professional office of a dentist, doctor, or psychologist is located in a private home, the portion of the home dedicated to office use . . . would be considered a place of public accommodation."); *id.* at 704 (implementing section 302(b)(1)(E) of the ADA, which prohibits a public accommodation from denying services to an individual or entity because of the known disability of an individual with whom the individual or entity is known to have a relationship or association, and noting that "it would be a violation of this section . . . to seek to evict a health care provider because that individual or entity provides services to persons with mental impairments."); *id.* at 712 (illustrating 302(b)(2)(A)(ii) of the ADA by noting that "it would not be discriminatory for a physician who specializes only in burn treatment to refer an individual who is deaf to another physician for treatment of an injury other than a burn injury[]" and that "a clinic that specializes in the treatment of individuals with HIV could refuse to treat an individual that does not have HIV, but could not refuse to treat a person for HIV infection simply because that person is also a drug addict."); *id.* at 713 (noting that 28 C.F.R. § 36.302(c)(1) (2008) ("Modifications in policies, practices, or procedures.") requires that the "broadest feasible access be provided to service animals in all places of public accommodation, including . . . nursing homes . . ."); *id.* at 715 (noting that "[i]n the analysis of [28 C.F.R.] § 36.303(c) . . . a note pad and written materials [may be] insufficient to permit effective communication in a doctor's office when the matter to be decided [is] whether major surgery [is] necessary."); *id.* at 719 (illustrating 302(b)(2)(A)(v) of the ADA by noting that "[i]f it is not readily achievable to ramp a long flight of stairs leading to the front door of a . . . pharmacy, the . . . pharmacy must take alternative measures, if readily achievable, such as providing curbside service or home delivery."); *id.* at 730, 732 (noting that, although some facilities are exempted from installing elevators, the exemption does not apply to the professional office of a health care provider and if a building "is designed and marketed as medical or office suites, or as a medical office facility. Accessible vertical access must be provided to all areas."); 36 C.F.R. § 1191.1 & App. A 4.1.3 (17)(iii) (2003) (requiring hospitals to provide one TTY, or public text telephone, for speech and hearing impaired persons under certain circumstances).

A. *Public Programs and Institutions*

The ADA was not the first federal law to address disability-based discrimination in health care.⁷² The Rehabilitation Act of 1973 prohibits entities that receive federal funding for programs or activities from discriminating against people with disabilities.⁷³ The Act provides that “[n]o otherwise qualified individual with a disability . . . shall, solely by reason of her or his disability, be excluded from the participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance”⁷⁴ This means hospitals, clinics, and other health care agencies that accept Medicaid funds, Medicare funds, or any other form of federal funding must ensure equal access to programs and services.⁷⁵

Title II of the ADA extends the Rehabilitation Act’s nondiscrimination requirement to all public entities, including state and local public health programs, services, and activities, regardless of receipt of federal funding.⁷⁶ Specifically, it provides that “[n]o qualified individual with a disability shall, by reason of such disability, be excluded from participation in or be denied the benefits of the services, programs, or activities of a public entity, or be subjected to discrimination by any such entity.”⁷⁷ Although there are differences between the Rehabilitation Act and Title II, the standards adopted by Title II for state and local government services are generally the

72. Many states also have disability discrimination laws. See AM. BAR ASS’N, COMM’N ON MENTAL & PHYSICAL DISABILITY LAW, MONOGRAPH ON STATE DISABILITY DISCRIMINATION LAWS 3 (2005).

73. 29 U.S.C. § 701(a)(1) (2000). “Program or activity” is defined as “a department, agency, special purpose district, or other instrumentality of a State or of a local government; or . . . the entity of such State or local government that distributes such assistance” §794(b)(1)(A)–(B).

74. 29 U.S.C. § 794(a) (2000).

75. 29 U.S.C. § 794(b)(3)(A)(ii) (2000). Several courts have found that the receipt of Medicare or Medicaid funds constituted receipt of federal financial assistance within the meaning of the Rehabilitation Act. See, e.g., *Henrietta D. v. Bloomberg*, 331 F.3d 261, 272 (2d Cir. 2003) (noting lack of dispute on point under Rehabilitation Act and ADA); *Frazier v. Bd. of Trs. of Nw. Mississippi Reg’l Med. Ctr.*, 765 F.2d 1278, 1289 (5th Cir. 1985) (applied to a private provider of respiratory services at a county hospital that received Medicare and Medicaid payments); *U.S. v. Baylor Univ. Med. Ctr.*, 736 F.2d 1039, 1042 (5th Cir. 1984) (inpatient and emergency room services are a “program” appropriate for investigation of a violation of Section 504 of the Rehabilitation Act); *Bowen v. Rubin*, 385 F. Supp. 2d 168, 179-80 (E.D.N.Y. 2005); *Hubbard v. Twin Oaks Health & Rehab. Ctr.*, 408 F. Supp. 2d 923, 933 (E.D.Cal. 2004); *Ruffin v. Rockford Mem’l Hosp.*, 181 Fed.Appx. 582, 585 (7th Cir. 2006).

76. See 42 U.S.C. §§ 12131-12134 (2000); DEP’T OF JUSTICE, ADA TITLE II TECHNICAL ASSISTANCE MANUAL (1994) § II-1.2000 (“Public Entity”), at www.ada.gov/taman2.html (last visited Feb. 6, 2009) [hereinafter TITLE II TECHNICAL ASSISTANCE MANUAL].

77. 42 U.S.C. § 12132 (2000).

same as those required by the Rehabilitation Act for programs and activities that receive federal funding.⁷⁸

Public entities include "any State or local government . . . [or] any department, agency, special purpose district, or other instrumentality of a State or States or local government . . ." ⁷⁹ Title II also applies where a public entity provides any "aid, benefit, or service" through a contractual agreement.⁸⁰ In the context of health care, services, programs, or activities provided or made available by a public entity can include, for example, a prescription service offered by a detention center,⁸¹ medical licensing,⁸² or a state Medical Assistance program.⁸³

According to the regulations, public entities have an obligation to "operate each service, program, or activity so that the service, program, or activity, when viewed in its entirety, is readily accessible to and usable by individuals with disabilities."⁸⁴ A service, program or activity is not readily accessible where the "opportunity to participate in or benefit from the aid, benefit, or service . . . is not equal to that afforded others."⁸⁵ Similarly, in *Alexander v. Choate*, the Supreme Court held that the mandate of Section 504 of the Rehabilitation Act "to assure evenhanded treatment and the opportunity for handicapped individuals to participate in and benefit from programs receiving federal assistance" is met when people with disabilities are provided "meaningful access" to such programs.⁸⁶

"Meaningful access" is a key concept, and courts have interpreted this standard in different ways.⁸⁷ It has not been interpreted to mean that each facility or office must be accessible and usable by individuals with disabilities, but rather that each service, program or activity, when viewed in

78. *Henrietta D.*, 331 F.3d at 272. Similarly, "[t]he law developed under section 504 of the Rehabilitation Act is applicable to Title II of the ADA." *Helen L. v. DiDario*, 46 F.3d 325, 330 n.7 (3d Cir. 1995).

79. 42 U.S.C. § 12131(1)(A-B) (2000).

80. 28 C.F.R. 35.130(b)(1) (2008).

81. *McNally v. Prison Health Services*, 46 F. Supp. 2d 49, 51-52 (D. Me. 1999).

82. *Hason v. Med. Bd. of California*, 279 F.3d 1167, 1169-70 (9th Cir. 2002).

83. *Anderson v. Pennsylvania Dep't of Pub. Welfare*, 1 F. Supp. 2d 456, 459 (E.D. Pa.1998).

84. 28 C.F.R. § 35.150(a) (2008).

85. 28 C.F.R. § 35.130(b)(1)(ii) (2008).

86. *Alexander v. Choate*, 469 U.S. 287, 301, 304 (1985).

87. For a discussion of "meaningful access" in the context of health care, see Leslie Pickering Francis & Anita Silvers, *Debilitating Alexander v. Choate: "Meaningful Access" to Health Care for People with Disabilities*, 35 FORDHAM URB. L. J. 447 (2008). For a discussion of the interpretations of the "meaningful access" standard, as well as an overview of Title II and Section 504 litigation, see Laurence Paradis, *Title II of the Americans with Disabilities Act and Section 504 of the Rehabilitation Act: Making Programs, Services, and Activities Accessible to All*, 14 STAN. L. & POL'Y REV. 389 (2003).

its entirety, is readily accessible to and usable by individuals with disabilities. For example, in *Anderson v. Department of Public Welfare*, medical assistance recipients with impaired mobility or vision challenged Pennsylvania's mandatory managed care plan arguing, among other things, that the offices of some of the plan providers were not accessible due to architectural barriers.⁸⁸ The district court found the plan inaccessible as a matter of law, but noted:

Defendants need not require that every provider who participates in HealthChoices practice in an accessible facility so long as Defendants ensure that every provider complies with the above-described regulations applicable to 'new construction' and 'existing facilities' and thereby confer upon disabled individuals a meaningful opportunity to benefit from and participate in the mandatory managed care program.⁸⁹

However, it is clear that under Title II, a public entity must make reasonable modifications, policies, practices, and procedures, remove architectural barriers, and provide auxiliary aids unless it demonstrates that doing so would fundamentally alter the nature of the service, program, or activity.⁹⁰ For example, in *Hubbard v. Twin Oaks Health and Rehabilitation Center*, a California district court found that a visitor to a nursing facility stated a claim under Title II when the facility was not accessible to people using wheelchairs.⁹¹ Plaintiff argued that the projecting ramp made it difficult for her to stabilize her wheelchair after exiting her car, the ramps leading to the nursing home entrance were too steep, she was unable to use soap and towel dispensers in restrooms, and that these architectural features did not meet the minimum requirements for accessibility in buildings and facilities subject to Title II and Title III as established by the ADA Accessibility Guidelines for Buildings and Facilities (ADAAG).⁹²

88. *Anderson v. Dep't of Public Welfare*, 1 F. Supp. 2d at 459.

89. *Id.* at 65.

90. 28 C.F.R. § 35.130(b)(7) (2008).

91. See generally *Hubbard v. Twin Oaks Health and Rehab. Ctr.*, 408 F. Supp. 2d 923 (E.D. Cal. 2004).

92. *Id.* at 926. Once adopted by the Department of Justice, the ADAAG became the standards for accessible design under Title III. See 28 C.F.R. pt. 36 Nondiscrimination on the Basis of Disability by Public Accommodations and in Commercial Facilities, Final Rule (Title III regulation; subpart C contains requirements for existing facilities, subpart D covers new construction and alterations, incorporating ADAAG as Appendix A); 28 C.F.R. pt. 35 Nondiscrimination on the Basis of Disability in State and Local Government Services, Final Rule (Title II regulation, subpart D contains requirements for existing facilities and new construction and alterations). Currently, Title II entities may choose either ADAAG or the Uniform Federal Accessibility Standards. The Department of Justice is currently considering revising its regulations to adopt the 2004 ADAAG for both Title II and Title III entities. See Nondiscrimination on the Basis of Disability in State and Local Government Services; Correction, 73 Fed. Reg. 36,964, 36,964 (proposed June 30, 2008) (to be codified at 28

The ADAAG's requirements generally apply to the removal of architectural barriers or fixed features of buildings and structures, such as entryways, doorways, stairs and elevators, floor surfaces, restrooms, parking areas, and curbs.⁹³ The ADAAG does not include standards for furniture or equipment, which includes medical equipment. However, the Department of Justice has specifically identified the acquisition or redesign of equipment as a method of ensuring program accessibility.⁹⁴ The acquisition or modification of equipment or devices may also fall under the requirement to provide auxiliary aids.⁹⁵ For example, in *Evans v. Page*, an Illinois state court found that a paraplegic prisoner stated a cause of action under Title II for the prison's failure to provide access to comprehensive physical examinations because of the lack of a wheelchair-accessible scale at the medical facility.⁹⁶ The court noted that "the benefit plaintiff sought was to be handled and physically examined in a safe and appropriate manner consistent with his disability" as required under the Act.⁹⁷

B. Private Facilities and Offices

Title III of the ADA prohibits discrimination in privately-owned places of public accommodation,⁹⁸ and provides that "[n]o individual shall be discriminated against on the basis of disability in the full and equal enjoyment of the goods, services, facilities, privileges, advantages, or accommodations of any place of public accommodation by any person who owns, leases (or leases to), or operates a place of public accommodation."⁹⁹ "Public accommodation" includes a wide range of commercial facilities and establishments,¹⁰⁰ and explicitly includes the private offices of health care providers and private hospitals.¹⁰¹ In order to

C.F.R. pt. 35); see also *Nondiscrimination on the Basis of Disability by Public Accommodations and in Commercial Facilities; Correction*, 73 Fed. Reg. 37,009, 37,009 (proposed June 30, 2008) (to be codified at 28 C.F.R. pt. 36). For the full text of the 2004 ADAAG, see U.S. Architectural & Transportational Barriers Compliance Board, *Americans with Disabilities Act (ADA), Accessibility Guidelines for Buildings and Facilities*, available at www.access-board.gov/adaag/ADAAG.pdf (last visited Feb. 6, 2009) [hereinafter ADAAG].

93. See generally ADAAG, *supra* note 92.

94. TITLE II TECHNICAL ASSISTANCE MANUAL, *supra* note 76, § II.5.2000 ("Methods for Providing Program Accessibility").

95. 28 C.F.R. § 35.104(3) (2008).

96. *Evans v. Page*, 755 N.E. 2d 105, 108 (Ill. App. 5d 2001).

97. *Id.* (citing 28 C.F.R. § 35.130(b)(1) (1996) ("public entity may not provide services that deny disabled individuals the equal benefit of the service").

98. See 42 U.S.C. § 12181(7)(F) (2000); 42 U.S.C. § 12182(a) (2000).

99. 42 U.S.C. § 12182(a) (2000).

100. *Id.* § 12181(7).

101. *Id.* § 12181(7)(F); 28 C.F.R. § 36 app. B at 696 (2008) (the office of a health care provider may be included even if it is located in a private home).

meet the nondiscrimination mandate of Title III, a place of public accommodation may be required to apply nondiscriminatory criteria, make reasonable modifications to policies, practices, and procedures, provide auxiliary aids and services, remove architectural barriers, or provide alternative means of providing a service.¹⁰² A place of public accommodation is not required to make such modifications where it can demonstrate that doing so “would fundamentally alter the nature of [such] goods, services, facilities, privileges, advantages, or accommodations.”¹⁰³

As with Title II, ADAAG standards apply to buildings and facilities subject to Title III. In addition, one method of ensuring full and equal enjoyment of health care services is the acquisition or redesign of equipment and devices.¹⁰⁴ The regulations require that a public accommodation “maintain in operable working condition those features of facilities and equipment that are required to be readily accessible to and usable by persons with disabilities”¹⁰⁵ Purchase or modification of equipment and furniture is also required under other sections, although not in the health care context. For example, a video arcade may be required to provide accessible video machines in order “to ensure full and equal enjoyment of the facilities and to provide an opportunity to participate in the services and facilities it provides.”¹⁰⁶

The largest lawsuit challenging a health care facility under Title III of the ADA was a class action lawsuit filed in 2000 by Disability Rights Advocates against Kaiser Foundation Health Plan, the nation’s largest nonprofit health maintenance organization (HMO), on behalf of its California members with disabilities. The action, *Metzler v. Kaiser*, was the first of its kind and alleged discriminatory care, including inaccessible equipment such as examination tables, scales, and mammography machines.¹⁰⁷

The three named plaintiffs are all Kaiser members who use wheelchairs. One of them, John Metzler, had pressure sores on his buttocks for a year, but his doctors had not visually examined them because the examination table was inaccessible. Another, Johnnie Lacy, had not had a gynecological examination in more than 15 years because of the same problem[.] The

102. See 42 U.S.C. §§ 12182(b)(2)(A), 12183(a) (2000). *But see* 28 C.F.R. § 36 app. B at 713 (2008) (referrals by treating physician permissible where the disability itself raises complications requiring experience or expertise not possessed by the practitioner).

103. 28 C.F.R. § 36.302(a) (2008).

104. *Id.* § 36.303(b)(3).

105. *Id.* § 36.211(a).

106. *Id.* § 36 app. B at 722-23.

107. Settlement Agreement, *Metzler v. Kaiser Found. Health Plan* (Case No. 829265-2, Cal. Super. Ct., Alameda County), Mar. 2001, available at www.dralegal.org/downloads/cases/metzler/settlement.pdf (last visited Feb. 6, 2009) [hereinafter *Metzler v. Kaiser Settlement*].

third, John Lonberg, was not weighed for 15 years because there was no scale accessible to a wheelchair at his Kaiser doctors' office.¹⁰⁸

The case was settled in 2001, and Kaiser agreed to a range of remedial measures addressing architectural barriers, inaccessible medical equipment, and policies, and procedures throughout its hospitals and medical offices in California.¹⁰⁹

A few years later in 2003, a similar case was brought by the Equal Rights Center against Washington Hospital Center (WHC), the largest private acute-care hospital in the Washington, D.C. area.¹¹⁰ The action brought by plaintiffs alleged that patients with disabilities had been denied equal access to treatment because of the inaccessibility of WHC's medical facilities, including examination rooms, tables, and equipment, and policies and procedures that left patients with disabilities without adequate assistance to eat, drink, and care for themselves.¹¹¹ The parties ultimately settled the lawsuit, and the agreement provided that WHC would, among other things, make at least thirty-five patient rooms accessible, remove architectural barriers based on expert recommendations, purchase at least one accessible exam table in each department, and make other changes of policies, practices, and procedures to ensure that people with disabilities receive equal and high quality care.¹¹²

More recently, Disability Rights Advocates filed a class action in California state court against Sutter Health, a California hospital chain.¹¹³ Plaintiffs alleged, among other things, failure to provide accessible medical

108. Tamar Lewin, *Disabled Patients Win Sweeping Changes from H.M.O.*, N.Y. TIMES, Apr. 13, 2001, at A14.

109. Metzler v. Kaiser Settlement, *supra* note 107, at 3.

110. Neil Adler, *Washington Hospital Center Settles Lawsuit, Agrees to Changes*, WASH. BUS. J., Nov. 3, 2005, at <http://washington.bizjournals.com/washington/stories/2005/10/31/daily38.html> (last visited Feb. 6, 2009); Press Release, Washington Lawyers' Committee for Civil Rights & Urban Affairs, Washington Hospital Center Agrees to Landmark Settlement to Improve Access for Patients with Disabilities (Nov. 2, 2005), at www.equalrightscenter.org/releases/pr_2005-11-02.php (last visited Feb. 6, 2009).

111. Press Release, Washington Lawyers' Committee for Civil Rights & Urban Affairs, *supra* note 110.

112. See Settlement Agreement Among the United States of America and Washington Hospital Center, at www.ada.gov/whc.htm (last visited Feb. 6, 2009) [hereinafter WHC Settlement].

113. See [Proposed] Order Certifying a Settlement Class and Finally Approving Class Action Settlement, *Olson v. Sutter Health*, No. RG06-302354 (Cal. Super. Ct., Alameda County, July 11, 2008), available at www.dralegal.org/downloads/cases/Sutter/Order_7-11-08.pdf (last visited Feb. 6, 2009); News Release, Sutter Health Adopts Sweeping Plans for Improved Access under ADA: Agreement with Disability Rights Advocates Puts Sutter in the Lead in Hospital Access (Apr. 18, 2008), at www.sutterhealth.org/about/news/news08_disabilityaccess.html (last visited Feb. 6, 2009).

equipment, "including, but not limited to, examination tables, examination chairs, lift equipment, scales, diagnostic equipment (e.g., x-ray, mammography and MRI equipment), dental chairs, [and] ophthalmology equipment."¹¹⁴ A settlement agreement was approved on July 11, 2008, in which Sutter Health agreed to assess and address a range of issues, including architectural barriers, inaccessible medical equipment, and policies and procedures for all of its hospitals.¹¹⁵

III. THE GAP BETWEEN LAW AND EXPERIENCE

Although there have been cases challenging the outright denial of care on the basis of disability,¹¹⁶ and the failure to provide sign language interpreters,¹¹⁷ there are relatively few cases brought challenging inaccessible facilities or equipment in the context of medical care.¹¹⁸ Only

114. See Class Action Consent Decree at 4, *Olson v. Sutter Health*, No. RG06-302354 (Cal. Super. Ct., Alameda County, Apr. 2008), available at www.dralegal.org/downloads/cases/Sutter/Olson_v_Sutter_Health-Consent_Decree.pdf (last visited Feb. 6, 2009).

115. *Id.* at 11; Class Action Consent Decree Exhibit C: Sutter Health Mediation Superseding Memorandum of Understanding Re: Accessible Medical Equipment, *Olson v. Sutter Health*, No. RG06-302354 (Cal. Super. Ct., Alameda County, July 2008), available at http://dralegal.org/downloads/cases/Sutter/Olson_v_Sutter_Health-Exhibit-C.pdf (last visited Feb. 6, 2009) [hereinafter *Olson v. Sutter Health Settlement*]; Motion for Final Approval of Class Settlement Granted, *Olson v. Sutter Health*, No. RG06-302354 (Cal. Super. Ct., Alameda County, July, 11 2008).

116. See, e.g., *Bragdon v. Abbott*, 524 U.S. 624 (1998) (patient infected with HIV brought ADA action against dentist who refused to treat her); *United States v. Happy Time Day Care Center*, 6 F. Supp. 2d 1073 (W.D. Wis. 1998) (U.S. brought ADA action against day care facilities which had refused to enroll a five year-old child who was infected with HIV); *United States v. Morvant*, 898 F. Supp. 1157 (E.D.La. 1995) (U.S. brought ADA action against dentist who refused to provide dental care to one patient who had AIDS, and, another patient who had tested positive for HIV).

117. See, e.g., *United States v. York Obstetrics & Gynecology*, No. 00-8-P-DMC, 2001 WL 80082, at *2 (D. Me. Jan. 30, 2001) (U.S. filed suit against doctor's office for failing to provide interpreter to deaf patient); *Devinney v. Maine Med. Ctr.*, No. Civ. 97-276-P-C, 1998 WL 271495, at *1 (D. Me. May 18, 1998) (U.S. filed suit against Maine Medical Center for failing to provide an interpreter to a deaf patient); *Naiman v. New York Univ.*, No. 95 CIV. 6469(LMM), 1997 WL 249970, at *2 (S.D.N.Y. May 13, 1997) (finding that plaintiff stated a claim of disability discrimination in his allegation that defendant hospital failed to provide a qualified interpreter); *Tugg v. Towey*, 864 F. Supp. 1201, 1211 (S.D. Fla. 1994) (holding that mental health counselors must provide sign language interpreters).

118. There have been a few cases brought under state law. See, e.g., *Perino v. St. Vincent's Med. Ctr. of Staten Is.*, 502 N.Y.S.2d 920, 920 (1986) (N.Y. state court held that it was not a violation of state law to exclude a blind man accompanied by his guide dog from the delivery room during the birth of his child). There have also been reports of access issues being resolved without litigation. See, e.g., Disability Rights Advocates, Cases: Sterling Visioncare, at www.dralegal.org/cases/health_insurance/sterling_visioncare.php (last visited

one of the multi-plaintiff cases, *Metzler v. Kaiser*, specifically addressed women's health issues.¹¹⁹ The paucity of private actions is unfortunate, but not surprising. As I and others have written elsewhere, the ADA is underenforced, in significant part due to various limitations on private actions.¹²⁰

This section first addresses possible objections to enforcement of the duty to acquire accessible equipment: claims that there is no consensus on the definition of accessible equipment, that accessible equipment is not available, and that accessible equipment is not necessary because patients can be lifted onto or held in position on existing equipment. It then reveals an underlying obstacle to acquiring accessible equipment—social resistance to sexuality, reproduction, and parenting on the part of women with disabilities.

A. Possible Objections

Health care institutions and providers may argue that there are no specific requirements or standards for accessible equipment. Although the ADA requires equal access to health care in public and private health care settings, including a duty to acquire or redesign equipment, it does not require health care institutions or private providers to have any specific equipment. Compare this with the specific requirements regarding the removal of architectural and structural barriers: new construction of both public and private accommodations must meet numerous and detailed

Feb. 6, 2009) (reporting that Sterling VisionCare agreed to provide accessible examination chairs to patrons with disabilities).

119. *Metzler v. Kaiser Settlement*, *supra* note 107. There was a similar case in 1988 in which a plaintiff alleged that she was denied assistance to help her transfer from her wheelchair to an examination table for a gynecological exam in Georgetown University Hospital's Obstetrics and Gynecology Clinic. See Settlement Agreement Between the United States of America and Georgetown University, Under the Americans with Disabilities Act, at www.ada.gov/gtownhos.htm#anchor262953 (last visited Feb. 6, 2009) (the Clinic did have an adjustable examination table, but it was inoperable at the time of plaintiff's visit). *Id.* ¶ 6.

120. See Samuel R. Bagenstos, *The Perversity of Limited Civil Rights Remedies: The Case of "Abusive" ADA Litigation*, 54 UCLA L. Rev. 1, 30 (2006) ("The limited remedies have led to massive underenforcement of the ADA's public accommodations title, and they have left serial litigation as one of the only ways to achieve anything approaching meaningful compliance with the statute."); Ruth Colker, *ADA Title III: A Fragile Compromise*, 21 BERKLEY J. EMP. & LAB. L. 377 *passim* (2000) (discussing the trend of underenforcement of ADA's public accommodations provisions); Michael Waterstone, *A New Vision of Public Enforcement*, 92 MINN. L. REV. 434, 458, 460-61 (2007) ("There has been a notable lack of systemic and class action litigation under the ADA, particularly with regard to the law's employment provisions.").

requirements to ensure accessibility,¹²¹ and existing facilities must remove architectural barriers in accordance with these requirements where “readily achievable.”¹²² Moreover, as explained above, the requirements for new and existing facilities are detailed in the ADAAG.¹²³ Thus, some would argue that there is a relative lack of specificity with regard to the obligation to acquire and use accessible equipment.

More specific requirements for furnishings and equipment, which would include medical equipment, have been contemplated by the Department of Justice at least twice. In 1991, the Department proposed a regulation regarding the acquisition and use of free-standing equipment or furniture by places of public accommodation under Title III.¹²⁴ At that time, the Department omitted that section from the final rule, asserting that such requirements “are more properly addressed under other sections” (though such sections were left unspecified), and because “there are currently no

121. See 42 U.S.C. § 12183(a) (2000); see also 28 C.F.R. §§ 35.149, 35.151 (2008) (requiring that each public facility built after January 26, 1992 be readily accessible to disabled individuals).

122. 42 U.S.C. § 12182(b)(2)(A)(iv) (2000) (requiring that public facilities “remove architectural barriers, and communications barriers that are structural in nature, in existing facilities, and transportation barriers in existing vehicles and rail passenger cars used by an establishment for transporting individuals (not including barriers that can only be removed through the retrofitting of vehicles or rail passenger cars by the installation of a hydraulic or other lift), where such removal is readily achievable[.]”). In the regulations, “readily achievable” is defined as “easily accomplishable and able to be carried out without much difficulty or expense.” 42 U.S.C. § 12181(9) (2000). Factors to be considered include (1) the nature and cost of the action to be taken; (2) the financial resources of the place of public accommodation, and the effect of the action on its expenses and resources; and (3) the type of operations of the place of public accommodation, and the impact of the action on its operations. *Id.* See also 28 C.F.R. § 35.151(b) (2008) (requiring that “[e]ach facility or part of a facility altered by, on behalf of, or for the use of a public entity in a manner that affects or could affect the usability of the facility or part of the facility shall, to the maximum extent feasible, be altered in such manner that the altered portion of the facility is readily accessible to and usable by individuals with disabilities, if the alteration was commenced after January 26, 1992.”).

123. See discussion of ADAAG, *supra* notes 92-97 and accompanying text.

124. 28 C.F.R. § 36 app. B (2008). Proposed Section 36.309 would have required that “newly purchased furniture or equipment made available for use at a place of public accommodation be accessible, to the extent such furniture or equipment is available, unless this requirement would fundamentally alter the goods, services, facilities, privileges, advantages, or accommodations offered, or would not be readily achievable.” *Id.* Proposed Section 36.309 was omitted because, among other reasons, there were not standards addressing appropriate accessibility standards for different types of furniture and equipment. *Id.* Proposed Feb. 22, 1991 and rejected July 26, 1991. See Nondiscrimination on the Basis of Disability by Public Accommodations and in Commercial Facilities, 56 Fed. Reg. 35,544 (July 26, 1991); Nondiscrimination on the Basis of Disability by Public Accommodations and in Commercial Facilities, 56 Fed. Reg. 7452 (Feb. 22, 1991).

appropriate accessibility standards addressing many types of furniture and equipment."¹²⁵ In 2008, the Department again explicitly declined to include regulatory guidance with respect to the acquisition and use of free-standing equipment or furnishings used by covered entities to provide services under Title II and Title III, which would include medical equipment.¹²⁶

Although the Department has not addressed requirements for accessible medical equipment, suitable standards have emerged from other sources. For example, the Disability Rights Education and Defense Fund (DREDF) has recommended that the Department adopt minimum standards for "high-priority" medical equipment, including: height adjustable examination tables "with a minimum height of 15" from the floor, extra-wide top[s] and higher weight capacities, adjustable hand rails, and adjustable foot/leg supports, weight scales with accessible features, diagnostic and imaging equipment (including mammogram machines) with accessible features, [and] medical chairs (including dental chairs) with accessible features[.]"¹²⁷ Similarly, the proposed Promoting Wellness for Individuals with Disabilities Act of 2007 called for the Architectural and Transportation Barriers Compliance Board to develop and publish a detailed set of standards for medical and diagnostic equipment within nine months of the date of enactment,¹²⁸ and set interim standards to be used in the meantime for all purchases of such equipment made after January 1, 2008, including: examination tables that are "height-adjustable between a range of at least 18 inches to 37 inches";

125. 28 C.F.R. § 36 app. B (2008) (Proposed Section 36.309: Purchase of Furniture and Equipment).

126. In its June 2008 Notices of Proposed Rulemaking, the Department of Justice announced that it had declined to include regulatory guidance with respect to the acquisition and use of free-standing equipment or furnishings used by covered entities to provide services, which would include medical equipment. *Nondiscrimination on the Basis of Disability in State and Local Government Services*, 73 Fed. Reg. 34,466, 34,474-75 (proposed June 30, 2008) (to be codified at 28 C.F.R. pt. 35); see also *Nondiscrimination on the Basis of Disability by Public Accommodations and in Commercial Facilities*, 73 Fed. Reg. 126 (proposed June 30, 2008) (to be codified at 28 C.F.R. pt. 36). Although it declined to address medical equipment, the Department did state its intent to analyze the economic impact of future regulations governing specific types of free-standing equipment, which would include medical and diagnostic equipment. *Nondiscrimination on the Basis of Disability in State and Local Government Services*, 73 Fed. Reg. at 34,474-75; see also *Nondiscrimination on the Basis of Disability by Public Accommodations and in Commercial Facilities*, 73 Fed. Reg. 126.

127. See Disability Rights Education & Defense Fund, Summary of the Department's Proposed Regulation on Medical Care Facilities, at www.dredf.org/DOJ_NPRM/medical_facilities.shtml (last visited Feb. 6, 2009). Also, at least one state has adopted standards for accessible medical equipment. Massachusetts requires, in part, that "[w]here examining tables are provided in exam rooms, they shall be adjustable in height from 15 inches (381mm) above the floor." 521 MASS. CODE REGS. 13.2.1 (2008), available at www.mass.gov/Eeops/docs/dps/aab_regs/521013.pdf (last visited Feb. 6, 2009).

128. H.R. 3294, 110th Cong. § 510(a) (2007).

weight scales “capable of weighing individuals who remain seated in a wheelchair or other personal mobility aid”; and mammography machines and equipment capable of being used by people in a standing or seated position, including people seated in a wheelchair.¹²⁹

Accessible medical and diagnostic equipment meeting these minimum requirements is readily available, and at reasonable cost. Although specific comparative cost data is difficult to find, according to a 2001 report published by Disability Rights Advocates, accessible examination tables can be obtained for \$3,000 (as compared to about \$2,000 for an adjustable but inaccessible table) and wheelchair-accessible scales for \$200.¹³⁰ Tax incentives are also available for expenses incurred in the removal of barriers or increasing accessibility to people with disabilities.¹³¹

In addition, it does not appear that health care institutions and offices would be required to replace all existing medical equipment with accessible equipment. As explained above, in terms of public programs under Title II, the accessibility requirement has not been interpreted to mean that each facility or office must be accessible, but that each service, program, or activity, when viewed in its entirety, be readily accessible to and usable by individuals with disabilities.¹³²

Some have suggested that accessible equipment is not necessary because patients can be lifted onto the table for examination or held in a standing position for mammography. Although this suggestion appears reasonable at first glance, this practice has negative consequences for both the patient and the medical professionals involved. Many health care professionals are not trained in safe patient lifting techniques, and patient lifting and positioning are a major source of injury.¹³³ People with

129. *Id.* § 510(c).

130. H. STEPHEN KAYE, DISABILITY RIGHTS ADVOCATES, DISABILITY WATCH: THE STATUS OF PEOPLE WITH DISABILITIES IN THE UNITED STATES 19 (2001), available at www.dralegal.org/downloads/pubs/disability_watch_2.pdf (last visited Feb. 6, 2009).

131. See, e.g., Expenditures to Remove Architectural and Transportation Barriers to the Handicapped and Elderly, 26 U.S.C. § 190(a)(1), (c) (2000) (authorizing a tax deduction for “qualified architectural and transportation barrier removal expenses” not to exceed \$15,000 for any taxable year); Expenditures to Provide Access to Disabled Individuals, 26 U.S.C. § 44(a), (b) (2000) (available to eligible small businesses with 30 or fewer employees or \$1 million or less in gross annual receipts, and authorizing a tax credit of 50% of eligible access expenditures that exceed \$250 but do not exceed \$10,250 made for the purpose of complying with the ADA during the tax year).

132. 28 C.F.R. § 35.150(a). See, e.g., TITLE II TECHNICAL ASSISTANCE MANUAL, *supra* note 76, § II-6.3300(4) (“Types of Facilities”).

133. See, e.g., PETER D. HART RESEARCH ASSOCS., SAFE PATIENT HANDLING: A REPORT 4-5 (2006), available at www.aft.org/topics/no-lift/download/PeterHartSurvey-final-03-16-06.pdf (last visited Feb. 6, 2009) (reporting that “38 percent of nurses and 42 percent of radiology technicians have suffered an injury related to moving, lifting, or repositioning patients.”);

disabilities also report feeling a loss of dignity when they are hoisted onto examination tables or into examination position by either one or many medical professionals. Once on the examination table or in front of the mammography machine, a woman needs a safe way to stay in the correct position for the duration of the exam.¹³⁴ Being held in position can add unnecessary discomfort and result in an incomplete exam, as indicated in this report on experiences with mammography:

[women] are sometimes balanced precariously on stools in order to be at the right height for the equipment, or must be supported by nurses or technicians to hold a steady position. The pain and indignity of an already painful and exposing procedure is, therefore, magnified. Some women report that only a small portion of their breast tissue can be scanned.¹³⁵

Not surprisingly, patients with disabilities have reported not showing up for regular medical examinations due to fears of being dropped, falling off the table, or feeling humiliated.¹³⁶

Consider also that the Department of Justice has opined that carrying an individual with a disability is not an acceptable method of achieving program access in general,¹³⁷ and is permitted only as a temporary measure until structural alterations are completed, or in exceptional circumstances and with appropriate training to ensure that the service is safe, dignified, and reliable.¹³⁸ Although some amount of lifting and positioning is required in the medical context, the routine use of patient lifting as an alternative to acquiring accessible equipment would not appear to meet this standard.

MARIO FELETTA & WALTER GRAZE, CAL/OSHA CONSULTATION SERVICE, A BACK INJURY PREVENTION GUIDE FOR HEALTH CARE PROVIDERS 3 (2001), available at www.dir.ca.gov/dosh/dosh_publications/backinj.pdf (last visited Feb. 6, 2009); J. Li et al., *Use of Mechanical Patient Lifts Decreased Musculoskeletal Symptoms and Injuries Among Health Care Workers*, 10 INJURY PREVENTION 212 *passim* (2004) (noting that the majority of injuries to health care workers are musculoskeletal, and that such injuries are often the result of frequent patient lifting and transferring).

134. See generally, Sandra L. Welner et al., *Practical Considerations in the Performance of Physical Examinations on Women with Disabilities*, 54 OBSTETRICAL & GYNECOLOGICAL SURVEY 457 (1999).

135. Nosek & Howland, *supra* note 66, at S-42.

136. Kailes, *The Patient's Perspective on Access to Medical Equipment*, *supra* note 1, at 5.

137. TITLE II TECHNICAL ASSISTANCE MANUAL, *supra* note 76, § II-5.2000 ("Methods for Providing Program Accessibility").

138. *Id.*

B. Underlying Social Resistance

*Whether a woman is born with a disability or acquires it later in life, the message she gets from the medical system and society is that she is ineligible for normal societal female roles of lover, wife, or mother.*¹³⁹

Framing the problem simply as a lack of equipment suggests a straightforward solution—simply get accessible tables, scales, and machines into doctor's offices. The problem is serious, there are legal requirements regarding accessible equipment, and equipment meeting those standards is affordable and available. So why hasn't this been done? Perhaps the problem needs to be framed more broadly, starting with the failure to recognize the need for accessible equipment.

There is evidence that physicians fail to recognize the need—a survey conducted by CROWD in 1995 found that surveyed physicians saw fewer than ten women with disabilities over the course of a year.¹⁴⁰ They knew that women with disabilities were “out there,” but they did not know where they were going” to get basic women's health and reproductive care.¹⁴¹ Interestingly, “[t]he physicians reported [that] [they] knew of no problems of access to the buildings in which they treated their patients, while investigators were aware of accessibility complaints by women with physical disabilities who tried to use those same buildings.”¹⁴² The continuing *invisibility* of the problem suggests that it needs to be put into a broader context.

Part of the problem is the considerable evidence that suggests people without disabilities are unable to identify with people with disabilities, and in fact significantly and unreasonably devalue the lives of people with disabilities. As I have written elsewhere, people with disabilities consistently report a good or excellent quality of life despite the negative assessments of people without disabilities, a phenomenon known as the “disability paradox.”¹⁴³ In one study, people with serious disabilities reported a quality of life averaging only slightly lower than that reported by people without disabilities.¹⁴⁴ The inaccurate and negative assessments of people without

139. Carrie Killoran, *Women with Disabilities Having Children: It's Our Right Too*, 12 *SEXUALITY & DISABILITY* 121, 122 (1994).

140. See Grabois & Nosek, *supra* note 8, at 687.

141. *Id.*

142. *Id.*

143. Pendo, *Substantially Limited Justice?*, *supra* note 13, at 267; Gary L. Albrecht & Patrick J. Devlieger, *The Disability Paradox: High Quality of Life Against All Odds*, 48 *SOC. SCI. & MED.* 977, 978-79 (1999).

144. Ron Amundson, *Biological Normality and the ADA*, in *AMERICANS WITH DISABILITIES: EXPLORING IMPLICATIONS OF THE LAW FOR INDIVIDUALS AND INSTITUTIONS* 102, 106 (Leslie Pickering Francis & Anita Silvers eds., 2000).

disabilities about the lives of people with disabilities may be the result of a "spoiling process," whereby the physical impairment "obscure[s] all other characteristics behind that one and swallow[s] up the social identity of the individual within that restrictive category."¹⁴⁵ Disability also has been discussed in the social science literature as a source of stigmatization, as a "master status" that prevents seeing the entire person, or a source of "spread," whereby a person who is disabled in one way is seen as disabled in all other ways.¹⁴⁶ These concepts could explain why a health care provider might make limiting assumptions about the sexual and reproductive life of a woman with a mobility disability based solely on her disability, or why he or she might see the wheelchair but not the woman using it.

Studies have consistently demonstrated that the attitudes of physicians and other health care professionals toward people with disabilities are as negative, if not more negative, than the general public.¹⁴⁷ As one study found, "health professionals significantly underestimate the quality of life of people with disabilities compared with the actual assessments made by people with disabilities themselves. In fact, the gap between health professionals and people with disabilities in evaluating life with disability is consistent and stunning."¹⁴⁸ For example, "[i]n a survey study of attitudes of 153 emergency care providers, only 18% of physicians, nurses, and technicians imagined they would be glad to be alive with a severe spinal cord injury. In contrast, 92% of a comparison group of 128 persons with high-level spinal cord injuries said they were glad to be alive."¹⁴⁹

The specific context of sexual and reproductive care for women with mobility disabilities has the potential to intensify the negative attitudes of physicians. The long and shameful history of stigmatization of sexuality, reproduction, and parenting by people with disabilities is well known.¹⁵⁰ In the words of one scholar, "the story of disabled women's reproductive lives

145. Irving Kenneth Zola, *Self, Identity, and the Naming Question: Reflections on the Language of Disability*, in *THE SOCIAL MEDICINE READER* 77, 80 (Gail E. Henderson et al. eds., 1997).

146. See generally ERVING GOFFMAN, *STIGMA: NOTES ON THE MANAGEMENT OF SPOILED IDENTITY* (1963).

147. Carol J. Gill, *Health Professionals, Disability, and Assisted Suicide: An Examination of Relevant Empirical Evidence and Reply to Batavia* (2000), 6 *PSYCHOL. PUB. POL'Y & L.* 526, 530 (2000).

148. *Id.*

149. *Id.* (internal citations omitted).

150. See, e.g., Paul A. Lombardo, *Taking Eugenics Seriously: Three Generations of ??? Are Enough?*, 30 *FLA. ST. U. L. REV.* 191, 202-04 (2003); see also Virginia Kallianes & Phyllis Rubinfeld, *Disabled Women and Reproductive Rights*, 12 *DISABILITY & SOC'Y* 203, 203 (1997); Barbara Faye Waxman, *Up Against Eugenics: Disabled Women's Challenge to Receive Reproductive Health Services*, 12 *SEXUALITY & DISABILITY* 155, 155-56 (1994).

is largely the history of eugenics.¹⁵¹ Physicians played a key role in this history, performing, for example, involuntary or coerced contraception, sterilization, and abortion involving women with disabilities.¹⁵² The long shadow of eugenics over health care for women with disabilities also reveals a fundamental tension—the sexuality and reproductive capacity of women with disabilities is the subject of both denial and dread, something that does not exist but is also a threat that must be controlled through social, medical, and legal means.¹⁵³

That tension continues to impact the health and well-being of women today. For example, women with disabilities are not seen as sexually active.¹⁵⁴ As one researcher put it, “[p]eople may wonder how a woman “‘confined to a wheelchair’ can participate in intercourse, or how a woman with sensory loss can feel her genitals. More usually, people assume a disabled woman has no sexuality.”¹⁵⁵ Of course, women with disabilities are sexually active. According to the CROWD Study, ninety-four percent of the women surveyed were sexually active at some point,¹⁵⁶ and report as much sexual desire as women in general.¹⁵⁷ Falsely assuming that women with disabilities are asexual leads health care providers to withhold needed information and services.

There is an unfortunate stereotype that women with physical disabilities are asexual; we have no interest in sex, nor should we, heaven forbid, reproduce. This stereotype plays out in the assumption of some physicians that we are not sexually active and that if pelvic exams or mammograms are too much trouble because of inaccessible exam tables, they can be overlooked.¹⁵⁸

Women with disabilities are as susceptible to sexually transmitted infections (STIs) as women without disabilities, and prevalence is similar between these two groups.¹⁵⁹ However, STIs may be less likely to be

151. Waxman, *supra* note 150.

152. See *id.* at 155-56.

153. See *id.*

154. See, e.g., Kallianes & Rubinfeld, *supra* note 150, at 205. This assumption of course is not limited to women with mobility disabilities. See, e.g., DISABILITY RIGHTS EDUCATION & DEFENSE FUND, *supra* note 36, at 4 (“A woman with mental retardation who had difficulty undergoing gynecological exams reported that her doctor downplayed the importance of such exams, ostensibly because the doctor assumed she was not sexually active.”).

155. Killoran, *supra* note 139, at 123.

156. Nosek et al., *CROWD Study*, *supra* note 19, at 8.

157. *Id.*

158. Nosek, *Overcoming the Odds*, *supra* note 36, at 136.

159. Margaret A. Nosek & Michelle Colvard, Center for Research on Women with Disabilities, Baylor College of Med., *Going Beyond Assumptions: Researching the Health of Women with Disabilities*, at www.bcm.edu/crowd/?pmid=2068 (follow link to PowerPoint show) (last visited Feb. 6, 2009).

detected and treated in women with disabilities because women with some disabilities are less likely to notice symptoms, and because physicians may assume that they are not sexually active.¹⁶⁰ This puts women with disabilities "in jeopardy of getting pelvic inflammatory disease (PID) and increasing their risk of cervical cancer, contracting HIV, ectopic pregnancy, and infertility."¹⁶¹ Women with disabilities are often not seen as mothers:

I heard about an orthopedically disabled woman who swam daily at a public pool throughout her pregnancy. Because she didn't like 'pregnant' bathing suits, she wore a bikini, her belly roundly, proudly displayed. After she gave birth, she walked into the pool with her new baby. A lifeguard who had seen her nearly every day throughout her pregnancy asked, 'Whose baby is that?' 'Mine.' 'You were pregnant?' *What cannot be imagined cannot be seen.*¹⁶²

Of course, women with disabilities are mothers. According to 1993 census data, nearly seven million people with disabilities are parents, comprising about eleven percent of all parents,¹⁶³ and more than thirty percent of women with disabilities have children at home.¹⁶⁴ Moreover, some studies indicate that "normal labor and delivery are possible, even routine, and generally pose little or no added risk to the mother or baby."¹⁶⁵

Tellingly, when women with disabilities are provided with health care services in this area, it is often sterilization. The literature suggests that women with disabilities "are more likely to have hysterectomy[ies] at a younger age than are women without disabilities", and "more likely than their able-bodied counterparts to have a hysterectomy for non-medically necessary reasons such as birth control, personal convenience, or at the request of a parent or guardian."¹⁶⁶ Women's narratives suggest that this is

160. Nosek et al., *CROWD Study*, *supra* note 19, at 24.

161. *Id.*

162. FLORENCE P. HASELTINE ET AL., *REPRODUCTIVE ISSUES FOR PERSONS WITH PHYSICAL DISABILITIES* 120 (1993) (emphasis added).

163. LITA JANS & SUSAN STODDARD, U.S. DEP'T. OF EDUC., NAT'L INST. ON DISABILITY AND REHAB. RESEARCH, *CHARTBOOK ON WOMEN AND DISABILITY IN THE UNITED STATES* 31 (1999), available at www.infouse.com/disabilitydata/womendisability/womendisability.pdf (last visited Feb. 6, 2009) (based on the U.S. Census Bureau's report entitled "The Survey of Income and Program Participation" (1993)).

164. *Id.*; Nosek et al., *CROWD Study*, *supra* note 19, at 22. According to one study, thirty-seven percent of the women with disabilities surveyed had natural children, compared to fifty percent of the able-bodied group. *Id.* These numbers may be on the increase, as the majority of women who acquire spinal cord injuries (SCI) are of childbearing age, and there is evidence that an increasing number of women with SCI are giving birth. *Id.*

165. Nosek et al., *CROWD Study*, *supra* note 19, at 24. The same study also reported that no significant difference was found between the groups in the rate of miscarriages, abortions, or stillbirths. *Id.* at 22-23 (also noting studies with contrary findings).

166. *Id.* at 35.

often at the suggestion of health care providers, not the woman herself. One woman opined, “[t]hey always want to do a hysterectomy on you before they even examine you,” noting that insurance was more than willing to pay for a hysterectomy than a second opinion¹⁶⁷ Another woman shared, “[r]ight before we got married, I went to a doctor that someone recommended and told him I wanted to know what form of birth control to take. He told me that I needed to have my uterus removed.”¹⁶⁸

Women with disabilities have less knowledge about reproductive health than women without disabilities, and often do not receive adequate reproductive health care.¹⁶⁹ A study published in 2001 reported that many women “learned about reproduction as a result of their own unplanned pregnancies.”¹⁷⁰ Women also lack confidence in the advice they receive: the CROWD Study reported that thirty percent of women with disabilities believe that their doctor has given them incorrect information about birth control, compared to only nine percent of women without disabilities.¹⁷¹

No particular medical equipment is necessary for a physician to provide basic sexual and reproductive information to women, including women with disabilities. There is evidence that both are lacking. In terms of information, there is insufficient research on how disability affects a variety of issues relating to sexuality and reproduction, including sexual functioning, desire, satisfaction, fertility, pregnancy, childbirth, the safety and efficacy of various forms of birth control, risk for STIs, and risk for hysterectomy.¹⁷² According to the CROWD Study,

[i]t is truly astounding how little information physicians are given about the effect of disability on reproductive capacity or the value women with disabilities ascribe to the ability to bear children. Few articles in the medical literature discuss the safety of oral contraceptives for women with various types of disabilities, alternative techniques for conducting pelvic exams, or the importance of breast cancer screening for women who have difficulty accessing mammography equipment.¹⁷³

167. Nosek et al., *The Meaning of Health*, *supra* note 42, at 16.

168. Nosek et al., *CROWD Study*, *supra* note 19, at 33.

169. Stephanie Pendergrass et al., *Design and Evaluation of an Internet Site to Educate Women with Disabilities on Reproductive Health Care*, 19 *SEXUALITY & DISABILITY* 71, 72-74 (2001) (reviewing studies on knowledge of health care of women with disabilities); Heather Becker et al., *Reproductive Health Care Experiences of Women with Physical Disabilities: A Qualitative Study*, 78 *ARCHIVES PHYSICAL MED. & REHABILITATION (SUPPLEMENT 5)* S-26, S-26 (1997).

170. Pendergrass et al., *supra* note 169, at 73 (internal citation omitted).

171. Nosek et al., *CROWD Study*, *supra* note 19, at 34.

172. Nosek & Colvard, *supra* note 159.

173. Nosek et al., *CROWD Study*, *supra* note 19, at 34.

Given the lack of research, it is not surprising that the sexual and reproductive health of women with disabilities is under-taught in medical schools, and under discussed with patients.¹⁷⁴

IV. STATE MEDICAID AGENCIES AS A PLACE TO START

How can we increase equitable access to women's health care for women with disabilities in light of the physical and societal barriers identified above? Some of the medical literature suggests provider education and other non-litigation solutions,¹⁷⁵ and there have been calls for research on a wide range of issues relating to the sexual and reproductive health of women with disabilities.¹⁷⁶ Another approach would be to set more detailed standards through regulation, either through promulgation of more specific guidelines by the Department of Justice or by passage of legislation such as the Promoting Wellness Act.¹⁷⁷ While I agree that these efforts have a role to play, they have not been and will not be sufficient to solve the problem in light of the barriers discussed above.

The law confers the right to nondiscriminatory access to health care, and to be meaningful, this right must be enforced. Therefore, litigation, or the credible threat of litigation, has a role in the solution. As noted above, Titles II and III are weak in the areas of enforcement and implementation, and several scholars have noted that these titles are underenforced. While those limitations can and should be addressed, the key role of Medicaid in providing health care services to women with disabilities suggests that addressing the responsibility of states to ensure Medicaid program accessibility is a step in the right direction.

A. Key Role of the Medicaid Program

One litigation strategy that seems to be emerging is class action litigation by disability rights organizations against hospitals and health plans seeking injunctive relief, such as in *Metzler v. Kaiser*,¹⁷⁸ *WHC*,¹⁷⁹ and *Sutter*

174. Nosek, *Overcoming the Odds*, *supra* note 36, at 136 ("Few physicians truly understand the effect of our disability on our reproductive health. This is never taught in medical schools, so physicians have very little information with which to help us make decisions about contraception, pregnancy, or hormone replacement therapy. They are much less likely to discuss these topics with their disabled patients.").

175. See, e.g., Kirschner et al., *supra* note 18, at 1122 (recommending change from within the health care system to combat access disparities).

176. Nosek et al., *CROWD Study*, *supra* note 19, at 37.

177. Kirschner et al., *supra* note 18, at 1122; Promoting Wellness for Individuals with Disabilities Act, H.R. 3294, 110th Cong. (2007).

178. See *Metzler v. Kaiser Settlement*, *supra* note 107.

179. *WHC Settlement*, *supra* note 112.

v. *Olson*.¹⁸⁰ Seeking primarily injunctive relief avoids the twin issues of severely limited damages and sovereign immunity against actions for money damages under Title II.¹⁸¹ In addition, class or associational litigation avoids in part the stringent standing requirements imposed by some courts in Title II actions.¹⁸²

Adapting this strategy to address state responsibility to ensure that Medicaid programs are accessible for women with disabilities is a promising next step. Medicaid is the nation's largest group insurance program, covering fifty-nine million people including over eight million people with disabilities.¹⁸³ Half of all women with disabilities are covered by Medicaid, so any improvements to that program could reach a significant number of

180. *Olson v. Sutter Health Settlement*, *supra* note 115.

181. In general, remedies available to private plaintiffs under Title II of the ADA include injunctive relief, compensatory damages, and attorney's fees under certain circumstances, but not punitive damages. *Barnes v. Gorman*, 536 U.S. 181, 189 (2002). Sovereign immunity issues complicate the remedies analysis, and a full analysis of those issues is beyond the scope of the article. However, injunctive relief would be available under *Ex Parte Young*, 209 U.S. 123, 167-68 (1908). *Bd. of Trs. of Univ. of Ala. v. Garrett*, 531 U.S. 356, 374 n.9 (2001). As for money damages, the Supreme Court held in *Garrett* that the 11th Amendment bars private money damages actions for state violations of Title I of the ADA, which prohibits employment discrimination. 531 U.S. at 360. Three years later in *Tennessee v. Lane*, the Court declined to extend that immunity to a private money damages action for failure to provide access to the courthouse in violation of Title II, 541 U.S. 509, 533-34 (2004), and it remains unclear whether money damages would be available in other types of cases under Title II that do not involve fundamental rights.

182. To obtain an injunction, a party must have standing and thus must demonstrate that he or she suffered actual injury and that it is "likely" . . . that the injury will be 'redressed by a favorable decision.'" *Lujan v. Defenders of Wildlife*, 504 U.S. 555, 560-61 (1992). In health care access cases, some courts have found that plaintiffs lack standing because they cannot make such a showing. For example, in *Bravin v. Mount Sinai Medical Center*, 186 F.R.D. 293, 299 (S.D.N.Y. 1999), the district court found that a deaf father who was denied a sign language interpreter for his wife's Lamaze classes and during his newborn child's hospital stay lacked standing to challenge the defendant's policy to deny interpreters to non-patients because he would not show a real or immediate threat of being harmed by the policy again in the near future. Similarly, in *McInnis-Misenor v. Maine Medical Center*, 211 F. Supp. 2d 256, 260 (D. Me. 2002), a district court found that a woman of childbearing age who was actively attempting to become pregnant lacked standing to compel a hospital to make its birthing-center wheelchair accessible because she was not yet pregnant. The standing issue seems less of a problem in the context of women's health, however, which requires periodic office visits, examinations, and testing. See Section I, *supra*. For a detailed analysis of the standing issue under Titles II and III, see Adam A. Milani, *Wheelchair Users Who Lack "Standing": Another Procedural Threshold Blocking Enforcement of Titles II and III of the ADA*, 39 WAKE FOREST L. REV. 69 (2004).

183. See The Henry J. Kaiser Family Found., *Medicaid Enrollees and Expenditures by Enrollment Group 2005*, at <http://facts.kff.org/chart.aspx?ch=465> (last visited Feb. 6, 2009).

women.¹⁸⁴ As noted above, the types of basic women's health care services most at issue here—routine pelvic examinations including Pap tests, weight measurement, and screening mammograms—are generally covered under the Medicaid program.¹⁸⁵

Addressing a statewide program provides a better opportunity for systemic reform by reaching all participating institutions. This approach is more efficient than individual, private actions litigated institution by institution or office by office, as suggested by the fact that the few cases challenging inaccessible medical equipment to date were brought against large hospitals or hospital chains.¹⁸⁶ Although addressing a state's Medicaid program would not reach all providers in the state,¹⁸⁷ it could be an effective way to reach a key group of physicians who provide care to over half of all women with disabilities, and to frame a solution viewing them as a whole.

B. Framing the Legal Argument

As noted above, Title II provides that qualified individuals with a disability cannot be excluded from participation in or be denied the benefits of the services, programs, or activities of a public entity.¹⁸⁸ Similarly, Section 504 of the Rehabilitation Act prohibits discrimination against otherwise qualified individuals with a disability under any program or activity receiving federal financial assistance. Although there are differences between the Rehabilitation Act and Title II, the standards adopted by Title II for state and local government services are generally the same as those required by the Rehabilitation Act for federal assisted programs and activities.¹⁸⁹

In order to establish a violation under Title II of the ADA, a plaintiff must demonstrate that: she is a qualified individual with a disability, the state

184. See THE HENRY J. KAISER FAMILY FOUND., *THE MEDICAID PROGRAM AT A GLANCE*, *supra* note 27.

185. THE HENRY J. KAISER FAMILY FOUND., *COVERAGE OF GYNECOLOGICAL CARE AND CONTRACEPTIVES*, *FACT SHEET*, *supra* note 30.

186. *Metzler v. Kaiser Settlement*, *supra* note 107; see also *WHC Settlement*, *supra* note 112; *Olson v. Sutter Health Settlement*, *supra* note 115.

187. See Sidney D. Watson, *Medicaid Physician Participation: Patients, Poverty, and Physician Self-Interest*, 21 AM. J. L. & MED. 191, 193 (1995) (noting that twenty-five percent of physicians "refuse to treat Medicaid patients" primarily due to low Medicaid reimbursement rates); Steven Zuckerman et al., *Changes in Medicaid Physician Fees, 1998-2003: Implications for Physician Participation*, W4 HEALTH AFF. 374, 374 (2004), at <http://content.healthaffairs.org/cgi/reprint/hlthaff.w4.374v1> (last visited Feb. 6, 2009) (documenting low physician participation in Medicaid).

188. 42 U.S.C. § 12132 (2000).

189. *Henrietta D. v. Bloomberg*, 331 F.3d 261, 272 (2nd Cir. 2003). Similarly, the law developed under Section 504 of the Rehabilitation Act is considered applicable to Title II. See *Helen L. v. DiDario*, 46 F.3d 325, 330 n.7 (3d Cir. 1995).

Medicaid agency is subject to the ADA, and that she was denied the opportunity to participate in or benefit from the Medicaid program, or was otherwise discriminated against because of her disability.¹⁹⁰ As to the first requirement, people with mobility impairments are generally considered “disabled” for purpose of the Rehabilitation Act and the ADA.¹⁹¹ A qualified individual with a disability is defined in relevant part as someone who “meets the essential eligibility requirements for the receipt of services or the participation in programs or activities provided by a public entity.”¹⁹² In addition, women with mobility disabilities who have been found eligible for and enrolled in a state Medicaid program are clearly otherwise qualified individuals with a disability under both Title II and the Rehabilitation Act.¹⁹³

As to the second requirement, Title II applies to services and programs made available by the state or a state agency. A state Medicaid program is also a “program or activity” within the meaning of the Rehabilitation Act,

190. *Henrietta D.*, 331 F. 3d at 272.

191. The ADA defines “disability” to mean, “with respect to an individual—(A) a physical or mental impairment that substantially limits one or more of the major life activities of such individual; (B) a record of such an impairment; or (C) being regarded as having such an impairment” regardless of whether the individual actually has the impairment. 42 U.S.C. § 12102 (2) (2000). The issue is determined on a case by case basis and remains a controversial and hotly litigated issue. See Pendo, *Substantially Limited Justice?*, *supra* note 13, at 1179; Paula E. Berg, *Ill/Legal: Interrogating the Meaning and Function of the Category of Disability in Antidiscrimination Law*, 18 YALE L. & POL’Y REV. 1, 5-23 (1999). It is also the subject of a new law, the ADA Amendments Act of 2008, Pub. L. No. 110-325, 122 Stat. 3553, 3553, 3555 (2008) (amending the ADA, including a definition of disability). However, several courts have found people with mobility disabilities to be “disabled” for purposes of the ADA. See, e.g., *Sutton v. United Air Lines*, 527 U.S. 471, 488 (1999) (noting that “individuals who use prosthetic limbs or wheelchairs may be mobile and capable of functioning in society but still be disabled because of a substantial limitation on their ability to walk or run.”); *Finical v. Collections Unlimited*, 65 F. Supp. 2d 1032, 1039 (D. Ariz. 1999) (finding same); *Johnson v. Trs. of Durham Technical Cmty. Coll.*, 535 S.E.2d 357, 363 (N.C. App. 2000) (finding a plaintiff who used a wheelchair and whose doctor testified that her ability to walk was limited was disabled for purposes of the ADA). See also *Toyota Motor Mfg., Ky. v. Williams*, 534 U.S. 184, 193-94 (2002) (stating that “Congress drew the ADA’s definition of disability almost verbatim from the definition of ‘handicapped individual’ in the Rehabilitation Act, § 706(8)(B), and that Congress’ repetition of a well-established term generally implies that Congress intended the term to be construed in accordance with pre-existing regulatory interpretations.”); *Bragdon v. Abbott*, 524 U.S. 624, 646 (1998) (“The Justice Department’s interpretation of the definition of disability is consistent with our analysis. The regulations acknowledge that Congress intended the ADA’s definition of disability to be given the same construction as the definition of handicap in the Rehabilitation Act.”).

192. 42 U.S.C. § 12131(2) (2000).

193. See, e.g., *Olmstead v. Zimring*, 527 U.S. 581, 601-02 (1999).

and several courts have found that receipt of Medicaid funding is receipt of federal financial assistance for its purposes.¹⁹⁴

The third requirement is more difficult. Under both Title II and the Rehabilitation Act, qualified individuals with a disability must be afforded an opportunity to benefit from and participate in public programs that is both meaningful and equal to the opportunity afforded to people without disabilities.¹⁹⁵ For example, in *Alexander v. Choate*, the Supreme Court considered a challenge to Tennessee's fourteen day limit on hospital stays per year for Medicaid recipients on the basis that it disparately impacted Medicaid recipients with disabilities because they required longer stays more frequently than recipients without disabilities.¹⁹⁶ The Court upheld the limit, stating that the Rehabilitation Act required "meaningful access" to the package of provided services for people with disabilities, but not equal results or health outcomes.¹⁹⁷

Title II also imposes a requirement of reasonable accommodation.¹⁹⁸ For example, in *Henrietta D. v. Bloomberg*, a class of Medicaid-eligible residents of New York City with AIDS or HIV-related conditions requiring treatment brought claims under the Rehabilitation Act, Title II, and state law against city and state officials claiming failure to reasonably accommodate in the access of benefits and services.¹⁹⁹ As the court explained, "[q]uite simply, the demonstration that a disability makes it difficult for a plaintiff to access benefits that are available to both those with and without disabilities is sufficient to sustain a claim for a reasonable accommodation."²⁰⁰

So what exactly would our class of plaintiffs need to show to establish a violation of Title II by a state Medicaid agency in this context?²⁰¹ The claim

194. See, e.g., *Anderson v. Dep't of Pub. Welfare*, 1 F. Supp. 2d 456, 462-63 (E.D. Pa. 1998); *Wolford by Mackey v. Lewis*, 860 F. Supp. 1123, 1136 (S.D.W.Va. 1994) (finding a prima facie case established against the state of West Virginia for denial of meaningful access to Medicaid services by denying residential care facility residents transportation when it was reasonable to do so); see also *supra*, note 77 and accompanying text.

195. 28 C.F.R. § 35.130(b)(1)(ii) (2008); *Alexander v. Choate*, 469 U.S. 287, 301 (1985).

196. *Alexander v. Choate*, 469 U.S. 287, 289-90 (1985) (finding that "27.4% of all handicapped users of hospital services who received Medicaid required more than 14 days of care, while only 7.8% of nonhandicapped users required more than 14 days of inpatient care.").

197. *Id.* at 302-03. For a discussion of the "meaningful access" standard, see Francis & Silvers, *supra* note 87.

198. See Section I.A., *supra*. DEP'T OF JUSTICE, ADA TITLE II TECHNICAL ASSISTANCE MANUAL, *supra* note 76, § II-4.3200 ("Reasonable Accommodation").

199. *Henrietta D. v. Bloomberg*, 331 F.3d 261, 264-65 (2nd Cir. 2003).

200. *Id.* at 277.

201. Arguments could be made under the Medicaid statute, as well. See DISABILITY RIGHTS EDUCATION & DEFENSE FUND, DREDF LEGAL POSITION PAPER ON MEDICAID HEALTHCARE

should be framed as one for nondiscriminatory and meaningful access to women's health services currently covered under the Medicaid program, equal to that provided to women without disabilities. In other words, a showing that covered women's health care services are not made equally available to some women because they have mobility disabilities is a sufficient showing of discrimination.

The *Anderson* case discussed above provides some guidance. In that case, a class comprised of Medicaid enrollees with mobility or vision impairments challenged Pennsylvania's mandatory managed care plan arguing, among other things, that the offices of some of the plan providers were not accessible due to architectural barriers.²⁰² Pennsylvania administered the state Medicaid program through the Department of Public Welfare (DPW), and mandated that all recipients in five counties receive health care through a group of HMOs called "HealthChoices."²⁰³ Unfortunately, Pennsylvania's DPW did not require that the HealthChoices HMO network providers practice in offices that complied with the architectural accessibility requirements of the ADA.²⁰⁴ Indeed, at no point prior to litigation did Pennsylvania's DPW inquire as to whether any of the providers' offices were accessible to people with mobility impairments—not during the bidding process, in the reviews of the selected HMOs, or when it circulated a provider directory in which providers identified themselves as 'specializing in the treatment of people with special needs.'²⁰⁵ The court cited evidence indicating that on average, approximately thirty-eight percent of the listed providers practiced in accessible offices or claimed to specialize in the treatment of patients with special needs.²⁰⁶ On these facts, the court found that HealthChoices did "not comply with the minimum program accessibility regulations promulgated under Title II and Section 504" for new and existing construction.²⁰⁷ Pennsylvania's DPW failed to ensure that program providers met the requirements of Title II in terms of new

ACCESSIBILITY FOR PEOPLE WITH DISABILITIES (2005), at www.dredf.org/healthcare/DREDF_Legal_Position.html (last visited Feb. 6, 2009) [hereinafter DREDF LEGAL BRIEF].

202. *Anderson v. Dep't of Pub. Welfare*, 1 F. Supp. 2d 456, 459, 464 (E.D. Pa. 1998).

203. *Id.* at 459.

204. *Id.*

205. *Id.*

206. *Id.* at 460 n.4 (finding percentages of providers practicing in accessible offices or who self-identified as specializing in the treatment of people with special needs ranging from one percent to one hundred percent across counties and networks within counties).

207. *Anderson*, 1 F. Supp. 2d at 463. The court referred to the "program accessibility" standards of 28 C.F.R. §§ 35.130(b)(4) and 35.150(a)(1), which require that accessibility be assessed by viewing a program in its entirety, but the argument was not raised, and the court did not consider, that provider choice is itself an integral component of the Medicaid program. *Id.* at 465.

construction and existing facilities, and therefore failed to ensure that individuals with disabilities had a meaningful opportunity to benefit from and participate in HealthChoices.²⁰⁸ The court certified the plaintiff class, granted plaintiff's motion for summary judgment in part, and issued an order requiring that Pennsylvania's DPW ensure that every participating HealthChoices provider met the accessibility requirements of Title II.²⁰⁹

Anderson is the easier case, because the requirements regarding removal of architectural barriers apply to every new and existing building. Here, the requirement of meaningful access applies to the Medicaid program as a whole, not to every single institution and provider office within the program, so "meaningful access" in this context requires a definition. In terms of offices and institutions with accessible equipment—how much is enough to provide meaningful access?

In the context of a Medicaid program, it seems logical that meaningful access be defined in relation to the number or percentage of women with disabilities enrolled in that state or region, as well as the extent to which inaccessible medical equipment presents a barrier to women's health care for the class. Nationwide, fourteen percent of Medicaid recipients are individuals with disabilities,²¹⁰ and over half of them are women.²¹¹ The national data collected by the CROWD Study is a good start, and state-specific data would be helpful. Gathering state-specific data should involve an analysis of the number of women with disabilities enrolled in the state Medicaid program, as well as the type of data gathered by the CROWD Study—the types of women's health services they are attempting to access, the extent to which inaccessible equipment is a barrier, and any denial or delay of care as a result. It might be helpful to identify other populations that would be served by the acquisition of accessible equipment, such as men and children with different types of impairments or disabilities, and the elderly. Finally, it would also be helpful to discover the percentage of participating institutions and offices with accessible equipment, if such data was readily available.

Until that data is collected, there are examples of the use of percentages in defining architectural accessibility which could be helpful as a starting point. For example, the ADAAG requires that all public and common use areas of a medical facility be accessible, and sets the following standards for patient rooms: "[i]n general purpose hospitals, and in psychiatric and

208. *Id.* at 465.

209. *Id.* at 468-69.

210. THE HENRY J. KAISER FAMILY FOUND., THE MEDICAID PROGRAM AT A GLANCE, *supra* note 27, at fig.2.

211. THE HENRY J. KAISER FAMILY FOUND., ISSUE BRIEF: MEDICAID'S ROLE FOR WOMEN, *supra* note 27.

detoxification facilities, 10 percent of patient bedrooms and toilets must be accessible. The required percentage is 100 percent for special facilities treating conditions that affect mobility, and 50 percent for long-term facilities and nursing homes.²¹² The ADAAG also encourages medical facilities to consider other means of providing access, including providing equivalent services at an accessible site in the medical center, delivering services to persons with disabilities in their own homes, or transporting people with disabilities from their homes to an accessible facility where they can receive equivalent services.²¹³ These standards could be considered as a starting point for discussions regarding the Medicaid program as a whole.

C. *Potential Benefits*

Framing a legal argument and marshalling the evidence to support it could be used to create an opportunity to discuss the issue, and to open dialog about the meaning of meaningful access in the context of a state's Medicaid program.²¹⁴ Open discussions with state Medicaid agencies could lead to creative, collaborative solutions. Plaintiffs may be able to secure a broader array of benefits than the limited remedies available under the law, including a commitment to gathering disability access data, informing women of their rights to equal access, or monitoring, advising, and supporting HMOs and providers in meeting their obligations.²¹⁵ It would also provide an opportunity to discuss state-specific issues, including the impact of using or not using managed care programs to provide care for women with disabilities enrolled in Medicaid.²¹⁶

Open discussion would also serve an important role in developing expertise and legal solutions.²¹⁷ If a settlement agreement was reached, it

212. U.S. DEP'T OF JUSTICE, THE AMERICANS WITH DISABILITIES ACT, TITLE III TECHNICAL ASSISTANCE MANUAL COVERING PUBLIC ACCOMMODATIONS AND COMMERCIAL FACILITIES, § III-7.8300 ("Medical care facilities (ADAAG § 6)") (1994), at www.ada.gov/taman3.html (last visited Feb. 6, 2009) ("Medical care facilities (ADAAG § 6)").

213. *Id.* § III.4.5100 ("Alternatives to Barrier Removal - General.").

214. This also assumes that the state would be willing to enter into such a discussion, and would be capable of carrying out such solutions if they could be identified.

215. See DREDF LEGAL BRIEF *supra* note 201.

216. See generally THE HENRY J. KAISER FAMILY FOUND., MEDICAID FACTS: MEDICAID'S DISABLED POPULATION AND MANAGED CARE (2001), available at www.kff.org/medicaid/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=13728 (last visited Feb. 6, 2009). Of course, states with Medicaid programs that enroll people with disabilities into managed care programs, such as described in *Anderson v. Dep't of Pub. Welfare*, 1 F. Supp. 2d 456 (1998), are more able to regulate managed care organizations through contract. See DREDF LEGAL BRIEF, *supra* note 215.

217. This is the idea behind the Department of Justice's Project Civil Access (PCA), "a wide-ranging effort to ensure that counties, cities, towns, and villages comply with the ADA by eliminating physical and communication barriers that prevent people with disabilities from

could be used as a basis for future discussions in other states, much as Disability Rights Advocates intends to use the *Metzler v. Kaiser* settlement as a model agreement in negotiations with other hospital chains.²¹⁸ It could also serve as a model for private accreditation organizations such as the Joint Commission on Accreditation of Healthcare Organizations.²¹⁹

Also, as indicated above, any solution to the lack of access to women's health care for women with disabilities has to take into account social resistance to sexuality, reproduction, and parenting on the part of women with disabilities. Working with a public program on a state level makes a statement that equal access to women's health care for women with disabilities is an issue of social importance—something a publicly funded program should address. It is a symbolic statement that equality matters, and women with disabilities are women, lovers, and mothers—not “others.” Creating the opportunity for health care providers to interact positively with women with disabilities may also help to dispel certain stereotypes, as there is evidence that people with previous interactions with people with disabilities report more positive perceptions about people with disabilities than those without similar experiences.²²⁰

V. CONCLUSION

Although the Rehabilitation Act and the ADA require that health care institutions, offices, and programs be accessible, few actually are: over fifteen years after passage of the Act, women with mobility impairments cannot get on examination tables, cannot be weighed, and cannot use mammography equipment. This pervasive and unequal treatment has serious consequences for the health and well-being of millions of women.

participating fully in community life.” Dep’t of Justice, Project Civic Access (2008), at www.ada.gov/civicac.htm (last visited Feb. 6, 2009). Under PCA, the Disability Rights Section of the Department’s Civil Rights Division conducts reviews of local and state governments and develops technical assistance materials so that communities can comply with Title II. The Department has conducted 161 settlement agreements under this initiative. Dep’t of Justice, Project Civic Access Fact Sheet (2008), at www.ada.gov/civicfac.htm (last visited Feb. 6, 2009) (documenting 161 settlements involving 147 localities in all 50 states as of November, 2008.).

218. Tamar Lewin, *Disabled Patients Win Sweeping Changes from H.M.O.*, N.Y. TIMES, Apr. 13, 2001 at A14.

219. See generally The Joint Commission, Homepage, at www.jointcommission.org/ (last visited Feb. 28, 2009).

220. See Amy K. Wagner & Paula J. B. Stewart, *An Internship for College Students in Physical Medicine and Rehabilitation: Effects on Awareness, Career Choice, and Disability Perceptions*, 80 AM. J. PHYSICAL MED. & REHABILITATION 459, 461–62 (2001) (summarizing research).

Although it would be comforting to conclude this Article with a comprehensive solution, the stigmatization of disability—and the stigmatization of sexuality, reproduction, and parenting by women with disabilities in particular—is a deep-rooted problem in the medical community and society generally that will require continuing action. Given the key role of Medicaid in providing health care services to women with disabilities, addressing the responsibility of states to ensure Medicaid program accessibility for women with disabilities is a step in the right direction.

Addressing inaccessible medical equipment on a public and systemic level could provide an opportunity to think about the problem more broadly, and to connect any solution to a deeper understanding of disability rights and health care reform, generally.