

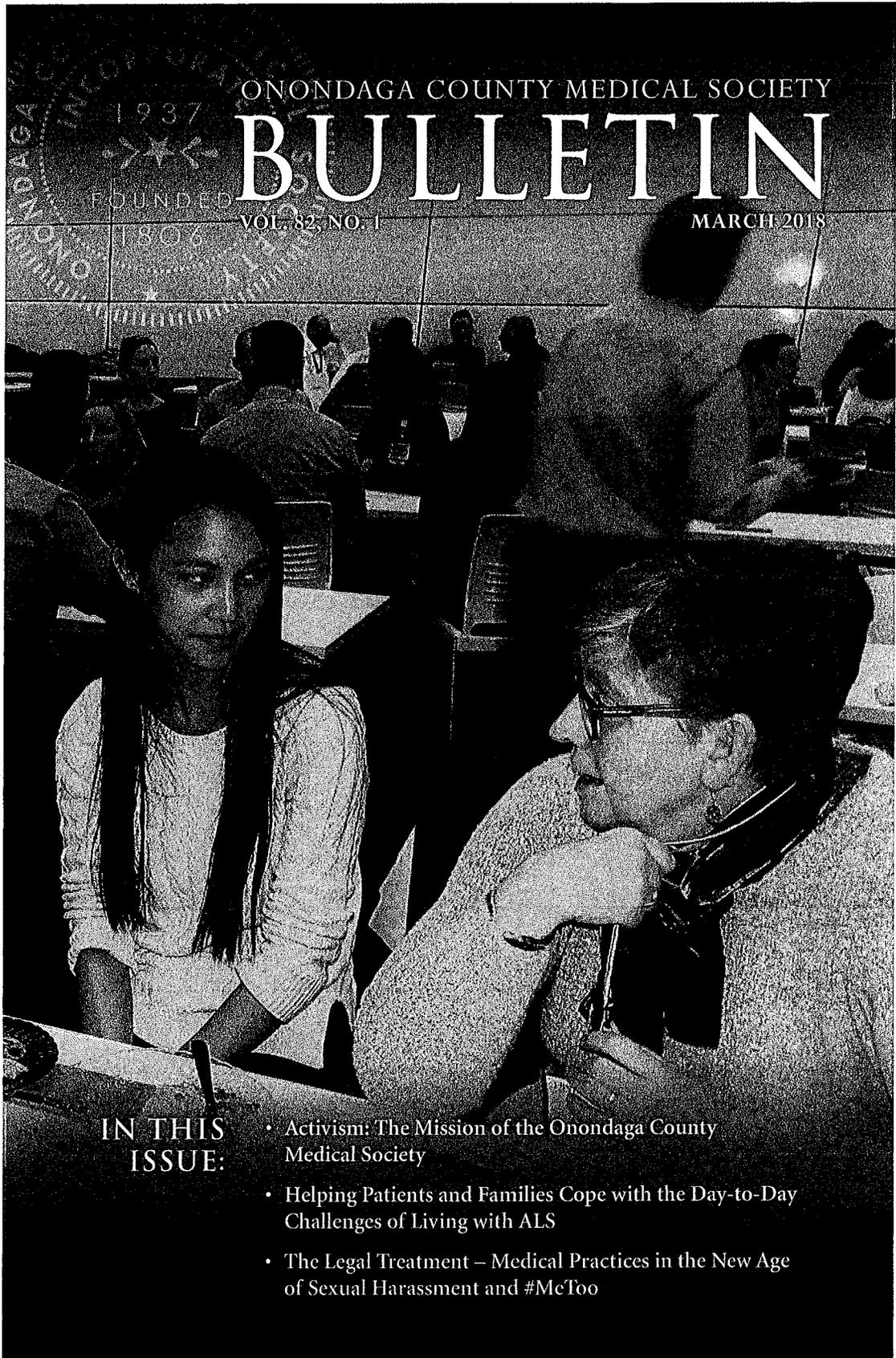
ONONDAGA COUNTY MEDICAL SOCIETY

BULLETIN

1937
FOUNDED
1806

VOL. 82, NO. 1

MARCH 2018



**IN THIS
ISSUE:**

- Activism: The Mission of the Onondaga County Medical Society
- Helping Patients and Families Cope with the Day-to-Day Challenges of Living with ALS
- The Legal Treatment – Medical Practices in the New Age of Sexual Harassment and #MeToo



ONONDAGA COUNTY MEDICAL SOCIETY BULLETIN

VOL. 82 NO. 1

MARCH 2018

Published by Onondaga County Medical Society, Inc.
Learbury Centre | 329 North Salina Street, Suite 303 | Syracuse, New York 13203
Telephone 315.424.8118 | Fax 315.424.0614

Cover photo: Dr. Kirsten Magowan (right) was one of many OCMS members who sat down with medical students to answer questions and offer their perspectives during this year's Upstate Medical Student Career Night.

Table of Contents

<u>Coming Events</u>	<u>1</u>
<u>President's Page</u>	<u>4</u>
<u>Executive Vice President's Page</u>	<u>6</u>
<u>Helping Patients and Families Cope with the Day-to-Day Challenges of Living with ALS</u>	<u>10</u>
<u>The Legal Treatment – Medical Practices in the New Age of Sexual Harassment and #MeToo</u>	<u>15</u>
<u>Providing Language Assistance to People with Limited English Proficiency in Medical Settings – It's Not Just About Hospitals</u>	<u>20</u>
<u>Electronic Report and Submission of Rabies Bite Form to Onondaga County Health Department Available in January 2018</u>	<u>25</u>
<u>March is American Red Cross Month</u>	<u>26</u>
<u>Medicare Now Pays for Care Planning Services for Individuals Who Are Cognitively Impaired</u>	<u>28</u>
<u>First Quarter Activities</u>	<u>31</u>
<u>OCMS Member Spotlight: Syracuse Orthopedic Specialists' Foot & Ankle Team</u>	<u>33</u>
<u>Welcome New Members</u>	<u>35</u>
<u>Medical Student Debate Centers on Personal Genetic Autonomy</u>	<u>42</u>
<u>Alliance Holiday Card</u>	<u>44</u>
<u>Thoughts on the Retired Physician's Lunch</u>	<u>45</u>
<u>Thank You for Voluntary Contributions</u>	<u>47</u>
<u>Alliance News</u>	<u>48</u>

Staff

James E. Coulthart, *Executive Vice President*
Debbie Colvin, *Director of Finance*
Patty Corasaniti, *Office Manager*
Sandy Emmi, *Director of Publications*

The Bulletin is published quarterly March, June, September and December. The Editors endeavor to publish only that which is authentic but disclaim any responsibility for the statements of contributors. The BULLETIN will accept advertising which it considers ethical, but such acceptance does not imply endorsement. Please address all correspondence to The Bulletin, c/o Onondaga County Medical Society, Learbury Centre, 329 N. Salina St., Ste. 303, Syracuse, New York 13203.

Onondaga County Medical Society Executive Council Officers

Brian Johnson, M.D.
President

Riya Chacko, M.D.
President-Elect

Justin Fedor, D.O.
Vice President

Michael G. Sheehan, M.D.
Treasurer

Geeta Sangani, M.D.
Secretary

Mary Abdulkly, M.D.
Past President

Members-At-Large

Ramsay Farah, M.D.
Michael Fischl, M.D.
LouAnn Giangreco, M.D.
Barbara Krenzer, M.D.
William D. Schreiber, M.D.
Kevin Walsh, M.D.

Delegates to MSSNY

Adrienne D. Allen, M.D.
David Halleran, M.D.
Ruth Hart, M.D.
Brian Johnson, M.D.
Digant Nanavati, M.D.
David T. Page, M.D.
Barry Rabin, M.D.
Richard D. Semeran, M.D.
Darvin Varon, M.D.

Delegate from SUNY Upstate Medical University

Sunny Aslam, M.D.

Resident Representative

George Salloum, M.D.
Sara Tabi, M.D.

Medical Student Representative

Elizabeth Piotrowski

Providing Language Assistance to People with Limited English Proficiency in Medical Settings –

It's Not Just About Hospitals

BARRIE GEWANTER

*Executive Director of the Onondaga County/
Syracuse Human Rights Commission*



A case manager or health care navigator calls to make an appointment for a patient who does not speak English. They say the patient will need an interpreter to communicate with doctors and staff. Does your office have to arrange this? You haven't budgeted for this kind of expense. Do you have to pay for the interpreter? The answer to both questions is YES.

Medical practices should provide language assistance, not only based on ethical and professional considerations, but in many cases based on state and federal law. Doctors and staff need to ensure "effective communication" with patients. Failure to do so can be considered discrimination. Medical practices should anticipate related expenses and prepare staff to accommodate patients' needs for language assistance. This is a cost of doing business, and a best practice to ensure quality care.

People who *cannot speak, read, write, or understand* English are considered "Limited English Proficient" (LEP). Title VI of the Civil Rights Act of 1964 prohibits discrimination on the basis of race, color and national origin in any program or activity that receives federal financial assistance. In 1974, the U.S. Supreme Court established that primary language use is so closely connected to national origin, that language-based discrimination is essentially discrimination based on national *origin* (*Lau v. Nichols* 414 U.S. 563). As a

result, failure to accommodate a person's primary language can be considered discrimination on the basis of national origin. If a medical practice accepts *any* federal funds in payment for services, including Medicare or Medicaid for *any* patient, it *must* provide language assistance for *all* patients who are LEP. Additionally, such assistance must also be provided for companions or caregivers the patient identifies as necessary. The 1974 Supreme Court case was followed by related state and federal executive orders, regulations and regulatory guidance that clarified this obligation. (See [Language Access Legal Cheat Sheet](#).) In addition to these regulatory requirements, New York State Human Rights Law also prohibits discrimination on the basis of national origin in all public accommodations, including professional services.

There is a parallel but separate legal obligation under the Americans with Disabilities Act (ADA) to accommodate the language needs of people who are Deaf or Hard of Hearing who use symbolic languages such as American Sign Language. The concept of providing "effective communication" actually comes from the ADA. However, it may be easiest to use the definition of LEP above to identify a need for language assistance; i.e., regardless of if the patient uses a non-English spoken language or a symbolic language like ASL. The result is the same. You have a legal obligation to avoid discrimination by ensuring "effective communication." However, providing appropriate language assistance is also likely to improve patient outcomes, because it helps practices avoid misunderstandings that can result in inaccurate diagnosis, ineffective treatment or worse. This is why the utilization of interpreters has been incorporated into many professional standards of practice. ([Click here](#) for information about the HHS National Standards for Culturally and Linguistically Appropriate Services [CLAS] standards.) From an ethical standpoint, this can also be seen as part of the first and all important rule for doctors – Do No Harm.

How can you assess a patient's language assistance needs? When should you arrange for an in-person interpreter? When can a phone- or video-based remote interpreter be adequate? This must be an *individualized* determination, based on the language needs of that individual. Ask patients about their preferences for language assistance, and respect them whenever possible, but always seek the approach that will provide effective communication for that individual in the specific medical setting or interaction. A one-size-fits-all policy is not appropriate. You should also be sure to identify if a patient speaks a particular regional language or dialect, or if they use a particular modality of symbolic communication. Don't assume that all people from Burma speak

Burmese, that all spoken Spanish or Arabic is the same, or that everyone who is Deaf uses ASL.

Additionally, you must consider the complexity and sensitivity of the communication, and the potential impact of misunderstanding. A phone or video-based remote interpreter may be fine for simple exchanges such as scheduling an appointment, but more complex interactions to identify medical or social history or to explain diagnosis or treatment plans, might require an in-person interpreter. Similarly, your staff may be able to write notes for simple interactions with people who are Deaf, but this will not be adequate for any interaction that is more complex or impactful. Check with your legal counsel. They may suggest that you develop written criteria or procedures for your staff to follow.

“Medical practices should provide language assistance, not only based on ethical and professional considerations, but in many cases based on state and federal law. Doctors and staff need to ensure “effective communication” with patients.”

It is also critical to seek interpreters who are *qualified* to provide this professional service. Qualified interpreters are ready to translate what doctors or staff say in a way that the patient will understand, and then accurately convey the patient responses in English. They should know related medical terminology, and have a good understanding of an interpreter’s professional role and ethical responsibilities, especially in regards to

neutrality and confidentiality. Also, doctors and staff should *never* expect patients to bring their own interpreter, nor rely on their children to interpret. Avoid relying on family members, unless this is the express preference of a patient and you are confident in communication will be effective.

The most important thing is to be prepared. Office and practice managers should identify local language assistance services and resources, then provide training for staff so that they are ready to accommodate patients’ language assistance needs, *in person or on the phone*. This includes accepting relay calls

from Deaf patients. (For an article with helpful information about working with interpreters see <https://www.aafp.org/afp/2014/1001/p476.html>.) Your staff should also understand that it is never the responsibility of a non-English speaking patient to schedule, provide or pay for an interpreter. You may NOT charge patients for interpretation services, but you may be able to bill their insurance for this service, including Medicaid patients. In some cases, insurance reimbursements will not cover the entire cost of an interpreter, but you cannot deny service to LEP patients because of this. Your staff can check on the reimbursement rates of different insurance companies, so you can better anticipate this expense.

I urge you to be proactive about this aspect of medical practice. There are many different immigrant and refugee groups in this region, and there is an active Deaf Community. Your practice is likely to encounter new patients who need language assistance, and this article is only an introduction to this topic. For a more detailed review of this issue, see this factsheet by The National Council on Interpreting in Healthcare: <http://www.ncihc.org/faqs-for-healthcare-professionals> or <http://refugeehealthta.org/access-to-care/language-access/faq/>. To contact the Human Rights Commission staff about local resources, best practices or staff awareness training, call (315) 435-3565, email bgewanter@ongov.net, or visit our website at www.ongov.net/humanrights.