

clinical conditions in which antibacterial drug therapy has limited benefits.

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DOI: 10.1056/NEJMp1302726

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Discrimination at the Doctor's Office

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Doctors dedicate themselves to helping others. But how selective can they be in deciding whom to help? Recent years have seen some highly publicized examples of doctors who reject patients not because of time constraints or limited expertise but on far more questionable grounds, including the patient's sexual orientation, parents' unwillingness to vaccinate (in surveys, as many as 30% of pediatricians say they have asked families to leave their practice for this reason), and most recently, the patient's weight.

Sometimes these refusals are couched in terms of a physician's conscientious beliefs or appear to be attempts to encourage behavior the physician deems desirable. In other cases, the physician seeks to justify such actions using outwardly neutral terms. For example, the Massachusetts doctor who recently decided to reject all new patients weighing more than 200 lb claimed that she needed to protect her staff from injuries.¹ Similarly, 14% of obstetrics-gynecology practices polled by the *South Florida Sun-Sentinel* in 2011 said they have set weight limits for new patients, citing rea-

sons ranging from lack of specialized equipment to fear of malpractice suits over complications caused by obesity.

Despite the varied rationales, patients who are rejected are likely to feel discriminated against. Unlike physicians who refuse to provide a particular service across the board, so that no patient can argue that he or she has been treated differently from others, the physicians in these instances do treat certain patients differently because of their personal characteristics. Of course, physicians ought to tailor their behavior to patients' characteristics when doing so is medically relevant, but differential treatment based on negative moral judgments about patients should not be tolerated. Indeed, the American Medical Association's Ethical Rule 10.05 permits refusal of services that are beyond the physician's competence, not medically indicated, or "incompatible with the physician's personal, religious, or moral beliefs" but emphasizes that physicians "cannot refuse to care for patients based on race, gender, sexual orientation, gender identity, or any other

criteria that would constitute invidious discrimination."

Legal standards largely accord with this formulation, with some additional nuance. Although physicians owe substantial duties to their existing patients, including an obligation to avoid abandonment, initiation of a doctor-patient relationship is voluntary for both parties. There is, however, an important exception: physicians may refuse a prospective patient only for a reason that is not prohibited by contract or law. Local, state, and federal laws prohibit certain types of discrimination against patients. For example, many states prohibit places of "public accommodation," including doctors' offices and hospitals, from discriminating on the basis of characteristics such as race, color, national origin, nationality, ancestry, religion, creed, age, marital status, familial status, sex, sexual orientation, gender identity, medical condition, disability, or other personal features — although, beyond the baseline federal protections, the grounds that are included vary by jurisdiction. Title VI of the federal Civil Rights Act of

1964 prohibits discrimination on the basis of race, color, and national origin in programs and activities that receive federal financial assistance, including Medicaid and Medicare. The Rehabilitation Act of 1973 adds disability to that list, and the Americans with Disabilities Act of 1990 (ADA) prohibits discrimination against individuals with disabilities in any place of public accommodation, including health care providers' offices or hospitals, regardless of funding source.

Collectively, these laws prohibit many but not all grounds for discrimination against potential patients. Race, religion, sex, and disability are among the most uniformly protected categories, whereas less than half of states prohibit health care discrimination based on sexual orientation or gender identity, for example.² Moreover, the rejection of patients because they smoke, play contact sports, or engage in other risky behavior is legally within the realm of physician discretion, as is discrimination based on other characteristics not protected by law. Some bases for discrimination fall within a gray zone, however, and discrimination based on obesity raises some particularly challenging issues.

Perhaps one of the last comparatively socially acceptable bases for discrimination, weight has not traditionally been treated as a protected category under civil rights laws. There have, however, been increasing calls for weight-based discrimination to be directly prohibited, and it has been in several jurisdictions that ban various types of "personal appearance" discrimination (including Michigan; the District of Columbia; San Francisco and Santa

Cruz, California; Madison, Wisconsin; Urbana, Illinois; Binghamton, New York; and Howard County, Maryland). These laws tend to be seldom used, but another strategy is to address weight-based discrimination indirectly by prohibiting disability-based discrimination.³

The ADA defines disability as having "a physical or mental impairment that substantially limits one or more major life activities," having a record of such impairment, or being regarded as having such an impairment. In the past, obese persons have had little success convincing courts that they satisfy this definition, and in general, the few who have succeeded have been severely obese, able to establish that their obesity had a physiological cause, or both.^{3,4} In 2008, however, Congress amended the ADA to clarify its intention that disability be understood quite broadly. Moreover, the question of whether an impairment substantially limits a major life activity must now be determined without regard to the ameliorative effects of mitigating measures, which might include diet and exercise.

Against this background, it seems more likely that obesity could qualify as a disability under the law. However, the centrality of impairment to the ADA's protection against discrimination raises a critical issue regarding obese patients: patients are likely to be discriminated against not because of their impairment (if any), which would be irrelevant at the doctor's office, but simply because of their appearance or physical characteristics — and appearance is not generally considered a disability.⁴ Nevertheless, because the ADA also protects

against discrimination that is based on being "regarded" as having an impairment, discrimination against patients on the grounds that their weight renders them less capable or lacking in mental discipline or because of other stigmas linking weight to impairment would fall within the law's purview.

In addition, the ADA's prohibition of disability discrimination in places of public accommodation generally forbids imposing eligibility criteria that would tend to keep disabled persons from fully and equally enjoying goods, services, and facilities that are available to others; it also requires policies and practices to be modified when necessary to ensure access. Thus, if doctors' concerns about accepting obese patients were rooted in a lack of adequate equipment, for example, the lawful solution would probably be to obtain that equipment, not to bar such patients. None of this implies that a doctor can never reject a prospective patient who is disabled by obesity; it means only that obesity itself cannot be the reason. However, rejection of an obese patient who is neither impaired to the extent of being disabled nor regarded as disabled would be legally permissible under the ADA,³ even if it is questionable from the standpoint of medical professionalism.

Although antidiscrimination laws have become more comprehensive and the duty to avoid abandoning existing patients offers some additional protection against discriminatory behavior, we continue to hear about such troubling behavior by doctors toward potential and existing patients. Discrimination on some grounds may be legally imper-

missible, whereas discrimination on other grounds is only morally blameworthy, but these cases are newsworthy precisely because they are so unexpected from a profession with a strong tradition of helping people in need and rejecting the stigmas that may bias other members of society.

Fortunately, most physicians take this tradition and their professional obligations seriously, and overt discrimination is rare. Evidence suggests, however, that even medical professionals are susceptible to implicit biases based on

race, social class, sex, weight, and myriad other factors that may affect the care they provide.⁵ Thus, although we should condemn all types of invidious discrimination against patients, we should be particularly vigilant against the sort of subtle discrimination that can fly under the radar.

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DOI: 10.1056/NEJMp1211375

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Eastern Equine Encephalitis Virus — Old Enemy, New Threat

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Last summer, Vermont documented its first human cases of eastern equine encephalitis (EEE), a mosquito-borne disease that is endemic in the eastern United States. Since the discovery of EEE virus in the 1930s, cases in humans had been sporadic and restricted to areas south of northern New England until a disease outbreak struck New Hampshire in 2005.¹ Over the past decade, we have witnessed a sustained resurgence of EEE virus activity within longstanding foci in the northeastern United States and northward expansion into regions where the virus was historically rare or previously unknown, including northern New England and eastern Canada.

Although the specific factors responsible for the reemergence of EEE virus are unknown, vector-borne diseases are ecologi-

cally complex and exquisitely sensitive to environmental changes. For example, Lyme disease arose, in part, because of landscape changes that increased the habitat and wild-animal hosts of vector ticks. West Nile virus is highly sensitive to heat waves and drought that promote the breeding of mosquitoes in standing water in urban storm drains and accelerate virus amplification. Similarly, EEE virus transmission is highly seasonal and dependent on weather conditions, occurring within specific forested swamp habitats where the main mosquito vector (*Culiseta melanura*) resides.

EEE virus causes severe disease in horses and humans, resulting in high mortality as well as neurologic impairment in survivors. Although cases in humans are relatively rare, as compared with those of other vector-borne diseases, an estimated case-fatality

rate of 35 to 75% makes EEE virus the most deadly mosquito-borne pathogen in North America.^{2,3} Half of survivors suffer permanent neurologic sequelae and require long-term care, which is estimated to cost as much as \$3 million per patient over the rest of their lifetime.⁴ Currently, there is no vaccine or effective treatment available for infection in humans, although veterinary vaccines exist for horses. To curtail infections in humans in affected states, public health authorities routinely implement prevention and control measures that include enhanced mosquito surveillance, public education and outreach that emphasize personal protection measures, and insecticide spraying designed to limit rates of infection when epidemic conditions arise. The costs for implementing aerial application of chemical insecticides in affected