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Knowledge Of Practicing Physicians About Their Legal Obligations When Caring For Patients With Disability

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Abstract

Disability civil rights laws require equitable treatment of the approximately sixty-one million Americans with disability. However, federal reports and numerous research studies indicate that this diverse and growing population often experiences health care disparities. To examine one possible contributing factor, we interviewed practicing physicians to explore their knowledge of their obligations to accommodate patients with disability under federal civil rights law. Interviewees reported having had little formal training about, and demonstrated superficial or incorrect understanding of, their obligations in three potentially problematic areas: deciding which accommodations their practices should implement, refusing patients with disability, and holding patients accountable for costs of accommodations. The fact that practicing physicians might not fully understand their legal responsibilities when caring for people with disability may contribute to persisting inequity in their care, and it suggests that further education in the Americans with Disabilities Act and other disability civil rights laws may be warranted.

Healthy People 2010—the 2000 decennial federal review of national public health priorities¹—introduced people with disability as a subpopulation whose members experienced systematic inequities in their health care. Subsequent federal reports and growing numbers of academic research studies have confirmed frequent disparities in care for people with disability.^{2–5} The Americans with Disabilities Act (ADA) of 1990 protects the civil rights of people with disability, a population estimated at roughly fifty-seven million Americans as of 2010.⁶ The number of Americans with disability has grown to an estimated sixty-one

million as of 2016.⁷ Persistent health care disparities for people with disability raise the question about whether better educating physicians about their obligations to provide equitable care under the ADA could help improve care for this growing and historically disadvantaged population.

In other contexts, educating physicians about their responsibilities under civil rights laws has become one tool for reducing health care disparities. Various training curricula have addressed health care professionals' legal responsibilities for populations experiencing disparities,^{8,9} including those related to race or ethnicity¹⁰ and sexual orientation or gender identity.¹¹ The Accreditation Council for Continuing Medical Education provides training on civil rights and physicians' legal responsibilities for patient care.¹² However, little is known about the knowledge of practicing physicians concerning their legal responsibilities to patients with disability under the ADA and other disability civil rights laws.

The purpose of this study was to use in-depth, qualitative interviews to explore the experiences of physicians in caring for patients with disability and the physicians' understanding of their legal obligations under the ADA. Below we present our findings, following a brief review of the civil rights laws that govern disability in the US and their applications to health care.^{13,14}

Background

The major federal disability civil rights laws are the Rehabilitation Act of 1973 and the ADA, amended by the ADA Amendments Act of 2008.^{15,16} Section 504 of the Rehabilitation Act prohibits entities that receive federal funding, such as Medicare or Medicaid, to have programs or activities that discriminate against people with disability.¹⁷ Enacted under the guarantee of equal treatment of the Fourteenth Amendment to the Constitution, the ADA prohibits disability-based discrimination by public and private entities, regardless of whether they receive federal funding.¹⁵ The ADA uses a three-part definition of *disability* as described in online appendix exhibit A.¹⁸ Congress enacted the ADA Amendments Act to clarify its intent that the statutory definition of *disability* should be construed broadly.¹⁶

Disability civil rights protections differ from civil rights protections for other populations, such as racial or ethnic minority groups, in important ways: Disability civil rights laws not only prohibit discrimination¹⁹ but also require entities to "take proactive steps to offer equal opportunity to persons with disabilities."²⁰ This requirement for proactive responses stymied passage of the ADA, as some business leaders protested potential costs of disability accommodations despite studies showing that many accommodations require minimal expenditures.²¹ To address cost concerns, the ADA stipulated that accommodations be "reasonable" and not an "undue burden" upon an organization's resources. Accommodations such as accessible medical equipment may be required because physicians' practices and hospitals are covered by ADA Title II or Title III, and medical care providers must ensure "full and equal access to their health care services and facilities."²² Requirements for accommodations may be specific to the setting, and legal requirements are determined based on the classification of an entity under different ADA titles as described in appendix exhibit

B.¹⁸ Given that clinical practices are classified as either Title II (public) or Title III (private, but serving the public) entities, all of them must comply with accommodation requirements.

Summary Of ADA Requirements For Physicians

Appendix exhibit A summarizes requirements of the ADA for physicians and medical practices.¹⁸ These requirements ensure equal access to medical services for patients with disability. The requirements have implications for individual physicians and are not solely the responsibility of clinical practices. Equal access requires that a patient cannot be refused on the basis of disability;^{23,24} effective communication modalities (that is, auxiliary aids or services) are required;^{25,26} and the practice must engage in reasonable modification of policies, physical space, and procedures when necessary to accommodate patients' needs.^{27,28} The medical service must be accessible either through removal of physical barriers (Title III entities)²⁹ or by making the medical service accessible in another capacity—for example, arranging to see the patient elsewhere (Title II entities)—subject to certain limits.³⁰ The ADA also requires that patients be seen in the most integrated setting possible (that is, patients cannot be relegated to a “separate” or “specialized” clinic under the pretense that it is better suited to their needs).^{31,32}

Study Data And Methods

The Partners HealthCare System–Massachusetts General Hospital Institutional Review Board approved this study and viewed willingness to participate after being informed of interview procedures as representing implied informed consent.

Recruitment Of Interviewees

For this qualitative study, we aimed to recruit twenty-five practicing physicians across five specialties in which patients may frequently require reasonable accommodations: primary care (general internal medicine and family practice), rheumatology, neurology, obstetrics/gynecology (for example, women late in pregnancy), and orthopedics. We used the commercial SK&A Health-care Databases to obtain contact information for a random sample of 520 physicians in these specialties practicing in Massachusetts. Physicians associated with Partners HealthCare and affiliated institutions and practices were excluded because of bias concerns. We also excluded fellows, residents, and trainees, which left 365 physicians across all specialties. We stopped recruitment after twenty interviews because we had reached data saturation—that is, no new qualitative information was emerging from the interviews.

Interview Protocol And Procedures

We designed an open-ended protocol for telephone interviews (available on request) that addressed various issues relating to caring for patients with physical or mental health disabilities. Exhibit 1 shows the questions addressed in this article, as well as potential responses that met ADA requirements. We included these questions because they addressed salient issues that have been targets of ADA litigation in medical settings. A concluding question asked for recommendations about improving care for people with disability.

One author (Lisa Iezzoni) conducted all of the interviews, which averaged forty-one minutes in length. We treated the first three interviews as pilot tests. Subsequent changes to the interview protocol were minor, so we included results from those first three interviews in the analysis. We offered \$100 for participation; four interviewees refused payment. A professional service transcribed verbatim the audio files of the interviews. Another author (Nicole Agaronnik) made minor corrections to the transcripts while listening to the audio files.

Analysis

We used conventional content analysis,³³ a descriptive qualitative analysis method,^{34,35} to draw themes from responses to each question without overinterpreting the data. We designated coding categories after reviewing all twenty transcripts. Researchers in different states reviewed the transcripts independently. Consensus was reached through conference calls, during which the research team discussed data interpretations and agreed upon major findings. Below, we sometimes indicate numbers of interviewees reporting specific themes to avoid vague terms such as “some,” “several,” or “many.” We do not present percentages given the small sample size and sampling procedures.

Limitations

Our study had several limitations. First, since we excluded physicians employed by Partners HealthCare, our results are not generalizable to all physicians in Massachusetts, let alone the entire US. Attitudes and approaches—although not federal laws—vary across regions.

Second, our results are not generalizable to all physicians within the selected specialties or to different practice types (for example, private or hospital-based practices).

Third, we interviewed eleven physicians educated before and nine educated after the ADA was enacted, but these small numbers precluded robust comparisons between these groups.

Fourth, we did not inquire about numbers of people with disability in participants’ patient panels. The numbers and types of patients with disability physicians see could affect their familiarity with the ADA.

Fifth, because of concerns about respondent burden, we limited the number of questions about legal obligations under the ADA. Therefore, we did not comprehensively explore physicians’ understanding of disability civil rights relevant to health care (for example, informed consent for patients with intellectual disability).

Study Results

Exhibit 2 provides data on personal and professional characteristics of the twenty participating physicians. The physicians’ mean number of years in practice was 27.4 (exhibit 2). The results below describe participants’ experience with training about responsibilities under the ADA, their understanding of making accommodation decisions, whether they could refuse to see patients with disability, whether they could hold patients accountable for accommodation costs, and recommendations for improving care for patients with disability.

We include quotations below that exemplify responses, with exhibit 3 and appendix exhibit C¹⁸ presenting additional selected quotations. Eleven participants had completed medical school before the 1990 passage of the ADA. Physicians educated before and after 1990 did not appear to differ in the availability of accommodations in their practices or their knowledge of the ADA.

Training Of Physicians About Responsibilities

Four participants reported having received some formal training about ADA-related obligations to patients with disability during their medical careers, while twelve denied having had any such training and four were unsure. Of the four participants who had received some formal disability training, only one, who had graduated from medical school after passage of the ADA, had received this training in medical school. The other three had done so through either continuing medical education or another format within their clinical setting. An orthopedist mentioned that periodic training modules required of all physicians at his hospital contained some information about the ADA but noted: “It’s not like you’re actually paying 100 percent attention to it.... I think we do less of a good job, honestly, than we could.”

Twelve interviewees denied having had formal training about their obligations to patients with disability. However, one participant said: “I’ve always been in an institution where people with disabilities are a major part of our population. So in terms of taking a specific course in terms of my licensure....there was always a little bit in fine print somewhere that I’ve blasted through reading.”

Four physicians were unsure whether they had received any formal disability training about their obligations under the ADA. One participant, who is also a lawyer, responded: “I have no clue, so I will be completely guessing.... But in my most recent institutional training that we have to do every six months, I don’t recall reading anything about the ADA specifically.”

Responsibility For Accommodation Decisions

Thirteen participants reported that they knew who should be primarily responsible for deciding which accommodations the clinical practice would provide to a patient with disability. However, designation of the responsible party varied across physicians. Different participants felt that the responsibility rested with physicians, clinical staff, the patient, the patient’s caregiver, or a collaborative team effort, as described in appendix exhibit C.¹⁸ “When the patient comes to me,” said a rheumatologist, “I typically will be the one to help make decisions for them.” Other participants described the roles clinical staff played in making accommodation decisions. “Maybe I’m just lucky enough,” said a general internist, “that my team takes care of... this before I have to...figure out how to do things.” Another general internist assigned primary responsibility to a patient’s caretaker: “Often the caretaker—if it’s a big disability, they come and request it.” According to a family practitioner, “If the patient has ability, has autonomy, the patient makes that decision.”

Seven physicians were unsure who is responsible for making accommodation decisions. “I don’t feel comfortable doing that assessment,” reported a general internist, describing various disabilities requiring accommodation. “I am still trying to figure out that.”

Refusing To See Patients With Disability

Three physicians indicated that a practice may refuse to see a patient with disability, sixteen believed that a practice cannot refuse a patient with disability, and one was unsure.

“Sometimes because of the challenges,” said a general internist, “I can see why somebody would choose that.” A neurologist responded: “My first instinct was to say no. But I guess if they just can’t accommodate to something the patient needs through no fault of their own, then I guess” refusing a patient with disability is allowed.

Other interviewees believed that it is illegal to refuse to see a patient with disability. “No, I don’t think it’s allowed,” said a rheumatologist. “I think every physician should be seeing patients equally. It doesn’t matter if they have a disability or not.” A general internist noted, “If we were unable to meet their needs appropriately, we would find them an alternative place...or figure out how to adjust things so that we could meet their needs.”

Holding Patients Accountable For Accommodation Costs

None of the participants definitively stated that patients with disability could be required to cover accommodation costs. However, eight participants were uncertain, as indicated in appendix exhibit C.¹⁸ “I don’t know the legal answer,” said an orthopedist. “We don’t.” A general internist demurred: “Charge is totally outside of my realm of commentary.”

Recommendations For Improving Care For Patients With Disability

Participants’ recommendations for improving care for patients with disability fell into three themes: addressing accommodation challenges, providing compensation for the extra resources required to see patients with disability, and providing disability training to physicians and clinical staff. For meeting accommodation needs, a neurologist suggested consolidating care for people with disability in specialized units equipped to handle specific needs. She suggested that this would improve care compared to situations when “the concentrated need isn’t there” (that is, in practices where few patients require extensive accommodations). An orthopedist suggested that patients who are deaf or hard of hearing should assume primary responsibility for the accommodations needed for effective communication, such as arranging for an American Sign Language interpreter.

Participants voiced concern about not being given additional time or remuneration by insurers for seeing patients with disability. An orthopedist urged “recognizing how labor-intensive and resource-intensive it is at every level,” suggesting that this was essential to ensure that future providers would be willing to care for patients with disability. A general internist observed, “Sometimes the E&M [evaluation and management] coding system doesn’t always reflect the extra work that’s involved.”

Finally, participants recommended providing formal disability training to both physicians and clinic staff, although suggestions focused primarily on clinical care and accommodation approaches rather than on legal obligations. One general internist admitted that she did not “know all of the resources that are available to them” to assist in caring for patients with disability. Another general internist acknowledged: “I’ve never been trained on how to talk to someone who doesn’t hear well. I’m sure there are actually real tips for that that I don’t

think I ever learned.” An orthopedist urged training for clinical staff: “It would be great if there were a specific set of modules...to train them on caring for people with disabilities.”

Discussion

In this qualitative interview study, most physician participants exhibited a superficial or incorrect understanding of their legal responsibilities to patients with disability. These results are consistent with the 2011 *World Report on Disability*, which found that many health care professionals worldwide hold attitudes that compromise the quality of care for this population.³⁶ In the US, few undergraduate or graduate medical education programs include training on legal obligations under the ADA.³⁷ Two leading medical educators recommend that understanding these legal responsibilities should be a core competency of disability training for health care professionals.³⁸

We focused here on foundational principles for making services available and accessible to people with disability and found that knowledge varied across these areas. We refer to the ADA because, although there are differences between the Rehabilitation Act and the ADA, the standards adopted by ADA Title II are generally the same as those required by Section 504 of the Rehabilitation Act.^{39,40} As noted above, appendix exhibit A summarizes ADA requirements for physicians to make their practices accessible for people with disability.¹⁸

Accommodation Decisions Are Made Collaboratively

Physicians designated different responsible parties for making accommodation decisions, ranging from the physician to the patient. The ADA provides that accommodation decisions be made through a collaborative process that incorporates both physicians’ judgments about what is clinically appropriate and patients’ preferences and needs.

Accommodation decisions are also based on slightly different requirements under Title II (state and local governmental providers) and Title III (private entities that serve the public). Both Title II and Title III require equal access to health care services and facilities. To meet this obligation, a clinical practice may need to make accommodations, provide effective means of communication, or remove architectural barriers.^{30,32}

Title III clinical practices are responsible for “readily achievable barrier removal,” which means that architectural barriers must be removed in a practice when this can be achieved without imposing much difficulty or expense. For example, not every exam room must have a height-adjustable table. However, a physician should ensure that when a patient with mobility disability comes for an appointment, the patient will be examined using that table and not in their wheelchair. Title II clinical practices have slightly different obligations: Title II does not specifically require “readily achievable barrier removal” but rather stipulates general accessibility of services and programs.³⁰ If a clinical practice is not accessible because it does not have a height-adjustable table for a patient with mobility impairment and acquisition of equipment would be an undue financial burden, then the physician and clinical staff must make arrangements to see the patient and provide the same services elsewhere.

22,30

The ADA requires accommodations to ensure effective communication in health care settings. Again, requirements for making accommodation decisions differ for Title II and Title III practices. In relation to communication and auxiliary aids, Title II requires that the request of people with disability be given primary consideration. Title III requires only consultation.

The Americans With Disabilities Act Prohibits Refusal Of Medical Services

The ADA prohibits the refusal of a patient with a disability, unless physicians identify another way of serving the patient. Physicians also cannot refuse patients if the visit may take longer or the physician is not reimbursed for the extra time required to see the patient.^{22,41} Our study suggests that most physicians understand this obligation. Other research supports this finding: Only 3.2 percent of practices in a study involving sixty-three practices refused to see patients with disability because of access barriers.⁴² Physicians' appreciation of their obligation to see patients with disability may reflect more their sense of professionalism than their understanding of the law.⁴³

Patients Cannot Be Charged For Accommodation Costs

Charging a patient for accommodations is prohibited under the ADA, and all participants expressed this belief—although with varying levels of certainty. A clinical practice is required to cover the costs of accommodations, such as an auxiliary aid for a patient who is deaf or hard of hearing, unless the cost would impose an “undue hardship” for the clinical practice. In that case, the practice would have to find another way of delivering high-quality care to the patient.⁴⁴

Despite a common understanding that refusing a patient would be wrong and that practices should not impose accommodation costs upon patients, physicians voiced concern and frustration with the challenges of accommodating patients with disability, the additional time required to see these patients, and the lack of financial compensation for that additional time.

Patients Cannot Be Required To Arrange Their Accommodations

One physician suggested that people requiring a sign language interpreter bring someone who can fill that role to clinical appointments. However, this might not ensure the effective communication the ADA requires. ADA mandates place the responsibility for providing effective communication on the clinician, who cannot require a patient to bring someone to interpret for them.^{25,45} Furthermore, this approach might also compromise patient confidentiality as required under provisions of the Health Insurance Portability and Accountability Act (HIPAA) of 1996. Other research suggests that some physicians expect patients to bring someone to transfer them onto exam tables.⁴⁶ That is also prohibited under the ADA and similarly could breach HIPAA protections.²²

Medical Care Must Be Provided In Integrated Settings

One physician recommended creating separate facilities that would specialize in caring for people with disability. Both Title II and Title III require that services be provided in the most integrated setting appropriate to the needs of the individual, not in a separate facility.^{23,32} Instead of creating specialized providers for people with disability, clinical practices should

adopt universal design principles—which would ensure accessibility for all who use the space, including patients, family members, staff, and others.⁴⁷

Medical Services Must Be Accessible Regardless Of Patient Volume

Some physicians claimed that their practice does not have enough patients with disability to justify investment in the accessibility of their practice. This reason is not acceptable under the ADA. The requirement for accessibility is not based on numbers of patients with disability that practices serve, and practices should consider accessibility as a non-negotiable overhead cost of running a business. Though accessible medical equipment may be expensive, some clinical practices may be eligible for federal tax credits to offset the costs of acquiring such equipment.⁴⁸ Previous research has demonstrated that most clinical practices are not aware of this potential support.⁴⁹

Future Directions

Numerous factors likely explain the health care disparities experienced by people with disability. Research indicates that in some instances, inaccessible care and failure to accommodate disability contribute to these disparities.² Our findings suggest that physicians have little formal training in legal requirements to provide equitable care to people with disability. Thus, perhaps not surprisingly, our results also suggest that practicing physicians might not fully understand their legal responsibilities when caring for people with disability. Physicians may also be unaware of approaches to accommodating patients with different disability types. Therefore, one critical future direction involves educating physicians on several levels—about disability disparities, their legal obligation to provide equitable care and reasonable accommodations, and approaches to accommodating disability.

However, whether formal training in legal obligations under disability civil rights laws would improve accessibility is unclear. For instance, we are unaware of research showing that civil rights training reduces racial and ethnic health care disparities. Nonetheless, because of accommodation requirements, the considerations that must be addressed to ensure equitable care for people with disability differ in important ways from those that pertain to members of racial or ethnic minority groups. Future research should investigate whether incorporating civil rights and legal training into undergraduate and continuing medical education is a productive approach toward raising physicians' awareness and ultimately improving care. Research on health care disparities affecting racial/ethnic minority, rural, and low-income populations suggests that multilevel interventions that encourage collaboration among health care systems, providers, community organizations, and patients may precipitate effective changes.⁵⁰

Finally, physicians may be unaware of their performance relating to their patients with disability because they are not required to gather data on this population. Although meant for federal survey use, data collection standards for identifying disability—developed as stipulated by Section 4302 of the Affordable Care Act⁵¹—could prove useful for this purpose in health care settings. Future efforts to improve practice-level knowledge about the health care experiences of patients with disability should be investigated.

Used in combination, these strategies could help inform targeted initiatives to provide equitable health care services to people with disability.

Supplementary Material

Refer to Web version on PubMed Central for supplementary material.

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Exhibit 1**Selected interview questions with answers consistent with the Americans with Disabilities Act**

Question	Answer
When a patient with disability needs accommodations to see a doctor, who makes those accommodation decisions?	A clinical practice should engage a patient in an interactive process to decide what would constitute a reasonable accommodation. The patient's needs should be prioritized, but the clinical practice can assert that the accommodation would pose an "undue burden." In the case of an "undue burden," the program or service would have to be provided in another way with the same quality of care. ^a
Can practices refuse to see patients with specific types of disability, and if so, under what circumstances?	Practices cannot refuse a patient with a disability because of the extra time and resources required for accommodation. If staff does not want to accommodate a patient because they fear injury, such as from transferring patients without assistive devices, the patient still cannot be refused. Staff should be protected from injury, but equal access to medical care for patients with disability must be ensured. ^b
Can practices charge patients for costs of accommodations?	A clinical practice cannot charge a patient for cost of accommodation and should treat such cost as part of the overhead expenses of running a business. The clinical practice is responsible for this as long as it does not impose an "undue burden" or fundamentally alter the quality of services provided. If cost imposes an "undue burden," the program or services must be provided in another way with the same quality of care. ^{a,b}

Source Authors' interview protocol.

Note The answers were developed by the authors based on the items in the exhibit footnotes.

^aEligibility Criteria (see note 41 in text).

^bDepartment of Health and Human Services, Americans with Disabilities Act (see note 22 in text).

Exhibit 2

Characteristics of physicians interviewed for the study on practices' legal obligations regarding patients with disability

Characteristic	Number ^a
Mean age (years)	53.5 ^b
Age range (years)	38–76
Sex	
Male	10
Female	10
Race	
White	18
Nonwhite	2
Hispanic ethnicity	1
Specialty	
General internal medicine	7
Family practice	1
Rheumatology	2
Neurology	6
Obstetrics/gynecology	2
Orthopedics	2
Mean time in practice (years)	27.4 ^c
Completed medical school before passage of the ADA	11
Type of practice	
Hospital based	16
Private, not hospital based	4

Source Authors' data.

Notes There were twenty interviewees. ADA is the Americans with Disabilities Act of 1990.

^aUnless otherwise specified.

^bStandard deviation (SD): 11.7 years.

^cSD: 12.5 years.

Exhibit 3

Physicians' comments about their disability rights training

Physician specialty	Trained pre or post ADA	Years in practice	Quotation
General internal medicine	Post	19	"Well, I don't think—I'm really organized during residency. Obviously, we had some. But not really. I don't think so."
General internal medicine	Pre	23	"No.... That's why I was—and that is exactly why, I think, I don't know what the definition is."
General internal medicine	Pre	34	"Not that I can recall."
General internal medicine	Pre	40	"What I know about it is only what I've read. So I've never been trained.... Well, I think most of what I know is because I've spent so much time with the disability process, OK? So it's probably not—it's learning through that the kinds of things that people are struggling with.... And we do a lot of home visits. And in doing the home visits is when I learned a lot about the struggles when you're disabled.... And then I started to pay attention what the ADA actually was saying you're supposed to have. And I realized how few places really have it."
General internal medicine	Post	25	"Oh golly. I have no idea. I'm sure I had to read or study something sometime. I've been doing this a long time. I've been a doctor for quite a while, so I suspect I had to learn it somewhere, but I don't remember where."
Rheumatology	Post	14	"I think just from my pediatric rheumatology training but nothing that's really specific for disability—no."
Rheumatology	Pre	35	"Not formally.... No, not much. There may be a module that we have to do (I'm trying to remember) that covers some of that. But I wouldn't say it's—it's either minimal or none."
Family practice	Post	8	"Oh, I most certainly have, and I hope you don't test me on them.... Oh, I have in medical school. I just don't—like, it was the second—no, the third year [we had a] couple modules, and I don't remember everything about it."
Neurology	Pre	43	"Not in the recent ten years that I can think of. No. We did have a lecture at one point on accommodation assesses.... From that perspective, I have, yes."
Neurology	Post	12	"I did in fellowship. That was six years ago.... I mean, it was really basically about if you're trying to distinguish between does someone qualify or do you treat them for payment or for—if you're going to submit paperwork, when do things count as a disability?... I'm at a loss for the word that they'd always try and compare it to."
Neurology	Pre	41	"I can't say that I actually have."
Neurology	Post	11	"Oh, I would say absolutely not."
Neurology	Pre	51	"Zero."
Obstetrics/gynecology	Pre	29	"I can't answer that question. I don't think so.... Yeah, I mean, I'm sure that being an employee of the hospital, I've probably done my mandatory yearlies, and there's been some blubs on that we don't discriminate against people. But I've never had any formal, sit-down. 'This is the best way to take care of folks! American College of OB/GYN [American College of Obstetricians and Gynecologists] does a nice job of periodically updating their care of the person with disabilities committee opinion, but it's pretty light. You know it doesn't really get into...the nuts and bolts or mechanics of actually how you do what they suggest doing."
Orthopedics	Pre	31	"Yeah. I think we have. I think we have—part of our annual health stream stuff has to do with disability.... I think that we do get a little bit of training though the residents get that too now."

Source Authors' analysis.

Notes Participants were asked: "What training have you had about responsibilities of health care providers under ADA?" "Trained" means that postgraduate medical education was completed. ADA is the Americans with Disabilities Act of 1990.