Refusal to Treat in the COVID-19 Era

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In New York State, a health care professional is generally under no obligation to accept a patient unless they choose to do so. Once a professional relationship is established, however, a provider has a duty to treat the patient, and a refusal of care could lead to a charge of patient abandonment under professional misconduct laws, possibly civil damages if the patient is harmed by the refusal, or both. There is one important exception to this general rule: a provider in private practice cannot refuse to treat a patient for a discriminatory reason (i.e., on the basis of disability, race, gender, or any other legally protected classification). In *Cahill v. Rosa, 89 N.Y.2d 14 (1996)*, the New York Court of Appeals concluded that private dental practices were to be considered "places of public accommodation" within the meaning of the New York State Human Rights Law. Because their offices were considered to be places of public accommodation, the dentists were guilty of an unlawful discriminatory practice because they refused to treat patients who were known or suspected to be HIV positive.

The current COVID-19 pandemic raises the question, Can a private medical practice lawfully refuse to treat a COVID-19 patient? Is COVID-19 considered to be a protected classification? Federal and state nondiscrimination laws do not entirely answer this question. The Americans with Disabilities Act (ADA) prohibits discrimination on the basis of disability, which is defined as a physical or mental impairment that substantially limits one or more of a person's major life activities, a person with a record of such an impairment, or a person who is regarded as having such an impairment. A place of public accommodation cannot deny medical care to an individual because of his or her disability, unless the individual poses a direct threat or significant risk to the health and safety of others that cannot be eliminated by adequate precautions or reasonable modification of practices and procedures.

Recently, the US Department of Health and Human Services (HHS) Office for Civil Rights (OCR) and the Civil Rights Division of the Department of Justice issued guidance to health care providers on the question of patients suffering from "long COVID". The Centers for Disease Control and Prevention (CDC) states that individuals with long COVID have a range of new or ongoing symptoms that can last weeks or months after they are infected with the virus that can worsen with physical or mental activity. The guidance document states that these patients may have a legally protected disability if the person's condition or any of its symptoms presents a "physical or mental" impairment that "substantially limits" one or more major life activities. However, the guidance goes on to state:

> 3. Is long COVID always a disability?
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> No. An individualized assessment is necessary to determine whether a person's long COVID condition or any of its symptoms substantially limits a major life activity. The CDC and health experts are working to better understand long COVID.

This leaves the ultimate question unsettled. Patients with long COVID may or may not have a protected disability, depending on that patient's condition.

On the state level, New York State nondiscrimination laws have not included individuals who have COVID-19. On its "Coronavirus Discrimination" page, the New York State Division of Human Rights states:

> Public places . . . cannot deny you entry or access to goods or services based on a perception that your national origin, race, or disability indicates possible exposure to the coronavirus. . . . If you believe that you have been discriminated against because of a perceived connection between your race, national origin, or disability and the novel coronavirus, also known as COVID-19, you can file a complaint with the New York State Division of Human Rights.

New York stops short of proclaiming that having COVID-19 is a protected classification; rather, it states that it is unlawful to discriminate only if there is a "perceived connection" between an individual's race, national origin, or disability and COVID-19. By way of example, if a person of Asian descent is denied services due to an assumption that they were exposed to the coronavirus based upon their national origin, it would constitute a discriminatory practice under the New York State Human Rights Law.

In New York City, the rule is different: on its "COVID-19 & Public Accommodations Protections" page, the New York City Human Rights Law does consider COVID-19 to be a disability and prohibits harassment and discrimination on that basis.

> Based on current available information, the [NYC] Commission considers actual or perceived infection with COVID-19 to be protected as a disability under the New York City Human Rights Law (NYCHRL). A business must not discriminate against or harass customers because of actual or perceived infection with COVID-19, or based on an actual or perceived history of such infection. It is also illegal for a business to harass or discriminate against customers based on the presumption that they have contracted or are more likely to contract COVID-19 due to actual or perceived race, national origin, disability, or another protected status.

The bottom line is, a patient with COVID-19 may or may have a protected disability, depending on the patient's condition and the region where the medical practice is located. The law is still evolving in this area, and we may well see new pronouncements from state and federal authorities. In the meantime, since medical offices routinely employ robust personal protective equipment and cleaning procedures as universal precautions, it is likely that a practice could not justify a refusal of care on the basis that the patient poses a direct threat or significant risk to health and safety that cannot be reasonably accommodated. From a risk management perspective, a medical practice should not refuse care to COVID-19 patients, unless the patient presents with symptoms or a condition that is not within the provider's specialty or that the provider is not clinically competent to manage. In that case, an appropriate referral should be made. In those cases, the reasons why the patient was not treated should be fully documented in the medical record.

If you have any questions regarding the content of this article, please contact Fran Ciardullo, special counsel, at fciardullo@barclaydamon.com, or another member of Barclay Damon's Health Care & Human Services Practice Area.

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As special counsel at Barclay Damon LLP, Fran primarily concentrates her legal practice on health care and risk-management issues. She counsels physicians, physician groups, dentists, hospitals and health systems, nursing homes, and other providers on matters involving professional misconduct, professional liability, medical-staff issues, scope of practice, mandated reporting, peer review, and regulatory compliance. Fran also handles consent for treatment and surrogate decision making, patient care, EMTALA, and health-information privacy issues.

A former Town of Schroeppel town justice, Fran is also trained in alternative dispute resolution and has mediated and arbitrated a variety of civil actions and disputes. She routinely publishes industry articles and presents educational programs on legal matters to hospitals, medical and dental practices, and trade associations.