THE CASE OF *ELAINE W. v. JOINT DISEASES NORTH GENERAL HOSPITAL, INC.*: WHEN TREATING WOMEN EQUALLY MEANS EQUAL ACCESS TO TREATMENT

*Nadine Taub, Sheryl Felecia Davidson, Wanda Evans, and Tamasine Warden**

In recent years, society has been much concerned with the problem of pregnant women who are substance users and abusers. Though the studies do not conclusively show the extent and nature of fetal harm attributable to drugs, it seems clear the prenatal use of illicit drugs can disturb the course of pregnancies and undermine the health of later-born children. Much of the response to the problem has taken a punitive form—prosecutions, heightened sentences, and attempts to terminate parental rights. At the same time, pregnant women who do seek help have found the doors of treatment programs closed in their faces.

In 1989, three pregnant women brought a class action suit challenging the exclusionary practices of four substance abuse treatment programs in the New York City area. The suit led to several favorable settlements and a decision from the Appellate Division of the New York Supreme Court. The decision, *Elaine W. v. Joint Diseases North General Hospital, Inc.*,[1] states that general assertions, by doctors responsible for the treatment programs, that pregnant women cannot be treated consistent with sound medical policy suffice to justify the exclusion.

What follows is the *amicus* brief submitted to the Appellate Division in the *Elaine W.* case by the American Public Health Association arguing that, consistent with New York State's Human Rights Law, treatment programs cannot exclude pregnant women without demonstrating a bona fide consideration of public policy.[2]

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[1] 580 N.Y.S.2d 246 (1st Dep't 1992), appeal granted, 80 N.Y.2d 760 (Oct. 22, 1992).

[2] The brief published herein differs slightly from the brief submitted to the Appellate Division as a result of the editing process.

NEW YORK SUPREME COURT

Appellate Division-First Department

ELAINE W., on her own behalf and on behalf of all others similarly situated; SHAWN S., on her own behalf and on behalf of all others similarly situated; and MARJORIE C., on her own behalf and on behalf of all others similarly situated,

Plaintiffs-Respondents,

v.

JOINT DISEASES NORTH GENERAL HOSPITAL, INC.,

Defendant-Appellant,

and

ST. BARNABAS HOSPITAL, BRONX-LEBANON HOSPITAL CENTER, and PUERTO RICAN ORGANIZATION TO MOTIVATE, ENLIGHTEN AND SERVE ADDICTS, INC. (P.R.O.M.E.S.A.),

Defendants.

Brief of Amicus Curiae
American Public Health Association

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STATEMENT OF INTEREST

The American Public Health Association (APHA), founded in 1872 and with a membership of 55,000, is the oldest and largest multi-disciplinary society of public health professionals in the world. Throughout its 119-year history, the APHA has been in the forefront of countless efforts to protect and promote personal and public health. Included in these efforts have been numerous activities dedicated to the control of illicit drug use.

The APHA's membership includes physicians, nurses, social workers, behavioral scientists, bioethicists, and maternal and child health specialists who are experts in prenatal care, neonatology, women's health issues, and drug abuse prevention and treatment. Included in this group of experts are both practitioners and researchers.

The issue of treatment for pregnant drug abusers is of grave concern to the APHA, which has repeatedly made known its view that drug use during pregnancy is a public health, not a criminal law, matter.

The APHA has long espoused a public health model, as opposed to a criminal deviancy model, as the means of addressing and resolving the drug problem. In particular, it believes that, if pregnant women who use drugs are to be helped, prenatal care and drug treatment must be made available to every pregnant woman and barriers to such care must be eliminated.

PROCEDURAL HISTORY AND STATEMENT OF FACTS

Amicus American Public Health Association hereby adopts the statements set forth in the brief of Plaintiffs-Respondents.

ARGUMENT

POINT I.
UNEXAMINED ACCEPTANCE OF DEFENDANTS' ASSERTIONS AS TO MEDICAL JUDGMENT WOULD HAVE SERIOUS CONSEQUENCES FOR THE HEALTH OF THE NATION AS WELL AS THE PLAINTIFFS AND IS CONTRARY TO EXISTING JURISPRUDENCE

Defendants North General and St. Barnabas Hospitals have asserted that their policies of excluding pregnant women from their drug and alcohol detoxification programs are justified by legitimate medical judgments which the Court must simply accept at face value. In urging this position, Defendants ask the Court to ignore its own important role in examining the validity of medical assertions and the serious health consequences of Defendants' position.

A. There Is a Compelling Need To Provide Treatment for Pregnant Substance Dependents

America's drug epidemic has evolved in recent years from an urban plight to a national crisis.[3] Millions of women in this country use drugs or alcohol.[4] Evidence also suggests a significant increase in drug use during pregnancy during this decade.[5] As the federal government has found:

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[3] Drug Abuse in the United States: The Next Generation, Board Trustees Rep. (American Medical Ass'n), 1989, at 95 [hereinafter AMA, Next Generation].

A 1986 study conducted by the National Household Survey on Drug Abuse revealed that millions of Americans regularly use alcohol and drugs exclusive of medical purposes. Approximately 29 million Americans used marijuana at least once in 1985. An estimated 12 million Americans used cocaine at least once in 1985. While marijuana continues to be used more than any other illicit drug, cocaine abuse increased more than any other drug in the 1980s. Drug Abuse in the United States: A Policy Report, Board Trustees Rep. (American Medical Ass'n), 1988, at 236-37 [hereinafter AMA, Policy Report].

[4] Approximately 8 million American women aged 15 to 44 reported that they have used an illicit drug at least once; 34 million use alcohol; more than 18 million use tobacco; and more than 6 million use marijuana. AMA, Next Generation, supra, at 95.

[5] Wendy Chavkin, Drug Addiction and Pregnancy: Policy Crossroads, 80 Am. J. Pub. Health 483 (1990) [hereinafter Chavkin, Policy Crossroads].

> Drug use among pregnant women is increasing, especially among those who live in urban areas. The National Institute on Drug Abuse has estimated that 10 of every 100 pregnant women in the United States have used or are using cocaine. A survey of 54 urban, suburban, and rural hospitals indicated that, on average, 11 percent of women presenting for prenatal care or delivery had used drugs during their pregnancy.[6]

Pregnancy is an opportune time to treat women who are substance-dependent because of their desire to terminate their addiction and deliver a healthy baby. Termed a "window of opportunity," pregnancy promises to be an exceptionally effective time for treatment in light of the enhanced motivation to overcome addiction.[7] Indeed, National Institute on Drug Abuse data indicate that concern for children has repeatedly motivated addicted women to seek drug treatment.[8] For example, a study of 150 drug-using mothers in New York City found that three-quarters of the women interviewed reported concern for their child as a major motive for initiating treatment, and eighty percent reported these concerns as the motive for decreasing or stopping drug use during pregnancy.[9]

There is widespread recognition of the need to respond to this growing problem.[10] However, the need for treatment services for pregnant women and mothers far exceeds their availability.[11] Consequently, obtaining treatment is not a real alternative for drug- or alcohol-dependent pregnant women. Even the most persistent woman is likely to fail to find a treatment program for her substance dependency.

Policies, such as Defendants', of excluding pregnant women clearly aggravate the general shortage of treatment slots.[12] The problem is particularly acute in New York City, where a recent survey revealed that fifty-four percent of drug treatment programs categorically excluded pregnant substance abusers.[13] Restrictions on the method of payment further

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[6] Caring for Our Future: The Content of Prenatal Care, Panel Rep. (U.S. Dep't Health & Human Servs.), 1989, at 83 (citations omitted) [hereinafter Caring for Our Future].

[7] Wendy Chavkin, Mandatory Treatment for Drug Abuse During Pregnancy, 266 JAMA 1556, 1559 (1991) [hereinafter Chavkin, Mandatory Treatment].

[8] Id. at 1560.

[9] Id. at 1559.

[10] See, e.g., Caring for Our Future, supra, at 93.

[11] Chavkin, Mandatory Treatment, supra, at 1557.

[12] See generally Chavkin, Policy Crossroads, supra, at 485.

[13] The survey was conducted in 1989 by Dr. Wendy Chavkin, Research Associate at the Institute on Chemical Dependency at Beth Israel Medical Center. See Wendy Chavkin et al., Drug Abuse and Pregnancy: Some Questions on Public Policy, Clinical Management, and Maternal and Fetal Rights, 18 Birth 107, 107 (1991) [hereinafter

constrain availability. Sixty-seven percent of the programs rejected pregnant Medicaid patients, and only thirteen percent accepted pregnant Medicaid patients addicted to crack.[14] Thus addicted women excluded by Defendants will have great difficulty in obtaining treatment elsewhere in New York City. This paucity of treatment options for pregnant women is not surprising in light of the historic legacy of discrimination against addicted women by drug treatment programs.[15]

The need for treatment is also compelled by the alarming rise in the number of births of drug-exposed infants,[16] which is clearly related to the failure of many treatment centers to admit pregnant women. For example, a survey conducted in 154 cities around the country by the United States House of Representatives found that fifteen of eighteen hospitals surveyed reported three to four times as many drug-exposed births in 1988, compared to 1985.[17] Likewise, the proportion of birth certificates indicating maternal illicit substance use in New York City tripled between 1981 and 1987. Prevalent data indicate that in certain hospitals, many women have used illicit drugs within hours of delivery.[18]

The failure to obtain treatment can be highly costly to pregnant women. To date, there have been at least one hundred efforts to prosecute women for using drugs or alcohol while pregnant, with two convictions, and at least seven states have legislation pending that would alter child protective laws to encompass drug use during pregnancy under the rubric of fetal abuse.[19] Sanctions imposed on drug-dependent pregnant women

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Chavkin et al., Drug Abuse: Some Questions]; see also Chavkin, Mandatory Treatment, supra, at 1556–57 (underscoring the particular difficulty facing pregnant women who seek help with crack dependency).

[14] Chavkin et al., Drug Abuse: Some Questions, supra, at 107.

[15] AMA, Next Generation, supra, at 104.

[16] According to the National Center for Health Statistics, an estimated 9,202 drug-exposed infants were born in the United States in 1986, but by 1988, the number had increased to 13,765. In some hospitals, one in six of all newborns showed drug effects. The 1990 report by the General Accounting Office (GAO) revealed that these figures substantially underestimate the magnitude of the problem because not all possible means to detect drug use were utilized at all hospitals. Chavkin et al., Drug Abuse: Some Questions, supra, at 124.

[17] The House of Representatives asked survey questions which focused on births of infants exposed to cocaine, heroin, PCP, and marijuana, and any other drug measured. AMA, Next Generation, supra, at 96–97 (citing Select Committee on Children, Youth & Families of the U.S.).

[18] Anonymous urine toxicology surveys of women in labor and of neonates in several New York City inner city hospitals revealed that 11 to 20% were found positive for illicit drugs, mostly cocaine/crack abuse. Chavkin, Policy Crossroads, supra, at 483.

[19] State by State Case Summary of Criminal Prosecutions Against Pregnant Women

also include incarceration during pregnancy to prevent the continued use of the drug[20] and removal of the baby at birth from the mother if the infant is found to have traces of alcohol or an illicit drug in his or her system.[21] In short, the shortage in access to treatment threatens liberty interests as well as the health and life of the mother and her child.

B. The Court Is Duty Bound To Evaluate Claimed Rationales for Exclusionary Practices, Particularly in the Face of This Compelling Need

Many women are eager to help themselves and their future children but cannot control their powerful addictions without professional help.[22] If these hospitals are allowed to maintain their exclusionary policies, programs throughout the country will consider themselves justified in closing their doors. For this reason, the American Public Health Association, a national organization whose members are responsible for providing medical care during pregnancy and for developing health care policies and programs for pregnant women, is greatly concerned that a blanket exclusion of pregnant substance dependents from voluntary inpatient detoxification facilities, without a preliminary screening, will undermine public health efforts to address prenatal drug use in addition to violating the law.

Despite the fact that pregnant women, left untreated, and their later-born children face serious health problems, Defendants attempt to justify their discriminatory practices as sound medical policy. North General and St. Barnabas Hospitals both assert that to provide appropriate care to these patients, an obstetrical department is essential. In so doing, they substitute a gross generalization about their inability to treat all pregnant women for the sort of individualized assessment of risk they use in other cases. In short, they ask this Court to accept a discriminatory rule that (1) is doubtful on its face; (2) asks the Court to disregard the precedent that requires it to evaluate assertions as to medical judgment; and (3) adopts an approach that would allow health care discrimination throughout our system.

(ACLU/Reprod. Freedom Project, New York, N.Y.), July 26, 1991.

[20] Id.

[21] See In re Stefenal Tyesha, 157 A.D.2d 322, 556 N.Y.S.2d 280 (1st Dep't 1990).

[22] An interview survey of 35 crack-using women, for example, revealed that most of them were aware of the potential harm to the fetus and ironically used more crack to avoid feelings of remorse and self-loathing. Between a "Rock" and a Hard Place: Perinatal Drug Abuse, 85 Pediatrics 2123 (1990).

1. Contrary to Defendants' Assertions, There Is Strong Reason To Doubt that a Detoxification Program Must Have On-Site Obstetrical Services

Defendants claim that their exclusionary policies are justified as reasonable medical judgments. They assert, in other words, that pregnant women as a class cannot be treated safely in their facilities. The validity of these assertions is in grave doubt.

First, Defendants' class-based generalization—that ignores individual variations in needs and capacities—arguably is not even a medical judgment. Under one prominent view, the concept of medical judgment mandates that patients be treated as individuals and not as group members. Thus, a "judgment" must be employed to diagnose and/or treat a person, not to determine whether to accept a class of persons as patients in the first place. (See George J. Annas Aff. ¶ 5.) Simply put, reasonable medical judgments by their very nature must pertain, not to a patient's personal characteristics, such as pregnancy vel non, but rather, to the diagnosis of the person's particular medical condition. Id.

A proper approach would, therefore, require hospitals to review each case individually with the appropriate medical personnel to determine whether the woman can be accommodated in the detoxification program without undue risk to herself or her fetus. Following that review, it may in fact be sound medical judgment to refer a particular pregnant woman to another facility if she has special needs. However, Defendants' policy precludes any opportunity for individual assessments.

Furthermore, there is substantial evidence indicating that on-site obstetrical services, while desirable, are not essential to the safe operation of detoxification programs. As Plaintiffs' affiants state, treatment is currently provided both in hospital facilities that do not have full obstetrical services and in free-standing, non-hospital-based programs. (See Machelle Harris Allen, M.D. Aff. ¶¶ 10–13; Wendy Chavkin, M.D. Aff. ¶ 9; Nancy Paul Aff. ¶¶ 3–4.)

Plaintiffs are prepared to demonstrate that on-site obstetrical services are not essential to the success of such programs for at least two reasons. First, detoxification from some drugs, such as crack, is not inherently dangerous to pregnant women. (Allen Aff. ¶ 7.) Second, where necessary, consultation can be arranged. In the words of Dr. Wendy Chavkin, "[d]rug treatment programs can obtain consultation regarding the management of pregnant women and compensate for the lack of prenatal care by establishing referral arrangements." (Chavkin Aff. ¶ 9.)

Given this persuasive evidence, it is obvious that Defendants cannot establish a reasonable medical basis for their exclusionary policies as a

matter of law. Indeed, it is far from clear that they can prevail at trial.

2. *Defendants Would Have This Court Disregard Common Sense and Precedent Requiring It To Evaluate Assertions as to Reasonable Medical Judgments*

Defendants' claim that assertions of medical judgment are immune from judicial review is both implausible on its face and contrary to important legal precedent. In medical malpractice cases, for example, the decision maker must ascertain that any legitimate medical judgment asserted by the defense is not out-of-date and is otherwise sufficiently protective of the patient. This is important because, as may be the case here, medical judgments considered reasonable at one point in time are later understood to be extremely harmful. It is, therefore, crucial that the courts, at a minimum, determine the current viability of any medical judgment offered. Were a court to hold otherwise, it would be bound to accept medical views of the recent past, such as "expert views" that women should not gain weight during pregnancy, that the Dalkon Shield is a desirable form of contraception, or even that women's pelvises should be x-rayed during pregnancy.

Nor is the fact that Defendants' exclusionary policies have been articulated by established professionals sufficient to insulate them from court scrutiny. As the Court of Appeals for the District of Columbia has said:

> Although many medical decisions are ostensibly made to promote health, patients and doctors often choose among more or less equivalent options with largely unknown or unpredictable consequences. Not all choices are indispensable to the preservation of health or represent a clearly preferable medical alternative. New York State Ophthalmological Soc'y v. Bowen, 854 F.2d 1379, 1390 (D.C. Cir. 1988).

For this reason, in the words of the Washington Supreme Court, "[c]ourts must in the end say what is required; there are precautions so imperative that even their universal disregard will not excuse their omission." Helling v. Carey, 519 P.2d 981, 983 (Wash. 1974).

Courts' willingness to intervene in cases involving questions of medical judgment is clear from the very malpractice cases cited in North General's brief. (See North General's Appellate Brief at 42.) Bell v. New York City Health & Hosps. Corp., 90 A.D.2d 270, 456 N.Y.S.2d 787 (2d Dep't 1982) (holding physician liable for medical decision that lacks proper medical foundation) and Elbaum v. Grace Plaza, Inc., 148 A.D.2d 244, 544 N.Y.S.2d 840 (2d Dep't 1989) (per curiam) (holding that nursing home

cannot usurp patient's wishes to terminate treatment), for instance, illustrate the courts' willingness to override the medical judgment defenses. Other cases, such as Johnson v. Yeshiva University, 42 N.Y.2d 818, 364 N.E.2d 1340, 396 N.Y.S.2d 647 (1977) (finding defendant not liable where failure to perform test constituted permissible exercise of medical judgment) and Topel v. Long Island Jewish Medical Center, 55 N.Y.2d 682, 431 N.E.2d 293, 446 N.Y.S.2d 932 (1981) (holding that doctor's decision to keep suicidal patient on observation at fifteen minute intervals did not deviate sufficiently from good medical practice so as to subject the doctor to liability), demonstrate the judicial need to evaluate assertions of medical judgment before rejecting findings of liability. In neither situation does a simple assertion of medical judgment insulate a defendant's conduct from review.

3. Judicial Scrutiny Is Particularly Important Where "Medical Judgments" Are Offered To Justify Discrimination

By asserting "reasonable medical judgment" as an absolute defense to New York Executive Law Section 296, it is clear that Defendants seek to insulate all hospital decisions, even those based upon impermissible considerations, from judicial review. But allegations of discrimination must receive particularly careful scrutiny. Under the Human Rights Law, there is no exception for hospitals and medical facilities; in applying this law, courts and legal agencies are obligated to examine all assertions of medical judgment. Arnot Ogden Memorial Hospital v. State Division of Human Rights, 67 A.D.2d 543, 416 N.Y.S.2d 372 (3d Dep't 1979), for example, explicitly affirmed the power and the duty of the State Division of Human Rights both to review medical testimony and hospital administrative judgment and to reject a hospital's medical judgment that a nurse with high blood pressure could not be employed.

Similarly, in District 27 Community School Board by Granirer v. Board of Education, 130 Misc. 2d 398, 502 N.Y.S.2d 325 (Sup. Ct. 1986) the state Supreme Court overturned the New York City Department of Health's policy that prohibited automatic exclusion of children with AIDS from attending city public schools. Unwilling simply to accept purported medical rationales for the school's exclusionary policy, the court heard testimony from medical experts concerning AIDS, HIV, and related medical issues and ordered the children with AIDS to be admitted to school. Likewise, this Court "is duty bound to objectively evaluate the issue of automatic exclusion according to the evidence gathered and not be influenced by unsubstantiated fears of catastrophe." Id. at 335.

Perhaps the most disturbing result that would flow from Defendants' argument for total deference to assertions of medical judgment would be reversal of important civil rights gains of the 1960s. Prior to this time, discrimination against Blacks, often justified by claims of "sound medical practice," was the order of the day. Black patients were routinely turned away irrespective of their ability to pay for services, and segregation was claimed to be good for both sets of patients[23] even though the discriminatory practices clearly contributed to the Black patients' health problems.[24] Only if courts are willing to question flat assertions of medical reasons can the discrimination that has characterized large segments of the American health care system be eliminated. Should courts defer, without inquiry, to such assertions—as Defendants ask this court to do—they will abdicate their critical role in enforcing antidiscrimination laws and unjustified exclusionary practices will persist.

The present case is inappropriate for judicial deference for precisely this reason. Allegations of discrimination must receive careful judicial scrutiny. Defendants' "medical judgment" that automatically excludes all pregnant addicts from their alcohol and drug detoxification programs is discriminatory. It is, therefore, essential for this Court to determine at trial whether there is a basis for the hospitals' medical judgment defense.

POINT II.
BECAUSE THE DEFENDANT HOSPITALS HAVE NOT YET SHOWN THAT THEIR POLICIES OF EXCLUDING PREGNANT WOMEN FROM THEIR SUBSTANCE ABUSE PROGRAMS ARE NECESSITATED BY "BONA FIDE CONSIDERATIONS OF PUBLIC POLICY," THEY ARE NOT ENTITLED TO SUMMARY JUDGMENT

A. North General's and St. Barnabas' Policy of Excluding Pregnant Women from Their Detoxification

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[23] In Wood v. Hogan, 215 F. Supp. 53, 55-56 (W.D. Va. 1963), the defendant hospital's justification for segregating patients by race in wards and rooms was based on the fact that "segregation is for the good of the patients—of both races." Unfortunately the court agreed.

[24] See, e.g., Simkins v. Moses H. Cone Memorial Hosp., 323 F.2d 959, 970 n.23 (4th Cir. 1963), cert. denied, 376 U.S. 938 (1964) ("Racial discrimination in medical facilities is at least partly responsible for the fact that in North Carolina the rate of Negro infant mortality is twice the rate for whites and maternal deaths are five times greater.")

Programs Constitutes Facial Discrimination on the Basis of Sex

North General and St. Barnabas both concede that their admission policies exclude each and every pregnant woman from their detoxification programs; in other words, their policies discriminate against pregnant women as a class.[25] Since the lower court correctly noted that hospital programs are public accommodations designated in the law, the New York Executive Law (generally known as the Human Rights Law) governs the practices of these hospitals with respect to the availability of their facilities. Elaine W. v. Joint Diseases North General Hosp., Inc., No. 90-6230, slip op. at 15-16 (Sup. Ct. 1991) (citing N.Y. Exec. Law § 296(2)(a) (McKinney 1982)). This law provides that "[i]t shall be an unlawful discriminatory practice for any person . . . because of . . . the sex, or disability . . . of any person, directly or indirectly to refuse, withhold from or deny to such person any of the . . . advantages, facilities or privileges [of public accommodations]." N.Y. Exec. Law § 296(2)(a).

The New York courts have consistently held that discrimination based on a woman's pregnancy is sex discrimination prohibited by the Human Rights Law.[26] See, e.g., Board of Educ. v. New York State Div. of Human Rights, 56 N.Y.2d 257, 436 N.E.2d 1301, 451 N.Y.S.2d 700 (1982); Brooklyn Union Gas Co. v. New York State Human Rights Appeal Bd., 41 N.Y.2d 84, 359 N.E.2d 393, 390 N.Y.S.2d 884 (1976); Union Free Sch. Dist. v. New York State Human Rights Appeal Bd., 35 N.Y.2d 371, 320 N.E.2d 859, 362 N.Y.S.2d 139 (1974); Energy Expo, Inc. v. New York State Div. of Human Rights, 112 A.D.2d 302, 491 N.Y.S.2d 748 (2d Dep't 1985); Jericho Union Free Sch. Dist. v. New York State Human Rights Appeal Bd., 97 A.D.2d 762, 468 N.Y.S.2d 393 (2d Dep't 1983); State Div. of Human Rights ex rel. Truitt v. Stromberg Carlson Corp., 66 A.D.2d 990, 412 N.Y.S.2d 72 (4th Dep't 1978); American Airlines, Inc. v. State Human Rights Appeal Bd., 50 A.D.2d 450, 378 N.Y.S.2d 697 (1st Dep't 1976), rev'd, 41 N.Y.2d 84, 359 N.E.2d 393, 390 N.Y.S.2d 884 (1976).

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[25] Defendants' exclusionary policies regarding substance abusers might also be analyzed in terms of disability. However, since the pregnancy discrimination is so blatant and pregnancy discrimination is so clearly within the statute, that point need not be addressed here.

[26] For this reason, the state, unlike the federal government, had no need to adopt a Pregnancy Discrimination Act, 42 U.S.C. § 2000e(k) (1988), to bring pregnancy discrimination within its prohibitions.

B. Facially Discriminatory Policies Can Exist Only When a "Bona Fide Consideration of Public Policy" Is Shown

Formulated to address the problem of discrimination in a variety of areas, the New York Human Rights Law permits facial discrimination in public accommodations only where the defendant is able to establish that a "bona fide consideration of public policy" exists such that no member of the excluded group would be able to utilize the facility. N.Y. Exec. Law § 296(2)(b) (McKinney 1988). Similarly, the only exception to facially discriminatory policies is the proof that a "bona fide occupational qualification" (BFOQ) exists such that no member of the excluded group would be able to perform the job. N.Y. Exec. Law § 296(1)(d). As is evident from the statute, these analogous exceptions are extremely limited.[27]

The case law interpreting the exception in the employment law context makes this plain. As State Division of Human Rights ex rel. Cox v. New York State Department of Correctional Services, 61 A.D.2d 25, 401 N.Y.S.2d 619 (4th Dep't 1978), clearly held, the statutory defense can only be upheld if it can be proven that the sex of a member of the excluded group would preclude the activities that fall within the essence of the particular business. Accord New York State Div. of Human Rights v. New York-Pennsylvania Baseball League, 36 A.D.2d 364, 367-68, 320 N.Y.S.2d 788, 792 (4th Dep't 1971), aff'd, 29 N.Y.2d 921, 279 N.E.2d 856, 329 N.Y.S.2d 99 (1972) (finding that the employer bears the burden of proving "that he had reasonable cause to believe, that is, a factual basis for believing, that all or substantially all women would be unable to perform safely and efficiently the duties of the job involved").

Although the trial court did not address the question, New York consistently follows the federal courts' interpretation of the BFOQ defense. Thus, Plaintiffs are correct in citing the Supreme Court's recent decision in UAW v. Johnson Controls, Inc., 111 S. Ct. 1196 (1991). The unanimous decision is right on point. The Court there struck down the company's discriminatory policy which banned all women capable of becoming pregnant from participation in the manufacturing of batteries as violative of Title VII of the Federal Civil Rights Act. Finding that the policy was not saved by the statute's BFOQ, the Court emphasized that "[t]he [federal] BFOQ defense. . . . [which is substantially identical to the state BFOQ] is

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[27] Stated bluntly, the only thing these "exceptions" allow is the implicit recognition that discrimination is not occurring. If no member of the excluded group is capable of benefiting from the proscribed activity, then to exclude him or her is not discrimination, only reality.

written narrowly, and this Court has read it narrowly. The wording of the BFOQ defense contains several terms of restriction that indicate that the exception reaches only special situations." Id. at 1204.

While the lower court did not find it necessary to rule on the standard of review required in the case of facially discriminatory policies, the statute's message is clear: Facially discriminatory policies will not be tolerated unless virtually no one in the excluded group could engage in the proscribed activity. To rely on the "long line of decisions" (North General's Appellate Brief at 20) that discuss disparate impact is to ignore the limited exception provided by the New York Executive Law. Only a bona fide consideration of public policy can survive the judicial scrutiny given to these exclusionary policies.

C. Summary Judgment Was Correctly Denied Inasmuch as Defendants Have Not Shown a "Bona Fide Consideration of Public Policy" as a Matter of Law

Plaintiffs contend that the defendant hospitals are capable of treating pregnant substance abusers. As the affidavit of Dr. Wendy Chavkin plainly affirms, "[d]rug treatment programs can obtain consultation regarding the management of pregnant women and compensate for the lack of prenatal care by establishing referral arrangements." (Wendy Chavkin, M.D. Aff. ¶ 9.) Defendant hospitals dispute this contention, asserting that, in the words of Dr. Arnold Fenton, it is "medically inappropriate . . . to admit and detoxify a pregnant alcoholic." (Arnold Fenton, M.D. Aff. ¶ 7.)

It seems clear that Defendants will have a hard time demonstrating that virtually no pregnant women can be treated responsibly in the absence of an obstetrical department. In outlining the circumstances which require obstetrical help, even Dr. Fenton indicated that, in his view, intensive drug therapy in the detoxification process does not always lead to severe consequences.[28] At the same time, Plaintiffs are prepared to show that pregnant women can be safely detoxified without the presence of an obstetrical department or attending obstetricians. See, e.g., Nancy Paul Aff. (describing Stanley Street Treatment and Resources, Inc. (SSTAR), the free-standing Massachusetts treatment center that has consistently and safely detoxified hundreds of pregnant women without the benefit of an obstetrical department). They therefore seek a case-by-case evaluation of the applicant women.

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[28] Dr. Fenton stated that, in his opinion, the St. Barnabas procedure may increase the risk of abortion, premature labor, and the possibility of an operative procedure such as Cesarean section. (Fenton Aff. ¶ 6.) (emphasis added).

There has simply been no showing of the requisite "bona fide consideration of public policy" to date. The defendant hospitals have not even attempted to meet their burden of proving that virtually no pregnant women can be treated at their facilities. According to the process outlined by Dr. Stanley Reichman, it seems perfectly feasible. (See Stanley Reichman, M.D. Aff. ¶¶ 5-7.)[29] Nor is it readily apparent from the pleadings in this case whether these women can be treated at these facilities. Thus it is a factual matter to be decided at trial. Defendants cannot satisfy their burden by simply asserting "legitimate reasons for their policy." The court must evaluate their proofs as to a bona fide consideration of public policy. Accordingly, the denial of summary judgments should be upheld.

POINT III.
WHERE, AS HERE, EXCLUSIONARY POLICIES AND PRACTICES HAVE A PARTICULARLY DELETERIOUS IMPACT ON NON-WHITE WOMEN, AT A MINIMUM, THE COURT MUST DETERMINE AT TRIAL WHETHER LESS DISCRIMINATORY MEANS SERVE THE INTERESTS DEFENDANTS ASSERT

Recognizing, as the Court must, that Defendants' policies constitute facial sex-based discrimination obviously entails a recognition of the fact that one hundred percent of the persons affected by these exclusionary policies are women. But Defendants' policies of denying services to pregnant women also have a severely disproportionate impact on non-White women. Whether or not the court is willing to take judicial notice of this obvious fact, Plaintiffs can easily demonstrate which women will bear the brunt of their exclusionary policies. As the New York City Department of Planning states, the Harlem and Bronx communities served by the defendant hospitals are overwhelmingly Black and Hispanic.[30] Thus, the hospitals

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[29] For instance, as Dr. Reichman's affidavit explains, admission into North General's detoxification program is accomplished either (1) by referral from the emergency room or an out-patient clinic, and/or (2) by coming to the screening area to be interviewed. (Reichman Aff. ¶ 5.) At this step in the admission process, the overall condition of the pregnant women could be properly evaluated.

[30] Located on upper Madison Avenue, North General serves the Harlem community. According to the New York City Department of City Planning, the population of the area served by Manhattan Community Board No. 10 (East Harlem) is 7.1% White, 38.9% Black, and 45.9% Hispanic, while the population served by Manhattan Community Board No. 11 (Central Harlem) is 1.5% White, 87.6% Black, and 10% Hispanic. St. Barnabas, located on Third Avenue in the Bronx, serves the

will be hard put to dispute the policies' extreme impact.

In addition to the facial discrimination inherent in Defendants' exclusionary policies, the policies have a disproportionate impact on the basis of race and/or national origin. As a result, the Court must evaluate the need for these policies. In making such an evaluation, the Court must determine whether any alternative, less discriminatory, measures are available to address the concerns articulated by Defendants. If Plaintiffs are able to show that less discriminatory alternatives do exist, they are entitled to prevail on their discrimination claim, for, in essence, they will have shown that Defendants chose to discriminate.

The analysis outlined here is analogous to that followed in cases involving facially neutral employment practices with a disparate impact. See, e.g., People v. New York City Transit Auth., 59 N.Y.2d 343, 452 N.E.2d 316, 465 N.Y.S.2d 502 (1983); State Div. of Human Rights v. Kilian Mfg. Corp., 35 N.Y.2d 201, 318 N.E.2d 770, 360 N.Y.S.2d 603 (1974), cert. denied, 420 U.S. 915 (1975); see also Griggs v. Duke Power Co., 401 U.S. 424 (1971) (relying on Title VII); Wards Cove Packing Co. v. Atonio, 490 U.S. 642 (1989). While sufficiently important concerns may excuse the disparate impact, this is only so where there is no way to achieve this end without having the discriminatory impact. As the Supreme Court recently explained in Wards Cove, Plaintiffs meet their burden of persuasion when they show that "other tests or selection devices, without a similarly undesirable racial [or sexual] effect, would also serve the employer's legitimate hiring interests." Id. at 660 (citation omitted).

That Plaintiffs stand ready to show that individual patient assessment measures meet Defendants' asserted health concerns is evident. As the trial court noted, Plaintiffs have already submitted an array of affidavits from professionals contending that substance abuse programs should not contain a blanket prohibition against the admission of pregnant women, but should evaluate each potential patient individually.[31] For example, they present the sworn affidavit of Dr. David Orentlicher who takes the position that "[t]he blanket preclusion of all pregnant women from inpatient alcohol and drug detoxification programs is not supportable as sound medical policy." (David Orentlicher, M.D. Aff. ¶ 5.) Rather, Dr. Orentlicher submits that

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area of Bronx Community Board No. 6. According to the New York City Department of City Planning, the population of that area is 14.1% White, 25.2% Black, and 58.8% Hispanic.

[31] Interestingly, in order to meet its obligations under New York State licensing and regulatory provisions, St. Barnabas apparently clinically evaluates all candidates for admission individually except pregnant women who are excluded as a class. See Elaine W. v. Joint Diseases North General Hosp., Inc., No. 90-6230, slip op. at 9-10 (Sup. Ct. 1991).

"[e]ven those facilities that lack on-site obstetrical and/or neonatal services, departments or units, must consider the risks associated with each patient as an individual." Id. In his view, "[a]n absolute exclusionary policy cannot be supported by current medical research, knowledge or literature." Id. Thus, he concludes that "[t]he exclusion of women from treatment programs because they are pregnant is . . . unwise as a matter of public policy and will have long term consequences for these women and their children." Id. ¶ 7.

Similarly, George Annas, J.D., M.P.H., Edward R. Utley Professor of Health Law at Boston University School of Medicine, states in his affidavit that "[t]he blanket exclusion of all pregnant women from drug and alcohol detoxification programs cannot be supported by current medical knowledge or sound public policy. . . . Empirical data to support this discriminatory policy is lacking." (George Annas Aff. ¶¶ 3–4.)

Indeed, Plaintiffs' affiant Nancy Paul names in her affidavit at least one feasible way to meet health concerns about the dangers of providing detoxification services to pregnant women while, at the same time, meeting health concerns about the dangers of not providing such services. As the affidavit details, the SSTAR project provides services to both alcohol- and drug-dependent pregnant women although the program does not have an obstetrician on staff. Cited as a "model project" by the Massachusetts Commissioner of Public Health, SSTAR uses a system of individual assessment and medical clearance from one of two local hospitals. (Nancy Paul Aff. ¶¶ 1–4.)

Plaintiffs have thus made clear that, at the very least, there is a triable issue of fact as to whether Defendants can, like SSTAR and a number of other programs, provide services that do not discriminate against pregnant substance abusers through individual risk assessment systems. Under such circumstances, summary judgment is inappropriate.

CONCLUSION

For all the foregoing reasons, Defendants have failed to establish that they are entitled to prevail as a matter of law. Therefore the denial of summary judgment in their favor must be affirmed.

Respectfully submitted,

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