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SYMPOSIUM THE AMERICANS WITH DISABILITIES ACT -- PAST PRESENT AND FUTURE: DEVELOPING LAW OVER A DECADE: HIV/AIDS AND THE PUBLIC ACCOMMODATIONS PROVISIONS OF THE AMERICANS WITH DISABILITIES ACT

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SUMMARY:
... The public hysteria and ignorance surrounding the advent of the HIV/AIDS epidemic have resulted in an unforeseen challenge to the fulfillment of the high aspirations of the Americans with Disabilities Act of 1990 (ADA). ... Part III reviews the treatment of the "direct threat" standard in these decisions with an eye toward assessing whether the high aspirations of the ADA and the Rehabilitation Act have been substantially met where HIV/AIDS discrimination is at issue, or if the courts are permitting ignorance and stereotypes regarding the disease and its transmission to influence their decisions. ... While Bragdon will continue to direct HIV/AIDS jurisprudence within its principal context of health care services as well as outside of it, Bragdon has been by no means the only case interpreting the direct threat or significant risk standards, or analogous standards, in health care and other service facilities. ... Scientists are concluding that the risk of becoming infected with the virus that causes AIDS based on transmission from an infected health care worker is infinitesimal: in fact, only one health care worker has ever been documented as the source of HIV transmission to a patient. ... The law lags behind science and has not yet incorporated the facts about the low risk of HIV transmission into its treatment of HIV-infected health care workers. ...

TEXT:
[*395]

Introduction

The public hysteria and ignorance surrounding the advent of the HIV/AIDS n1 epidemic have resulted in an unforeseen challenge to the fulfillment of the high aspirations of the Americans with Disabilities Act of 1990 n2 (ADA). As the Supreme Court noted in School Board of Nassau County v. Arline: n3

Congress acknowledged [by amending the definition of "handicapped individual"] that society's accumulated myths and fears about disability and disease are as handicapping as are the physical limitations that flow from actual impairment. Few aspects of a handicap give rise to the same level of public fear and misapprehension as contagiousness. Even those who suffer or have recovered from such noninfectious diseases as epilepsy or cancer have faced

discrimination based on the irrational fear that they might be contagious. [The Rehabilitation Act of 1973 n4] is carefully structured to replace such reflexive reactions to actual or perceived handicaps with actions based on reasoned and medically sound judgments n5

The unfounded apprehension that revolved around an asymptomatic tuberculosis carrier in Arline has been magnified manyfold in the HIV/AIDS cases. Fear of exposure is for the most part unjustified by medical understanding of the disease or the factual circumstances surrounding the cases, and has resulted in a judicial distortion of the accommodation/modification **[*396]** mandate of the ADA for HIV/AIDS claimants. This article will present and analyze a number of significant federal court decisions that have addressed the application of the Arline standard to HIV/AIDS in public accommodations, and in so doing will seek to raise the question whether courts have inappropriately rushed to judge HIV/AIDS as a "direct threat" not subject to reasonable accommodation or modification under the ADA. This article begins in Part I by establishing a contextual framework for assessing the threat of HIV/AIDS transmission with a short summary of current medical understanding of HIV/AIDS, and proceeds to the role the disease played in the drafting and consideration of the ADA. Part I also discusses the significant appellate decisions applying the ADA standards to HIV/AIDS, particularly Bragdon v. Abbott. n6 Part II discusses appellate decisions under Section 504 of the Rehabilitation Act n7 ("Section 504"), the ADA, and other civil rights causes of action in three particular contexts: (A) health care providers, (B) correctional facilities, and (C) athletic and recreational facilities. Part III reviews the treatment of the "direct threat" standard in these decisions with an eye toward assessing whether the high aspirations of the ADA and the Rehabilitation Act have been substantially met where HIV/AIDS discrimination is at issue, or if the courts are permitting ignorance and stereotypes regarding the disease and its transmission to influence their decisions.

I. Overview of HIV/AIDS and the ADA

A. Transmission and Pathogenesis of HIV/AIDS n8

1. HIV/AIDS Progression

The HIV virus is a remarkably complex retrovirus with a "profound pathogenicity," or ability to cause disease. n9 From onset, the virus targets and infects the host's T cells which activate and regulate the immune system's response. n10 The virus uses the T cells' own genes to manufacture new viruses that infect other cells, destroying increasing numbers of T cells in the process. n11 **[*397]** HIV targets those T cells which "may be the most essential in maintaining normal immune function," as well as cells that ingest pathogens and other harmful substances such as bacteria, viruses, and dead tissue. n12 While a person who has tested HIV-positive may be outwardly asymptomatic for years after the first manifestations of infection, the virus continues to spread throughout the body. n13 An infected individual experiences a very high level of continuous "virologic mayhem," that is, there is a daily massive production of HIV virus, matched with a massive destruction of T cells and generation of new cells attempting to replace them. n14 Even outwardly asymptomatic persons are at an increased risk for numerous potentially serious diseases including mycobacterium tuberculosis, syphilis, acute and chronic hepatitis, toxoplasma condii, and pneumocystis carinii pneumonia. n15 In most persons infected with the virus, HIV progresses to severe immunodeficiency and AIDS. n16

In addition to physical health, the HIV virus threatens psychological health, as many persons newly diagnosed with HIV suffer from severe mental and emotional distress. n17 One medical commentator describes the impact of HIV:

All patients with HIV disease, regardless of physical health status, face fundamental questions regarding the quality and length of their lives. Specific stressors experienced by HIV-positive people may include prolonged periods of physical discomfort, disability, and dependence, lifestyle disruption, loss of work and reduced socioeconomic status, disruption of support networks including family supports, decreased self-esteem, and sustained periods of loss of personal autonomy. n18

Most HIV patients also fear that disclosure of their condition will result in stigmatization, rejection by family, friends and co-workers, and discrimination. n19 Stigma and discrimination are a significant source of depression and **[*398]** anxiety in many patients, as is others' fear of their infection, fears which can include a belief that an individual can be infected even through casual contact. n20

HIV patients are counseled to set their personal health as the first priority in their lives. n21 Patients are prescribed medications to slow the progression of the disease and prophylactic medications to prevent opportunistic infections. n22 In recent years, anti-retroviral drugs called protease inhibitors and the practice of "combination therapy" (taking several anti-retroviral drugs in combination) have proven to be of great benefit in managing the symptoms of the disease and extending life expectancies. n23 These medications have enabled AIDS patients in developed countries to enter a new era of extended life expectancies and quality of life. n24 Many children with HIV are now surviving well into adolescence. n25 Although AIDS repeatedly has been characterized by courts as invariably fatal, n26 this view is no longer universally accepted following recent reports on the efficacy of new treatments to moderate the extreme effects of HIV virus on the immune system.

2. HIV/AIDS Transmission

The vehicles of HIV transmission have been well established since the mid 1980s - blood and blood products, semen, cervical and vaginal secretions, and breast milk. n27 In the health care setting, where much of the study of the transmission of HIV has taken place, the primary risk of transmission from a patient to a health care worker arises from percutaneous exposure, such as a needlestick or a cut with a sharp object. n28 This is because such an incident exposes the worker to a potential invasion of the virus into the worker's own blood stream resulting in delivery of a higher viral load into the **[*399]** hemitic system. However, even in such unlikely circumstances, the risk of actual transmission to infected blood following percutaneous exposure is only three-tenths of one percent (.3%), or one transmission for every 333 exposures. n29 Likewise, no case of HIV transmission by exposure to aerosolized (airborne in water vapor) HIV particles in the context of dental treatment has ever been documented, and the possibility of such transmission in the occupational setting has been called merely "theoretical." n30 According to the Centers for Disease Control and Prevention (CDC), there have been no documented cases of transmission of HIV through physical contact in athletics in the nearly twenty-year history of the disease. n31

B. History and Intent of the ADA

AIDS is the leading cause of illness-related mortality of young adults between the ages of twenty-five and forty-four. n32 Because of the unique characteristics of the disease and the fear it engenders, persons with HIV/AIDS have been subjected to considerable social stigmatization and unreasonable and unfounded discrimination. n33 The American Medical Association (AMA) has noted that "an HIV-seropositive individual ... may be subject to many and varied discriminations - by family and loved ones, neighbors and friends, employers and fellow employees, and other providers and services." n34 **[*400]** Numerous federal and state courts have recognized this deeply-rooted stigma against HIV carriers. n35

For these reasons, and because discrimination undermines public health efforts to limit the spread of the virus, the problem of discrimination against HIV-positive individuals was a particular concern to the drafters of the ADA. n36 The President's Commission on the HIV Epidemic stated in a report, the conclusions of which were adopted by Congress:

As long as discrimination occurs, and no strong national policy with rapid and effective remedies against discrimination is established, individuals who are infected with HIV will be reluctant to come forward for testing, counseling, and care. This fear of potential discrimination ... will undermine our efforts to contain the HIV epidemic and will leave HIV-infected individuals isolated and alone. n37

Surgeon General C. Everett Koop testified before Congress, "If counseling [about HIV prevention] and testing are to work most effectively, individuals must have confidence that they will be protected fully from HIV-related discrimination." n38 In order to prevent such discrimination from endangering the public health, Congress incorporated into the ADA a pre-existing definition of "disability" that applied to all persons with HIV. n39 The Supreme Court confirmed this congressional intent in Bragdon v. Abbott, n40 in which it held that HIV-positive status may constitute a disability within the meaning of the ADA. n41

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C. Bragdon v. Abbott: How is the Arline Standard Applied to HIV/AIDS?

The prohibitions against discrimination in the ADA contain a specific exception where an "individual poses a direct threat to the health or safety of others. ...". n42 In codifying the direct threat defense into the ADA, Congress expressly adopted the test enunciated for Section 504 of the Rehabilitation Act in Arline. n43 The Court in Arline established an objective test to determine whether discrimination is justified by a direct threat defense, and in making this objective determination of threat, "courts normally should defer to the reasonable medical judgments of public health officials." n44 Arline sets out the proper analysis for an ADA claim:

The district court will need to conduct an individualized inquiry and make appropriate findings of fact. ... In the context of the employment of a person handicapped with a contagious disease ... this inquiry should include "[findings of] facts, based on reasonable medical judgments given the state of medical knowledge, about (a) the nature of the risk (how the disease is transmitted), (b) the duration of the risk (how long is the carrier infectious), (c) the severity of the risk (what is the potential harm to the parties) and (d) the probabilities the disease will be transmitted and will cause varying degrees of harm." n45

The Court stressed the importance of an objective test because the direct threat test aims to "protect[] handicapped individuals from deprivations based on prejudice, stereotypes, or unfounded fear, while giving appropriate weight to such legitimate concerns ... as avoiding exposing others to significant health and safety risks." n46 Likewise, the regulations implementing Title III of the ADA require a finding of direct threat to be "based on reasonable judgment that relies on current medical knowledge or on the best available objective evidence. ..." n47 The regulations also specify that "sources for **[*402]** medical knowledge include guidance from public health authorities, such as the U.S. Public Health Service, the Centers for Disease Control, and the National Institutes of Health, including the National Institute of Mental Health." n48

Following Arline, the federal appellate courts have occasionally acknowledged this directive in addressing speculative determinations of whether the risk of transmission of HIV or AIDS

amounts to a direct threat under the ADA and the Rehabilitation Act. n49 For example, in Abbott v. Bragdon, n50 the First Circuit observed:

Generalities about health-care workers aside, [the defendant-dentist] does not cite a single confirmed instance of HIV transmission to a dentist. He does, of course, point to seven instances of "possible transmissions" of HIV to dental workers, but mere possibilities are too speculative to satisfy a litigant's burden of production at the summary judgment stage. n51

In Chalk v. United States District Court, n52 a teacher of hearing-impaired students, Vincent Chalk, was diagnosed with AIDS after a bout with pneumocystis carinii pneumonia. n53 Upon his recovery and return to work, his employer reassigned him to an administrative position and barred him from teaching in the classroom, in spite of the opinion of the Director of Epidemiology and Disease Control for the Orange County Health Care Agency that ""nothing in [Chalk's] role as a teacher should place his students or others in the school at any risk of acquiring HIV infection.'" n54 The district court had declined to grant injunctive relief requiring the school district to reinstate Chalk in his teaching position; however, on appeal the Ninth Circuit reversed on the ground that the plaintiff had demonstrated a strong probability of success on the merits. n55 The appeals court weighed the evidence adduced by the plaintiff, including the declarations of five experts in the field of AIDS, noting that "none of the identified cases of AIDS in the United States are known or are suspected to have been transmitted from one child to **[*403]** another in school, day care or foster care settings." n56 The court also credited the position of its amicus, the AMA, which "summarized the medical evidence and concluded that "there is no evidence in the relevant medical literature that demonstrates any appreciable risk of transmitting the AIDS virus under the circumstances likely to occur in the ordinary school setting.'" n57

Against this "overwhelming evidentiary consensus" n58 the school district introduced the declaration of one expert who opined that "there is a significant[,] ... even though it's small, potential for transmission of AIDS in ways which we have not yet determined and, therefore, may pose a risk. ..." n59 The Ninth Circuit weighed the Arline factors and placed particular emphasis on the "catastrophic" nature of the risk of contracting AIDS and the absence, in its view, of sufficient medical data to make a definite determination of the extent of the risk:

Now, here, according to present knowledge, the risk probably is not great because of the limited ways that medical science believes the disease is transmitted. But, of course, if it is transmitted the result is horrendous. It seems to me the problem is that we simply do not know enough about AIDS to be completely certain. The plaintiff has submitted massive documentation tending to show a minimal risk. ... The likelihood is that the medical profession knows exactly what it's talking about. But I think it's too early to draw a definite conclusion, as far as this case is concerned, about the extent of the risk. n60

Nonetheless, the court of appeals found that in denying the injunction on this basis, the district court had "failed to follow the legal standards set forth in Arline and improperly placed an impossible burden of proof on the petitioner." n61 The district court erred by "improperly relying on speculation for which there was no credible support in the record." n62

The Ninth Circuit in Chalk also relied upon decisions by other federal and state courts rejecting a speculative approach to the risk of transmission of disease, notably Thomas v. Atascadero United School District. n63 In Thomas, the district court had granted a preliminary injunction prohibiting a school district from excluding a child with AIDS, Ryan Thomas, from his kindergarten classroom. n64 Even though the child was involved in a biting incident, the appeals court found:

The overwhelming weight of medical evidence is that the AIDS virus **[*404]** is not transmitted by human bites, even bites that break the skin ... . Any theoretical risk of transmission of the AIDS virus by Ryan in connection with his attendance in regular kindergarten class is so remote that it cannot form the basis for any exclusionary action by the School District. n65

The Ninth Circuit concluded in Chalk:

To allow the court to base its decision on the fear and apprehension of others would frustrate the goals of section 504. "The basic purpose of [Section 504 is] to ensure that handicapped individuals are not denied jobs or other benefits because of the prejudiced attitudes or ignorance of others." The Supreme Court recognized in Arline that a significant risk of transmission was a legitimate concern which could justify exclusion if the risk could not be eliminated through reasonable accommodation; however, it soundly rejected the argument that exclusion could be justified on the basis of "pernicious mythologies" or "irrational fear." n66

Similarly, the Eleventh Circuit ruled in Doe v. DeKalb County n67 that the district court had improperly found only a "remote and theoretical" risk of transmission of HIV via "blood-to-blood contact between a teacher and his sometimes-violent" emotionally disabled students. n68 The district court erred by failing to make specific factual findings with respect to the Arline factors to support its conclusion that an unacceptable threat existed despite that **[*405]** the risk was "remote." n69

The ADA's directive against determining the existence of a direct threat on the basis of speculative evidence was reinforced by the Supreme Court's decision in Bragdon v. Abbott, n70 which will almost certainly become the seminal case in ADA HIV/AIDS direct threat jurisprudence for some time to come. The Court in Bragdon addressed whether an individual who is infected with the HIV virus, but has not manifested its most serious symptoms, has a disability for the purposes of an ADA claim. The Court held that even if an individual infected with HIV had not progressed to the so-called symptomatic phase, HIV still potentially constituted a "disability" under the ADA, n71 as "a physical impairment that substantially limits one or more of the [individual's] major life activities. ..." n72

The Court reasoned that from "the moment of infection" and "during every stage of the disease" HIV infection satisfies the statutory and regulatory definition of a "physical impairment." n73 The Court also discussed a "comprehensive and significant administrative precedent," an opinion issued by the Justice Department's Office of Legal Counsel (OLC). n74 Citing the OLC opinion, the Court concluded that HIV infection must be regarded as a physiological disorder with an immediate, constant, and detrimental effect on the hemic and lymphatic systems. n75

The Court further held that an individual's ability to reproduce and to bear children constitutes a "major life activity" under the ADA, since "reproduction and the sexual dynamics surrounding it are central to the life process itself." n76 The Court rejected the argument "that Congress intended the ADA only to cover those aspects of a person's life which have a public, economic, or daily character." n77 According to the Court, medical evidence reveals that an HIV-infected woman's ability to reproduce is substantially limited in two ways. First, she imposes on her male partner a statistically significant risk of becoming infected. Second, she risks infecting her child during gestation and childbirth through perinatal transmission. n78 "The decision to reproduce [also] carries economic and legal consequences," such as "added costs for anti-retroviral therapy, supplemental insurance, and **[*406]** long-term health care for the child who must be examined and ... treated. ..." n79

Finally, the Court noted that "a uniform body of administrative and judicial precedent" interpreting similar language in the Rehabilitation Act confirmed the Court's holding. n80 Furthermore, every agency and court that had considered the issue under the Rehabilitation Act "found statutory coverage for persons with asymptomatic HIV. ..." n81 The Court also found its holding confirmed by the guidance issued by the Justice Department and other agencies authorized to administer the ADA. n82

Regarding the Arline objectivity requirement within the context of HIV/AIDS, the Supreme Court in Bragdon placed particular stress in its interpretation on the necessity for medical evidence pertaining not just to a theoretical presence of risk, but to a quantification of the risk based upon the best science available. "Because few, if any, activities in life are risk free, Arline and the ADA do not ask whether a risk exists, but whether it is significant." n83 Reviewing the evidence adduced in the lower courts, the Supreme Court questioned the First Circuit's reliance on the 1993 CDC Dentistry Guidelines and the 1991 American Dental Association Policy on HIV on the ground that the policies were inconclusive because "they [did] not assess the level of risk." n84 The Court stated that "efforts to clarify dentists' ethical obligations and to encourage dentists to treat patients with HIV infection with compassion may be commendable, but the question under the statute is one of statistical likelihood, not professional responsibility." n85 Although Bragdon involved a medically sophisticated provider of health services, a licensed dentist, the Court nonetheless instructed that Dr. Bragdon could not rely on his own opinion in refusing to treat an HIV-infected individual in his office; instead, he had a "duty to assess the risk of infection based on the objective, scientific information available to him and others in his profession." n86 "His belief that a significant risk existed, even if maintained in good faith, would not relieve him from liability." n87

[*407] Bragdon and the cases that have arisen in the educational context, such as Chalk, Thomas, and DeKalb County, represent the better-reasoned of the HIV/AIDS public accommodations cases. Nonetheless, as will be seen from a comparison with the results in the federal courts of appeal both before and after Bragdon in other contexts, for the most part the aspirational purposes of the ADA remain to be truly fulfilled for HIV/AIDS afflicted claimants.

II. The Public Accommodations Provisions of Titles II and III and HIV/AIDS

Title II of the ADA governs discrimination in public entities. n88 Title III of the ADA governs public accommodations and services operated by private entities. "Public accommodations" are "private entities" n89 whose "operations ... affect commerce." n90 Public accommodations that are subject to the reach of the act are listed in a fairly exhaustive manner. n91

[*408] Because the ADA's direct threat test parallels the standards promulgated under Section 504 of the Rehabilitation Act, the cases discussed in this section will include cases addressing HIV/AIDS under both statutes. Likewise, because the threat-to-safety concepts explicated by the regulations implementing Titles I, II and III of the ADA are largely analogous, n92 cases proceeding under each of these titles are included where they advance the issue under analysis.

A. Health Care Providers and Other Service Facilities n93

A health care facility that affects commerce is a public accommodation subject to Title III if it is a "professional office of a health care provider, hospital, or other service establishment." n94 Under the Title III regulations, public accommodations do not have "to permit an individual to participate in or benefit from the goods, services, facilities, privileges, advantages and accommodations of such entity where such individual poses a direct threat to the health or safety of others." n95 A "direct threat" is "a significant risk to the health or safety of others

that cannot be eliminated by a modification of policies, practices, or procedures or by the provision of auxiliary aids or services." n96

While Bragdon will continue to direct HIV/AIDS jurisprudence within its principal context of health care services as well as outside of it, Bragdon **[*409]** has been by no means the only case interpreting the direct threat or significant risk standards, or analogous standards, in health care and other service facilities. For example, one of the earliest cases to consider the threat of infection posed by an HIV-positive health care worker is Leckelt v. Board of Commissioners. n97 In Leckelt, the Fifth Circuit held that Kevin Leckelt, a licensed practical nurse, was not "otherwise qualified" under the Rehabilitation Act to perform his job because of his refusal to submit the results of an HIV test under a hospital's policy for monitoring its employees for their exposure to infectious diseases. n98 In spite of documentation showing that he would be placed on leave without pay if he tested positive for HIV, the court of appeals held that "the district court was not clearly erroneous in finding that Leckelt failed to establish that he was discriminated against solely because of a perception that he was infected with HIV." n99

The Fifth Circuit appeared to countenance an assumption by the district court that Leckelt would pose an unacceptable risk if he were HIV-positive, finding no error in the court's determination that because Leckelt "would not allow defendants to conduct the inquiry necessary to protect patients, co-workers and plaintiff himself from any possible risk he may pose because of his particular situation, defendants had a reasonable belief that plaintiff was not "otherwise qualified' for employment. ..." n100 The appellate court reasoned:

Even though the probability that a health care worker will transmit HIV to a patient may be extremely low and can be further minimized through the use of universal precautions, there is no cure for HIV or AIDS at this time, and the potential harm of HIV infection is extremely high. n101

American Dental Ass'n v. Martin n102 had a profound influence on the approach taken by courts to the "direct threat" and "otherwise qualified" standards, n103 although Martin arose in a completely different context. Martin involved **[*410]** a challenge brought by dentists, represented by the American Dental Association, and medical-personnel and home-health employers, both represented by the Home Health Services and Staffing Association, to the Occupational Safety and Health Administration (OSHA) rule on occupational exposure to bloodborne pathogens. n104

Chief Judge Posner, writing for the Seventh Circuit, upheld the regulations, stating that the bloodborne pathogens standard as applied to dentists merely recognized the risk that "the saliva of dental patients frequently contains blood - even in such routine procedures as having one's teeth cleaned by a dental hygienist - and that it is possible, though far from certain, that even a small quantity of blood, diluted by saliva or some other fluid, can sometimes be infective." n105 Martin is a formative articulation of the cost-benefit type of analysis for finding direct threat that would come to predominate case law in this area. n106 For example, Judge Posner's remarkable opinion states:

The [universal precautions] rule's implicit valuation of a life is high - about $ 4 million - but not so astronomical, certainly by regulatory standards ... as to call the rationality of the rule seriously into question, especially when we consider that neither Hepatitis B nor AIDS is a disease of old people. These diseases are no respecters of youth; they cut off people in their working years, and thus in their prime, and it is natural to set a high value on the lost years. n107

This approach, which balances the degree of threat posed by HIV/AIDS with the presence of risk, is not derived from the language of the Rehabilitation Act or the ADA, neither is it justified by the policies that gave birth to those statutes.

The essential holding of Martin was that the Seventh Circuit declined to **[*411]** carve out an exception to OSHA's universal precautions requirement for dentists, reasoning that OSHA was not required to promulgate workplace specific regulations within an industry. n108 In so doing, Judge Posner may have germinated the notion that even a hypothetical risk was sufficient to pose a direct threat:

[OSHA] pointed out that the saliva of dental patients frequently contains blood - even in such routine procedures as having one's teeth cleaned by a dental hygienist - and that it is possible, though far from certain, that even a small quantity of blood, diluted by saliva or some other fluid, can sometimes be infective. This was not some fantasy of OSHA. The Centers for Disease Control, while generally exempting saliva from the list of body fluids to which universal precautions should apply, recommended "special precautions" for dental workers exposed to saliva from patients. n109

Nonetheless, this was certainly not the standard the Seventh Circuit intended to convey for all contexts of potential exposure. As the court itself recognized, "OSHA was entitled to adopt an interpretation that leaned "on the side of overprotection rather than underprotection.'" n110 Proactive worker protection from all possible risks, including unlikely ones, is undoubtedly the proper role of OSHA. However, by falling into the mistaken view that the anti-discrimination provisions of the ADA require "error on the side of protection" (much like the prophylactic protections of OSHA safety regulations), courts subsequently began to stray from the stricter direct threat standard imposed by Arline.

Bradley v. University of Texas M.D. Anderson Cancer Center n111 adopted the same approach. The court held that an HIV-positive surgical assistant could be denied surgical privileges because he was not otherwise qualified within the meaning of Section 504. n112 The court recited the Arline standard calling for findings of fact based on the state of medical knowledge about the nature, duration and severity of the risk and the probability of transmission. n113 Nonetheless, the court concluded that it would be impossible to eliminate the risk of percutaneous injury to a surgical technician through reasonable accommodation because to do so would eliminate essential functions of his employment. "While the risk [of HIV transmission via a surgical accident] is small, it is not so low as to nullify the catastrophic consequences of an accident. A cognizable risk of permanent duration with lethal consequences suffices to make a surgical technician with Bradley's responsibilities not "otherwise qualified.'" n114

[*412] Doe v. University of Maryland Medical System Corp. n115 is to the same effect. University of Maryland Medical System involved a neurosurgical resident who contracted HIV from a needlestick. n116 The employee was held not to be an otherwise qualified individual with a disability because he posed a significant risk to patients at the medical center that could not be eliminated by reasonable accommodation, and thus the medical center did not violate Section 504 or Title II of the ADA by suspending his surgical privileges. "Although there may presently be no documented case of surgeon-to-patient transmission, such transmission clearly is possible. And, the risk of percutaneous injury can never be eliminated through reasonable accommodation." n117 In assessing the degree of risk pursuant to the Arline standards, the court acknowledged the role of statistical data of the CDC, "the only judgment of a public health official that was presented to the district court." n118 The CDC had estimated that the risk to a single patient from an HIV-positive surgeon ranged from .0024% (1 in 42,000) to .00024% (1 in 417,000), and that over the career of an HIV-positive surgeon, the cumulative

risk of transmission ranged from .8% to 8.1%. n119 However, the court also adopted the view of the district court that the Arline factors required what was in essence a cost-benefit analysis, ""discounting the severity of anticipated harms by the statistical probability that they will occur.'" n120

While the CDC recommended that seropositive surgeons be permitted to perform invasive surgical procedures, it left the determination to individual health-care organizations whether, and under what circumstances, infected surgeons should perform "exposure-prone procedures." n121 The University of Maryland Medical System had concluded that "all neurosurgical procedures that would be performed by Dr. Doe fit the definition of exposure-prone procedures," and the court felt "reluctant under these circumstances to substitute [its] judgment for that of [the University]." n122

Similarly, in Estate of Mauro v. Borgess Medical Center n123 an HIV-positive surgical technician was laid off after refusing a transfer to a non-surgical position, and brought an action under the Rehabilitation Act and Title II of the ADA. n124 The Sixth Circuit dutifully recited the Arline standard, as well as the CDC statistics relating to the incidental risk of exposure from a **[*413]** surgeon. n125 The court further noted that "neither [Section 504 nor the ADA] require[] the elimination of all risk posed by a person with a contagious disease. ... If the risk is not significant ... the person is qualified to perform the job." n126 The court further looked to the Equal Employment Opportunity Commission (EEOC) guidelines, which state:

An employer, however, is not permitted to deny an employment opportunity to an individual with a disability merely because of a slightly increased risk. The risk can only be considered when it poses a significant risk, i.e., high probability, of substantial harm; a speculative or remote risk is insufficient. n127

Nonetheless, the plaintiff was held to constitute a direct threat to the health and safety of others that could not be eliminated by reasonable accommodation:

The district court based this conclusion on both the description of a Borgess surgical technician's duties indicating the necessity for a surgical technician to place his or her hands upon and into the surgical incision to provide room and visibility for the surgeon, and the risk of sustaining a needle stick or minor laceration which Mauro had in the past sustained. All the evidence, together with the uncontradicted fact that a wound causing an HIV-infected surgical technician to bleed while in the body cavity could have catastrophic results and near certainty of death, indicates that Mauro was a direct threat. n128

The Sixth Circuit found support for its reasoning in University of Maryland Medical System and Bradley, which the lower court had also found ""materially indistinguishable and properly reasoned.'" n129

Reported cases outside the health services field are fairly rare, so much so that it is difficult to draw any firm conclusions concerning how HIV-positive employees in other service-related public accommodations fare in relation to those in health services. The few cases known show mixed results, although on balance these results are arguably more favorable to employees. For example, in Greenway v. Buffalo Hilton Hotel, n130 the appeals court upheld a jury award pursuant to the ADA on behalf of an HIV-positive bartender, n131 although it reduced the compensatory damages award for failure of the plaintiff to mitigate his losses. n132

[*414] On the other hand, EEOC v. Prevo's Family Market, Inc. n133 is an excellent illustration of the proclivity of courts to search the record for any evidentiary basis, however ill-substantiated, to justify a finding of a direct threat. Prevo's involved an employee who worked

with fresh produce and was fired for refusing to submit to a medical examination. n134 His employer had asked him to obtain from his doctor verification of his HIV status. n135 The Court of Appeals for the Sixth Circuit reversed summary judgment and the damages awarded the employee, holding that the requirement for a medical examination for HIV infection was job-related. The appeals court so ruled in spite of testimony from the EEOC's expert that the chance of transmitting HIV in the context of a produce department was one in ten million, or, in the case of direct blood-to-blood contact, one in three thousand: "HIV is a blood borne pathogen and can be transmitted in an environment such as that of a produce department of a grocery store, where one is susceptible to cuts and scrapes on a regular basis." n136

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B. Correctional Facilities n137

Title II of the ADA covers discrimination in public entities, and defines "public entity" to include "any State or local government" or "any department, agency, special purpose district, or other instrumentality of a State or States or local government. ..." n138 Despite this clear language, the status of correctional facilities under the ADA and the Rehabilitation Act was unclear n139 until the Supreme Court's recent decision in Pennsylvania Department of Corrections v. Yeskey. n140 In Yeskey the Court unanimously held that state prisons fall squarely within the provisions of Title II as an "instrumentality of a State ... or local government." The Court explained:

Modern prisons provide inmates with many recreational "activities," **[*416]** medical "services," and educational and vocational "programs," all of which at least theoretically "benefit" the prisoners (and any of which disabled prisoners could be "excluded from participation in"). Indeed, the statute establishing the Motivational Boot Camp at issue in this very case refers to it as a "program." The text of the ADA provides no basis for distinguishing these programs, services, and activities from those provided by public entities that are not prisons. n141

The federal courts have struggled with the application of the ADA and the Rehabilitation Act to prison programs. Onishea v. Hopper n142 was an Eleventh Circuit prison HIV/AIDS case brought under the Rehabilitation Act. The court of appeals had requested briefing on the application of the Rehabilitation Act to prisons, but upon the decision in Yeskey applying the ADA to prisons, conceded the Rehabilitation Act's application to prisons as well, noting, "We find Yeskey indistinguishable. ..." n143

Onishea addressed the Alabama Department of Corrections' practice of segregating both male and female HIV-positive prisoners in special facilities offering different, and often inferior, programs to inmates than those available to non-seropositive prisoners. The plaintiffs challenged the practice and its statutory basis under the Rehabilitation Act. n144 The district court had dismissed their suit. n145 In 1991, the Court of Appeals for the Eleventh Circuit reinstated the suit, requiring the district court to consider the merits on a program-by-program basis, and particularly to evaluate the risk of HIV transmission in each program to determine whether the plaintiffs were otherwise qualified within the meaning of Section 504. n146

On remand, the plaintiffs had urged that the odds of transmission were remote:

Their evidence fell into two categories. First, the plaintiffs presented expert testimony that incidents of HIV transmission in many activities are rare or virtually unknown. For instance, at the time of trial there were no reported cases of transmission as a result of lesbian sex. There was a similar lack of reported incidents of transmission from sports injuries, stabbing, or

tattooing. Only "sporadic" instances of transmission from oral sex and fistfights had been reported. In short, the possibility of transmission in certain unusual circumstances (for instance in a fight if both participants bleed copiously **[*417]** into each other's wounds, or during barbering if bloody razors are immediately reused) had not been realized in any commonly recurring way. n147

However, the district court credited the state's evidence of high seroconversion rates among non-segregated prison populations, and found as facts that "sex, intravenous drug use, and bloodshed are a perpetual possibility in prison" and that "HIV is transmitted by sex, intravenous drug use, and blood-to-blood contact." n148

In 1997, an Eleventh Circuit panel reversed the district court, n149 but the court sitting en banc later affirmed. n150 The full appeals court quoted from the trial court's finding of a significant transmission risk in all programs and emphasized the consequences of transmission of the virus:

Given this degree of harm, even slim odds of transmission make the risk significant. As the court put it in words echoed throughout its 476-page opinion, "elimination of high risk behavior is impossible. ... Because the Defendant/Prison system has decided that such conduct is likely, and because of the catastrophic severity of the consequences if such conduct does occur, this Court holds that integrating the [program under discussion] would present a significant risk of transmitting the deadly HIV virus. Accordingly, the HIV+ inmates are not "otherwise qualified.'" n151

The district court had also found that the only potential accommodation, hiring more guards, would place an undue financial burden on the department. n152 The full appeals court concluded that the court could find the necessary additional expenditure an undue burden. n153

The full appeals court rejected, moreover, the plaintiffs' chief contention that the lower court wrongly interpreted a "significant risk" of HIV transmission to mean "any risk." n154 The court reviewed the state of the law regarding the quantum of risk:

When the adverse event is the contraction of a fatal disease, the risk of transmission can be significant even if the probability of transmission is low: death itself makes the risk "significant." But federal courts disagree about how low the odds may be, and how much evidence it takes to prove a significant risk. On one hand, the Fourth, Fifth, and Sixth Circuits have implicitly followed a cautious rule. n155 For these courts, a showing of a specific and theoretically **[*418]** sound means of possible transmission was enough to justify summary judgment against an HIV-positive plaintiff on the ground that the infection posed a "significant risk" to others in the workplace, even though reported incidents of transmission were few or nonexistent, and the odds of transmission were admittedly small. n156

Citing the First Circuit's initial decision in Abbott v. Bragdon, the court of appeals observed that the court had "construed the phrase "significant risk' to mean that not only must the danger be theoretically justifiable, it must also have been realized in at least several cases." n157 The Eleventh Circuit acknowledged its own apparent adherence to this view in Martinez v. School Board, n158 which the court said "arguably anticipated the First Circuit's view." n159 Onishea further noted, "The Ninth Circuit arguably anticipated the First Circuit's position, as well, [in Chalk]." n160

Nonetheless, the court determined that the U.S. Supreme Court's review of Abbott did "not resolve the conflict on this question. The [Supreme] Court stated no rule, and it neither

affirmed nor reversed the First Circuit's conclusion on this issue." n161 The Eleventh Circuit concluded that a "cautious approach" like that of the Fourth, Fifth and Sixth Circuits, was the better course on two bases: First, the requirement "that the asserted risk of transmission has a sound theoretical basis prevents the [ADA] from overlooking the unfounded prejudices that Congress intended to uproot." n162 Second, the court eschewed a reading of the ADA that, in its view, would be tantamount to a decree by Congress of "even a few painful deaths in service of the Act's noble goals." n163

The Eleventh Circuit phrased its evidentiary standard for a showing of direct threat in the context of HIV/AIDS in terms that virtually requires a finding of direct threat where any possibility of transmission is conjecturable:

We thus hold that when transmitting a disease inevitably entails death, the evidence supports a finding of "significant risk" if it shows both (1) that a certain event can occur and (2) that according to reliable medical opinion the event can transmit the disease. This is not an "any risk" standard: the asserted danger of transfer must be rooted in sound medical opinion and not be speculative or fanciful. **[*419]** But this is not a "somebody has to die first" standard, either: evidence of actual transmission of the fatal disease in the relevant context is not necessary to a finding of significant risk. n164

Gates v. Rowland n165 further illustrates the point. Gates addressed Eighth Amendment and ADA claims by HIV-positive prisoners at the California Medical Facility for their exclusion from food service and segregation from the main prison population. n166 The facility had negotiated a consent decree whereby seropositive prisoners would be excluded only from food service, and not other programs, and a prisoner would be assigned to an HIV-only ward only upon a showing that he was likely to engage in high risk behavior or assaultive conduct resulting in bloodletting. n167

The Ninth Circuit initially assumed that the Rehabilitation Act, informed by its corollary definition of "disability" in the ADA, applied to asymptomatic HIV-positive individuals, and that the Rehabilitation Act was applicable to state prisons. n168 Instead of adhering strictly to an objective demonstration of significant risk pursuant to Arline, however, the court of appeals determined that the standard of reasonableness established in Turner v. Safley n169 regarding the constitutional rights of prisoners should govern. n170 Effectively, the court gave with one hand, elevating the rights of HIV-positive prisoners to constitutional status, but took back with the other, since the rule of Turner - whether a regulation is "reasonably related to a legitimate penological interest" n171 - is of the lowest possible constitutional magnitude, akin to the rational relationship test of Equal Protection jurisprudence.

In the case of the HIV-positive prisoners in Gates, the constitutional status of their disability made no practical difference, and the Ninth Circuit upheld both challenged practices as reasonable. n172 In fact, the basis on which the court upheld the exclusion of prisoners from food service bore no relation to objective medical evidence of the risk of transmission whatsoever, as **[*420]** both parties and the court acknowledged that the risk was only "slight." n173 Rather, the regulation was upheld as a legitimate concern over the mere perception by other inmates that transmission was possible:

The prison authorities testified that if HIV-seropositive inmates are placed in food service jobs, the other inmates will perceive a threat regardless of scientific research or medical pronouncements ... . If HIV-seropositive inmates are placed in food service jobs, the other inmates will think the worst - that they will bleed into the food, spit into the food, or even worse. If the inmate population perceives a risk from the food they must eat, they will want the infected inmates removed from the food service jobs. If they have no assurance that the

infected inmates are removed, there may be violent actions against the inmates with the virus, inmates they perceive to have the virus, or the staff that permits the perceived risk. n174

Thus, the standard for "protection" of HIV-positive prisoners under the Rehabilitation Act adopted by the Ninth Circuit ultimately bore no correlation to the standards articulated under the Rehabilitation Act and ADA, as it allowed correctional facilities to deny prisoners equal access to a prison program contrary to objective medical evidence. n175

[*421] Anderson v. Romero n176 involved a suit alleging the denial of numerous prison rights and privileges based upon an inmate's HIV status, as well as violations of his right of medical privacy when his status was disclosed to other inmates. The Seventh Circuit affirmed dismissal of the privacy claim on the ground of qualified immunity. Judge Posner, writing for the court, harkened back to his opinion in Martin, n177 reasoning that the prisoner had no right to preclude disclosure under any circumstances:

We do not think that defendant Douglas can be criticized for having warned inmate Curry that the prisoner in whose cell he was seen sleeping was HIV-positive. Or even for having warned the inmate barber about Anderson. The danger that a barber would be infected by an HIV-positive customer is slight. But so is the danger to a dental worker. Yet OSHA, in the regulation that we upheld in the Martin case, requires that dental workers take precautions against being infected by their patients; and HIV is far more prevalent in state prisons than in the population at large. ...

A barber, especially if he uses a razor, may cut the skin of the person whose hair he is cutting and if he gets the person's blood on a part of his skin where he has a cut or abrasion may become infected. The danger, as we said, is slight, though given the violence endemic to American prisons and the prevalence of HIV and AIDS in those prisons cannot be considered entirely fanciful. n178

As in Gates, this "slight danger" was held to be a sufficient basis to justify the facility's denial of the prisoner's right to privacy, regardless of the objective reasonableness of the risk.

C. Athletic and Recreational Facilities

There are very few ADA cases arising in the context of athletic and recreational facilities. n179 The chief concern raised has been the theoretical possibility of transmission where bodily fluids (blood or sweat) may come into contact with other patrons. The principal case to date is Montalvo v. Radcliffe. n180 Michael Montalvo was a twelve-year-old child with AIDS who attempted to enroll in contact karate classes. n181 The karate school director **[*422]** learned of the plaintiff's condition and refused to allow him to participate in the school's classes, despite a written opinion by the plaintiff's treating physician, a pediatric AIDS expert, that Michael's participation would not pose a health risk to himself or other students. The school offered to accommodate him with private lessons in lieu of participation in classes with the other students. The plaintiff's father rejected this proposal because it defeated his purpose to integrate his son into social activities with other children and help him live a normal young person's life to the extent possible. n182 The karate school claimed that Michael's participation put other class participants and instructors "at significant risk of acquiring HIV." n183

The plaintiff filed claims under Title III of the ADA, seeking an injunction requiring the school to admit him and requesting compensatory damages. The parties stipulated that the karate school was a place of entertainment and recreation which was a "gymnasium ... or other place of exercise or recreation" and thus constituted a place of public accommodation

under the ADA. n184 They also agreed that the school would not allow the plaintiff to participate in karate classes because it believed he was infected with HIV or had AIDS, n185 and that the school had offered private lessons. n186 After a trial, the district court found that allowing the plaintiff to train in group classes would place the students, instructors, and all other relevant participants in "grave danger of contracting HIV and/or AIDS," n187 and that the accommodation of private lessons was reasonable. n188

The U.S. Court of Appeals for the Fourth Circuit affirmed, holding that "the nature of the risk, combined with its severity, creates a significant risk to the health and safety of hard-style karate class members." n189 Montalvo is notable for two things. First is the district court's refusal to permit the plaintiff's medical expert to even attempt to quantify the risk associated with the minor's participation in hard contact karate. Second is the court of appeals' refusal to apply Abbott, which had been decided in the interim, to hold the trial court to a stricter standard of proof. n190 As Jeffrey A. Van Detta summarized the Montalvo analysis in his article, "Typhoid Mary" Meets the ADA:

Significantly, Montalvo viewed speculative evidence of HIV transmission much more generously than the Supreme Court did in Bragdon. Citing no studies or other scientific research, the Montalvo panel simply drew its own conclusions from two excerpts of testimony from the parties' medical and non-medical witnesses: **[*423]** (1) that there is a "high frequency of minor but bloody abrasions among the students" of the karate class and (2) that "blood-to-blood contact is a means of HIV transmission." The appellate court, like the district court, simply combined these two pieces of testimony to conclude that "although the exact mathematical probability of transmission [of HIV] is unknown, the mode of transmission is one which is likely to occur in [the defendant's] combat-oriented group karate classes because of the frequency of bloody injuries and body contact." Seemingly in contrast to the concerns rejected by the First Circuit and the Supreme Court in Bragdon, the Montalvo court justifies its gloss on this slender reed of record evidence by emphasizing that "the gravity of one factor might well compensate for the relative slightness of another," for example, "when the disease at risk of transmission is, like AIDS, severe and inevitably fatal, even a low probability of transmission could still create a significant risk." n191

III. Sutton v. United Air Lines and the Future of ADA Coverage of HIV/AIDS Disability

The Supreme Court's recent decisions clarifying the ADA requirement that a disability substantially limit a major life activity - Sutton v. United Air Lines, Inc., n192 Albertson's, Inc. v. Kirkingburg, n193 and Murphy v. United Parcel Service, Inc. n194 - will undoubtedly have some impact on HIV/AIDS employment discrimination actions. The exact effect, though, is far from clear, because HIV/AIDS as a disability is distinctively different from almost any other type of disability. Bragdon established only that HIV/AIDS, whether symptomatic or not, may constitute a disability within the meaning of the ADA. n195 The rationale for the holding, however, that the ability to have intercourse and reproduce is a major life activity that was substantially limited for the plaintiff, has application for almost all claimants, converting that aspect of the holding in Bragdon to a virtual per se rule. n196 Sutton and its companion cases clarified, in accordance with Bragdon, that the determination whether a disability "substantially limits one or more major life activities" is a factor-specific, case-by-case analysis. n197

On the other hand, unlike the poor vision of the claimants in Sutton and Albertson's, and the high blood pressure of the driver in Murphy, HIV status cannot be "corrected" in any real sense. The reasons that HIV/AIDS constitutes a disability are manyfold, but the reason the Court centered on in **[*424]** Bragdon, reproductive limitation, suggests that the risk of

transmission itself is what makes the disease a disability. Further, even assuming that the secondary effects of HIV/AIDS, such as opportunistic infections, are the actual limiting condition, recent protease inhibitor therapy regimes do not, in most cases, completely vitiate the debilitating effects of HIV/AIDS. Consequently, in this author's estimation, the central holdings of Sutton and its companion cases will not have much application in the context of HIV/AIDS discrimination.

Conclusion

Obviously, a thoroughgoing analysis of the apparent disparities in the interpretation of ADA standards as applied to HIV/AIDS is not possible in this short work. It is questionable whether such a comparison can even be made to any degree of usefulness, given the myriad factors involved in judicial review. But if "hard cases make bad law," as Justice Holmes once observed, n198 the hardest cases of all may be those that require a balancing of the right of the fortunate many who are seronegative to remain free from this debilitating and deadly disease, with the right of the unfortunate few to be free from the ostracization and abuse often imposed upon them by the many. It would be truly unfortunate if the judicial balancing in these cases is being unduly influenced by ignorance, personal prejudice or apathy. As the American Bar Association's AIDS Coordinating Committee concluded after a review of cases involving HIV discrimination in health care settings:

Scientists are concluding that the risk of becoming infected with the virus that causes AIDS based on transmission from an infected health care worker is infinitesimal: in fact, only one health care worker has ever been documented as the source of HIV transmission to a patient. ... The law lags behind science and has not yet incorporated the facts about the low risk of HIV transmission into its treatment of HIV-infected health care workers. Until courts and legislatures recognize the scientific facts about the low risk of HIV transmission and incorporate them into cases and statutes, HIV-infected health care workers are likely to suffer unnecessary discrimination and other mistreatment. n199

FOOTNOTES:

n1. The Human Immunodeficiency Virus (HIV) and its related disease complex Acquired Immunodeficiency Syndrome (AIDS) will be referred to together herein for ease of discussion as "HIV/AIDS."

n2. *42 U.S.C. 12101*-12213 (1994) and *47 U.S.C. 225,* 611 (1994).

n3. *480 U.S. 273 (1987).*

n4. *29 U.S.C. 701*-796 (1994). Hereinafter this statute will be referred to as the "Rehabilitation Act."

n5. *Arline, 480 U.S. at 284* (footnotes omitted). See also *Bragdon v. Abbott, 524 U.S. 624, 649 (1998)* ("The ADA's direct threat provision stems from the recognition in [Arline] of the importance of prohibiting discrimination against individuals with disabilities while protecting others from significant health ... risks, resulting, for instance, from a contagious disease.").

n6. *524 U.S. 624 (1998).*

n7. *29 U.S.C. 794* (1994).

n8. The medical information set out in this article is derived in part from the extant medical literature and in part from the body of case law addressing HIV/AIDS. That portion derived

from case law comes principally from the briefs by the parties and amici in *Abbott v. Bragdon, 107 F.3d 934 (1st Cir. 1997).* Any inaccuracies or outdated information contained in the discussion of HIV/AIDS pathology are solely the responsibility of the author.

n9. Warner C. Greene, Molecular Insights Into HIV-1 Infection, in The Medical Management of AIDS 17 (Merle A. Sande & Paul A. Volberding eds., 5th ed. 1997) [hereinafter Medical Management of AIDS 5th Ed.].

n10. Silvija I. Staprans & Mark T. Feinberg, Natural History and Immunopathogenesis of HIV-1 Disease, in *Medical Management of AIDS 5th Ed., supra* note 9, at 29. See also *Bragdon, 524 U.S. at 634.*

n11. See Greene, supra note 9; Staprans & Feinberg, supra note 10, at 29; *Bragdon, 524 U.S. at 634.*

n12. See Staprans & Feinberg, supra note 10, at 29; *Bragdon, 524 U.S. at 634.*

n13. See Sharon A. Riddler & John W. Mellors, HIV-1 Viral Dynamics and Viral Load Measurement: Implications for Therapy, in AIDS Clinical Review 1997/1998, 47, 50 (Paul Volbedering & Mark A. Jacobson eds., 1998); *Bragdon, 524 U.S. at 635-36.*

n14. See Greene, supra note 9, at 21; Riddler & Mellors, supra note 13, at 49-50.

n15. See Margaret A. Fischl, An Introduction to the Clinical Spectrum of AIDS, in Textbook of AIDS Medicine 149, 150 (Samuel Broder et al. eds., 1994); *Bragdon, 524 U.S. at 635-36.*

n16. See National Inst. of Health, Report of the NIH Panel to Define Principles of Therapy of HIV Infection 4 (1997) [hereinafter NIH Panel Report].

n17. See Lynda S. Doll & Beth A. Dillon, Counseling Persons Seropositive for Human Immunodeficiency Virus Infection and Their Families, in AIDS: Etiology, Diagnosis, Treatment and Prevention 533, 534 (Vincent T. DeVita et al. eds., 4th ed. 1997).

n18. Lisa Capaldini, HIV Disease: Psychosocial Issues and Psychiatric Complications, in The Medical Management of AIDS 289, 296 (Merle A. Sande & Paul A. Volberding eds., 4th ed. 1995) [hereinafter Medical Management of AIDS 4th Ed.].

n19. See Doll & Dillon, supra note 17, at 535.

n20. See id.

n21. See id. at 534-38.

n22. See Michael Clement & Harry Hollander, Initial Evaluation of and Health Care Maintenance for the HIV-Infected Adult, in *Medical Management of AIDS 4th Ed., supra* note 18, at 130.

n23. See Paul A. Volberding, Protease Inhibitors Vindicated, 350 Lancet SIII 10 (1997); NIH Panel Report, supra note 16, at 7; Steven F. Decks & Paul A. Volberding, HIV-1 Protease Inhibitors, in AIDS Clinical Review 1997-1998, 145, 174-75 (Paul A. Volberding & Mark A. Jacobson eds., 1998).

n24. See Oren J. Cohen & Anthony S. Fauci, HIV/AIDS in 1998 - Gaining the Upper Hand?, *280 JAMA 87, 87-88 (1998)* (editorial).

n25. See American Academy of Pediatrics, Committee on Pediatric AIDS, Disclosure of Illness Status to Children and Adolescents with HIV Infection, 103 Pediatrics 164, 164 (1999).

n26. See, e.g., *Bragdon, 524 U.S. at 637* ("Given the pervasive, and invariably fatal, course of the disease, its effect on major life activities of many sorts might have been relevant

to our inquiry."); *Chalk v. United States District Court, 840 F.2d 701, 710 (9th Cir. 1988)* ("The virus is fatal in all reported cases.").

n27. John Barlett, Medical Management of HIV Infection 2-3, 9-11 (1997); Staprans & Feinberg, supra note 10, at 29.

n28. See generally David M. Bell, Human Immunodeficiency Virus Transmission in Health Care Settings: Risk and Risk Reduction, 91 Am. J. Med. 3B-294S (1991).

n29. See id.

n30. Ruthanne Marcus & David M. Bell, Occupational Risk of Human Immunodeficiency Virus Infection in Health Care Workers, in AIDS: Etiology, Diagnosis, Treatment and Prevention 645, 651 (Vincent T. DeVita, Jr. et al. eds., 4th ed. 1997). See also *Bell, supra* note 28, at 3B-298S ("There are no known instances of transmission of a blood-borne pathogen by aerosol in a clinical setting."); *Bragdon, 524 U.S. at 653* ("Petitioner's expert witness conceded ... that no evidence suggested the spray could transmit HIV. His opinion on airborne risk was based on the absence of contrary evidence, not on positive data.").

n31. Centers for Disease Control and Prevention, Should I Be Concerned About Getting Infected With HIV While Playing Sports? (visited Mar. 31, 2000) <http://www.cdc.gov/nchstp/hiv<uscore>aids/pubs/faq/faq30.htm>. Another researcher supports this conclusion:

Only one instance of HIV infection thought to be related to sports has been reported in the medical literature; this infection was diagnosed in a recreational soccer player in Italy. However, public health officials in Italy who reviewed the available data could not satisfactorily rule out nonathletic risk factors for this man, who had been working in a drug-dependency rehabilitation center, nor could they definitively establish athletic activity as the source of infection... . [A] study of on-the-field bleeding injuries during professional football competitions in the United States concludes that the potential risk for HIV transmission to each player is extremely low (less than 1 per 85 million game contacts).

Eric E. Mast et al., Transmission of Blood-Borne Pathogens During Sports: Risk and Prevention, 122 Annals Internal Med. 283, 283 (1995) (internal citations omitted).

n32. See Update: Trends in AIDS Incidence, Deaths and Prevalence - United States, 1996, 46 Morbidity & Mortality Weekly Rep. 165, 171 (1997).

n33. See Roger Steinbrook, Battling HIV on Many Fronts, *337 N. Eng. J. Med. 779, 780 (1997)* (editorial) ("[The] prejudices, fears, and legacy of discrimination associated with the [HIV] infection have deep roots in society.").

n34. American Med. Ass'n Board of Trustees, Prevention and Control of Acquired Immunodeficiency Syndrome: An Interim Report, *258 JAMA 2097, 2098 (1987).* See also Steinbrook, supra note 33, at 780.

n35. See, e.g., *Doe v. City of New York, 15 F.3d 264, 267 (2d Cir. 1994)* (noting that disclosure of HIV status could subject an individual to social ostracism and discrimination in employment, insurance and health care); *Severino v. North Fort Myers Fire Control Dist., 935 F.2d 1179, 1182, n.4 (11th Cir. 1991)* (finding that HIV-negative firefighter was regarded as handicapped and noting that the "contagiousness of the disease brings AIDS within the definition of handicap"); *Support Ministries v. Village of Waterford, 808 F. Supp. 120, 132 (N.D.N.Y. 1992)* (finding individuals with asymptomatic HIV were substantially limited in major life activities due to the social prejudice and apprehension toward AIDS); *Cain v. Hyatt, 734 F.*

Supp. 671 (E.D. Pa. 1990) ("The pervasive anxiety that AIDS is easily transmitted converges with and often ostensibly justifies the disapprobation of AIDS victims.").

n36. See S. Rep. No. 101-116, at 8, 19 (1989); H. Rep. No. 101-485, pt. 2, at 48 (1990), reprinted in 1990 U.S.C.C.A.N. 303; H. Rep. No. 101-485, pt. 3, at 25 n.7 (1990), reprinted in 1990 U.S.C.C.A.N. 445.

n37. S. Rep. No. 101-116, at 8 (1989); H. Rep. No. 101-485, pt. 2, at 31 (1990).

n38. Americans With Disabilities Act of 1989: Hearings Before the Senate Comm. on Labor and Human Resources, 101st Cong. 367 (1989).

n39. See S. Rep. No. 101-116, at 22 (1989); H. Rep. No. 101-485, pt. 2, at 52 (1990); H. Rep. No. 101-485, pt. 3, at 28 n.18 (1990).

n40. *524 U.S. 624 (1998).*

n41. See *id. at 630-31.*

n42. *42 U.S.C. 12182*(b)(3). See also discussion infra Part II.A.

n43. See H. Rep. No. 101-485, pt. 3, at 34, 45 (1990) ("The Committee intends to codify the "direct threat' standard used by the Supreme Court [in Arline]."); H. Rep. No. 101-485, pt. 2, at 27 (1990); ("The term "direct threat' is meant to connote the full standard set forth in Arline."); S. Rep. No. 101-116, at 27 (1989). See also *Bragdon, 524 U.S. at 649.*

n44. *Arline, 480 U.S. at 288.*

n45. *Id. at 287-88* (quoting AMA amicus brief, at 19). It should be noted that trial courts inevitably must rely upon the opinions of medical experts in assessing the relative weight of the Arline factors. While such experts must often extrapolate from existing data, nothing in the rules for scientific evidence enunciated in *Daubert v. Merrell Dow Pharmaceuticals, Inc., 509 U.S. 579, 589-95 (1993), Kumho Tire v. Carmichael, 526 U.S. 137 (1999),* or the Federal Rules of Evidence, Rules 702-704, require a district court to admit or credit opinion evidence which is unconnected to existing data except by the ipse dixit of the expert. A court may conclude that there is simply too great an analytical gap between the data and the proffered opinion, and therefore refuse to admit opinion evidence or decline to credit it. See *General Electric Co. v. Joiner, 522 U.S. 136, 146 (1997).*

n46. *Arline, 480 U.S. at 287.*

n47. 28 C.F.R. 36.208(c) (1999). For an excellent discussion of the history of the direct threat analysis, see Jeffrey A. Van Detta, "Typhoid Mary" Meets the ADA: A Case Study of the "Direct Threat" Standard Under the Americans with Disabilities Act, *22 Harv. J.L. & Pub. Pol'y 849 (1999).*

n48. 28 C.F.R. pt. 36, app. B 36.208 (1999).

n49. See, e.g., *American Dental Ass'n v. Martin, 984 F.2d 823, 828 (7th Cir. 1992)* ("Judgments of the ... CDC are entitled to respect... . "). See also *id. at 832* (Coffey, J., concurring) ("[The CDC] is medically and scientifically qualified to determine and evaluate if there is in fact a significant risk in the health care arena... ."); *Chalk, 840 F.2d 701, 706-708 (9th Cir. 1988)* (noting that Arline "admonishes" courts to defer to public health officials and crediting the position of the CDC, U.S. Surgeon General, and AMA).

n50. *107 F.3d 934 (1st Cir. 1997).*

n51. *Id. at 947.*

n52. *840 F.2d 701 (9th Cir. 1988).*

n53. See *id. at 703.*

n54. Id. (quoting Director of Epidemiology and Disease Control for the Orange County Health Care Agency) (alteration in the original) (footnote omitted).

n55. See *id. at 709.*

n56. U.S. Public Health Service, Surgeon General's Report on Acquired Immune Deficiency Syndrome 13 (1986), quoted in *Chalk, 840 F.2d at 706.*

n57. *Chalk, 840 F.2d at 707* (quoting AMA amicus brief, at 28).

n58. *Id. at 706.*

n59. *Id. at 707* (quoting defendant's expert witness, Dr. Steven Armentrout).

n60. Id. (quoting district court judge from the transcript).

n61. Id.

n62. *Id. at 708.*

n63. *662 F. Supp. 376 (C.D. Cal. 1987)*, discussed in *Chalk, 840 F.2d at 708.*

n64. See id. at 377.

n65. Id. at 380 (emphasis added). See also *New York State Ass'n of Retarded Children v. Carey, 612 F.2d 644, 650 (2d Cir. 1979)* (holding that segregation of hepatitis B carriers violated section 504 of the Rehabilitation Act on the grounds that the evidence did not show that the health hazard posed was "anything more than a remote possibility"); *Ray v. Sch. Dist. of DeSoto County, 666 F. Supp. 1524, 1535 (M.D. Fla. 1987)* (prohibiting school district from excluding three seropositive brothers from the classroom based on the "future theoretical harm" of transmission of AIDS); *District 27 Community Sch. Bd. v. Bd. of Educ., 502 N.Y.S.2d 325, 335-37 (Sup. Ct. 1986)* (upholding board's policy of admitting students with AIDS on a case-by-case basis because transmission of AIDS in the classroom setting was "a mere theoretical possibility").

n66. *Chalk, 840 F.2d at 711* (quoting *Arline 480 U.S. at 284, 286 n.12)* (citations omitted) (alteration in original). In Ray v. School District of DeSoto County, a district court for the Middle District of Florida similarly refused to permit a school to segregate three young boys who were HIV-positive:

The Court recognizes the concern and fear which is flowing from this small community, particularly from the parents of school age children in DeSoto County. However, the Court may not be guided by such community fear, parental pressure, and the possibility of lawsuits. "These obstacles, real as they may be, cannot be allowed to vitiate the rights... ." of [the Ray children].

Ray, 666 F. Supp. at 1535 (quoting *New York State Ass'n for Retarded Children, 466 F. Supp. at 485).* Suppose, however, that a plaintiff has a skin disease that is unsightly and also very expensive to treat, but neither the disease itself nor the treatment for it would interfere with her ability to work. And suppose that her employer fired her nevertheless, either because he was revolted by her disfigured appearance or because the welfare plan that he had set up for his employees was unfunded. Either way he would not be guilty of disability discrimination.

n67. *145 F.3d 1441 (11th Cir. 1998).*

n68. See *id. at 1443.*

n69. See id.

n70. *524 U.S. 624 (1998)*, on remand, *163 F.3d 87 (1st Cir. 1998)*, cert. denied, *526 U.S. 1131 (1999).*

n71. *42 U.S.C. 12102*(2)(A).

n72. See *42 U.S.C. 12102*(2). See also *Bragdon, 524 U.S. at 641.*

n73. See *Bragdon, 524 U.S. at 637.*

n74. See *id. at 642* (quoting letter by C. Everett Koop, U.S. Surgeon General). The OLC opinion relied on a letter from the Surgeon General stating that HIV is a physical impairment regardless of the level of one's symptoms because HIV affects the hemic and lymphatic systems. See id.

n75. See *id. at 642.*

n76. See *id. at 638.*

n77. *Id. at 638.*

n78. See *id. at 639-41.*

n79. *Id. at 641.*

n80. See *id. at 642-45.*

n81. See *id. at 644.*

n82. See *id. at 642-44.*

n83. *Id. at 649* (emphasis added) (citing *Arline, 480 U.S. at 287; 42 U.S.C. 12182*(b)(3)).

n84. Id. at 652.

n85. Id. (emphasis added).

n86. Id. at 649.

n87. Id. The case of Jairath v. Dyer concerned similar alleged discrimination. See *154 F.3d 1280 (11th Cir. 1998).* Jairath involved a claim under Title III of the ADA against a cosmetic surgeon for refusing to perform facial surgery on an HIV-positive patient, Vimal Jairath. Jairath consulted with the defendant to have a Gore-Tex implant procedure performed on his face. He desired the implant to reduce the effect HIV had on his face, which he felt made him appear "thin and gaunt," and which for him created a "badge" of the HIV virus. The physician, upon learning that Jairath was HIV-positive, refused to perform the procedure. The defendant testified that Jairath's HIV-positive status increased the risk of infection and made the procedure inadvisable in light of its cosmetic purpose. See id. The case was dismissed on procedural grounds. See *id. at 1284.* See also *Henderson v. Mullady, No. 98-5114, 1999 U.S. App. LEXIS 18316* (6th Cir. Aug. 2, 1999) (unpublished opinion) (holding that examining physician's exclamation to HIV-positive social security disability claimant, "I don't handle that AIDS shit!", did not constitute tort of outrage).

n88. The operative provision reads as follows:

Subject to the provisions of this subchapter, no qualified individual with a disability shall, by reason of such disability, be excluded from participation in or be denied the benefits of the services, programs, or activities of a public entity, or be subjected to discrimination by any such entity.

42 U.S.C. 12132 (1994).

n89. Private entities are defined to include all non-public entities that fall within the reach of Title II of the ADA. See *42 U.S.C. 12181*(6).

n90. The term "commerce" is defined broadly to reach all conduct within the aegis of Commerce Clause jurisdiction:

The term "commerce" means travel, trade, traffic, commerce, transportation, or communication -

(A) among the several States;

(B) between any foreign country or any territory or possession and any State; or

(C) between points in the same State but through another State or foreign country.

42 U.S.C. 12181(1).

n91. The list of private entities that are public accommodations if they affect commerce is as follows:

(A) an inn, hotel, motel, or other place of lodging, except for an establishment located within a building that contains not more than five rooms for rent or hire and that is actually occupied by the proprietor of such establishment as the residence of such proprietor;

(B) a restaurant, bar, or other establishment serving food or drink;

(C) a motion picture house, theater, concert hall, stadium, or other place of exhibition or entertainment;

(D) an auditorium, convention center, lecture hall, or other place of public gathering;

(E) a bakery, grocery store, clothing store, hardware store, shopping center, or other sales or rental establishment;

(F) a laundromat, dry-cleaner, bank, barber shop, beauty shop, travel service, shoe repair service, funeral parlor, gas station, office of an accountant or lawyer, pharmacy, insurance office, professional office of a health care provider, hospital, or other service establishment;

(G) a terminal, depot, or other station used for specified public transportation;

(H) a museum, library, gallery, or other place of public display or collection;

(I) a park, zoo, amusement park, or other place of recreation;

(J) a nursery, elementary, secondary, undergraduate, or postgraduate private school, or other place of education;

(K) a day care center, senior citizen center, homeless shelter, food bank, adoption agency, or other social service center establishment; and

(L) a gymnasium, health spa, bowling alley, golf course, or other place of exercise or recreation.

42 U.S.C. 12181(7).

n92. See 29 C.F.R. 1630.2(r) (Title I); 28 C.F.R. Pt.35, app. A 35.104 (Title II); 29 C.F.R. 36.208(c) (Title III).

n93. For an overview of the direct threat standard in relation to HIV-positive health care workers, see R. Bradley Prewitt, The "Direct Threat" Approach to the HIV-Positive Health Care Employee Under the ADA, *62 Miss. L.J. 719 (1993).*

n94. *42 U.S.C. 12181*(7)(F).

n95. 28 C.F.R. pt. 36, app. B 36.208. The ADA, at *42 U.S.C. 12182*(b)(3), provides the direct threat exception to application of the strictures that are at issue here:

Nothing in this subchapter shall require an entity to permit an individual to participate in or benefit from the goods, services, facilities, privileges, advantages and accommodations of such entity where such individual poses a direct threat to the health or safety of others. The term "direct threat" means a significant risk to the health or safety of others that cannot be eliminated by a modification of policies, practices, or procedures or by the provision of auxiliary aids or services.

42 U.S.C. 12182(b)(3).

n96. 28 C.F.R. pt. 36, app. B 36.208.

n97. *909 F.2d 820 (5th Cir. 1990).*

n98. See. *id. at 830.*

n99. *Id. at 826* (emphasis in original).

n100. *Id. at 827* (quoting *Leckelt v. Bd. of Comm'rs, 714 F. Supp. 1377, 1389 (E.D. La. 1989)).*

n101. Id. at 829.

n102. *984 F.2d 823 (7th Cir. 1993)*, cert. denied, *510 U.S. 859 (1993).*

n103. See, e.g., *Anderson v. Romero, 72 F.3d 518, 524 (7th Cir. 1995)* (rejecting adoption of universal precautions as means to reconcile privacy interests of HIV-positive inmates with interest in avoiding infection of other prisoners); American Bar Ass'n AIDS Coordinating Comm. (Eric N. Richardson & Salvatore J. Russo eds.), Calming AIDS Phobia: Legal Implications of the Low Risk of Transmitting HIV in the Health Care Setting, 28 U. Mich. J.L. Reform 733 (1995) (concluding that "until courts and legislatures recognize the scientific facts about the low risk of HIV transmission and incorporate them into cases and statutes, HIV-infected health care workers are likely to suffer unnecessary discrimination and other mistreatment"); Paula E. Berg, When the Hazard is Human: Irrationality, Inequity, and Unintended Consequences in Federal Regulation of Contagion, *75 Wash. U. L. Q. 1367 (1997);* Scott Burris, Dental Discrimination Against the HIV-Infected: Empirical Data, Law and Public Policy, 13 Yale J. Reg. 1 (1996); Van Detta, supra note 47.

n104. See *984 F.2d at 827.* See also Occupational Exposure to Bloodborne Pathogens, *56 Fed. Reg. 64,004 (1991);* Occupational Exposure to Bloodborne Pathogens, Correction, *57 Fed. Reg. 29,206 (1992)* (codified at 29 C.F.R. 1910.1030 (2000)); *American Textile Mfrs. Inst., Inc. v. Donovan, 452 U.S. 490, 509-12, 530-36 (1981)* (the cotton dust case); *Industrial Union Dep't, AFL-CIO v. American Petroleum Inst., 448 U.S. 607, 642-45, 655-56,* (1980) (plurality opinion) (the benzene case).

n105. See *Martin, 984 F.2d at 827.*

n106. The Seventh Circuit observed that a cost-benefit type analysis could not be utilized by OSHA in imposing the CDC's Bloodborne Pathogens standard on all health care workers:

In deciding to impose this extensive array of restrictions on the practice of medicine, nursing, and dentistry, OSHA did not (indeed is not authorized to) compare the benefits with the costs and impose the restrictions on finding that the former exceeded the latter. Instead it asked whether the restrictions would materially reduce a significant workplace risk to human health without imperiling the existence of, or threatening massive dislocation to, the health care industry. For this is the applicable legal standard.

Id. at 825 (citing *29 U.S.C. 655*(b)(5)).

n107. Id. With regard to home health care personnel and employers, however, the court struck down the rule as applied to work sites not controlled either by the employer or by a hospital, nursing home, or other entity that is itself subject to the bloodborne-pathogens rule. See *id. at 829-30.*

n108. *Id. 827-29.*

n109. *Id. at 827.*

n110. Id. (quoting *Industrial Union Dep't, 448 U.S. at 656).*

n111. *3 F.3d 922 (5th Cir. 1993)*, cert. denied, *510 U.S. 1119 (1994).*

n112. See *id. at 924.*

n113. See id.

n114. Id.

n115. *50 F.3d 1261 (4th Cir. 1995).*

n116. See *id. at 1262.*

n117. *Id. at 1266.*

n118. Id.

n119. See *id. at 1263* (citing statement of Dr. David Bell, Centers for Disease Control).

n120. *Id. at 1265* (quoting lower court decision granting summary judgment).

n121. See *id. at 1264.* In University of Maryland Medical System, the court defined "exposure-prone procedures" as those involving a high degree of risk of percutaneous injury and contact with the patient's body cavity, subcutaneous tissues, or mucous membranes. See *id. at 1263.*

n122. *Id. at 1266.*

n123. *137 F.3d 398 (6th Cir. 1998)*, cert. denied, *525 U.S. 815 (1998).*

n124. See *id. at 400.*

n125. See *id. at 402-03, 405.*

n126. *Id. at 402-03.*

n127. 29 C.F.R. pt.1630, app. 1630.2(r) (1996) (emphasis added), quoted in *Mauro, 137 F.3d at 403.*

n128. *Mauro, 137 F.3d at 407.*

n129. *Id. at 401* (quoting *Mauro v. Borgess Medical Ctr., 886 F. Supp. 1349, 1353 (W.D. Mich. 1995)).*

n130. *143 F.3d 47 (2d Cir. 1998).*

n131. See *id. at 53.*

n132. See *id. at 54.*

n133. *135 F.3d 1089 (6th Cir. 1998).*

n134. See *id. at 1091-92.*

n135. See *id. at 1091.*

n136. *135 F.3d at 1094.* See also *Wesely v. Churchill Development Corp., No. 95-4024, 1996 U.S. App. LEXIS 27857, at 9* (6th Cir. Oct. 24, 1996) (unpublished opinion) (reversing Rule 11 sanctions against counsel in ADA action brought by HIV-positive dishwasher against his employer, a hotel); 8 *Ball Tattoo v. Ohio Civil Rights Comm'n, No. 95-4117, 1995 U.S. App. LEXIS 38462, at 3* (6th Cir. Dec. 13, 1995) (unpublished opinion) (granting motion to dismiss against tattoo parlor which had challenged an administrative complaint alleging that it refused to tattoo customer because of his HIV-positive status); *Watson v. City of Miami Beach, 177 F.3d 932, 936 (11th Cir. 1999)* (affirming summary judgment where police officer brought action against employer under Title I alleging city violated the ADA's medical examination and inquiries prohibitions). The Watson court found "no evidence from which a reasonable jury could find the City acted improperly in testing for tuberculosis and requiring Watson to disclose his HIV/AIDS status as part of the examination." Id.

n137. This article will not address cases brought under the Eighth Amendment's prohibition against cruel and unusual punishment, or cases in which HIV-positive prisoners argued that their seropositive status mandated a downward departure from sentencing guidelines, which encompass many reported cases. See, e.g., *Rish v. Johnson, 131 F.3d 1092 (4th Cir. 1997)* (holding in Eighth Amendment Bivens action that prison authorities were not deliberately indifferent to rights of inmate orderlies by failing to provide them protective garb for cleaning blood and body fluids from cell); *Moore v. Mabus, 976 F.2d 268, 272 (5th Cir. 1992)* (reversing order denying assistance of counsel to HIV-positive prisoners who alleged that inferior conditions and privileges provided to seropositive inmates amounted to deprivation of Eighth Amendment rights); *Massick v. North Central Correctional Facility, 136 F.3d 580, 581 (8th Cir. 1998)* (dismissing on grounds of immunity inmate's Eighth Amendment claim concerning his placement in cell with HIV-positive prisoner with open wounds); *Tokar v. Armontrout, 97 F.3d 1078, 1085 (8th Cir. 1996)* (affirming summary judgment against inmate's claim that segregation in an HIV ward with inferior facilities and programs violated the Eighth Amendment); Robbins v. *Clarke, 946* F.2d 1331 (8th Cir. 1991) (affirming dismissal of inmate's claims that failure to segregate HIV-positive inmates from healthy population was a denial of Eighth Amendment rights); *Rand v. Rowland, 113 F.3d 1520, 1522 (9th Cir. 1997)*, aff'd in part, rev'd in part en banc, *154 F.3d 952 (1998)* (vacating order in case alleging that HIV-positive prisoner was transferred to a facility where he was denied health care); *Perkins v. Kansas Dep't of Corrections, 165 F.3d 803 (10th Cir. 1999)* (affirming dismissal of HIV-positive plaintiff's Eighth Amendment claim based on alleged denial of medical treatment, but reversing sua sponte dismissal of due process and Eighth Amendment claims based on alleged denial of exercise and requirement that inmate wear a face mask at all times outside of cell); *Bell v. Beeler, No. 97-5662, 1998 U.S. App. LEXIS 9370, 4* (6th Cir. May 6, 1998) (unpublished opinion) (holding that complaint concerning denial of compassionate release of prisoner was properly dismissed where prisoner's HIV status was not the basis for denying him the release); *Campbell v. Sheahan, No. 94-1184, 1995 U.S. App. LEXIS 33996, 13* (7th Cir. Nov. 2, 1995) (unpublished opinion) (affirming dismissal of Eighth Amendment claim of deliberate indifference to prisoners' medical needs and failure to treat HIV and tuberculosis).

n138. *42 U.S.C 12131.*

n139. As late as 1998, in Owens v. O'Dea, the Sixth Circuit noted a "split in the circuits that have confronted this issue... ." See *Owens, No. 97-5517, 1998 U.S. App. LEXIS 10761, at 7* (6th Cir. May 27, 1998) (citing *Armstrong v. Wilson, 124 F.3d 1019, 1023 (9th Cir. 1997), Yeskey v. Pennsylvania Dep't of Corrections, 118 F.3d 168, 172 (3d Cir. 1997)*, cert. granted, *522 U.S. 1086 (1998), Amos v. Maryland Dep't of Pub. Safety and Correctional Servs., 126 F.3d 589, 601 (4th Cir. 1997), Crawford v. Indiana Dep't of Corrections, 115 F.3d 481, 487 (7th Cir. 1997), White v. Colorado, 82 F.3d 364, 366 (10th Cir. 1996)*, and *Harris v. Thigpen, 941 F.2d 1495, 1522 n.41 (11th Cir. 1991)).* The Sixth Circuit accordingly reserved the question pending the resolution of Yeskey in the U.S. Supreme Court. See id. at 7-8.

n140. *524 U.S. 206 (1998).*

n141. *524 U.S. at 210* (quoting *Pa. Stat. Ann., tit. 61, 1123* (Purdon Supp. 1998)).

n142. *171 F.3d 1289 (11th Cir. 1999)*, vac'g, sub. nom., *Harris v. Thigpen, 941 F.2d 1495 (11th Cir. 1991)).*

n143. Id. at 1296 n.11. Cf. *Bonner v. Lewis, 857 F.2d 559 (9th Cir. 1988)* (assessing applicability of Rehabilitation Act to provision of sign language interpreters for hearing impaired inmates in state correctional facilities).

n144. See *Onishea, 171 F.3d at 1293.*

n145. See *id. at 1293* (reporting that after a bench trial the lower court found no constitutional rights violated).

n146. See *Harris, 941 F.2d at 1526-27.*

n147. *Onishea, 171 F.3d at 1293-94.*

n148. *Id. at 1295.*

n149. See *Onishea v. Hopper, 126 F.3d 1323 (11th Cir. 1997).*

n150. See *Onishea v. Hopper, 171 F.3d 1289, 1292 (11th Cir. 1999)* (en banc).

n151. *Id. at 1295* (alteration and emphasis in original).

n152. See *id. at 1296.*

n153. *Id. at 1304.*

n154. See *id. at 1296.*

n155. The court cited *Bradley, 3 F.3d at 924, University of Maryland Medical System, 50 F.3d at 1264-65*, and *Mauro, 137 F.3d at 407.* See Part II.A supra for a more extensive discussion of these cases.

n156. *Onishea, 171 F.3d at 1297.*

n157. See *id. at 1298* (citing *Abbott, 107 F.3d at 948).*

n158. *861 F.2d 1502 (11th Cir. 1988).* See also discussion supra Part II.A.

n159. *Onishea, 171 F.3d at 1298* (citing *Martinez, 861 F.2d at 1502).* Martinez found a "remote theoretical possibility" of HIV transmission through tears, saliva, and urine was not a significant risk. See *Martinez, 861 F.2d at 1502* (remanding for determination of possibility of blood-to-blood transmission).

n160. See *Onishea, 171 F.3d at 1298.* In Chalk, the court had found, "It was error to require that every theoretical possibility of harm be disproved." See *Chalk, 840 F.2d at 709.* See also discussion supra Part I.C.

n161. See *Onishea, 171 F.3d at 1298* (discussing *Bragdon, 524 U.S. 624).*

n162. Id. at 1298.

n163. Id. at 1298-99.

n164. Id. at 1299.

n165. *39 F.3d 1439 (9th Cir. 1994).*

n166. See *id. at 1442.*

n167. See *id. at 1445.*

n168. *Id. at 1446* (citing *Harris, 941 F.2d at 1522-24).*

n169. *482 U.S. 78 (1987).*

n170. See *Gates, 39 F.3d at 1447.* The Ninth Circuit articulated the Turner standard as follows:

> Turner identifies four factors relevant in determining the reasonableness of prison policies: (1) whether there is a valid, rational connection between the prison policy and the legitimate governmental interest put forward to justify it; (2) whether there are alternative means of exercising the right; (3) the impact that accommodation of the constitutional right will have on guards, on other inmates, or on the allocation of prison resources; and (4) whether the regulation or policy is an "exaggerated response" to prison concerns. The burden is on the inmates to show that the challenged regulation is unreasonable under Turner.

Id. (quoting *Casey v. Lewis, 4 F.3d 1516, 1520 (9th Cir. 1993)).*

n171. *Turner, 482 U.S. at 89.*

n172. See *Gates, 39 F.3d at 1448.*

n173. *Id. at 1447.*

n174. *Id. at 1447-48.*

n175. A decision based upon similar reasoning is *Baldetta v. Harborview Med. Ctr., No. 96-35426, 1997 U.S. App. LEXIS 13939* (9th Cir. June 11, 1997) (unpublished decision). In Baldetta, an HIV-positive healthcare worker was fired for refusing to cover an "HIV-positive" tattoo and brought suit under the ADA and Rehabilitation Act. The court held that he had not been excluded from the position "solely because of his handicap," but for insubordination. See *Baldetta, 1997 U.S. App. LEXIS 13939, at 3.* Cf. *Owens v. O'Dea, No. 97-5517, 1998 U.S. App. LEXIS 10761* (6th Cir. May 27, 1998) (unpublished decision). In Owens, the Sixth Circuit addressed a claim made by an HIV-positive inmate under the Rehabilitation Act and Title II that a prison doctor refused to prescribe AZT. See id. at 2. The court found that because the plaintiff's condition was asymptomatic, and his immune system was within normal limits, he failed to make a prima facie case under either act, since he did not show the denial was "because of" his HIV status. See id. at 8. See also *Murdock v. Washington, 193 F.3d 510 (7th Cir. 1999)* (finding that prisoner who refused to undergo HIV testing and was therefore excluded from culinary arts program was not a qualified individual with a disability because he was neither seropositive nor regarded as such); *Harris v. Shuman, No. 97-1937, 1999 U.S. App. LEXIS 1694, at 2* (7th Cir. Feb. 1, 1999) (unpublished decision) (affirming dismissal of ADA and constitutional claims for failure to provide psychological counseling for HIV affliction). These cases suggest that courts may be giving free rein to pretextual discrimination in the context of HIV/AIDS. Contrast the strict interpretation of the "because of" requirement in these cases with the Supreme Court's liberal construction of the phrase "because of sex" in Title VII.

See, for example, *Oncale v. Sundowner Offshore Services, Inc., 523 U.S. 75 (1998)*, and its expansive interpretation of the burden-shifting analysis for employment discrimination actions, *Reeves v. Sanderson Plumbing Products, Inc., 120 S. Ct. 2097, 2107-09 (2000).* One case may signal a turn in treatment of HIV pretext cases. See *Holiday v. City of Chattanooga, 206 F.3d 637 (6th Cir. 2000).* Holiday reversed summary judgment for employer who made offer of employment to police officer but withdrew it after applicant revealed he was seropositive. See *id. at 640.* The Baldetta court also rejected the plaintiff's First Amendment claim, reasoning:

Appellees' interests in facilitating their patients' recovery outweigh Baldetta's interest in displaying the tattoo. Several doctors questioned by Appellees concluded that display of the tattoo would cause stress in severely injured or ill patients which could hinder their recovery. Given the precarious state of their patients' health, Appellees have made "a substantial showing that the speech is, in fact, likely to be disruptive."

Baldetta, 1997 U.S. App. LEXIS 13939, at 4 (quoting *Waters v. Churchill, 511 U.S. 661 (1994)* (plurality opinion)).

n176. *72 F.3d 518 (7th Cir. 1995).*

n177. *984 F.2d 823.* See also discussion supra Part II.A.

n178. *Anderson, 72 F.3d at 525-26* (citations omitted).

n179. See, e.g., 12th *St. Gym, Inc. v. General Star Indemnity Co., 93 F.3d 1158 (3d Cir. 1996)* (remanding to trial court for consideration of extrinsic evidence to decide whether insurance covered damages awarded to HIV-positive individual who had been expelled from gym because of his HIV status).

n180. *167 F.3d 873 (4th Cir. 1999)*, cert. denied, *528 U.S. 813 (1999).*

n181. See *id. at 874.*

n182. See *id. at 875.*

n183. Montalvo v. Radcliffe, No. 3:97cv487, *1998 U.S. Dist. LEXIS 4885, at 15* (E.D. Va. Jan. 29, 1998).

n184. See id. at 12. See also *42 U.S.C. 12181*(7)(L).

n185. See *Montalvo, 1998 U.S. Dist. LEXIS 4885, at 10.*

n186. See id. at 18.

n187. Id. at 13.

n188. See id. at 18.

n189. *Montalvo, 167 F.3d at 879.*

n190. See supra notes 50-51 and related text.

n191. Van Detta, supra note 47, at 876 n.117 (alterations in the original) (citations omitted) (quoting *Montalvo, 167 F.3d at 877-78).*

n192. *527 U.S. 471 (1999).*

n193. *527 U.S. 555 (1999).*

n194. *527 U.S. 516 (1999).*

n195. *524 U.S. at 637.*

n196. *524 U.S. at 641-42.*

n197. See *Sutton*, *527 U.S. at 481; Bragdon*, *524 U.S. at 641-42.*

n198. *Northern Securities Co. v. United States*, *193 U.S. 197, 400 (1904)* (Holmes, J., dissenting).

n199. *American Bar Ass'n AIDS Coordinating Comm., supra* note 103, at 733-34.