VISUAL DISABILITIES: AN ANALYSIS UNDER THE VARIOUS DISABILITY LAWS

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Chapter Overview

The Americans with Disabilities Act (ADA), signed by George H. W. Bush in 1990, changed the landscape for individuals with disabilities significantly. Its ramifications can be seen in the ramps, curb cuts, and handicapped parking spots outside almost every public building in the United States. However, most eye care practitioners do not realize that the definition of visual disability under the ADA was almost completely changed, and that under the new Americans with Disabilities Act Amendments Act (ADAAA), signed by the younger Bush in September 2008, this new definition is an even greater departure from the old Social Security/AMA definition (SSA). This chapter will outline the major components of the ADAAA, as well as the Individuals with Disabilities in Education Act (IDEA) and Section 504 of the Rehabilitation Act (§504), and how those laws differ significantly from the SSA. Implications of the law for the optometric practice and optometric patients will be illustrated with some brief summaries of important case law. The visual conditions that can cause disability under those new laws are also discussed, with specific case examples.

Objectives

After completion of this chapter, the reader should be able to:

1. Explain the major components of the SSA, ADAAA, §504, and IDEA.
2. Review the major court cases that further defined the ADA, the predecessor to the ADAAA.
3. Evaluate ocular components and visual function for visual impairments in ways that are relevant to each of these laws.
4. Explain the difference between impairment and disability.
5. Report on visual impairments and disabilities in ways that will assist patients in obtaining benefits, equal access, and optimal quality of life.

Public Health Principles in Disability Evaluation

Laws designed to benefit individuals within a population can be roughly divided into two categories: entitlement law and civil rights law. An **entitlement** law grants some type of compensation to those individuals who have been deemed disadvantaged in some way. The major example of an entitlement law in the United States for the last 80 years has been the Social Security Act. If a person retires or loses a certain percentage of his physical abilities, as calculated by a formula, then that person is entitled to compensation from the federal government through Social Security payments or income tax credits.

In contrast, a **civil rights** law does not entitle an individual to compensation. Civil rights laws are still designed to help people who are deemed as

disadvantaged, but with two distinct differences. These laws are designed to protect entire classes of people, rather than individuals, and they are designed to grant equal access to the rights and privileges that people who are not in those classes routinely enjoy. The Civil Rights Act of 1964 is the most well-known example of this type of law.

The Americans with Disabilities Act (now the ADAAA) is often misinterpreted as an entitlement law, but it is, in fact, a civil rights law. No one is entitled to compensation from the federal government under the ADAAA. However, it is an important law from a public health perspective because it gives people with disabling health conditions, whether physical, sensory, or mental, equal access to employment opportunities with any employer (Title I), state and local government services and facilities (Title II), and the services and facilities of non-profit organizations and for-profit corporations (Title III) within the United States.

Current Disability Laws in the United States

The Social Security Act (SSA)

This entitlement law, signed by Franklin D. Roosevelt in 1935, was designed as a "safety net" to financially protect Americans who had retired or who had severe disabilities. The disability sections of the law are well-known and quite formulaic. The definition of disability in this law is geared toward the individual's ability to become gainfully employed. Visual disability is only described as "blindness" in this law, and the law specifically and exclusively names visual acuity loss as the definitive characteristic of blindness. Visual field is included in the definition of blindness, but only in the sense that "[a]n eye which is accompanied by a limitation in the fields of vision such that the widest diameter of the visual field subtends an angle no greater than 20 degrees *shall be considered for purposes of this paragraph* as having a central visual acuity of 20/ 200 or less. (emphasis mine)"[i] Therefore, loss of visual acuity means visual disability, and the only visual disability is blindness.

This "blindness provision" of the Social Security Act allows an individual who has been determined to be blind a significant deduction in reportable income for tax purposes. If the individual is not employed, the provision allows for financial benefits to be paid monthly.

Until March 2007, the determination of blindness could not be made by optometrists, but only by "a physician skilled in the diseases of the eye." This provision in the law created the absurd situation in which, by some interpretations, doctors of internal medicine could declare a patient blind but an optometrist could not. It is entirely possible that this provision prevented many visually-disabled people from receiving proper low vision care, which optometrists are uniquely trained to provide. However, now the law has been amended to specifically include optometrists as professionals who can make the determination of disability.[ii]

Section 504 of the Rehabilitation Act (§504)

This Rehabilitation Act, signed by Richard Nixon in 1973, was the next step by the United States government in addressing the needs of individuals with disabilities. Its purpose was to "empower individuals with disabilities to maximize employment, economic self-sufficiency, independence, and inclusion and integration into society...[and] to ensure that the Federal Government plays a leadership role in promoting the employment of individuals with disabilities..., and in assisting States and providers of services in fulfilling the aspirations of such individuals with disabilities for meaningful and gainful employment and independent living."[iii] As such, it is largely a civil rights law. The law provides for vocational rehabilitation services, research, independent living services, and employment opportunities. It also created a National Council on Disability, appointed by the President, to promote these services and opportunities.

Title V of the Rehabilitation Act is the portion of the law that deals with rights of and advocacy for disabled individuals. It is under this title that §504 is contained. This section provides for "Nondiscrimination under Federal Grants and Programs." Because almost all educational systems in the United States, and certainly all K-12 public education, receive federal aid, all schools are subject to §504 regulations. Higher education institutions are also specifically listed as agencies subject to Rehabilitation Act regulation. It is important to realize that §504 is an unfunded mandate, and although they must comply, many school districts, because of budget constraints, will often need to find other ways to provide needed services for disabled children.

The nature of this law is such that it applies mostly to those students with physical or emotional challenges, but it can also apply to those with learning disabilities or attention deficit/hyperactivity disorder (ADHD). The physical disabilities covered under this law include vision impairments. Sometimes, the Committee on Special Education addresses children who fall under §504 and those who have been identified as learning disabled, but in other jurisdictions the children who qualify for §504 resources are covered by the counseling office or some other office within the school or district and only children covered by the IDEA fall under the Committee on Special Education. It is important for the optometrist to know which structure is used at neighboring school districts, because it will facilitate better communication regarding school-age patients who have visual impairments or dysfunctions.

CLINICAL PEARL: ***Before sending a visual evaluation report on a student with a visual impairment to a school district, it may be beneficial to find out if the most appropriate recipient is the counseling office or the Committee on Special Education.***

Individuals with Disabilities Education Act (IDEA)

This is an entitlement law, its latest permutation (the Individuals with Disabilities Education Improvement Act) signed by George W. Bush in 2004. In its first

permutation, as PL94-142, this law created Committees for Special Education and other school and school district-based initiatives to help in the education of learning disabled students.

The intent of the IDEA is to ensure educational services to children with disabilities throughout the nation. The IDEA has four parts.[iv] Part A includes the legislative details and provisions of the Act. Part B deals with children and young adults from ages three to twenty-one years. Part C deals with children younger than three who are identified as being "at risk." Part D gives support for grants and other initiatives to improve the education of disabled children nationally.

The presence of a disability under the IDEA is determined by a team that includes the individual's parents, his "regular teacher," and an evaluator. The Department of Education website on the IDEA specifically identifies school psychologists, speech/language pathologists, or remedial reading teachers as the professionals that might qualify as evaluators. This team has two general criteria that they may use to determine disability, summarized as:

- There is a significant difference between the child's achievement and her grade level or chronological age (the discrepancy definition); or,
- The child does not make significant progress over the course of one or two years; or,
- The child exhibits a pattern of strengths and weaknesses relative to his age.

These last two definitions of disability are a significant departure from the older versions of the law, and are the result of increasing criticism of the discrepancy definition by educational professionals and child advocates alike. The major criticism of the discrepancy definition is that a child who is not achieving under the normal system of education has to remain in that system, not achieving, for up to two years before she qualifies for services under that model. The two new aspects of the definition allow for a child to be defined as learning disabled based on results of testing at one moment in time.

Because of the definition of disability under the IDEA, this law deals with children who are classically learning disabled, that is, children who have normal or above-normal intellect but are not achieving as well as expected at school. Children with broad cognitive challenges or developmental disorders typically fall under §504, although if they are not achieving academically, they also fall under the IDEA.

ADA Amendments Act (ADAAA)

George H.W. Bush first signed this civil rights law in 1990, and the Amendments Act was passed nearly unanimously by the House and Senate and signed by George W. Bush in 2008. This law has three sections, or titles. **Title I** covers employers of every sort, with the notable and specifically cited exceptions of those employers with fewer than 15 employees, the United States government, and "bona fide private membership club[s]."[v] **Title II** covers access to services of facilities of state and local governments, including public transportation, and Amtrak. It implicitly does not cover the Federal government's services or

facilities, other than Amtrak. **Title III** covers public access to services and facilities of privately-held corporations with 15 or more employees and non-profit organizations. As such, the ADAAA is first and foremost and employment law, and most of the intent of the new law was to close off loopholes being used by the nation's largest employers to skirt the law.

The definition of a disability under the ADAAA has far more in common with that of §504 than it does with the SSA. The definition has three fundamental aspects:

- "A physical or mental impairment that substantially limits one or more major life activities...
- "a record of such impairment; or
- "being regarded as having such and impairment...."

This is the same language as the original ADA of 1990. It largely left it to the courts to decide the meaning of the two major descriptors in the definition: *substantially limits* and *major life activities*. The issues raised by these two descriptors were so contentious that the major cases that came before the Supreme Court on the ADA hinged on them. The Supreme Court's decisions with regard to those two descriptors were so offensive to many of the disabled, and to members of Congress, that Congress saw fit to amend the ADA in 2008 to "clarify" the intent of the law.[vi] The new law, as amended, attempted to further clarify the two descriptors. In the ADAAA, **major life activities** are defined as including, "but are not limited to, caring for oneself, performing manual tasks, seeing, hearing, eating, sleeping, walking, standing, lifting, bending, speaking, breathing, learning reading concentrating, thinking, communicating, and working." It also includes "major bodily functions..., including but not limited to functions of the immune system, normal cell growth, digestive, bowel bladder, neurological, brain, respiratory, circulatory, endocrine, and reproductive functions."

The ADAAA also attempts to define the term **substantially limits**. It specifies that only one "major life activity" needs to be substantially limited for the individual to be disabled. Additionally, the effects of mitigating measures, such as medications or "learned behaviors," should not be considered when determining whether an individual is substantially limited, with the specific exception of glasses or contact lenses, but only those glasses or contact lenses that are used "to fully correct visual acuity or eliminate refractive error." Low vision devices are specifically cited as mitigating measures that should *not* be considered in determining if an individual is substantially limited by a disabling condition.

KEY CONCEPT: ***Under the ADA Amendments Act, an individual's ability to "self-accommodate" or to use mitigating factors should not be used in the analysis of whether or not that individual is considered disabled, although the Supreme Court had done just that in a series of cases in the late 1990's.***

The long list of activities that are now considered to be "major life activities" effectively will make the only contentious issue the definition of what is meant by "substantially limits," which the new law has still left surprisingly vague, especially

given Congress's obvious distaste for the *Toyota* decision[vii] (see below), cited several times in the new law under the "Findings" and "Purposes" sections, which concluded that working in one particular job could not be considered a major life activity. However, Congress has asked the Equal Employment Opportunity Commission (EEOC) to present suggested guidelines for employers on a more clear definition of "substantially limited," which the EEOC is expected to do sometime in the fall of 2009.

Title III covers the access to almost every optometrist practicing today, unless that optometrist is working directly for an employer and exclusively seeing the employees of that same employer. Therefore, practitioners need to be aware of the provisions of this law. The process for accommodating a disabled individual in your practice is not straight-forward, but it does involve three distinct steps and one caveat:

1. *The individual must make you aware of his or her disability and request accommodation*. This step is the **sine qua non** of the entire process. If you are not informed beforehand that the patient is disabled, you cannot be held responsible for any diminished access that patient may later claim.
2. *You must review the requested accommodation and determine if it is appropriate and reasonable.* The **appropriateness** of the requested accommodation is key. For example, many hearing-disabled patients request that an American Sign Language (ASL) interpreter accompany them to every doctor appointment. However, this may not be appropriate for a visual examination in a darkened room with the patient's head in an instrument through most of the examination. Caution should be used in making this determination, however. Almost every time the question has gone to court, the jury has given deference to the patient's viewpoint on the adequacy of the accommodation. When in doubt, one should probably err on the side of providing the requested accommodation. If it turns out that it was as ineffective as you had originally thought, you should then be able to come to a mutual understanding with your disabled patient on accommodations during future visits.
3. *Do not assume that determining if an accommodation is "reasonable" has anything to do with the **cost** of that accommodation.* Hearing-impaired patients have successfully sued doctors who did not provide what the patients considered a **reasonable** accommodation of ASL interpreters despite the fact that the cost of the interpreter was three times the reimbursement for the examination. The lawsuits often award the plaintiffs hundreds of thousands of dollars, and your income tax returns will be part of the discovery documents.
4. *Work with the patient during the visit to assure that the quality of care, from the patient's perspective, is at least equivalent to that a non-disabled individual would receive.* Do not be afraid to discuss this with the patient, and document everything. This is the key aspect in your compliance with the law. If you can demonstrate that the patient received care that was of at least the same quality as that offered to non-disabled patients, and that the

patient felt that that standard was met, you will have met the spirit and the letter of the law.

Important Cases to the Analysis of Visual Disability

Sutton v. UAL

This case is of particular interest to optometrists because it involves myopic twin sisters who were pilots for a local carrier of United Airlines and wanted to be promoted to flying transcontinental jets for UAL. However, one of UAL's requirements for that duty was uncorrected visual acuity of 20/100 or better. Because the sisters' myopia decreased their uncorrected visual acuity to worse that 20/100, they did not qualify to fly commercial jets, under UAL's requirements. The Supreme Court, in a 7-2 decision written by Sandra Day O'Connor, determined that myopia was not a disability because if the necessity of wearing refractive correction inferred disability, far more than 43 million Americans that Congress had described in the preamble to the ADA would be disabled. Further, UAL did not consider the sisters to be disabled, only that they did not meet the visual acuity requirement of that particular job.

This case became an anathema to disability rights advocates because the court seemed to be saying that you could be impaired enough to not be able to meet job requirements but not impaired enough to be disabled under the law. This case was one of three major cases — *Sutton* and *Albertsons* (see below) before the Supreme Court and *Bartlett* before the US Court of Appeals — that dealt with the question of "mitigating factors" in the determination of disability. In the *Sutton* case, the mitigating factor is, obviously, glasses or contact lenses, which would, when prescribed and worn correctly, almost completely mitigate the effects of the impairment. Therefore, the question is: If a factor completely mitigates the impairment caused by a condition, is that condition still disabling? Every time this question has come before the Supreme Court, its answer has been no. The Court opined that, because Congress used the present indicative verb form, their intent was that an individual had to be substantially limited under normal, everyday circumstances, and if those circumstances included the incorporation of mitigating factors, such as eyeglasses, than that was the state under which impairment had to be measured. In other words, the Sutton twins were not disabled because, under normal circumstances, they wore contact lenses for their myopia and, under those circumstances, their visual acuity was normal. Thus, they were not disabled under the definition set forth by the ADA.

The Court went on to write that Congress must have considered functioning under normal, everyday circumstances because they did not write in the law that someone be considered disabled if she "'might,' 'could,' or 'would' be substantially limit[ed]" if mitigating factors were taken away. O'Connor here argued that the only way to make a "individualized inquiry" of disability, as required in both the Equal Employment Opportunity Commission (EEOC) and Department of Justice's (DoJ) compliance guidelines, was to take into account the mitigating factors used by each individual.

Albertsons v. Kirkenburg

This case is also of particular interest to optometrists because it involved another visual condition, this time amblyopia. And again, the case hinged on mitigating factors, but in this case they were intrinsic. Kirkenburg was employed as a truck driver for the grocery chain, Albertsons, after the doctor who gave him a physical missed his left eye amblyopia and erroneously documented him as having passed the Department of Transportation (DoT) standards of 20/40 best corrected visual acuity in each eye. When his visual acuity was correctly determined as 20/200 at his physical two years later, the doctor told him he could get a waiver of the DoT standard and still drive. However, Albertsons fired him for failing to meet the physical standards of the DoT. He sued to get his job back, claiming that he was visually disabled but otherwise qualified to do his job, and therefore was being illegally discriminated against under the ADA.

The Supreme Court unanimously found that, since Kirkenburg was able to function without significant impairment because his brain had adapted to the amblyopia in the left eye, he was not disabled. Like in *Sutton*, the decision in this case hinged on mitigating factors. However, in *Sutton*, the mitigating factor was contact lenses or eyeglasses. In *Albertsons*, the mitigation came from the patient's own ability to adapt to his situation.

Although the *Albertsons* decision was unanimous, this analysis of the definition of "significantly restricted" that incorporated the individual's own cognitive or subconscious adaptation to an impairment, often termed "self-accommodation" by disability rights advocates, as a mitigating factor was one of the driving forces behind Congress's decision to revisit the ADA in 2008.

Toyota Motor Manufacturing, Kentucky, Inc. v. Williams

Williams was a worker on the assembly line at a Toyota plant in Kentucky. She developed carpal tunnel syndrome, which made it very difficult to hold implements above her shoulder level or any objects heavier than ten pounds for any extended period of time. She therefore asked her employer to accommodate her disability, which they did, but not to Williams satisfaction. After a workers' compensation claim that was settled and an ADA claim, that was also settled, Williams returned to work on a quality control team. After a few years, part of the job requirement for the quality control team involved wiping down about a car a minute with oil to aid in the paint inspection process. The plaintiff and defendant versions of what happened next diverge. Williams either asked for her prior accommodations and Toyota refused, or she simply began a long period of absenteeism. Whatever the case, she was terminated from her job and sued for discrimination under the ADA.

The Supreme Court, in another decision written by O'Connor, ruled for Toyota. They found that Williams was not "substantially limited" because her impairment did not "prevent or severely restrict the individual from doing activities that are of central importance to most people's daily lives. The impairment's impact must also be permanent or long-term." One aspect of the *Toyota* decision that was cited several times in the new Amendments Act as particularly galling to Congress was that the impairment was not disabling if it only affected the

individual's activities at work. If the person can attend to matters of hygiene and household chores, then the impairment does not affect "the types of manual tasks of central importance to people's daily lives...." Therefore, by the Court's analysis under *Toyota,* these impairments should not be considered as disabling under the ADA.

Gonzales v. NBME and *Bartlett v. New York State Board of Law Examiners*

Both these cases before the Supreme Court determined that the aspect of the ADA definition of disability about "substantially limit[ations]" has to be considered on a individual basis, and that the consideration must include any mitigating factors normally used by the individual. However, these cases did not really address the question of the cohort against whom to compare the individual when you are determining if she is substantially limited. The *Gonzales* and *Bartlett* cases attempted to address this question. The Supreme Court refused to hear either case, although the two cases had polar opposite decisions on that question. These cases were both critical to the crafting of the new ADA law in 2008.

In the Gonzales case, a medical student claimed that he was learning disabled and requested the accommodation of extended time on the United States Medical Licensing Examination Step 1, which he needed to pass in order to proceed to his third year of medical school at the University of Michigan. He based his claim on testing he had received four years prior, while he was an undergraduate student at the University of California at Davis. That testing found that he was learning disabled, despite the fact that he had scored at least at the average level on every aspect of the psycho-educational battery. However, because his performance was not at a uniform level, the psychologist determined that he was learning disabled based on the discrepancies between the superior areas of his performance and those that were merely average. Because Gonzales had tested at least at the average level in all areas, the National Board of Medical Examiners (NBME) denied his request for accommodations. He took the Step 1 examination without accommodation and failed. By this time, he had begun his first third-year clinical rotation, so he took a leave of absence to prepare for re-taking the Step 1 exam, and he underwent a second battery of psycho-educational testing. His psychologist at the University of Michigan also diagnosed a learning disability, again based on variability of scores, none of which were below average. The NBME again denied his request for extended time because they determined that he had not proven a substantial limitation, Gonzales again took the Step 1 exam without accommodation, and he again failed.

At this point, Gonzales sued the NBME for injunctive relief. This was denied, he took the exam again, and failed a third time. He appealed the court's decision to the Sixth Circuit. In that 2-1 opinion, the Court of Appeals found that the NBME was correct in comparing Gonzales's functioning to that of the general population when determining if he was substantially limited. He had argued that he should be compared to his colleagues in medical school, but the court did not find that argument compelling in light of the "Findings and Purpose" section of the original

ADA. In that section, Congress wrote that the disabled "occupy an inferior status in our society and are severely disadvantaged...educationally." Gonzales had taken advanced placement courses in high school, had graduated with a 4.3/5.0 GPA, and had an average score on the SAT, and had a high enough score on his second attempt at the MCAT to make it into the University of Michigan Medical School, all without any accommodation. The court found that these academic successes precluded any claim to substantial limitation in comparison to the general population.

However, in a very similar case, Bartlett sued the New York State Bar Examiners for extended time to accommodate her diagnosed learning disability. In her case, she had already successfully completed a MBA and her law degree but was having difficulty passing the NY State Bar Exam so applied for extended time. The NY State Bar, on the recommendation of their learning disability consultant, denied accommodations. The judge in that case ruled that Bartlett was, indeed, entitled to accommodations since she had only made it through her extensive academic career due to self-accommodation, and those self-accommodations should not have been considered in determining whether or not she was substantially limited. The judge in that case also held that Bartlett's level of functioning should have been compared to others "with similar training, knowledge, skills, and abilities." This is a clear contrast with the *Gonzales* decision. Although, to date, almost every court has used the *Gonzales* and *Sutton* cases as the precedent to be followed, the House of Representatives version of ADAAA bill specifically cited the *Bartlett* decision as one that more accurately captures the spirit the law intended. The final law, after House and Senate conference editing, does not cite *Bartlett.*

James Paul Doherty v. Southern College of Optometry (1989)

This case is of interest to optometrists mostly because it involved a college of optometry. However, it also happens to be the classic illustration of "academic deference." That is, if an academic program determines that a condition cannot be accommodated without significantly altering the program so that the disabled individual could not be considered to be "otherwise qualified," and the institution followed policy at every step in the determination, then it is within the rights of that institution to deny accommodation to that individual.

Doherty applied to Southern College of Optometry (SCO), disclosing that he had retinitis pigmentosa, but not disclosing other neurological impairments, and his application was unsuccessful two years in a row. At the recommendation of the Tennessee Department of Human Services, he underwent visual evaluations from three members of the faculty of SCO who determined at the time that Doherty's condition was stable and that his "motivation" should allow him to overcome his visual impairment, and that he should be able to complete the program. Partly on the evidence of this evaluation, Doherty was admitted to SCO on his third application. He also underwent a neurological evaluation from an internist, who was of the opinion that it would be "most difficult" for Doherty to function as an optometrist. This report was not disclosed to SCO.

He then completed three years of the optometry degree program at SCO and had entered the fourth and last year of optometry school. At this same time, the laws governing optometrists in Tennessee had changed so that they could now use pharmaceuticals for diagnostic purposes. As a result, SCO changed its curriculum to require a clinical proficiency examination before beginning the fourth year of the program. Doherty did not have a successful outcome on this clinical proficiency exam because he could not complete gonioscopy in a manner that was safe for the patient. Doherty then requested a waiver of the proficiency examination requirement, which was denied by the committee that reviewed those requests, and was subsequently denied by SCO's Board of Trustees. However, they did allow him to practice the techniques he had not successfully completed in the proficiency for one academic term in preparation to retake the proficiency. He practiced diligently, under another faculty member's guidance, but still failed the retake examination. He was then sued SCO claiming breach of contract and discrimination under §504.

A jury awarded Doherty relief under breach of contract but not under §504. Both parties then appealed the jury decision and the Tennessee Court of Appeals found for SCO, giving deference to the academic decisions made by an academic institution. The case then when to the Sixth Circuit of the United States Court of Appeals, where the panel also found for SCO because "the clinical proficiency requirements are a necessary part of the curriculum and [Doherty] has admitted that he is unable to meet these requirements." The panel found that SCO should be given deference in deciding what are and are not necessary requirements for its curriculum.

The major emphasis and value of the Doherty decision was the panel's findings on the use of the phrase "otherwise qualified." If a task or course requirement is "reasonably necessary to [the] proper use of the degree conferred at the end of a course of study," then no waiver of that task or course requirement could be considered an accommodation, and the individual could not be considered "otherwise qualified" without accomplishing that requirement.

The breach of contract part of the suit was also found in SCO's favor because the court found that an opinion of individuals cannot be held as a fact or a contract.

Analysis of Visual Impairments under Disability Law

The new ADAAA has not yet gone through the series of cases that will help determine what information organizations will look for in evaluations of individuals claiming visual disability. However, it is clear that the ADAAA encompasses all visual conditions that could substantially limit an individual's ability to read, write, or perform any of the other activities listed in the Act. This would include visual conditions not traditionally considered as disabilities under the old Social Security analysis. Evaluators have successfully claimed that visual conditions such as convergence disorders, accommodative dysfunctions, and saccadic dysfunction are disabling under the ADA, and one could certainly assume that under the more flexible standards of the ADAAA these conditions would be considered disabling as well.

KEY CONCEPT: ***Any visual condition that would substantially limit a patient's ability to perform an activity at the same level as a non-impaired peer could be considered disabling under the ADAAA.***

Therefore, it is paramount in the evaluation of your patients, especially those that routinely perform near point visual activities such as reading or using a computer, that you thoroughly evaluate those patients' abilities to accommodate and converge. This assessment of near point visual functioning should include some survey for symptoms of visual disorders, such as the CITT (Convergence Insufficiency Treatment Trial) Symptoms Survey or the COVD (College of Optometrists in Vision Development) Quality of Life checklist. It should also include well-standardized tests such as MEM or Nott retinoscopy, near prism vergences, NRA and PRA, accommodative amplitudes, and, if loss of place is a complaint, the Developmental Eye Movement test or some type of eye movement recording system, such as the ReadAlyzer or Visagraph. Tests that are not as well-standardized or have dubious validity, such as the fused cross-cylinder evaluation of a pre-presbyopic patient, the Keystone Visual Skills, or the VO Star, may have diagnostic value but should only be used in disability analysis when better alternatives are not possible or available.

Deficits in visual information processing (VIP) could also be considered disabling under the ADAAA. Again, the evaluation of VIP disorders should be performed using well-standardized tests that would stand up to rigorous scrutiny. Age norms are notoriously unreliable because they make no account for the standard deviation or standard error of measurement of the test instrument. Therefore, tests that only have age- or grade-normative scores should be used with the understanding that they may have good clinical value but will be of very little use to a testing organization's disability experts in making a determination of disability. Instead, test results that include age adjusted percentile ranks, z scores, or confidence intervals should be used.

Of course, the more traditional impairments of central visual acuity and visual field are still considered disabling under the newer laws. Once again, the documentation for acuity loss or loss of visual field should be assessed using well-standardized testing. Most testing instruments of visual field released within the last 10-15 years have acceptable psychometrics and standards. Visual acuity measured with modern optotypes should be assessed. The Early Treatment of Diabetic Retinopathy Study (ETDRS) protocol for visual acuity measurement is probably the gold standard for acuity measurement today, but what is more important is that if your patient is claiming a disability of distance vision, a distance visual acuity is acceptable. If, on the other hand, your patient is claiming a disability of near vision, a measurement of near visual acuity is a necessity.

CLINICAL PEARL: ***The most effective assessments of visual disability use tests that are well-standardized and offer scaled scores or standard scores for reporting, and a review of symptoms that would demonstrate substantial limitation on major life activities.***

Well-standardized tests are useful for determining disability because, by definition, the individual's visual functioning is being compared to an average for the same age group. This exactly complies to the definition of disability used for the IDEA, Section 504 of the Rehabilitation Act, and the ADA Amendments Act. Symptom surveys are useful because they help to demonstrate the effect of the impairment on your patient's major life activities, again in exact compliance with the definitions of the three major non-Social Security disability laws.

Effective Reporting of Visual Disabilities

Once you have performed a thorough analysis of your patient's visual functioning that is relevant to the disability claimed, the means by which you report that analysis is critical to allowing a fair assessment by the organization's disability services office of the nature of that disability and the most appropriate and reasonable ways to accommodate the disability. You should always bear in mind the role of the disability expert as you are drafting your report.

The key steps in any examination of a patient who is claiming or desires to claim a visual disability should be:

1. Arrive at a correct, defendable, ICD-9 or DSM-IV diagnosis;
2. Establish the functional limitations caused by this diagnosis;
3. Determine what accommodations would most directly address the specific disability created by the diagnosis by performing the analysis that follows.

KEY CONCEPT: ***An expert in visual disabilities must review the clinical data you provide to determine: a) if the individual's impairment is substantially limiting; b) how that disability would impact the individual's performance in the relevant setting; and, c) if the accommodation(s) requested would be both appropriate and reasonable.***

Keeping in mind the three steps used to determine the appropriate accommodation for a disability is critical to effective report writing. The successful report will contain elements that address at least the first two elements, and in some cases even the third. The report on the symptoms of the condition and the data from testing should address the first aspect by documenting that the condition has significantly reduced some area of the patient's visual functioning to below that of the average American, and that there is an impact on the patient's daily life. For the second and third elements, you will need to do a task analysis with the patient to determine the specific impact the visual impairment will have on performance in the relevant situation and what strategies or accommodations would be most effective.

The last thing to bear in mind is that the diagnosis is *not* the disability. This is especially important in those patients who had a condition that responded to some type of therapy. In many of those cases, especially in binocular vision or accommodative disorders, the diagnostic label may still be appropriate. However, the data will indicate that the patient is no longer impaired and therefore there is no further disability. The determination of disability must always be decided on the basis of the data and the impact of the condition on the patient's functioning.

KEY CONCEPT: *The diagnosis is* not *the disability. In other words, just because a patient has been diagnosed with a condition that creates some impairment does not mean that the condition is disabling for that patient.*

That said, if a patient does have a treatable but disabling condition, you cannot consider the patient's willingness to undergo therapy in your disability analysis. If a patient has a visual impairment and is offered a treatment plan that you have decided would be effective, but the patient decides not to undergo that treatment, you should not use that refusal against the patient in making a determination of disability. Once again, under the laws, the determination of disability must always be decided on the basis of the data and the impact of the condition on the patient's quality of life under current condition, not under optimal conditions or with mitigating factors or treatment that has not yet happened.

Also, the evaluator should be aware that a patient may have a condition that is disabling, and be considered as disabled under the ADAAA, but does not qualify for accommodations because her level of functioning does not require accommodations.

Disability determination is not difficult, but it does require rigor. It requires a dispassionate, logical, data-driven analysis of the patient's visual impairment and a dispassionate, logical, data-driven reporting of the evaluation and your opinion, based on your evaluation (not on your emotions), of how the impairment will be disabling during the relevant situation and what could be done to effectively and appropriately accommodate that visual disability.

Take Home Conclusions

1. ADA, ADAAA, and Section 504 of IDEA all expand the legal definition and implications of visual disability. Visual conditions that impair a patient's ability to function in school or at work that cannot be fully compensated with glasses or contact lenses may be considered disabling.

2. Legal Blindness is the only disability under the Social Security Act.

3. To determine visual disability, thorough evaluation with standardized nationally accepted tests and review of symptoms with standardized survey instruments are necessary.

4. Optometric offices are mandated to accommodate individuals with disabilities based on the individual notifying the offices in advance of their needs.

Study Questions

1. In *Gonzales v NBME* what was Gonzales claim for disability? Do you feel the Supreme Court was correct in its verdit?

2. Courts rarely dictate professional requirements and defer to a profession's peer review, such as for licensure, test rules, continuing education, accreditation, or professional privileges. Do you feel the court system's deference to SCO's policies was appropriate in the *Doherty* case?

3. List several standardized tests which would be appropriate for assessing potential impairment in the following conditions: amblyopia, convergence insufficiency, visual motor integration deficit.

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