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Issues - ADA [Americans with Disabilities Act] - Bragdon v. Abbott [Folder 1] [1]

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Campaign diary

Gore faces AIDS protesters,
embraces Lesbian teenager.
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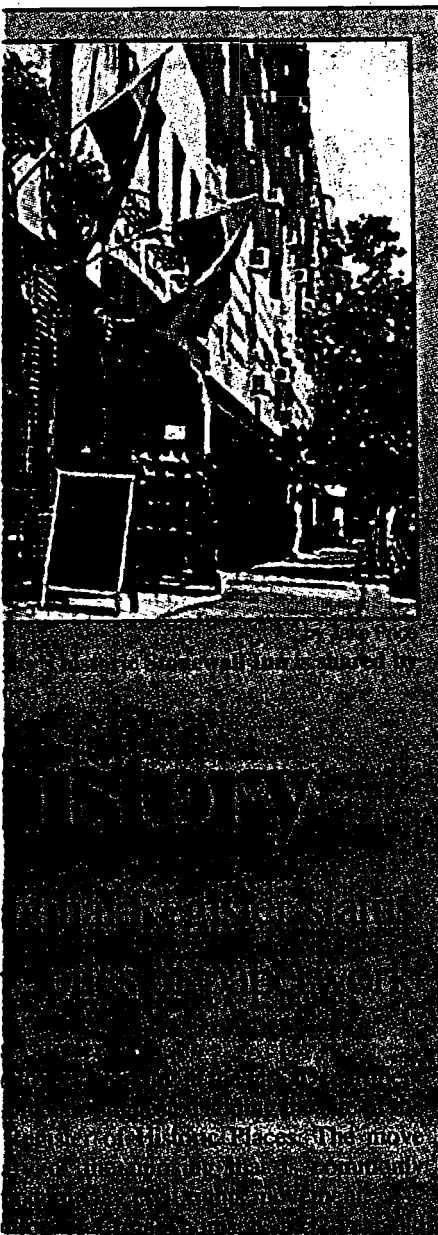


Film at 10

Strand Releasing celebrates a
decade of Gay movie distribution.
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SERVING THE NATION'S CAPITAL SINCE 1969

Washington Blade



Rulings cut into ADA

'Corrected' status doesn't count as disability

by Lisa Keen

Last year, the U.S. Supreme Court strengthened a federal law prohibiting discrimination based on disabilities, such as HIV infection; this week, the court "cut a big hole" in it.

In three separate decisions and 79 pages of opinion and dissent, the court ruled that a disability is a disability only if it is an uncorrectable disability. The intent of the ruling seemed to be to prevent a flood of litigation that some justices said they feared might result if the Americans with Disabilities Act were interpreted as protecting the 100 million Americans who wear eyeglasses and the 50 million who have high blood pressure.

But Chai Feldblum, a Lesbian activist attorney who helped draft the ADA, said the court was "inappropriately afraid of that result" because people who claimed they were fired for wearing glasses would have to be able to prove that they were fired *because* they wear glasses.



by Clint Steib

Chai Feldblum: Rulings "are so devastating for almost all people with disabilities."

Two of the three cases decided Tuesday, June 22, involved people who
Continued on page 23

Hill add-ons worry some

Youth bill addresses filters, 'charitable choice'

by Kai Wright

The U.S. House of Representative last week passed two amendments to an

While Gay civil rights advocates working on the Hill unanimously agree that the Internet filtering amendment threatens

Court: 'Corrected' status doesn't qualify for ADA

Possible implications for people living with HIV are still uncertain, Gay legal experts say

Continued from page 1

believe they were discriminated against because of their vision impairments; one involved an employee with high blood pressure. In all three cases, the employees believed that the corrective actions they took — wearing eyeglasses and taking medication — enabled them to do their jobs. But in each case, the employer argued that the impairment was not a "disability" and that it made them unable to meet industry safety standards and, therefore, unqualified for the job.

Congress adopted the ADA in 1990 to prohibit discrimination based on someone having a disability or being perceived as having a disability. A key aspect of the definition for "disability" under the ADA is that the disability "substantially limits" a "major life activity."

In each case this week — *Sutton v. United Air Lines*, *Murphy v. UPS*, and *Albertsons v. Kirkingburg* — an employee had filed a lawsuit claiming that his or her underlying impairment substantially limited his or her ability to work. Karen Sutton and her sister said United discriminated against them when it rejected their applications as pilots because their eyesight, without glasses, is worse than 20/100 that the airline requires of pilots. Vaughn Murphy said UPS discriminated against him when it fired him because his blood pressure, without medication, made him ineligible for a license he needed to perform his job as a mechanic. And Hallie Kirkingburg said the Albertsons grocery store chain in Oregon discriminated against him when it fired him because his vision in one eye was too weak to meet a federal standard required of truck drivers.

In the *United* case, a district court in Colorado ruled that, because the women could wear glasses, they did not suffer from a disability that substantially limited a major life activity — work. In the *UPS* case, a district court in Kansas said that, because the truck mechanic could control his blood pressure with medication, his impairment did not substantially limit his work. The 10th Circuit U.S. Court of Appeals upheld both those decisions. And in the *Albertsons* case, the 9th Circuit ruled that because the truck driver was virtually blind in one eye, he had a disability.

In its decisions this week, the Supreme Court upheld the results of the two 10th Circuit cases and reversed that of the 9th Circuit. Justice Sandra Day O'Connor delivered the majority decision in the 10th Circuit cases, joined by Chief Justice William Rehnquist and Justices Antonin Scalia, Anthony Kennedy, David Souter, Clarence Thomas, and Ruth Bader Ginsburg.

Justices John Paul Stevens and Stephen Breyer dissented on the 10th Circuit cases but agreed with the bulk of the court's reversal of the 9th Circuit case.

In her decision in the *United* case, Justice O'Connor

states that "if a person is taking measures to correct for, or mitigate, a physical or mental impairment, the effects of those measures — both positive and negative — must be taken into account when judging whether that person is 'substantially limited' in a major life activity and thus 'disabled'."

The decision continued, "A 'disability' exists only where an impairment 'substantially limits' a major life activity, not where it 'might,' or 'could,' or 'would' be substantially limiting if mitigating measures were not taken. A person whose physical or mental impairment is corrected by medication or other measures does not have an impairment that presently 'substantially limits' a major life activity. To be sure, a person whose physical or mental impairment is corrected by mitigating measures still has an impairment, but if the impairment is corrected it does not 'substantially limit' a major life activity."

The majority also seemed persuaded that, because Congress indicated, when passing the ADA, that it was intended to help "some 43,000,000 Americans" with disabilities, Congress could not have intended the law to protect people with impairments, such as vision impairments, that very often can be corrected.

"Had Congress intended to include all persons with corrected physical limitations," wrote O'Connor, "... it undoubtedly would have cited a much higher number of disabled persons in [its] findings."

In dissent, Justice Stevens wrote that the majority's decision "would seem to allow an employer to refuse to hire every person who has epilepsy or diabetes that is controlled by medication, or every person who functions efficiently with a prosthetic limb."

"Since the purpose of the ADA is to dismantle employment barriers based on society's accumulated myths and fears," wrote Stevens, "it is especially ironic to deny protection for persons with substantially limiting impairments that, when corrected, render them fully able and employable. ... Congress enacted the ADA in part because such individuals are not ordinarily substantially limited in their mitigated condition, but rather are often the victims of 'stereotypic assumptions not truly indicative of the individual ability of such individuals to participate in, and contribute to, society.'"

The majority upheld the 10th Circuit decision in the case involving UPS (United Parcel Service) and reversed the 9th Circuit decision in *Albertsons v. Kirkingburg*, citing its reasoning in *Sutton v. United*.

'Rulings endorse a Catch-22'

"These rulings strike at the very core of important civil rights protections for people with disabilities," said Catherine Hanssens, AIDS Project Director for Lambda Legal Defense and Education Fund, which helped submit a brief to the court in the three cases.

"The court rulings endorse a Catch-22," she said. "The court suggests that the ADA's safeguards against

workplace discrimination vanish when people with disabilities find ways to overcome their limitations and make themselves more employable."

"These opinions are so devastating for almost all

people with disabilities," said Feldblum. "It seems like the only group that we can be sure is protected now are people who are completely deaf, completely blind, use wheelchairs and — maybe — who are HIV-infected."

But both Hanssens and Feldblum said it's too soon to say for sure how the three decisions will have an impact on people with HIV.

"The reason might be the odd distinction with HIV is that the major life activity affected is reproduction, which cannot be fixed," said Feldblum. But it remains to be seen, said Feldblum, whether courts will buy that distinction for Gay men with HIV, many of whom are not interested in reproducing.

The Supreme Court, ruling in another ADA

case last year, did preserve protections for people with HIV under the law, to some extent. That ruling, in *Bradon v. Abbott*, stipulated that HIV infection — even before symptoms appear — substantially limits a person's ability to reproduce. A key definition under the ADA is that a disability is an impairment that "substantially limits" a major life activity. Reproduction, said the court, is a major life activity and HIV infection substantially limits that.

"So if Gay men with HIV have to demonstrate limitation in other life activities and they take medication, does that mean they're not protected under the law? It's confusing," said Feldblum.

"The bottom line," she continued, "is that these decisions create an absurd result where someone can be fired because of an impairment and yet would not be considered to have an impairment sufficiently disabling to justify bringing a lawsuit under ADA. You can be disabled enough to be fired but not disabled enough to challenge that firing."

Interestingly, just last month, in *Cleveland v. PMS*, the high court ruled unanimously that a person's eligibility for federal benefits when they are too disabled to work does not automatically preclude the person from also filing a lawsuit charging that his or her employer fired them for being disabled. That decision and the one in *Bradon*, however, were seen as strengthening the ADA.

Feldblum said that the three decisions issued Tuesday "cut such a big hole in it," she believes supporters of ADA will have to go back to Congress to address the "confusing language" in the legislation. But Hanssens held out hope that future cases might bring more helpful decisions.

"Future cases based on other life activities which HIV often affects, such as the ability to associate freely with other individuals, to get health care, or even drink water out of a faucet," said Hanssens in a press statement released Wednesday, "may produce a better analysis."

According to the *Washington Post*, employers have won 92 percent of the 700 ADA lawsuits filed between 1992 and 1997. ▼



by Clint Slob

Lambda's Catherine Hanssens said, "These rulings strike at the very core of important civil rights protections for people with disabilities."



Justice O'Connor: "A person whose physical or mental impairment is corrected ... does not have an impairment that presently 'substantially limits' a major life activity."

WASH. Times

HIGH COURT LIMITS WHO IS PROTECTED BY DISABILITY LAW

7-2 VOTES IN 3 BIAS CASES

Employees With Remediable
Handicaps Cannot Claim
Discrimination in Jobs

By LINDA GREENHOUSE

WASHINGTON, June 22 — Resolving one of the most pressing questions of Federal disability law, the Supreme Court ruled today that people with physical impairments who can function normally when they wear their glasses or take their medicine generally cannot be considered disabled, and therefore do not come within the law's protection against employment discrimination. By a 7-to-2 vote, the Court took a restrictive view of the definition of disability under the Americans With Disabilities Act of 1990. Employers greeted the decision with relief, saying it would prevent an uncontrollable expansion of the law, while advocates for the disabled said the Court's definition of disability would remove the law's protection from millions of people who needed it.

The Court ruled in three separate cases, rejecting the discrimination claims in each one by the same 7-to-2 vote. The dissenters in each case were Justices John Paul Stevens and Stephen G. Breyer. Justice Sandra Day O'Connor wrote two of the majority opinions and Justice David H. Souter wrote one.

In his dissent, Justice Stevens said in part that it was "especially ironic to deny protection for persons with substantially limiting impairments that, when corrected, render them fully able and employable."

The losing plaintiffs were two nearsighted women, twins, with vision correctable to 20/20, whom United Airlines turned down for jobs as pilots; a truck driver with functional vision in only one eye, who saw normally for most purposes but who was dismissed for not meeting the Federal vision standard for driving commercial vehicles; and a hypertensive automobile mechanic whose blood pressure kept him from meeting Federal standards for driving a truck, but, when kept under control by medication, left him able to hold mechanics jobs.

In a separate case today, the Court interpreted another provision of the Americans With Disabilities Act as obliging states to care for people with mental and other disabilities in group homes or other non-institutionalized settings when medically appropriate and not an unreasonable burden on the state's resources. [Article, page A16.]

In the three employment discrimi-

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Washington Times

Supreme Court Limits Who Can Be Protected Under Disability Law

Continued From Page A1

nation cases there were several secondary issues but one central question: should a "disability" be measured in its untreated state or in light of any corrective measures, such as medication, glasses or other devices that enable a person to function normally?

Justice O'Connor answered the question in the leading case of the three, the suit by the twin sisters against United Airlines, a subsidiary of the UAL Corporation. The sisters flew as pilots for regional airlines and met Federal vision standards for airline pilots, but were turned down by United because they did not meet its standard for uncorrected vision of 20/40.

Justice O'Connor said three provisions of the disability law led to the conclusion that people with remediable conditions were not disabled.

First, she said, was the law's definition of disability as an impairment that "substantially limits one or more of the major life activities," a definition that she noted was expressed in the "present indicative verb form."

"We think the language is properly read as requiring that a person be presently — not potentially or hypothetically — substantially limited in order to demonstrate a disability," Justice O'Connor said, adding that "a 'disability' exists only where an impairment 'substantially limits' a major life activity, not where it 'might,' 'could,' or 'would' be substantially limiting if mitigating measures were not taken."

A person with a corrected impairment still has the impairment, she added, "but if the impairment is corrected it does not 'substantially limit' a major life activity."

Second, she said, the law requires that people be assessed on the basis of their individual conditions, not as members of a group that is usually



Associated Press

Vaughn Murphy, a mechanic who figured in yesterday's court case.

affected in a particular way by an uncorrected impairment.

Finally, Justice O'Connor said, the findings that Congress incorporated in the text of the law included the statement that "some 43 million Americans have one or more physical or mental disabilities." She said that while the source of this figure was uncertain, Congress could not possibly have meant to include all the people who wear glasses or have some other correctable problem because the number in that case would be closer to 160 million.

"The 43 million figure reflects an understanding that those whose impairments are largely corrected by medication or other devices are not

'disabled' within the meaning" of the disability act, she said.

In the dissenting opinion in this case, *Sutton v. United Airlines*, No. 97-1943, Justice Stevens, joined by Justice Breyer, said that "in order to be faithful to the remedial purpose of the act, we should give it a generous, rather than a miserly, construction." Congress's use of the 43 million figure may have been a form of "legislative myopia," Justice Stevens said, that should not be invoked to determine the scope of the law.

"Since the purpose of the A.D.A. is to dismantle the employment barriers based on society's accumulated myths and fears," Justice Stevens continued, "it is especially ironic to deny protection for persons with substantially limiting impairments that, when corrected, render them fully able and employable."

The criticism from advocates for people with disabilities mirrored Justice Stevens's dissent. Prof. Chai Feldblum of Georgetown Law School, who was one of the law's drafters, said the decisions "create the absurd result of a person being disabled enough to be fired from a job, but not disabled enough to challenge the firing."

Senator Tom Harkin, an Iowa Democrat who was one of the chief Senate sponsors, said the decision "undermined one of the most basic principles" of the law, which he said was to "eliminate discrimination against every individual with a disability."

But Stephen Bokart, general counsel of the United States Chamber of Commerce, praised the Court's interpretation for avoiding a "huge growth in the number of cases."

Mr. Bokart said the most important aspect of the rulings from an employer's perspective was the Court's conclusion that "creating physical criteria for a job ordinarily does not violate" the disability act. He added, "The statute protects you from discrimination in a class of jobs, but it

does not guarantee you a particular job."

David Fram, director of the National Employment Law Institute, an organization here that trains corporate managers and others on how to apply the disabilities law, called the decisions "a great victory for management," adding that he was "shocked" by the Court's "very harsh line."

In her opinion in the *United Airlines* case, Justice O'Connor said that "an employer is free to decide the physical characteristics or medical conditions that do not rise to level of an impairment — such as one's height, build or singing voice — as preferable to others, just as it is free to decide that some limiting, but not substantially limiting, impairment makes individuals less than ideal suited for a job."

Justice O'Connor rejected a suggestion in the dissenting opinion that even people with artificial limbs would not be considered disabled under the majority's analysis. People may be highly functional with prosthetic devices but still be "substantially limited" in such activities as walking or running, she said.

She noted that under another provision of the law, people with correctable impairments may still be considered as disabled if their employers "regard" them as disabled. However, the majority's analysis of the law's "regarded as disabled" provision appeared to be somewhat limited to come within this section, Justice O'Connor said, a person would have to be regarded as "unable to work a broad class of jobs," not just a job in question.

The other two cases were *Murphy v. United Parcel Service*, No. 97-19 and *Albertson's v. Kirkingburg*, No. 98-591. Chief Justice William Rehnquist and Justices Antonin Scalia, Anthony M. Kennedy, Clarence Thomas and Ruth Bader Ginsburg joined the majority opinions by Justices O'Connor and Souter.

Washington Times

Post

FINAL

Inside: Food, Classified
Today's Contents on Page A2

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Prices may vary in areas outside
metropolitan Washington. (See box on Page A4)Post
6/23

Supreme Court Limits Meaning Of Disability

By JOAN BISKUPIC
Washington Post Staff Writer

The Supreme Court significantly curtailed the scope of a federal law designed to protect disabled workers from discrimination yesterday. By a 7 to 2 vote, the justices ruled that the Americans With Disabilities Act does not cover people whose disabilities can be sufficiently corrected with medicine, eyeglasses or other measures.

In their broadest look at the ADA to date, the justices decided four disabilities cases, the most important being a pair of rulings that would prevent millions of people from seeking coverage under the landmark 1990 law. The highly anticipated rulings would profoundly affect individuals with a range of impairments—from diabetes and hypertension to severe nearsightedness and hearing loss—who are able to function in society with the help of medicines or aids but whose impair-

ments may still make employers consider them ineligible for certain jobs.

"These decisions create the absurd result of a person being disabled enough to be fired from a job, but not disabled enough to challenge the firing," asserted Georgetown University law professor Chai Feldblum, who helped draft the statute and who was one of several advocates who said they would ask Congress to change the law.

The rulings represent a substantial win for employers, who praised the court's decision to limit those covered by the statute. "Employers make reasonable accommodations for employees who are truly disabled," said Steve Bokor, general counsel at the U.S. Chamber of Commerce, "but they should not have to relax necessary standards for employees who have common and easily correctable ailments."

The disability cases were

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Punitive damages backed in some job bias cases. | Page A10

High Court Limits Disability Meaning In Job Bias Cases

COURT, From A1

closely followed by workers, businesses, civil rights advocates and the Clinton administration, which had urged the justices to interpret the law in a broad manner.

■ By identical votes of 7 to 2 in a pair of cases—one involving two nearsighted pilots and the other a mechanic with high blood pressure—the court ruled that when judges assess whether a worker pressing a disability-bias suit qualifies as “disabled” under the law, they must take into account any measures that lessen the worker’s impairment.

■ By a unanimous vote in *Albertson’s v. Kirkingburg*, the justices ruled that employers who set job qualifications based on federal safety standards are not required to dispense with those standards when a worker—in this case, a truck driver blind in one eye—obtains a waiver from the federal agency.

■ By a 6 to 3 vote, the court ruled that states must place certain mentally disabled people in community homes rather than hospitals. In a case focused on a provision of the ADA that prohibits discrimination by public entities, the court generally sided with two Georgia women with mental illnesses who had sued state officials for keeping them in a psychiatric hospital long after their doctors said they were ready to live in a community residence.

Enacted after years of effort, the Americans With Disabilities Act was meant to open jobs and public spaces to the nation’s then-estimated 43 million disabled people. The law defines a “disability” as a “physical or mental impairment that substantially limits one or more . . . major life activities.” Yesterday, the court addressed the most fundamental

question of how to determine who is and is not “disabled.”

The main ruling dealt with twin sisters from Spokane, Karen Sutton and Kimberly Hinton, who were turned down for pilot jobs at United Air Lines because of their extreme nearsightedness, failing the airline’s minimum requirement for uncorrected visual acuity of 20/100. When they sued under the ADA, judges said the law did not cover people who can correct their disabilities—in this case, with glasses—and get along as well as most other people.

Yesterday, the Supreme Court agreed, rejecting the position of the U.S. Equal Employment Opportunity Commission and the majority of federal appeals courts.

“Looking at the act as a whole,” Justice Sandra Day O’Connor wrote for the majority, “it is apparent that if a person is taking measures to correct for, or mitigate, a physical or mental impairment, the effects of those measures—both positive and negative—must be taken into account when judging whether that person is ‘substantially limited’ in a major life activity.” She said the language of the law requires a person to be limited “presently—not potentially or hypothetically.”

O’Connor noted that Congress had written in the law that “some 43 million Americans have one or more physical or mental disabilities” and argued that if the law were intended to cover all those with common, correctable impairments such as nearsightedness, that figure would have been far larger.

But the majority also emphasized that whether a person has a disability is an individual question and that some people who have prosthetic limbs or other

corrective devices could still be considered “disabled” because of a substantial limitation of their life activities.

O’Connor was joined by Chief Justice William H. Rehnquist and Justices Antonin Scalia, Anthony M. Kennedy, David H. Souter, Clarence Thomas and Ruth Bader Ginsburg in *Sutton v. United Air Lines*, as well as in the related ruling involving a mechanic with hypertension, *Murphy v. United Parcel Service*.

Dissenting in both cases were Justices John Paul Stevens and Stephen G. Breyer. In a statement written by Stevens, they said, “[T]o be faithful to the remedial purpose of the Act, we should give it a generous, rather than a miserly, construction.”

Roy C. Englert Jr., who represented United, said he was pleased with the court’s ruling, which was cheered by other employers as well. Human resources lawyer Ted Gies said the court provided important “clarification” about who is covered by the ADA and its decision will help to reduce ADA lawsuits. “Most people would say,” Gies said, “that the biggest human resource and legal challenge is the ADA.”

But Michael A. Greene, a lawyer for the American Diabetes Association, said the ruling puts people who take medicine to function in society in a difficult position. “You’re damned if you don’t medicate, but you’re damned if you do, because you lose your legal rights,” Greene said, adding that sometimes impaired persons who can do the job might nonetheless seek special accommodations or extra time off for medical care.

The case on community placement, *Olmstead v. L.C.*, spoke to

increased efforts to move mentally ill people from institutions into communities in an effort to end their isolation. A key provision of the ADA says disabled persons shall not be discriminated against “by reason of their disability” by a government program or service, and the Justice Department has said that means programs must be offered “in the most integrated setting appropriate to the needs” of people with disabilities.

Georgia officials, backed by numerous other state and local governments, had argued that a state does not discriminate under the ADA when it keeps the mentally ill in hospitals, even though a community setting might be more desirable.

But in an opinion by Ginsburg, the court ruled that it is indeed illegal discrimination “when the state’s treatment professionals have determined that community placement is appropriate, the transfer from institutional care to less restrictive setting is not opposed by the affected individual, and the placement can be reasonably accommodated, taking into account the resources available to the state.”

Concurring justices stressed that states should have “wide discretion in adopting its own systems of cost analysis.”

Dissenting were Rehnquist, Scalia and Thomas. In a statement for the trio, Thomas said it is not “discrimination” when mentally ill people are temporarily excluded from community placement centers.

Staff writer Kirsten Downey
Grimsley contributed to this report.

The ADA Cases

■ *Sutton v. United Air Lines*

Twin sisters Karen Sutton and Kimberly Hinton of Spokane, Wash., wanted to be United pilots but were rejected because they are nearsighted. The sisters had 20/20 vision with corrective lenses, but United requires uncorrected vision of 20/100.

■ *Kirkingburg v. Albertson's*

Hallie Kirkingburg, a truck driver from Portland, Ore., was fired by the Albertson's supermarket chain after he failed a vision test. He was unable to meet vision requirements for commercial drivers, even with corrective lenses.

■ *Murphy v. United Parcel Service*

Vaughn Murphy, a mechanic from Kansas, was fired by UPS because of high blood pressure he has had since he was 10. Murphy's physician said he was unable to lower his blood pressure below the Transportation Department's required level without serious side effects.

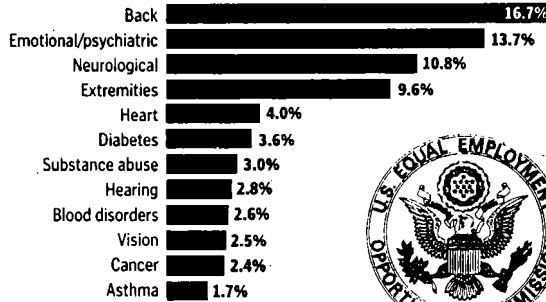
■ *Olmstead v. L.C.*

Elaine Wilson, who is mildly retarded and has a borderline personality disorder, and Lois Curtis, who is mildly retarded and was diagnosed as schizophrenic, sued Georgia to get out of a state mental hospital in Atlanta and into community-based care.

Defining Disabilities

From 1992 to 1998, there were 108,939 complaints filed with the Equal Employment Opportunity Commission under the Americans With Disabilities Act.

Impairments most often cited (as a percentage of all cases)



SOURCE: Equal Employment Opportunity Commission

THE WASHINGTON POST

Ruling Favors Workers Seeking Punitive Damages

By JOAN BISKUPIC
Washington Post Staff Writer

The Supreme Court yesterday slightly enhanced the ability of some workers alleging intentional discrimination based on sex or race to win punitive damages.

By a 7 to 2 vote in a case involving a woman who was passed over for a promotion by the American Dental Association in favor of a man with less experience, the justices ruled that an employer's conduct need not

be "egregious" to satisfy the law's requirements for punitive damages.

But the justices also declared, by a separate 5 to 4 vote in the same case, that companies need not pay punitive damages for supervisors' discriminatory conduct if the employer had made a good-faith effort to protect against bias on the job.

The law at issue in *Kolstad v. American Dental Association* says that once a worker has successfully made a case that a company intentionally discriminated, the worker

can win punitive damages if it can be shown that the employer acted "with malice or with reckless indifference to the federally protected rights of an aggrieved individual." The D.C. Circuit had interpreted that to mean "particularly egregious violations" of Title VII of the 1964 Civil Rights Act.

But yesterday, the high court, in an opinion by Justice Sandra Day O'Connor, ruled that terms "malice" and "reckless indifference" focus on the state of mind of the supervisor, and do not require a showing of

egregious or outrageous discrimination independent of that mind-set.

Chief Justice William H. Rehnquist and Justice Clarence Thomas dissented from the part of the rulings that said an employer's conduct need not be egregious for damages to apply. Dissenting from the part that lets companies off the hook for managers' discriminatory conduct if the employers made a good-faith effort to prevent bias were John Paul Stevens, David H. Souter, Ruth Bader Ginsburg and Stephen G. Breyer.



FILE PHOTO BY DRAKE SORRY—LAWRENCE JOURNAL WORLD VIA ASSOCIATED PRESS

Plaintiff Vaughn Murphy at his Kansas home in April. Murphy is a mechanic with hypertension who sued United Parcel Service after being fired.

Washington Post 6/23/99

Syllabus

NOTE: Where it is feasible, a syllabus (headnote) will be released, as is being done in connection with this case, at the time the opinion is issued. The syllabus constitutes no part of the opinion of the Court but has been prepared by the Reporter of Decisions for the convenience of the reader. See *United States v. Detroit Timber & Lumber Co.*, 200 U. S. 321, 337.

SUPREME COURT OF THE UNITED STATES

Syllabus

BRAGDON *v.* ABBOTT ET AL.CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR
THE FIRST CIRCUIT

No. 97-156. Argued March 30, 1998—Decided June 25, 1998

Respondent is infected with the human immunodeficiency virus (HIV), but had not manifested its most serious symptoms when the incidents in question occurred. At that time, she went to petitioner's office for a dental examination and disclosed her HIV infection. Petitioner discovered a cavity and informed respondent of his policy against filling cavities of HIV-infected patients in his office. He offered to perform the work at a hospital at no extra charge, though respondent would have to pay for use of the hospital's facilities. She declined and filed suit under, *inter alia*, the Americans with Disabilities Act of 1990 (ADA), which prohibits discrimination against any individual "on the basis of disability in the . . . enjoyment of the . . . services . . . of any place of public accommodation by any person who . . . operates [such] a place," 42 U. S. C. §12182(a), but qualifies the prohibition by providing: "Nothing [herein] shall require an entity to permit an individual to participate in or benefit from the . . . accommodations of such entity where such individual poses a direct threat to the health or safety of others," §12182(b)(3). The District Court granted respondent summary judgment. The First Circuit affirmed, agreeing with the lower court that respondent's HIV was a disability under the ADA even though her infection had not yet progressed to the symptomatic stage, and that treating her in petitioner's office would not have posed a direct threat to the health and safety of others. In making the latter ruling, the court relied on the 1993 Dentistry Guidelines of the Centers for Disease Control and Prevention (CDC) and on the 1991 American Dental Association Policy on HIV.

Held:

1. Even though respondent's HIV infection had not progressed to the so-called symptomatic phase, it was a "disability" under

Syllabus

§12102(2)(A), that is, “a physical . . . impairment that substantially limits one or more of [an individual’s] major life activities.” Pp. 3–21.

(a) The ADA definition is drawn almost verbatim from definitions applicable to §504 of the Rehabilitation Act of 1973 and another federal statute. Because the ADA expressly provides that “nothing [herein] shall be construed to apply a lesser standard than . . . under . . . the Rehabilitation Act . . . or the regulations issued . . . pursuant to [it],” §12201(a), this Court must construe the ADA to grant at least as much protection as the regulations implementing the Rehabilitation Act. Pp. 4–5.

(b) From the moment of infection and throughout every stage of the disease, HIV infection satisfies the statutory and regulatory definition of a “physical impairment.” Applicable Rehabilitation Act regulations define “physical or mental impairment” to mean “any physiological disorder or condition . . . affecting . . . the . . . body[s] . . . hemic and lymphatic [systems].” HIV infection falls well within that definition. The medical literature reveals that the disease follows a predictable and unalterable course from infection to inevitable death. It causes immediate abnormalities in a person’s blood, and the infected person’s white cell count continues to drop throughout the course of the disease, even during the intermediate stage when its attack is concentrated in the lymph nodes. Thus, HIV infection must be regarded as a physiological disorder with an immediate, constant, and detrimental effect on the hemic and lymphatic systems. Pp. 4–10.

(c) The life activity upon which respondent relies, her ability to reproduce and to bear children, constitutes a “major life activity” under the ADA. The plain meaning of the word “major” denotes comparative importance and suggests that the touchstone is an activity’s significance. Reproduction and the sexual dynamics surrounding it are central to the life process itself. Petitioner’s claim that Congress intended the ADA only to cover those aspects of a person’s life that have a public, economic, or daily character founders on the statutory language. Nothing in the definition suggests that activities without such a dimension may somehow be regarded as so unimportant or insignificant as not to be “major.” This interpretation is confirmed by the Rehabilitation Act regulations, which provide an illustrative, nonexhaustive list of major life activities. Inclusion on that list of activities such as caring for one’s self, performing manual tasks, working, and learning belies the suggestion that a task must have a public or economic character. On the contrary, the regulations support the inclusion of reproduction, which could not be regarded as any less important than working and learning. Pp. 10–12.

(d) Respondent’s HIV infection “substantially limits” her major

Syllabus

life activity within the ADA’s meaning. Although the Rehabilitation Act regulations provide little guidance in this regard, the Court’s evaluation of the medical evidence demonstrates that an HIV-infected woman’s ability to reproduce is substantially limited in two independent ways: If she tries to conceive a child, (1) she imposes on her male partner a statistically significant risk of becoming infected; and (2) she risks infecting her child during gestation and childbirth, i.e., perinatal transmission. Evidence suggesting that antiretroviral therapy can lower the risk of perinatal transmission to about 8%, even if relevant, does not avail petitioner because it cannot be said as a matter of law that an 8% risk of transmitting a dread and fatal disease to one’s child does not represent a substantial limitation on reproduction. The decision to reproduce carries economic and legal consequences as well. There are added costs for antiretroviral therapy, supplemental insurance, and long-term health care for the child who must be examined and treated. Some state laws, moreover, forbid HIV-infected persons from having sex with others, regardless of consent. In the context of reviewing summary judgment, the Court must take as true respondent’s unchallenged testimony that her HIV infection controlled her decision not to have a child. Pp. 12–15.

(e) The uniform body of administrative and judicial precedent interpreting similar language in the Rehabilitation Act confirms the Court’s holding. Every agency and court to consider the issue under the Rehabilitation Act has found statutory coverage for persons with asymptomatic HIV. The uniformity of that precedent is significant. When administrative and judicial interpretations have settled the meaning of an existing statutory provision, repetition of the same language in a new statute indicates, as a general matter, Congress’ intent to incorporate such interpretations as well. See, e.g., *Lorillard v. Pons*, 434 U. S. 575, 580–581. Pp. 15–19.

(f) The Court’s holding is further reinforced by the guidance issued by the Justice Department and other agencies authorized to administer the ADA, which supports the conclusion that persons with asymptomatic HIV fall within the ADA’s definition of disability. The views of agencies charged with implementing a statute are entitled to deference. See *Chevron U. S. A. Inc. v. Natural Resources Defense Council, Inc.*, 467 U. S. 837, 844. Pp. 19–21.

2. In affirming the summary judgment, the First Circuit did not cite sufficient material in the record to determine, as a matter of law, that respondent’s HIV infection posed no direct threat to the health and safety of others. The ADA’s direct threat provision, §12182(b)(3), stems from *School Bd. of Nassau Cty. v. Arline*, 480 U. S. 273, 287, in which this Court reconciled competing interests in prohibiting discrimination and preventing the spread of disease by construing the

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Rehabilitation Act not to require the hiring of a person who posed “a significant risk of communicating an infectious disease to others,” *id.*, at 287, and n. 16. The existence of a significant risk is determined from the standpoint of the health care professional who refuses treatment or accommodation, and the risk assessment is based on the medical or other objective, scientific evidence available to him and his profession, not simply on his good-faith belief that a significant risk existed. See *id.*, at 288; *id.*, at 288, n. 18, distinguished. For the most part, the First Circuit followed the proper standard and conducted a thorough review of the evidence. However, it might have mistakenly relied on the 1993 CDC Dentistry Guidelines, which recommend certain universal precautions to combat the risk of HIV transmission in the dental environment, but do not actually assess the level of such risk, and on the 1991 American Dental Association Policy on HIV, which is the work of a professional organization, not a public health authority, and which does not reveal the extent to which it was based on the Association’s assessment of dentists’ ethical and professional duties, rather than scientific assessments. Other evidence in the record might support affirmance of the trial court’s ruling, and there are reasons to doubt whether petitioner advanced evidence sufficient to raise a triable issue of fact on the significance of the risk, but this Court’s evaluation is constrained by the fact that it has not had briefs and arguments directed to the entire record. A remand will permit a full exploration of the issues through the adversary process. Pp. 21–29.

107 F. 3d 934, vacated and remanded.

KENNEDY, J., delivered the opinion of the Court, in which STEVENS, SOUTER, GINSBURG, and BREYER, JJ., joined. STEVENS, J., filed a concurring opinion, in which BREYER, J., joined. GINSBURG, J., filed a concurring opinion. REHNQUIST, C. J., filed an opinion concurring in the judgment in part and dissenting in part, in which SCALIA and THOMAS, JJ., joined, and in Part II of which O’CONNOR, J., joined. O’CONNOR, J., filed an opinion concurring in the judgment in part and dissenting in part.

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SUPREME COURT OF THE UNITED STATES

No. 97–156

RANDON BRAGDON, PETITIONER v. SIDNEY
ABBOTT ET AL.

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF
APPEALS FOR THE FIRST CIRCUIT

[June 25, 1998]

JUSTICE KENNEDY delivered the opinion of the Court.

We address in this case the application of the Americans with Disabilities Act of 1990 (ADA), 104 Stat. 327, 42 U. S. C. §12101 *et seq.*, to persons infected with the human immunodeficiency virus (HIV). We granted certiorari to review, first, whether HIV infection is a disability under the ADA when the infection has not yet progressed to the so-called symptomatic phase; and, second, whether the Court of Appeals, in affirming a grant of summary judgment, cited sufficient material in the record to determine, as a matter of law, that respondent’s infection with HIV posed no direct threat to the health and safety of her treating dentist.

I

Respondent Sidney Abbott has been infected with HIV since 1986. When the incidents we recite occurred, her infection had not manifested its most serious symptoms. On September 16, 1994, she went to the office of petitioner Randon Bragdon in Bangor, Maine, for a dental appointment. She disclosed her HIV infection on the patient reg-

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istration form. Petitioner completed a dental examination, discovered a cavity, and informed respondent of his policy against filling cavities of HIV-infected patients. He offered to perform the work at a hospital with no added fee for his services, though respondent would be responsible for the cost of using the hospital's facilities. Respondent declined.

Respondent sued petitioner under state law and §302 of the ADA, 104 Stat. 355, 42 U. S. C. §12182, alleging discrimination on the basis of her disability. The state law claims are not before us. Section 302 of the ADA provides:

"No individual shall be discriminated against on the basis of disability in the full and equal enjoyment of the goods, services, facilities, privileges, advantages, or accommodations of any place of public accommodation by any person who . . . operates a place of public accommodation." §12182(a).

The term "public accommodation" is defined to include the "professional office of a health care provider." §12181(7)(F).

A later subsection qualifies the mandate not to discriminate. It provides:

"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." §12182(b)(3).

The United States and the Maine Human Rights Commission intervened as plaintiffs. After discovery, the parties filed cross-motions for summary judgment. The District Court ruled in favor of the plaintiffs, holding that respondent's HIV infection satisfied the ADA's definition of disability. 912 F. Supp. 580, 585-587 (Me. 1995). The court held further that petitioner raised no genuine issue

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of material fact as to whether respondent's HIV infection would have posed a direct threat to the health or safety of others during the course of a dental treatment. *Id.*, at 587-591. The court relied on affidavits submitted by Dr. Donald Wayne Marianos, Director of the Division of Oral Health of the Centers for Disease Control and Prevention (CDC). The Marianos affidavits asserted it is safe for dentists to treat patients infected with HIV in dental offices if the dentist follows the so-called universal precautions described in the Recommended Infection-Control Practices for Dentistry issued by CDC in 1993 (1993 CDC Dentistry Guidelines). 912 F. Supp., at 589.

The Court of Appeals affirmed. It held respondent's HIV infection was a disability under the ADA, even though her infection had not yet progressed to the symptomatic stage. 107 F. 3d 934, 939-943 (CA1 1997). The Court of Appeals also agreed that treating the respondent in petitioner's office would not have posed a direct threat to the health and safety of others. *Id.*, at 943-948. Unlike the District Court, however, the Court of Appeals declined to rely on the Marianos affidavits. *Id.*, at 946, n. 7. Instead the court relied on the 1993 CDC Dentistry Guidelines, as well as the Policy on AIDS, HIV Infection and the Practice of Dentistry, promulgated by the American Dental Association in 1991 (1991 American Dental Association Policy on HIV). 107 F. 3d, at 945-946.

II

We first review the ruling that respondent's HIV infection constituted a disability under the ADA. The statute defines disability as:

"(A) a physical or mental impairment that substantially limits one or more of the major life activities of such individual;

"(B) a record of such an impairment; or

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“(C) being regarded as having such impairment.” §12102(2).

We hold respondent’s HIV infection was a disability under subsection (A) of the definitional section of the statute. In light of this conclusion, we need not consider the applicability of subsections (B) or (C).

Our consideration of subsection (A) of the definition proceeds in three steps. First, we consider whether respondent’s HIV infection was a physical impairment. Second, we identify the life activity upon which respondent relies (reproduction and child bearing) and determine whether it constitutes a major life activity under the ADA. Third, tying the two statutory phrases together, we ask whether the impairment substantially limited the major life activity. In construing the statute, we are informed by interpretations of parallel definitions in previous statutes and the views of various administrative agencies which have faced this interpretive question.

A

The ADA’s definition of disability is drawn almost verbatim from the definition of “handicapped individual” included in the Rehabilitation Act of 1973, 29 U. S. C. §706(8)(B) (1988 ed.), and the definition of “handicap” contained in the Fair Housing Amendments Act of 1988, 42 U. S. C. §3602(h)(1) (1988 ed.). Congress’ repetition of a well-established term carries the implication that Congress intended the term to be construed in accordance with pre-existing regulatory interpretations. See *FDIC v. Philadelphia Gear Corp.*, 476 U. S. 426, 437–438 (1986); *Commissioner v. Estate of Noel*, 380 U. S. 678, 681–682 (1965); *ICC v. Parker*, 326 U. S. 60, 65 (1945). In this case, Congress did more than suggest this construction; it adopted a specific statutory provision in the ADA directing as follows:

“Except as otherwise provided in this chapter, nothing

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in this chapter shall be construed to apply a lesser standard than the standards applied under title V of the Rehabilitation Act of 1973 (29 U. S. C. 790 et seq.) or the regulations issued by Federal agencies pursuant to such title.” 42 U. S. C. §12201(a).

The directive requires us to construe the ADA to grant at least as much protection as provided by the regulations implementing the Rehabilitation Act.

1

The first step in the inquiry under subsection (A) requires us to determine whether respondent’s condition constituted a physical impairment. The Department of Health, Education and Welfare (HEW) issued the first regulations interpreting the Rehabilitation Act in 1977. The regulations are of particular significance because, at the time, HEW was the agency responsible for coordinating the implementation and enforcement of §504. *Consolidated Rail Corporation v. Darrone*, 465 U. S. 624, 634, (1984) (citing Exec. Order No. 11914, 3 CFR 117 (1976–1980 Comp.)). The HEW regulations, which appear without change in the current regulations issued by the Department of Health and Human Services, define “physical or mental impairment” to mean:

“(A) any physiological disorder or condition, cosmetic disfigurement, or anatomical loss affecting one or more of the following body systems: neurological; musculoskeletal; special sense organs; respiratory, including speech organs; cardiovascular; reproductive, digestive, genito-urinary; hemic and lymphatic; skin; and endocrine; or

“(B) any mental or psychological disorder, such as mental retardation, organic brain syndrome, emotional or mental illness, and specific learning disabilities.” 45 CFR §84.3(j)(2)(i) (1997).

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In issuing these regulations, HEW decided against including a list of disorders constituting physical or mental impairments, out of concern that any specific enumeration might not be comprehensive. 42 Fed. Reg. 22685 (1977), reprinted in 45 CFR pt. 84, App. A, p. 334 (1997). The commentary accompanying the regulations, however, contains a representative list of disorders and conditions constituting physical impairments, including "such diseases and conditions as orthopedic, visual, speech, and hearing impairments, cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, mental retardation, emotional illness, and . . . drug addiction and alcoholism." *Ibid.*

In 1980, the President transferred responsibility for the implementation and enforcement of §504 to the Attorney General. See, e.g., Exec. Order No. 12250, 3 CFR 298 (1981). The regulations issued by the Justice Department, which remain in force to this day, adopted verbatim the HEW definition of physical impairment quoted above. 28 CFR §41.31(a)(1) (1997). In addition, the representative list of diseases and conditions originally relegated to the commentary accompanying the HEW regulations were incorporated into the text of the regulations. *Ibid.*

HIV infection is not included in the list of specific disorders constituting physical impairments, in part because HIV was not identified as the cause of AIDS until 1983. See Barré-Sinoussi et al., Isolation of a T-Lymphotropic Retrovirus from a Patient at Risk for Acquired Immune Deficiency Syndrome (AIDS), 220 Science 868 (1983); Gallo et al., Frequent Detection and Isolation of Cytopathic Retroviruses (HTLV-III) from Patients with AIDS and at Risk for AIDS, 224 Science 500 (1984); Levy et al., Isolation of Lymphocytopathic Retroviruses from San Francisco Patients with AIDS, 225 Science 840 (1984). HIV infection does fall well within the general definition set forth by the regulations, however.

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The disease follows a predictable and, as of today, an unalterable course. Once a person is infected with HIV, the virus invades different cells in the blood and in body tissues. Certain white blood cells, known as helper T-lymphocytes or CD4+ cells, are particularly vulnerable to HIV. The virus attaches to the CD4 receptor site of the target cell and fuses its membrane to the cell's membrane. HIV is a retrovirus, which means it uses an enzyme to convert its own genetic material into a form indistinguishable from the genetic material of the target cell. The virus' genetic material migrates to the cell's nucleus and becomes integrated with the cell's chromosomes. Once integrated, the virus can use the cell's own genetic machinery to replicate itself. Additional copies of the virus are released into the body and infect other cells in turn. Young, The Replication Cycle of HIV-1, in The AIDS Knowledge Base, pp. 3.1-2 to 3.1-7 (P. Cohen, M. Sande, & P. Volberding eds., 2d ed. 1994) (hereinafter AIDS Knowledge Base); Folks & Hart, The Life Cycle of Human Immunodeficiency Virus Type 1, in AIDS: Etiology, Diagnosis, Treatment and Prevention 29-39 (V. DeVita et al. eds., 4th ed. 1997) (hereinafter AIDS: Etiology); Greene, Molecular Insights into HIV-1 Infection, in The Medical Management of AIDS 18-24 (M. Sande & P. Volberding eds., 5th ed. 1997) (hereinafter Medical Management of AIDS). Although the body does produce antibodies to combat HIV infection, the antibodies are not effective in eliminating the virus. Pantaleo et al., Immunopathogenesis of Human Immunodeficiency Virus Infection, in AIDS: Etiology 79; Garner, HIV Vaccine Development, in AIDS Knowledge Base 3.6-5; Haynes, Immune Responses to Human Immunodeficiency Virus Infection, in AIDS: Etiology 91.

The virus eventually kills the infected host cell. CD4+ cells play a critical role in coordinating the body's immune response system, and the decline in their number causes

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corresponding deterioration of the body's ability to fight infections from many sources. Tracking the infected individual's CD4+ cell count is one of the most accurate measures of the course of the disease. Greene, Medical Management of AIDS 19, 24. Osmond, Classification and Staging of HIV Disease, in AIDS Knowledge Base 1.1-8; Saag, Clinical Spectrum of Human Immunodeficiency Virus Diseases, in AIDS: Etiology 204.

The initial stage of HIV infection is known as acute or primary HIV infection. In a typical case, this stage lasts three months. The virus concentrates in the blood. The assault on the immune system is immediate. The victim suffers from a sudden and serious decline in the number of white blood cells. There is no latency period. Mononucleosis-like symptoms often emerge between six days and six weeks after infection, at times accompanied by fever, headache, enlargement of the lymph nodes (lymphadenopathy), muscle pain (myalgia), rash, lethargy, gastrointestinal disorders, and neurological disorders. Usually these symptoms abate within 14 to 21 days. HIV antibodies appear in the bloodstream within 3 weeks; circulating HIV can be detected within 10 weeks. Carr & Cooper, Primary HIV Infection, in Medical Management of AIDS 89-91; Cohen & Volberding, Clinical Spectrum of HIV Disease, in AIDS Knowledge Base 4.1-7; Crowe & McGrath, Acute HIV Infection, in AIDS Knowledge Base 4.2-1 to 4.2-4; Saag, AIDS: Etiology 204-205.

After the symptoms associated with the initial stage subside, the disease enters what is referred to sometimes as its asymptomatic phase. The term is a misnomer, in some respects, for clinical features persist throughout, including lymphadenopathy, dermatological disorders, oral lesions, and bacterial infections. Although it varies with each individual, in most instances this stage lasts from 7 to 11 years. The virus now tends to concentrate in the lymph nodes, though low levels of the virus continue to

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appear in the blood. Cohen & Volberding, AIDS Knowledge 4.1-4, 4.1-8; Saag, AIDS: Etiology 205-206; Strapans & Feinberg, Natural History and Immunopathogenesis of HIV-1 Disease, in Medical Management of AIDS 38. It was once thought the virus became inactive during this period, but it is now known that the relative lack of symptoms is attributable to the virus' migration from the circulatory system into the lymph nodes. Cohen & Volberding, AIDS Knowledge Base 4.1-4. The migration reduces the viral presence in other parts of the body, with a corresponding diminution in physical manifestations of the disease. The virus, however, thrives in the lymph nodes, which, as a vital point of the body's immune response system, represents an ideal environment for the infection of other CD4+ cells. Strapans & Feinberg, Medical Management of AIDS 33-34. Studies have shown that viral production continues at a high rate. Cohen & Volberding, AIDS Knowledge Base 4.1-4; Strapans & Feinberg, Medical Management of AIDS 38. CD4+ cells continue to decline an average of 5% to 10% (40 to 80 cells/mm³) per year throughout this phase. Saag, AIDS: Etiology 207.

A person is regarded as having AIDS when his or her CD4+ count drops below 200 cells/mm³ of blood or when CD4+ cells comprise less than 14% of his or her total lymphocytes. U. S. Dept. of Health and Human Services, Public Health Service, CDC, 1993 Revised Classification System for HIV Infection and Expanded Surveillance Case Definition for AIDS Among Adolescents and Adults, 41 Morbidity & Mortality Weekly Rep., No. RR-17 (Dec. 18, 1992); Osmond, AIDS Knowledge Base 1.1-2; Saag, AIDS: Etiology 207; Ward, Petersen, & Jaffe, Current Trends in the Epidemiology of HIV/AIDS, in Medical Management of AIDS 3. During this stage, the clinical conditions most often associated with HIV, such as *pneumocystis carinii* pneumonia, Kaposi's sarcoma, and non-Hodgkins lym-

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phoma, tend to appear. In addition, the general systemic disorders present during all stages of the disease, such as fever, weight loss, fatigue, lesions, nausea, and diarrhea, tend to worsen. In most cases, once the patient's CD4+ count drops below 10 cells/mm³, death soon follows. Cohen & Volberding, AIDS Knowledge Base 4.1-9; Saag, AIDS: Etiology 207-209.

In light of the immediacy with which the virus begins to damage the infected person's white blood cells and the severity of the disease, we hold it is an impairment from the moment of infection. As noted earlier, infection with HIV causes immediate abnormalities in a person's blood, and the infected person's white cell count continues to drop throughout the course of the disease, even when the attack is concentrated in the lymph nodes. In light of these facts, HIV infection must be regarded as a physiological disorder with a constant and detrimental effect on the infected person's hemic and lymphatic systems from the moment of infection. HIV infection satisfies the statutory and regulatory definition of a physical impairment during every stage of the disease.

2

The statute is not operative, and the definition not satisfied, unless the impairment affects a major life activity. Respondent's claim throughout this case has been that the HIV infection placed a substantial limitation on her ability to reproduce and to bear children. App. 14; 912 F. Supp., at 586; 107 F. 3d, at 939. 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. Respondent and a number of *amici* make arguments about HIV's profound impact on almost every phase of the infected person's life. See Brief for Respondent Sidney Abbott 24-27; Brief for American Medical Association as *Amicus Curiae* 20; Brief for Infectious Diseases Society

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of America et al. as *Amici Curiae* 7-11. In light of these submissions, it may seem legalistic to circumscribe our discussion to the activity of reproduction. We have little doubt that had different parties brought the suit they would have maintained that an HIV infection imposes substantial limitations on other major life activities.

From the outset, however, the case has been treated as one in which reproduction was the major life activity limited by the impairment. It is our practice to decide cases on the grounds raised and considered in the Court of Appeals and included in the question on which we granted certiorari. See, e.g., *Blessing v. Freestone*, 520 U. S. 329, 340, n. 3 (1997) (citing this Court's Rule 14.1(a)); *Capitol Square Review and Advisory Bd. v. Pinette*, 515 U. S. 753, 760 (1995). We ask, then, whether reproduction is a major life activity.

We have little difficulty concluding that it is. As the Court of Appeals held, "[t]he plain meaning of the word 'major' denotes comparative importance" and "suggest[s] that the touchstone for determining an activity's inclusion under the statutory rubric is its significance." 107 F. 3d, at 939, 940. Reproduction falls well within the phrase "major life activity." Reproduction and the sexual dynamics surrounding it are central to the life process itself.

While petitioner concedes the importance of reproduction, he claims that Congress intended the ADA only to cover those aspects of a person's life which have a public, economic, or daily character. Brief for Petitioner 14, 28, 30, 31; see also *id.*, at 36-37 (citing *Krauel v. Iowa Methodist Medical Center*, 95 F. 3d 674, 677 (CA8 1996)). The argument founders on the statutory language. Nothing in the definition suggests that activities without a public, economic, or daily dimension may somehow be regarded as so unimportant or insignificant as to fall outside the meaning of the word "major." The breadth of the term confounds the attempt to limit its construction in this

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manner.

As we have noted, the ADA must be construed to be consistent with regulations issued to implement the Rehabilitation Act. See 42 U.S.C. §12201(a). Rather than enunciating a general principle for determining what is and is not a major life activity, the Rehabilitation Act regulations instead provide a representative list, defining term to include "functions such as caring for one's self, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning, and working." 45 CFR §84.3(j)(2)(ii) (1997); 28 CFR §41.31(b)(2) (1997). As the use of the term "such as" confirms, the list is illustrative, not exhaustive.

These regulations are contrary to petitioner's attempt to limit the meaning of the term "major" to public activities. The inclusion of activities such as caring for one's self and performing manual tasks belies the suggestion that a task must have a public or economic character in order to be a major life activity for purposes of the ADA. On the contrary, the Rehabilitation Act regulations support the inclusion of reproduction as a major life activity, since reproduction could not be regarded as any less important than working and learning. Petitioner advances no credible basis for confining major life activities to those with a public, economic, or daily aspect. In the absence of any reason to reach a contrary conclusion, we agree with the Court of Appeals' determination that reproduction is a major life activity for the purposes of the ADA.

3

The final element of the disability definition in subsection (A) is whether respondent's physical impairment was a substantial limit on the major life activity she asserts. The Rehabilitation Act regulations provide no additional guidance. 45 CFR pt. 84, App. A, p. 334 (1997).

Our evaluation of the medical evidence leads us to con-

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clude that respondent's infection substantially limited her ability to reproduce in two independent ways. First, a woman infected with HIV who tries to conceive a child imposes on the man a significant risk of becoming infected. The cumulative results of 13 studies collected in a 1994 textbook on AIDS indicates that 20% of male partners of women with HIV became HIV-positive themselves, with a majority of the studies finding a statistically significant risk of infection. Osmond & Padian, Sexual Transmission of HIV, in AIDS Knowledge Base 1.9-8, and tbl. 2; see also Haverkos & Battjes, Female-to-Male Transmission of HIV, 268 JAMA 1855, 1856, tbl. (1992) (cumulative results of 16 studies indicated 25% risk of female-to-male transmission). (Studies report a similar, if not more severe, risk of male-to-female transmission. See, e.g., Osmond & Padian, AIDS Knowledge Base 1.9-3, tbl. 1, 1.9-6 to 1.9-7.)

Second, an infected woman risks infecting her child during gestation and childbirth, i.e., perinatal transmission. Petitioner concedes that women infected with HIV face about a 25% risk of transmitting the virus to their children. 107 F.3d, at 942; 912 F.Supp., at 387, n. 6. Published reports available in 1994 confirm the accuracy of this statistic. Report of a Consensus Workshop, Maternal Factors Involved in Mother-to-Child Transmission of HIV-1, 5 J. Acquired Immune Deficiency Syndromes 1019, 1020 (1992) (collecting 13 studies placing risk between 14% and 40%, with most studies falling within the 25% to 30% range); Connor et al., Reduction of Maternal-Infant Transmission of Human Immunodeficiency Virus Type 1 with Zidovudine Treatment, 331 New Eng. J. Med. 1173, 1176 (1994) (placing risk at 25.5%); see also Strapans & Feinberg, Medical Management of AIDS 32 (studies report 13% to 45% risk of infection, with average of approximately 25%).

Petitioner points to evidence in the record suggesting

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that antiretroviral therapy can lower the risk of perinatal transmission to about 8%. App. 53; see also Connor, *supra*, at 1176 (8.3%); Sperling et al., Maternal Viral Load, Zidovudine Treatment, and the Risk of Transmission of Human Immunodeficiency Virus Type 1 from Mother to Infant, 335 New Eng. J. Med. 1621, 1622 (1996) (7.6%). The Solicitor General questions the relevance of the 8% figure, pointing to regulatory language requiring the substantiality of a limitation to be assessed without regard to available mitigating measures. Brief for United States as *Amicus Curiae* 18, n. 10 (citing 28 CFR pt. 36, App. B, p. 611 (1997); 29 CFR pt. 1630, App., p. 351 (1997)). We need not resolve this dispute in order to decide this case, however. It cannot be said as a matter of law that an 8% risk of transmitting a dread and fatal disease to one's child does not represent a substantial limitation on reproduction.

The Act addresses substantial limitations on major life activities, not utter incapacities. Conception and childbirth are not impossible for an HIV victim but, without doubt, are dangerous to the public health. This meets the definition of a substantial limitation. The decision to reproduce carries economic and legal consequences as well. There are added costs for antiretroviral therapy, supplemental insurance, and long-term health care for the child who must be examined and, tragic to think, treated for the infection. The laws of some States, moreover, forbid persons infected with HIV from having sex with others, regardless of consent. Iowa Code §§139.1, 139.31 (1997); Md. Health Code Ann. §18-601.1(a) (1994); Mont. Code Ann. §§50-18-101, 50-18-112 (1997); Utah Code Ann. §26-6-3.5(3) (Supp. 1997); *id.*, §26-6-5 (1995); Wash. Rev. Code §9A.36.011(1)(b) (Supp. 1998); see also N. D. Cent. Code §12.1-20-17 (1997).

In the end, the disability definition does not turn on personal choice. When significant limitations result from

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the impairment, the definition is met even if the difficulties are not insurmountable. For the statistical and other reasons we have cited, of course, the limitations on reproduction may be insurmountable here. Testimony from the respondent that her HIV infection controlled her decision not to have a child is unchallenged. App. 14; 912 F. Supp., at 587; 107 F.3d, at 942. In the context of reviewing summary judgment, we must take it to be true. Fed. Rule Civ. Proc. 56(e). We agree with the District Court and the Court of Appeals that no triable issue of fact impedes a ruling on the question of statutory coverage. Respondent's HIV infection is a physical impairment which substantially limits a major life activity, as the ADA defines it. In view of our holding, we need not address the second question presented, *i.e.*, whether HIV infection is a *per se* disability under the ADA.

B

Our holding is confirmed by a consistent course of agency interpretation before and after enactment of the ADA. Every agency to consider the issue under the Rehabilitation Act found statutory coverage for persons with asymptomatic HIV. Responsibility for administering the Rehabilitation Act was not delegated to a single agency, but we need not pause to inquire whether this causes us to withhold deference to agency interpretations under *Chevron U. S. A. Inc. v. Natural Resources Defense Council, Inc.*, 467 U. S. 837, 844 (1984). It is enough to observe that the well-reasoned views of the agencies implementing a statute "constitute a body of experience and informed judgment to which courts and litigants may properly resort for guidance." *Skidmore v. Swift & Co.*, 323 U. S. 134, 139-140 (1944).

One comprehensive and significant administrative precedent is a 1988 opinion issued by the Office of Legal Counsel of the Department of Justice (OLC) concluding that the

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Rehabilitation Act “protects symptomatic and asymptomatic HIV-infected individuals against discrimination in any covered program.” Application of Section 504 of the Rehabilitation Act to HIV-Infected Individuals, 12 Op. Off. Legal Counsel 264, 264–265 (Sept. 27, 1988) (preliminary print) (footnote omitted). Relying on a letter from Surgeon General C. Everett Koop stating that, “from a purely scientific perspective, persons with HIV are clearly impaired” even during the asymptomatic phase, OLC determined asymptomatic HIV was a physical impairment under the Rehabilitation Act because it constituted a “physiological disorder or condition affecting the hemic and lymphatic systems.” *Id.*, at 271 (internal quotation marks omitted). OLC determined further that asymptomatic HIV imposed a substantial limit on the major life activity of reproduction. The Opinion said:

“Based on the medical knowledge available to us, we believe that it is reasonable to conclude that the life activity of procreation . . . is substantially limited for an asymptomatic HIV-infected individual. In light of the significant risk that the AIDS virus may be transmitted to a baby during pregnancy, HIV-infected individuals cannot, whether they are male or female, engage in the act of procreation with the normal expectation of bringing forth a healthy child.” *Id.*, at 273.

In addition, OLC indicated that “[t]he life activity of engaging in sexual-relations is threatened and probably substantially limited by the contagiousness of the virus.” *Id.*, at 274. Either consideration was sufficient to render asymptomatic HIV infection a handicap for purposes of the Rehabilitation Act. In the course of its Opinion, OLC considered, and rejected, the contention that the limitation could be discounted as a voluntary response to the infection. The limitation, it reasoned, was the infection’s manifest

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physical effect. *Id.*, at 274, and n. 13. Without exception, the other agencies to address the problem before enactment of the ADA reached the same result. Federal Contract Compliance Manual App. 6D, 8 FEP Manual 405:352 (Dec. 23, 1988); *In re David Ritter*, No. 03890089, 1989 WL 609697, *10 (EEOC, Dec. 8, 1989); see also Comptroller General’s Task Force on AIDS in the Workplace, *Coping with AIDS in the GAO Workplace: Task Force Report 29* (Dec. 1987); Report of the Presidential Commission on the Human Immunodeficiency Virus Epidemic 113–114, 122–123 (June 1988). Agencies have adhered to this conclusion since the enactment of the ADA as well. See 5 CFR §1636.103 (1997); 7 CFR §15e.103 (1998); 22 CFR §1701.103 (1997); 24 CFR §9.103 (1997); 34 CFR §1200.103 (1997); 45 CFR §§2301.103, 2490.103 (1997); *In re Westchester County Medical Center*, [1991–1994 Transfer Binder] CCH Employment Practices Guide ¶5340, pp. 6110–6112 (Apr. 20, 1992), *aff’d*, *id.*, ¶5362, pp. 6249–6250 (Dept. of Health & Human Servs. Departmental Appeals Bd., Sept. 25, 1992); *In re Rosebud Sioux Tribe*, No. 93–504–1, 1994 WL 603015 (Dept. of Health & Human Servs. Departmental Appeals Bd., July 14, 1994); *In re David T. Martin*, No. 01954089, 1997 WL 151524, *4 (EEOC, Mar. 27, 1997).

Every court which addressed the issue before the ADA was enacted in July 1990, moreover, concluded that asymptomatic HIV infection satisfied the Rehabilitation Act’s definition of a handicap. See *Doe v. Garrett*, 903 F. 2d 1455, 1457 (CA11 1990), cert. denied, 499 U. S. 904 (1991); *Ray v. School Dist. of DeSoto County*, 666 F. Supp. 1524, 1536 (MD Fla. 1987); *Thomas v. Atascadero Unified School Dist.*, 662 F. Supp. 376, 381 (CD Cal. 1987); *District 27 Community School Bd. v. Board of Ed. of New York*, 130 Misc. 2d 398, 413–415, 502 N. Y. S. 2d 325, 335–337 (Sup. Ct., Queens Cty. 1986); cf. *Baxter v. Belleville*, 720 F. Supp. 720, 729 (SD Ill. 1989) (Fair Housing Amendments

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Act); *Cain v. Hyatt*, 734 F. Supp. 671, 679 (ED Pa. 1990) (Pennsylvania Human Relations Act). (For cases finding infection with HIV to be a handicap without distinguishing between symptomatic and asymptomatic HIV, see *Martinez ex rel. Martinez v. School Bd. of Hillsborough Cty.*, 861 F.2d 1502, 1506 (CA11 1988); *Chalk v. United States Dist. Ct.*, 840 F.2d 701, 706 (CA9 1988); *Doe v. Dolton Elementary School Dist. No. 148*, 694 F. Supp. 440, 444–445 (ND Ill. 1988); *Robertson v. Granite City Community Unit School Dist. No. 9*, 684 F. Supp. 1002, 1006–1007 (SD Ill. 1988); *Local 1812, AFGE v. United States Dept. of State*, 662 F. Supp. 50, 54 (DC 1987); cf. *Association of Relatives and Friends of AIDS Patients v. Regulations and Permits Admin.*, 740 F. Supp. 95, 103 (PR 1990) (Fair Housing Amendments Act).) We are aware of no instance prior to the enactment of the ADA in which a court or agency ruled that HIV infection was not a handicap under the Rehabilitation Act.

Had Congress done nothing more than copy the Rehabilitation Act definition into the ADA, its action would indicate the new statute should be construed in light of this unwavering line of administrative and judicial interpretation. All indications are that Congress was well aware of the position taken by OLC when enacting the ADA and intended to give that position its active endorsement. H. R. Rep. No. 101–485, pt. 2, p. 52 (1990) (endorsing the analysis and conclusion of the OLC Opinion); *id.*, pt. 3, at 28, n. 18 (same); S. Rep. No. 101–116, pp. 21, 22 (1989) (same). As noted earlier, Congress also incorporated the same definition into the Fair Housing Amendments Act of 1988. See 42 U. S. C. §3602(h)(1). We find it significant that the implementing regulations issued by the Department of Housing and Urban Development (HUD) construed the definition to include infection with HIV. 54 Fed. Reg. 3232, 3245 (1989) (codified at 24 CFR §100.201 (1997)); see also *In re Willie L. Williams*, 2A

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P–H Fair Housing–Fair Lending ¶25,007, pp. 25,111–25,113 (HUD Off. Admin. Law Judges, Mar. 22, 1991) (adhering to this interpretation); *In re Elroy R. and Dorothy Burns Trust*, 2A P–H Fair Housing–Fair Lending ¶25,073, p. 25,678 (HUD Off. Admin. Law Judges, June 17, 1994) (same). Again the legislative record indicates that Congress intended to ratify HUD’s interpretation when it reiterated the same definition in the ADA. H. R. Rep. No. 101–485, pt. 2, at 50; *id.*, pt. 3, at 27; *id.*, pt. 4, at 36; S. Rep. No. 101–116, at 21.

We find the uniformity of the administrative and judicial precedent construing the definition significant. When administrative and judicial interpretations have settled the meaning of an existing statutory provision, repetition of the same language in a new statute indicates, as a general matter, the intent to incorporate its administrative and judicial interpretations as well. See, e.g., *Lorillard v. Pons*, 434 U. S. 575, 580–581 (1978). The uniform body of administrative and judicial precedent confirms the conclusion we reach today as the most faithful way to effect the congressional design.

C

Our conclusion is further reinforced by the administrative guidance issued by the Justice Department to implement the public accommodation provisions of Title III of the ADA. As the agency directed by Congress to issue implementing regulations, see 42 U. S. C. §12186(b), to render technical assistance explaining the responsibilities of covered individuals and institutions, §12206(c), and to enforce Title III in court, §12188(b), the Department’s views are entitled to deference. See *Chevron*, 467 U. S., at 844.

The Justice Department’s interpretation of the definition of disability is consistent with our analysis. The regulations acknowledge that Congress intended the

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ADA's definition of disability to be given the same construction as the definition of handicap in the Rehabilitation Act. 28 CFR §36.103(a) (1997); *id.*, pt. 36, App. B, pp. 608, 609. The regulatory definition developed by HEW to implement the Rehabilitation Act is incorporated verbatim in the ADA regulations. §36.104. The Justice Department went further, however. It added "HIV infection (symptomatic and asymptomatic)" to the list of disorders constituting a physical impairment. §36.104(1)(iii). The technical assistance the Department has issued pursuant to 42 U. S. C. §12206 similarly concludes that persons with asymptomatic HIV infection fall within the ADA's definition of disability. See, *e.g.*, U. S. Dept. of Justice, Civil Rights Division, The Americans with Disabilities Act: Title III Technical Assistance Manual 9 (Nov. 1993); Response to Congressman Sonny Callahan, 5 Nat. Disability L. Rep. (LRP) ¶360, p. 1167 (Feb. 9, 1994); Response to A. Laurence Field, 5 Nat. Disability L. Rep. (LRP) ¶21, p. 80 (Sept. 10, 1993). Any other conclusion, the Department reasoned, would contradict Congress' affirmative ratification of the administrative interpretations given previous versions of the same definition. 28 CFR pt. 36, App. B, p. 609, 610 (1997) (citing the OLC Opinion and HUD regulations); 56 Fed. Reg. 7455, 7456 (1991) (same) (notice of proposed rulemaking).

We also draw guidance from the views of the agencies authorized to administer other sections of the ADA. See 42 U. S. C. §12116 (authorizing EEOC to issue regulations implementing Title I); §12134(a) (authorizing the Attorney General to issue regulations implementing the public services provisions of Title II, subtitle A); §§12149, 12164, 12186 (authorizing the Secretary of Transportation to issue regulations implementing the transportation-related provisions or Titles II and III); §12206(c) (authorizing the same agencies to offer technical assistance for the provisions they administer). These agencies, too, concluded

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that HIV infection is a physical impairment under the ADA. 28 CFR §35.104(1)(iii) (1997); 49 CFR §§37.3, 38.3 (1997); 56 Fed. Reg. 13858 (1991); U. S. Dept. of Justice, Civil Rights Division, The Americans with Disabilities Act: Title II Technical Assistance Manual 4 (Nov. 1993); EEOC, A Technical Assistance Manual on the Employment Provisions (Title I) of the Americans with Disabilities Act II-3 (Jan. 1992) (hereinafter EEOC Technical Assistance Manual); EEOC Interpretive Manual §902.2(d), pp. 902-13 to 902-14 (reissued Mar. 14, 1995) (hereinafter EEOC Interpretive Manual), reprinted in 2 BNA EEOC Compliance Manual 902:0013 (1998). Most categorical of all is EEOC's conclusion that "an individual who has HIV infection (including asymptomatic HIV infection) is an individual with a disability." EEOC Interpretive Manual §902.4(c)(1), p. 902-21; accord, *id.*, §902.2(d), p. 902-14, n. 18. In the EEOC's view, "impairments . . . such as HIV infection, are inherently substantially limiting." 29 CFR pt. 1630, App., p. 350 (1997); EEOC Technical Assistance Manual II-4; EEOC Interpretive Manual §902.4(c)(1), p. 902-21.

The regulatory authorities we cite are consistent with our holding that HIV infection, even in the so-called asymptomatic phase, is an impairment which substantially limits the major life activity of reproduction.

III

The petition for certiorari presented three other questions for review. The questions stated:

"3. When deciding under title III of the ADA whether a private health care provider must perform invasive procedures on an infectious patient in his office, should courts defer to the health care provider's professional judgment, as long as it is reasonable in light of then-current medical knowledge?

"4. What is the proper standard of judicial review

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under title III of the ADA of a private health care provider's judgment that the performance of certain invasive procedures in his office would pose a direct threat to the health or safety of others?

"5. Did petitioner, Randon Bragdon, D. M. D., raise a genuine issue of fact for trial as to whether he was warranted in his judgment that the performance of certain invasive procedures on a patient in his office would have posed a direct threat to the health or safety of others?" Pet. for Cert. i.

Of these, we granted certiorari only on question three. The question is phrased in an awkward way, for it conflates two separate inquiries. In asking whether it is appropriate to defer to petitioner's judgment, it assumes that petitioner's assessment of the objective facts was reasonable. The central premise of the question and the assumption on which it is based merit separate consideration.

Again, we begin with the statute. Notwithstanding the protection given respondent by the ADA's definition of disability, petitioner could have refused to treat her if her infectious condition "pose[d] a direct threat to the health or safety of others." 42 U. S. C. §12182(b)(3). The ADA defines a direct threat to be "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." *Ibid.* Parallel provisions appear in the employment provisions of Title I. §§12111(3), 12113(b).

The ADA's direct threat provision stems from the recognition in *School Bd. of Nassau Cty. v. Arline*, 480 U. S. 273, 287 (1987), of the importance of prohibiting discrimination against individuals with disabilities while protecting others from significant health and safety risks, resulting, for instance, from a contagious disease. In *Arline*, the Court reconciled these objectives by construing the Rehabilitation Act not to require the hiring of a person who posed "a

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significant risk of communicating an infectious disease to others." *Id.*, at 287, n. 16. Congress amended the Rehabilitation Act and the Fair Housing Act to incorporate the language. See 29 U. S. C. §706(8)(D) (excluding individuals who "would constitute a direct threat to the health or safety of other individuals"); 42 U. S. C. §3604(f)(9) (same). It later relied on the same language in enacting the ADA. See 28 CFR pt. 36, App. B, p. 626 (1997) (ADA's direct threat provision codifies *Arline*). 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. *Arline*, *supra*, at 287, and n. 16; 42 U. S. C. §12182(b)(3).

The existence, or nonexistence, of a significant risk must be determined from the standpoint of the person who refuses the treatment or accommodation, and the risk assessment must be based on medical or other objective evidence. *Arline*, *supra*, at 288; 28 CFR §36.208(c) (1997); *id.*, pt. 36, App. B, p. 626. As a health care professional, petitioner had the duty to assess the risk of infection based on the objective, scientific information available to him and others in his profession. His belief that a significant risk existed, even if maintained in good faith, would not relieve him from liability. To use the words of the question presented, petitioner receives no special deference simply because he is a health care professional. It is true that *Arline* reserved "the question whether courts should also defer to the reasonable medical judgments of private physicians on which an employer has relied." 480 U. S., at 288, n. 18. At most, this statement reserved the possibility that employers could consult with individual physicians as objective third-party experts. It did not suggest that an individual physician's state of mind could excuse discrimination without regard to the objective reasonableness of his actions.

Our conclusion that courts should assess the objective reasonableness of the views of health care professionals

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without deferring to their individual judgments does not answer the implicit assumption in the question presented, whether petitioner's actions were reasonable in light of the available medical evidence. In assessing the reasonableness of petitioner's actions, the views of public health authorities, such as the U. S. Public Health Service, CDC, and the National Institutes of Health, are of special weight and authority. *Arline, supra*, at 288; 28 CFR pt. 36, App. B, p. 626 (1997). The views of these organizations are not conclusive, however. A health care professional who disagrees with the prevailing medical consensus may refute it by citing a credible scientific basis for deviating from the accepted norm. See W. Keeton, D. Dobbs, R. Keeton, & D. Owen, *Prosser and Keeton on Law of Torts* §32, p. 187 (5th ed. 1984).

We have reviewed so much of the record as necessary to illustrate the application of the rule to the facts of this case. For the most part, the Court of Appeals followed the proper standard in evaluating the petitioner's position and conducted a thorough review of the evidence. Its rejection of the District Court's reliance on the Marianos affidavits was a correct application of the principle that petitioner's actions must be evaluated in light of the available, objective evidence. The record did not show that CDC had published the conclusion set out in the affidavits at the time petitioner refused to treat respondent. 107 F. 3d, at 946, n. 7.

A further illustration of a correct application of the objective standard is the Court of Appeals' refusal to give weight to the petitioner's offer to treat respondent in a hospital. *Id.*, at 943, n. 4. Petitioner testified that he believed hospitals had safety measures, such as air filtration, ultraviolet lights, and respirators, which would reduce the risk of HIV transmission. App. 151. Petitioner made no showing, however, that any area hospital had these safeguards or even that he had hospital privileges.

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Id., at 31. His expert also admitted the lack of any scientific basis for the conclusion that these measures would lower the risk of transmission. *Id.*, at 209. Petitioner failed to present any objective, medical evidence showing that treating respondent in a hospital would be safer or more efficient in preventing HIV transmission than treatment in a well-equipped dental office.

We are concerned, however, that the Court of Appeals might have placed mistaken reliance upon two other sources. In ruling no triable issue of fact existed on this point, the Court of Appeals relied on the 1993 CDC Dentistry Guidelines and the 1991 American Dental Association Policy on HIV. 107 F. 3d, at 945–946. This evidence is not definitive. As noted earlier, the CDC Guidelines recommended certain universal precautions which, in CDC's view, "should reduce the risk of disease transmission in the dental environment." U. S. Dept. of Health and Human Services, Public Health Service, CDC, Recommended Infection Control Practices for Dentistry, 41 Morbidity & Mortality Weekly Rep. No. RR-18, p. 1 (May 28, 1993). The Court of Appeals determined that, "[w]hile the guidelines do not state explicitly that no further risk-reduction measures are desirable or that routine dental care for HIV-positive individuals is safe, those two conclusions seem to be implicit in the guidelines' detailed delineation of procedures for office treatment of HIV-positive patients." 107 F. 3d, at 946. In our view, the Guidelines do not necessarily contain implicit assumptions conclusive of the point to be decided. The Guidelines set out CDC's recommendation that the universal precautions are the best way to combat the risk of HIV transmission. They do not assess the level of risk.

Nor can we be certain, on this record, whether the 1991 American Dental Association Policy on HIV carries the weight the Court of Appeals attributed to it. The Policy does provide some evidence of the medical community's

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objective assessment of the risks posed by treating people infected with HIV in dental offices. It indicates:

“Current scientific and epidemiologic evidence indicates that there is little risk of transmission of infectious diseases through dental treatment if recommended infection control procedures are routinely followed. Patients with HIV infection may be safely treated in private dental offices when appropriate infection control procedures are employed. Such infection control procedures provide protection both for patients and dental personnel.” App. 225.

We note, however, that the Association is a professional organization, which, although a respected source of information on the dental profession, is not a public health authority. It is not clear the extent to which the Policy was based on the Association’s assessment of dentists’ ethical and professional duties in addition to its scientific assessment of the risk to which the ADA refers. 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. Without more information on the manner in which the American Dental Association formulated this Policy, we are unable to determine the Policy’s value in evaluating whether petitioner’s assessment of the risks was reasonable as a matter of law.

The court considered materials submitted by both parties on the cross motions for summary judgment. The petitioner was required to establish that there existed a genuine issue of material fact. Evidence which was merely colorable or not significantly probative would not have been sufficient. *Anderson v. Liberty Lobby, Inc.*, 477 U. S. 242, 249–250 (1986).

We acknowledge the presence of other evidence in the

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record before the Court of Appeals which, subject to further arguments and examination, might support affirmance of the trial court’s ruling. For instance, the record contains substantial testimony from numerous health experts indicating that it is safe to treat patients infected with HIV in dental offices. App. 66–68, 88–90, 264–266, 268. We are unable to determine the import of this evidence, however. The record does not disclose whether the expert testimony submitted by respondent turned on evidence available in September 1994. See *id.*, at 69–70 (expert testimony relied in part on materials published after September 1994).

There are reasons to doubt whether petitioner advanced evidence sufficient to raise a triable issue of fact on the significance of the risk. Petitioner relied on two principal points: First, he asserted that the use of high-speed drills and surface cooling with water created a risk of airborne HIV transmission. The study on which petitioner relied was inconclusive, however, determining only that “[f]urther work is required to determine whether such a risk exists.” Johnson & Robinson, Human Immunodeficiency Virus-1 (HIV-1) in the Vapors of Surgical Power Instruments, 33 J. of Medical Virology 47, 47 (1991). Petitioner’s expert witness conceded, moreover, 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. App. 166. Scientific evidence and expert testimony must have a traceable, analytical basis in objective fact before it may be considered on summary judgment. See *General Electric Co. v. Joiner*, 522 U. S. ___, ___, ___ (1997) (slip op., at 7, 9).

Second, petitioner argues that, as of September 1994, CDC had identified seven dental workers with possible occupational transmission of HIV. See U. S. Dept. of Health and Human Services, Public Health Service, CDC, HIV/AIDS Surveillance Report, vol. 6, no. 1, p. 15, tbl. 11

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(Mid-year ed. June 1994). These dental workers were exposed to HIV in the course of their employment, but CDC could not determine whether HIV infection had resulted. *Id.*, at 15, n. 3. It is now known that CDC could not ascertain whether the seven dental workers contracted the disease because they did not present themselves for HIV testing at an appropriate time after their initial exposure. Gooch et al., *Percutaneous Exposures to HIV-Infected Blood Among Dental Workers Enrolled in the CDC Needlestick Study*, 126 J. American Dental Assn. 1237, 1239 (1995). It is not clear on this record, however, whether this information was available to petitioner in September 1994. If not, the seven cases might have provided some, albeit not necessarily sufficient, support for petitioner's position. Standing alone, we doubt it would meet the objective, scientific basis for finding a significant risk to the petitioner.

Our evaluation of the evidence is constrained by the fact that on these and other points we have not had briefs and arguments directed to the entire record. In accepting the case for review, we declined to grant certiorari on question five, which asked whether petitioner raised a genuine issue of fact for trial. Pet. for Cert. i. As a result, the briefs and arguments presented to us did not concentrate on the question of sufficiency in light all of the submissions in the summary judgment proceeding. "When attention has been focused on other issues, or when the court from which a case comes has expressed no views on a controlling question, it may be appropriate to remand the case rather than deal with the merits of that question in this Court." *Dandridge v. Williams*, 397 U. S. 471, 476, n. 6 (1970). This consideration carries particular force where, as here, full briefing directed at the issue would help place a complex factual record in proper perspective. Resolution of the issue will be of importance to health care workers not just for the result but also for the precision

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and comprehensiveness of the reasons given for the decision.

We conclude the proper course is to give the Court of Appeals the opportunity to determine whether our analysis of some of the studies cited by the parties would change its conclusion that petitioner presented neither objective evidence nor a triable issue of fact on the question of risk. In remanding the case, we do not foreclose the possibility that the Court of Appeals may reach the same conclusion it did earlier. A remand will permit a full exploration of the issue through the adversary process.

The determination of the Court of Appeals that respondent's HIV infection was a disability under the ADA is affirmed. The judgment is vacated, and the case is remanded for further proceedings consistent with this opinion.

It is so ordered.

STEVENS, J., concurring

SUPREME COURT OF THE UNITED STATES

No. 97-156

RANDON BRAGDON, PETITIONER *v.* SIDNEY
ABBOTT ET AL.

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF
APPEALS FOR THE FIRST CIRCUIT

[June 25, 1998]

JUSTICE STEVENS, with whom JUSTICE BREYER joins,
concurring.

The Court's opinion demonstrates that respondent's HIV infection easily falls within the statute's definition of "disability." Moreover, the Court's discussion in Part III of the relevant evidence has persuaded me that the judgment of the Court of Appeals should be affirmed. I do not believe petitioner has sustained his burden of adducing evidence sufficient to raise a triable issue of fact on the significance of the risk posed by treating respondent in his office. The Court of Appeals reached that conclusion after a careful and extensive study of the record; its analysis on this question was perfectly consistent with the legal reasoning in JUSTICE KENNEDY's opinion for the Court; and the latter opinion itself explains that petitioner relied on data that was inconclusive and speculative at best, see *ante*, at 27-28. Cf. *General Electric Co. v. Joiner*, 522 U. S. ____ (1997).

There are not, however, five Justices who agree that the judgment should be affirmed. Nor does it appear that there are five Justices who favor a remand for further proceedings consistent with the views expressed in either JUSTICE KENNEDY's opinion for the Court or the opinion of THE CHIEF JUSTICE. Because I am in agreement with the

STEVENS, J., concurring

legal analysis in JUSTICE KENNEDY's opinion, in order to provide a judgment supported by a majority, I join that opinion even though I would prefer an outright affirmation. Cf. *Screws v. United States*, 325 U. S. 91, 134 (1945) (Rutledge, J., concurring in result).

GINSBURG, J., concurring

SUPREME COURT OF THE UNITED STATES

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[June 25, 1998]

JUSTICE GINSBURG, concurring.

HIV infection, as the description set out in the Court's opinion documents, *ante*, at 8-10, has been regarded as a disease limiting life itself. See Brief for American Medical Association as *Amicus Curiae* 20. The disease inevitably pervades life's choices: education, employment, family and financial undertakings. It affects the need for and, as this case shows, the ability to obtain health care because of the reaction of others to the impairment. No rational legislator, it seems to me apparent, would require nondiscrimination once symptoms become visible but permit discrimination when the disease, though present, is not yet visible. I am therefore satisfied that the statutory and regulatory definitions are well met. HIV infection is "a physical . . . impairment that substantially limits . . . major life activities," or is so perceived, 42 U. S. C. §§12102(2)(A),(C), including the afflicted individual's family relations, employment potential, and ability to care for herself, see 45 CFR §84.3(j)(2)(ii) (1997); 28 CFR §41.31(b)(2) (1997).

I further agree, in view of the "importance [of the issue] to health care workers," *ante*, at 28, that it is wise to remand, erring, if at all, on the side of caution. By taking this course, the Court ensures a fully informed determination whether respondent Abbott's disease posed "a signifi-

GINSBURG, J., concurring

cant risk to the health or safety of [petitioner Bragdon] that [could not] be eliminated by a modification of policies, practices, or procedures” 42 U. S. C. §12182(b)(3).

Opinion of REHNQUIST, C. J.

SUPREME COURT OF THE UNITED STATES

No. 97-156

RANDON BRAGDON, PETITIONER v. SIDNEY
ABBOTT ET AL.

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF
APPEALS FOR THE FIRST CIRCUIT

[June 25, 1998]

CHIEF JUSTICE REHNQUIST, with whom JUSTICE SCALIA and JUSTICE THOMAS join, and with whom JUSTICE O’CONNOR joins as to Part II, concurring in the judgment in part and dissenting in part.

I

Is respondent—who has tested positive for the human immunodeficiency virus (HIV) but was asymptomatic at the time she suffered discriminatory treatment—a person with a “disability” as that term is defined in the Americans with Disabilities Act of 1990 (ADA)? The term “disability” is defined in the ADA to include:

“(A) a physical or mental impairment that substantially limits one or more of the major life activities of such individual;

“(B) a record of such an impairment; or

“(C) being regarded as having such an impairment.”
42 U. S. C. §12102(2).

It is important to note that whether respondent has a disability covered by the ADA is an individualized inquiry. The Act could not be clearer on this point: Section 12102(2) states explicitly that the disability determination must be made “with respect to an individual.” Were this

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not sufficiently clear, the Act goes on to provide that the "major life activities" allegedly limited by an impairment must be those "of such individual." §12102(3)(A).

The individualized nature of the inquiry is particularly important in this case because the District Court disposed of it on summary judgment. Thus all disputed issues of material fact must be resolved against respondent. She contends that her asymptomatic HIV status brings her within the first definition of a "disability."¹ She must therefore demonstrate, *inter alia*, that she was (1) physically or mentally impaired and that such impairment (2) substantially limited (3) one or more of her major life activities.

Petitioner does not dispute that asymptomatic HIV-positive status is a physical impairment. I therefore assume this to be the case, and proceed to the second and third statutory requirements for "disability."

According to the Court, the next question is "whether reproduction is a major life activity." *Ante*, at 11. That, however, is only half of the relevant question. As mentioned above, the ADA's definition of a "disability" requires

¹Respondent alternatively urges us to find that she is disabled in that she is "regarded as" such. 42 U. S. C. §12102(2)(C). We did not, however, grant certiorari on that question. While respondent can advance arguments not within the question presented in support of the judgment below, *Trans World Airlines, Inc. v. Thurston*, 469 U. S. 111, 119, n. 14 (1985); *Dandridge v. Williams*, 397 U. S. 471, 475, n. 6 (1970), we have rarely addressed arguments not asserted below. It was the United States, not respondent, that asserted the "regarded as" argument below. The Court of Appeals declined to address it, as should we.

In any event, the "regarded as" prong requires a plaintiff to demonstrate that the defendant regarded him as having "*such* an impairment" (*i.e.*, one that substantially limits a major life activity). 42 U. S. C. §12102(2)(C). Respondent has offered no evidence to support the assertion that petitioner regarded her as having an impairment that substantially limited her ability to reproduce, as opposed to viewing her as simply impaired.

Opinion of REHNQUIST, C. J.

that the major life activity at issue be one "of such individual." §12102(2)(A). The Court truncates the question, perhaps because there is not a shred of record evidence indicating that, prior to becoming infected with HIV, respondent's major life activities included reproduction² (assuming for the moment that reproduction is a major life activity at all). At most, the record indicates that after learning of her HIV status, respondent, whatever her previous inclination, conclusively decided that she would not have children. App. 14. There is absolutely no evidence that, absent the HIV, respondent would have had or was even considering having children. Indeed, when asked during her deposition whether her HIV infection had in any way impaired her ability to carry out any of *her* life functions, respondent answered "No." *Ibid*. It is further telling that in the course of her entire brief to this Court, respondent studiously avoids asserting even once that reproduction is a major life activity *to her*. To the contrary, she argues that the "major life activity" inquiry should not turn on a particularized assessment of the circumstances of this or any other case. Brief for Respondent Sidney Abbott 30-31.

But even aside from the facts of this particular case, the Court is simply wrong in concluding as a general matter that reproduction is a "major life activity." Unfortunately, the ADA does not define the phrase "major life activities." But the Act does incorporate by reference a list of such activities contained in regulations issued under the Reha-

²Calling reproduction a major life activity is somewhat inartful. Reproduction is not an activity at all, but a process. One could be described as breathing, walking, or performing manual tasks, but a human being (as opposed to a copier machine or a gremlin) would never be described as reproducing. I assume that in using the term reproduction, respondent and the Court are referring to the numerous discrete activities that comprise the reproductive process, and that is the sense in which I have used the term.

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bilitation Act. 42 U. S. C. §12201(a); 45 CFR §84.3(j)(2)(ii) (1997). The Court correctly recognizes that this list of major life activities “is illustrative, not exhaustive,” *ante*, at 12, but then makes no attempt to demonstrate that reproduction is a major life activity in the same sense that “caring for one’s self, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning, and working” are.

Instead, the Court argues that reproduction is a “major” life activity in that it is “central to the life process itself.” *Ante*, at 11–12. In support of this reading, the Court focuses on the fact that “‘major’ indicates ‘comparative importance,’” *ibid.*; see also Webster’s Collegiate Dictionary 702 (10th ed. 1994) (“greater in dignity, rank, importance, or interest”), ignoring the alternative definition of “major” as “greater in quantity, number, or extent,” *ibid.* It is the latter definition that is most consistent with the ADA’s illustrative list of major life activities.

No one can deny that reproductive decisions are important in a person’s life. But so are decisions as to who to marry, where to live, and how to earn one’s living. Fundamental importance of this sort is not the common thread linking the statute’s listed activities. The common thread is rather that the activities are repetitively performed and essential in the day-to-day existence of a normally functioning individual. They are thus quite different from the series of activities leading to the birth of a child.

Both respondent, Brief for Respondent Sidney Abbott 20, n. 24, and the United States as *amicus curiae*, Brief for United States as *Amicus Curiae* 13, argue that reproduction must be a major life activity because regulations issued under the ADA define the term “physical impairment” to include physiological disorders affecting the reproductive system. 28 CFR §36.104 (1997). If reproduction were not a major life activity, they argue, then it would have made little sense to include the reproductive

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disorders in the roster of physical impairments. This argument is simply wrong. There are numerous disorders of the reproductive system, such as dysmenorrhea and endometriosis, which are so painful that they limit a woman’s ability to engage in major life activities such as walking and working. And, obviously, cancer of the various reproductive organs limits one’s ability to engage in numerous activities other than reproduction.

But even if I were to assume that reproduction is a major life activity of respondent, I do not agree that an asymptomatic HIV infection “substantially limits” that activity. The record before us leaves no doubt that those so infected are still entirely able to engage in sexual intercourse, give birth to a child if they become pregnant, and perform the manual tasks necessary to rear a child to maturity. See App. 53–54. While individuals infected with HIV may choose not to engage in these activities, there is no support in language, logic, or our case law for the proposition that such voluntary choices constitute a “limit” on one’s own life activities.

The Court responds that the ADA “addresses substantial limitations on major life activities, not utter incapacities.” *Ante*, at 14. I agree, but fail to see how this assists the Court’s cause. Apart from being unable to demonstrate that she is utterly unable to engage in the various activities that comprise the reproductive process, respondent has not even explained how she is less able to engage in those activities.

Respondent contends that her ability to reproduce is limited because “the fatal nature of HIV infection means that a parent is unlikely to live long enough to raise and nurture the child to adulthood.” Brief for Respondent Sidney Abbott 22. But the ADA’s definition of a disability is met only if the alleged impairment substantially “limits” (present tense) a major life activity. 42 U. S. C. §12102(2)(A). Asymptomatic HIV does not presently limit

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respondent's ability to perform any of the tasks necessary to bear or raise a child. Respondent's argument, taken to its logical extreme, would render every individual with a genetic marker for some debilitating disease "disabled" here and now because of some possible future effects.

In my view, therefore, respondent has failed to demonstrate that any of her major life activities were substantially limited by her HIV infection.

II

While the Court concludes to the contrary as to the "disability" issue, it then quite correctly recognizes that petitioner could nonetheless have refused to treat respondent if her condition posed a "direct threat." The Court of Appeals affirmed the judgment of the District Court granting summary judgment to respondent on this issue. The Court vacates this portion of the Court of Appeals' decision, and remands the case to the lower court, presumably so that it may "determine whether our analysis of some of the studies cited by the parties would change its conclusion that petitioner presented neither objective evidence nor a triable issue of fact on the question of risk." *Ante*, at 29. I agree that the judgment should be vacated, although I am not sure I understand the Court's cryptic direction to the lower court.

"[D]irect threat" is defined as 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 aides or services." §12182(b)(3). This statutory definition of a direct threat consists of two parts. First, a court must ask whether treating the infected patient *without precautionary techniques* would pose a "significant risk to the health or safety of others." *Ibid*. Whether a particular risk is significant depends on:

"(a) the nature of the risk (how the disease is transmitted), (b) the duration of the risk (how long is the

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carrier infectious), (c) the severity of the risk (what is the potential harm to third parties) and (d) the probabilities the disease will be transmitted and will cause varying degrees of harm.'" *School Bd. of Nassau Cty. v. Arline*, 480 U. S. 273, 288 (1987).

Even if a significant risk exists, a health practitioner will still be required to treat the infected patient if "a modification of policies, practices, or procedures" (in this case, universal precautions) will "eliminat[e]" the risk. §12182(b)(3).

I agree with the Court that "the existence, or nonexistence, of a significant risk must be determined from the standpoint of the person who refuses the treatment or accommodation," as of the time that the decision refusing treatment is made. *Ante*, at 23. I disagree with the Court, however, that "[i]n assessing the reasonableness of petitioner's actions, the views of public health authorities . . . are of special weight and authority." *Ante*, at 24. Those views are, of course, entitled to a presumption of validity when the actions of those authorities themselves are challenged in court, and even in disputes between private parties where Congress has committed that dispute to adjudication by a public health authority. But in litigation between private parties originating in the federal courts, I am aware of no provision of law or judicial practice that would require or permit courts to give some scientific views more credence than others simply because they have been endorsed by a politically appointed public health authority (such as the Surgeon General). In litigation of this latter sort, which is what we face here, the credentials of the scientists employed by the public health authority, and the soundness of their studies, must stand on their own. The Court cites no authority for its limitation upon the courts' truth-finding function, except the statement in *School Bd. of Nassau Cty. v. Arline*, 480 U. S., at 288, that in making findings regarding the risk of

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contagion under the Rehabilitation Act, "courts normally should defer to the reasonable medical judgments of public health officials." But there is appended to that dictum the following footnote, which makes it very clear that the Court was urging respect for *medical* judgment, and not necessarily respect for "official" medical judgment over "private" medical judgment: "This case does not present, and we do not address, the question whether courts should also defer to the reasonable medical judgments of private physicians on which an employer has relied." *Id.*, at 288, n. 18.

Applying these principles here, it is clear to me that petitioner has presented more than enough evidence to avoid summary judgment on the "direct threat" question. In June 1994, the Centers for Disease Control and Prevention published a study identifying seven instances of possible transmission of HIV from patients to dental workers. See *Ante*, at 27. While it is not entirely certain whether these dental workers contracted HIV during the course of providing dental treatment, the potential that the disease was transmitted during the course of dental treatment is relevant evidence. One need only demonstrate "risk," not certainty of infection. See *Arline, supra*, at 288 ("the probabilities the disease will be transmitted" is a factor in assessing risk). Given the "severity of the risk" involved here, *i.e.*, near certain death, and the fact that no public health authority had outlined a protocol for *eliminating* this risk in the context of routine dental treatment, it seems likely that petitioner can establish that it was objectively reasonable for him to conclude that treating respondent in his office posed a "direct threat" to his safety.

In addition, petitioner offered evidence of 42 documented incidents of occupational transmission of HIV to healthcare workers other than dental professionals. App. 106. The Court of Appeals dismissed this evidence as irrelevant because these health professionals were not den-

Opinion of REHNQUIST, C. J.

tists. 107 F. 3d 934, 947 (CA1 1997). But the fact that the health care workers were not dentists is no more valid a basis for distinguishing these transmissions of HIV than the fact that the health care workers did not practice in Maine. At a minimum, petitioner's evidence was sufficient to create a triable issue on this question, and summary judgment was accordingly not appropriate.

Opinion of O'CONNOR, J.

SUPREME COURT OF THE UNITED STATES

No. 97-156

RANDON BRAGDON, PETITIONER *v.* SIDNEY
ABBOTT ET AL.

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF
APPEALS FOR THE FIRST CIRCUIT

[June 25, 1998]

JUSTICE O'CONNOR, concurring in the judgment in part
and dissenting in part.

I agree with THE CHIEF JUSTICE that respondent's claim of disability should be evaluated on an individualized basis and that she has not proven that her asymptomatic HIV status substantially limited one or more of her major life activities. In my view, the act of giving birth to a child, while a very important part of the lives of many women, is not generally the same as the representative major life activities of all persons—"caring for one's self, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning, and working"—listed in regulations relevant to the Americans with Disabilities Act of 1990. See 45 CFR §84.3(j)(2)(ii) (1997); 28 CFR §41.31(b)(2) (1997). Based on that conclusion, there is no need to address whether other aspects of intimate or family relationships not raised in this case could constitute major life activities; nor is there reason to consider whether HIV status would impose a substantial limitation on one's ability to reproduce if reproduction were a major life activity.

I join in Part II of THE CHIEF JUSTICE's opinion concurring in the judgment in part and dissenting in part, which concludes that the Court of Appeals failed to properly de-

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termine whether respondent's condition posed a direct threat. Accordingly, I agree that a remand is necessary on that issue.

June 22, 1998

MEMORANDUM TO THE DEPUTY SECRETARY AND THE SURGEON GENERAL

FROM: Eric Goosby, MD
Director, Office of HIV/AIDS Policy

Richard Sorian
Office of the Assistant Secretary for Public Affairs

SUBJECT: Reaction to Supreme Court Decision in *Bragdon v. Abbott*

On Friday, June 19, we attended a one-day conference sponsored by the Henry J. Kaiser Family Foundation to discuss the ramifications of a pending decision by the U.S. Supreme Court in a case known as *Bragdon v. Abbott*. The meeting was organized by the Georgetown University Federal Legislation Clinic and included Federal, State, and local government officials, legal experts, AIDS service organizations, AIDS policy advocates, and others.

Bragdon v. Abbott concerns a challenge to whether the Americans with Disabilities Act (ADA) provides anti-discrimination protection to individuals who are HIV-infected but asymptomatic. The Centers for Disease Control and Prevention (CDC) estimate that between 650,000 and 900,000 Americans are living with HIV. Until now, the anti-discrimination provisions of the ADA -- which cover such things as employment, housing, and public accommodation (including medical care) -- have been interpreted to include not only people who are diagnosed with AIDS, but also those who are HIV-positive.

A decision in Bragdon v. Abbot could come as early as TODAY or sometime next week.

The protections of the ADA have been a vital element in our public health response to the HIV epidemic, including our ability to convince at-risk individuals to voluntarily seek testing and to direct HIV-positive individuals into early treatment. Learning your HIV status and entering into combination drug therapy is critical to our recent success in improving people's immune status and extending their lives. It also is vital to our ability to interest people in participating in AIDS prevention programs and to enroll in clinical trials of drugs and vaccine candidates.

Bragdon v. Abbott involves a dentist who refused to care for a woman living with HIV on the grounds that she posed a threat to his health. He attempted to direct her to a nearby hospital for her care. Ms. Bragdon sued Dr. Abbott on the grounds that his refusal to provide her with needed dental care was a violation of the Americans with Disabilities Act's prohibition against discrimination in public accommodation. The Solicitor General, on behalf of the Administration, weighed in on behalf of Ms. Bragdon.

Bragdon v. Abbott threatens to dramatically change that landscape. Legal experts believe there is a significant chance that the Supreme Court will either limit or abridge the ADA's inclusion of HIV-positive individuals from its protections. This has broad ramifications for our ability to control and, eventually, end this epidemic.

Because of the case's focus on provision of health services, it is likely that the most immediate reaction to a Supreme Court decision narrowing or eliminating this protection will be in the health care arena. People at risk for HIV infection may be fearful of learning their status because of a concern about losing their jobs, losing their housing, or being refused medical care. People who are HIV positive may delay or refuse care because of a fear that they will be refused care or otherwise discriminated against. There also are ramifications affecting housing, employment, and other types of public accommodation.

It is imperative for the Federal government to be prepared to act to reassure and protect HIV-positive individuals who may be adversely affected by this decision or may believe themselves to be so affected. We take this position not only because of our concern for those individuals -- although that concern is quite deep -- but also for our greater efforts to protect and improve the public health. A failure to respond quickly and effectively could undermine much of the progress we have made toward reversing the direction of this epidemic and protecting society at a whole.

Based on the discussions during Friday's meeting, we expect AIDS advocates to approach the Administration seeking coordinated action to send strong messages to people living with HIV, medical professionals, and to the public at large. We thought it would be useful to begin preparing for these requests by laying out some options for you.

Immediate Actions

To reassure people living with HIV and AIDS, we believe it would be beneficial if the Federal government took steps immediately (i.e., the same day) following the Court's decision (assuming it is a negative one). They are:

- A written or oral statement by the President expressing concern about the decision and its impact on the landmark ADA and on people living with HIV/AIDS. This could be coupled with the announcement of several steps (see below) and a direction to relevant Federal agencies to examine all existing means to protect people with HIV/AIDS against discrimination. The President's statement also should highlight the anti-discrimination protections contained in such programs as Medicare, Medicaid, Ryan White CARE Act, veterans' health care facilities, public housing, and other areas. Finally, the President could indicate his intention to issue an Executive Order or Memorandum within 30 days to extend Federal protections to these individuals. Any Presidential statement should focus on our need to protect the public's health, not just the health of people living with HIV.

- An oral statement by the Surgeon General to the media expressing his concern or disappointment with the decision on behalf of the government and the public health community. Such a statement would also seek to reassure people living with HIV/AIDS that they continue to have a right to care; that discrimination will not be tolerated; and urging health care professionals to treat individuals with HIV with respect and care.
- A series of letters or memorandums could be sent to relevant officials stressing the need for confidentiality protections for people living with HIV who are seeking health care, housing, employment, etc. These could include:
 - ▶ A letter from HHS or HCFA to governors stressing the protections in the Medicaid program;
 - ▶ A letter from HHS or HRSA to all Ryan White CARE Act grantees reminding them of their responsibility to serve all those who seek care;
 - ▶ A letter from HUD to housing grantees reminding them of the prohibition against discrimination in Federal housing programs;
 - ▶ A memorandum from the Department of Veterans Affairs to all veterans' health facilities reminding them of the requirement to serve all veterans with service-connected conditions;
 - ▶ A memorandum from the Social Security Administration to all regional SSA offices reminding them of the prohibition against discrimination against people with HIV seeking or receiving benefits;
 - ▶ A memorandum or announcement to all Federal contractors reminding them that the Rehabilitation Act of 1974 still prohibits discrimination based on health status.

Short-Term Actions

Within days of the Supreme Court's decision, the Federal government and HHS in particular should be prepared to take several steps. They could include:

- Either a reprogramming of CDC funds or a request for supplemental funds to assist states and communities in expanding the number of anonymous HIV testing sites;
- A temporary respite in any attempts by the CDC to advocate for HIV reporting policies in the states. This is especially true of advocacy of name reporting. Policy arguments aside, this is a particularly dangerous time to engage in this dialogue and a "cooling off" period is essential.

Long-Term Actions

In addition to the above steps, there are several possible actions that could be taken in the months to come. They include:

- Development of a legislative strategy to seek to reverse or soften the Court's decision. A promise of such action should not be made quickly or lightly because it has many potential pitfalls, not least of which is the fact that the current Congress could take such an opportunity to further weaken the ADA in other ways.
- An increased effort to enact Federal laws protecting the confidentiality of medical records.
- A public service campaign by the CDC to promote anonymous HIV testing and early treatment for those who are infected (this should be considered no matter the scope of the Court's decision).

We are sure that there are other steps that could or should be taken. This memo is being written quickly because of the short timeframe within which we have to operate. This is a critical moment in our battle with HIV/AIDS. We will be pleased to assist in any way we can.

THE WHITE HOUSE

**Office of the Press Secretary
(Xi'an, People's Republic of China)**

For Immediate Release

June 26, 1998

STATEMENT BY THE PRESIDENT

I am pleased with today's Supreme Court decision in *Bragdon v. Abbott*. This decision reinforces the protections offered by the landmark Americans With Disabilities Act for Americans living with HIV and AIDS.

The ADA was enacted with strong bipartisan support to protect Americans with disabilities from discrimination. My Administration argued successfully in this case that people with HIV are disabled whether or not they have developed the symptoms of AIDS.

I am firmly committed to protecting all Americans, including those living with HIV and AIDS, from discrimination, and ensuring that each of us can benefit from all America has to offer. Today's decision will help in fulfilling that commitment.

-30-30-30-

BRAGDON v. ABBOTT
DRAFT Q & A

- Q: What is the Administration's reaction to the Bragdon v. Abbot decision released today by the Supreme Court?
- A: We are very pleased that the Court affirmed that people living with HIV, even if they are not yet symptomatic, are considered disabled. The Solicitor General had filed a "friend of the court" brief in this case, supporting the argument of Ms. Abbott that she was wrongfully denied routine dental services because she was HIV-positive. We argued that she was disabled and protected by the Americans With Disabilities Act.
- Q: But don't you think the dentist had a right not to treat this woman if he was afraid for himself and his patients?
- A: In general, we believe that the minimal risk of providing dental care to a person with HIV is easily mitigated by the use of universal precautions. A refusal to provide routine dental care to a person with HIV is discrimination.
- Q: How will this impact on other disabilities?
- A: While we will need some time to fully review the decision, it certainly reinforces the intent of the ADA to provide broad protections to all Americans with disabilities against discrimination.

BRAGDON v. ABBOTT

Talking Points

- Bragdon, a dentist, refused to treat Abbott in his office because she was HIV positive but asymptomatic. Abbott sued under the Americans with Disabilities Act and won. The lower courts found that being HIV positive was a disability because the infection was an impairment that limited a significant life activity, in this case, reproduction.
- The Supreme Court affirmed, by a vote of 5-4 on the central issue in the case. The Court agreed that HIV is a disability because it is an impairment that limits the major life activity of reproduction. The Court made clear that HIV may limit other major life activities as well, but the only issue before focused on reproduction.
- The Solicitor General filed a brief on behalf of Abbott. The Court's opinion is consistent with the position we took.
- Noting some factual errors, the Court remanded to the Court of Appeals for it to consider further whether the dentist was justified in not treating Abbott because her condition presented a direct threat to the health or safety of others. The Court made clear that there was considerable evidence in the record which would allow the Court of Appeals to uphold the finding against the dentist. However, because the issue was not fully briefed in the Supreme Court, the Court sent it to the lower court to resolve.

Bragdon v. Abbott

Summary of the Ruling and the Case

SUPREME COURT RULING

In *Bragdon v. Abbott*, the Supreme Court today reaffirmed that Sidney Abbott, a woman with HIV infection, is protected against discrimination under the Americans with Disabilities Act (ADA), and gave every indication that all people with HIV infection are so protected.

In an opinion with significant implications for people with AIDS, and for all people with disabilities, the Court ruled that an individual with asymptomatic HIV infection meets the required legal definition of having a physical impairment that substantially limits a major life activity.

The Supreme Court concluded that reproduction is a major life activity that is limited when a person is infected with HIV. The Court also emphasized "given the pervasive . . . course of the disease," its effects on many other major life activities would also be relevant.

Professor Chai Feldblum, author of an amicus brief on behalf of 59 AIDS, disability, and religious organizations, hailed the decision. "The Supreme Court recognized that when Congress passed the ADA, it intended to protect people with HIV infection," she said. "Today, the Supreme Court reaffirmed that unjustified discrimination against people with HIV infection violates the law." Tim Westmoreland, Director of the HIV Law and Policy Study stated, "With this decision, the Court has put medicine and law on parallel tracks. Medicine says get treatment early; the Court says antidiscrimination protections start at the moment of HIV infection."

The Supreme Court refused to create a special standard for doctors and dentists charged with violating the ADA. The Court ruled that all employers and businesses must rely on objective, scientific evidence in determining their actions with regard to people with HIV infection, with special reliance on established public health authorities. The Court sent the decision back to the Court of Appeals for further review, consistent with this ruling. All established medical and public health authorities, including the American Dental Association, the American Medical Association, and the Centers for Disease Control, agree that it is safe to treat a person with HIV infection in a private dental office.

FACTS OF THE CASE

On September 16, 1994, Sidney Abbott sought dental care from Dr. Randon Bragdon, in his office in Bangor, Maine. Ms. Abbott was HIV positive with no visible symptoms. In response to Dr. Bragdon's questions regarding her medical history, Ms. Abbott told him she was HIV positive. Dr. Bragdon informed Ms. Abbott that he would not provide routine dental treatment in his office for any HIV-infected individual and that he would fill her cavity only in a hospital setting. Ms. Abbott would have to pay the costs of the hospital facility, in addition to Dr. Bragdon's standard fee for filling a cavity. (Dr. Bragdon did not, at that time, actually have privileges at any hospital to treat his patients.) Ms. Abbott left the office without being treated and ultimately brought this suit challenging the treatment she had received from Dr. Bragdon as discriminatory and illegal under the ADA.

**QUESTIONS AND ANSWERS ON
*BRAGDON V. ABBOTT***

I. COVERAGE OF PEOPLE WITH HIV INFECTION UNDER THE ADA

Q. Why are people with asymptomatic HIV infection considered to be people with *disabilities*? Most people with HIV infection, who have no symptoms yet, do not seem to be disabled.

A. Many people with disabilities are able to function well and to work effectively. *Some* people with disabilities are not able to work, and those individuals become eligible for disability cash benefits. To be covered under a disability *benefit* law or program, an individual must have a type of disability that makes the individual unable to work.

By contrast, the Americans with Disabilities Act -- which is an *anti-discrimination* law -- covers a broad range of individuals who suffer discrimination because of an actual physical or mental impairment they have, or because other people regard them as having such impairments. **“Disability” in this context does not mean inability to function or to work. Rather, it means a serious physical or mental impairment that can cause an individual to experience some limitation in their lives, or can cause the individual to experience discrimination.**

People with asymptomatic HIV infection have a serious physical impairment of their immune system. While such individuals are able to work and participate in society, they are still limited in a range of life activities, including reproduction.

Q. What reasoning did the Supreme Court use to conclude that the plaintiff in this case, Sidney Abbott, was a person with a disability under the ADA?

A. The Court ruled that Sidney Abbott’s HIV infection was a physical impairment that substantially limited her major life activity of reproduction.

Q. What are the implications of the Supreme Court’s ruling in this case for other people with asymptomatic HIV infection?

A. The Court gave every indication that all people with HIV infection are covered under the ADA. The Court explained that given the pervasive nature of HIV infection the impact on many life activities could be relevant.

Q. What is the actual definition of “disability” under the ADA?

- A. The ADA defines a “disability” as: (A) a physical or mental impairment that substantially limits one or more of the major life activities of [an] individual; (B) a record of such impairment; or (C) being regarded as having such an impairment.

II. “DIRECT THREAT” DEFENSE UNDER THE ADA

Q. On what grounds did Dr. Bragdon, the dentist in this case, argue that he could legitimately treat Sidney Abbott differently from his other patients?

- A. The ADA allows businesses to refuse to serve customers or clients with disabilities if the client’s disability will pose a “direct threat” to the health or safety of the business owner or other customers. Dr. Bragdon argued that *he* believed that treating Sidney Abbott in his dental office, rather than in a hospital, would pose a direct threat to his own health and safety.

Q. Does the ADA allow any doctor to decide whether a person with HIV infection will pose a direct threat to him or her?

- A. No. The law simply states that a business is not required to serve a person with a disability if doing so would pose a direct threat to the health or safety of others. The law does not specify *who* is to make the determination of whether a direct threat exists. (See §302(b)(3) of the ADA).

The Department of Justice (DOJ) has the authority to issue regulations on this part of the ADA. DOJ has stated that the determination of whether a “direct threat” exists in the context of a communicable disease should be made “based on reasonable judgment that relies on current medical evidence or on the best available objective evidence.”

The Supreme Court refused to create a special standard for doctors and dentists charged with violating the ADA. The Court ruled that all employers and businesses must rely on objective, scientific evidence in determining their actions with regard to people with HIV infection, with special reliance on established public health authorities. The Court sent the decision back to the Court of Appeals for further review, consistent with this ruling. All established medical and public health authorities, including the American Dental Association, the American Medical Association, and the Centers for Disease Control, agree that it is safe to treat a person with HIV infection in a private dental office.

Q. What does the Supreme Court's ruling in *Abbott* mean for people with HIV infection who are seeking health care?

A. The Court's opinion in *Abbott* reaffirms that health care providers may not refuse to serve people with AIDS and HIV infection, and may not treat such patients differently from other patients, based on their own subjective myths and fears about HIV infection. Rather, such health care providers must be guided by objective medical and scientific facts regarding the risk of transmission of HIV. Based on those facts, no person with HIV infection may legitimately be denied service by a health care provider. (See also Q & A's on public health and HIV.)



Robert N. Weiner

06/25/98 01:14:20 PM

Record Type: Record

To: Beverly J. Barnes/WHO/EOP, Elizabeth R. Newman/WHO/EOP, Todd A. Summers/OPD/EOP
cc: Sean P. Maloney/WHO/EOP, Sylvia M. Mathews/WHO/EOP
Subject: Draft Statement by President

DOJ has signed off on this statement. Sylvia signed off on the prior version that was not substantively different.

DRAFT STATEMENT BY THE PRESIDENT
DRAFT

"I am pleased with today's Supreme Court decision in *Bragdon v. Abbott*. This decision reinforces the protections offered by the landmark Americans With Disabilities Act for Americans living with HIV and AIDS.

The ADA was enacted with strong bi-partisan support to protect Americans with disabilities from discrimination. My Administration argued successfully in this case that people with HIV are disabled whether or not they have developed the symptoms of AIDS.

I am firmly committed to protecting all Americans, including those living with HIV and AIDS, from discrimination, and ensuring that each of us can benefit from all America has to offer. Today's decision will help in fulfilling that commitment."



Todd A. Summers

06/25/98 01:05:02 PM

Record Type: Record

To:

cc:

Subject: Statement, Talking Points, and Q & A on Bragdon v. Abbott

BRAGDON v. ABBOTT
Talking Points

- Bragdon, a dentist, refused to treat Abbott in his office because she was HIV positive but asymptomatic. Abbott sued under the Americans with Disabilities Act and won. The lower courts found that being HIV positive was a disability because the infection was an impairment that limited a significant life activity, in this case, reproduction.
- The Supreme Court affirmed, by a vote of 5-4 on the central issue in the case. The Court agreed that HIV is a disability because it is an impairment that limits the major life activity of reproduction. The Court made clear that HIV may limit other major life activities as well, but the only issue before focused on reproduction.
- The Solicitor General filed a brief on behalf of Abbott. The Court's opinion is consistent with the position we took.
- Noting some factual errors, the Court remanded to the Court of Appeals for it to consider further whether the dentist was justified in not treating Abbott because her condition presented a direct threat to the health or safety of others. The Court made clear that there was considerable evidence in the record which would allow the Court of Appeals to uphold the finding against the dentist. However, because the issue was not fully briefed in the Supreme Court, the Court sent it to the lower court to resolve.

BRAGDON v. ABBOTT
Q & A

Q: What is the Administration's reaction to the Bragdon v. Abbot decision released today by the Supreme Court?

A: We are very pleased that the Court affirmed that people living with HIV, even if they are not yet symptomatic, are considered disabled. The Solicitor General had filed a "friend of the court" brief in this case, supporting the argument of Ms. Abbott that she was wrongfully denied routine dental services because she was HIV-positive. We argued that she was disabled and therefore protected by the Americans With Disabilities Act.

DRAFT

Q: But don't you think the dentist had a right not to treat this woman if he was afraid for himself and his patients?

A: No, and the Supreme Court has agreed--as had every court and Federal agency that has heard this case. The minimal risk involved was easily mitigated by the use of universal precautions. The dentist's refusal to provide routine care was plain and simple discrimination, and a violation of the ADA.

Q: How will this impact on other disabilities?

A: While we will need some time to fully review the decision, it certainly reinforces the intent of the ADA to provide broad protections to all Americans with disabilities against discrimination.

SAY WHAT

No Way, José

"I really feel that the more you promote condom use as a means to prevent becoming infected, the more infected people there will be."

—MEXICAN RED CROSS

PRESIDENT JOSE BARROSO CHAVEZ,
LA JORNADA, FEBRUARY 9, 1998

Knight Moves

"Elton [John] is now queen of the entire world...He works mourning better than anyone on this earth."

—VILLAGE VOICE GOSSIP GURU

MICHAEL MUSTO, OCT. MARCH 1998

As Good As He Gets

"I'd as soon cohabit with a warm garbage bag than wear a condom. I asked my doctor, who said, 'Look, if you're not shooting up and you're not an active homosexual, you're as likely to get AIDS as have a safe land on you.' I say these things not so much because they're politically incorrect, but because they don't teach this in civics class...I have, after all, been in Reichian therapy. Pleasure denial is what I'm fighting against here. Pleasure denial and the fear of freedom is a more negative component of our society than the AIDS scare."



—OSCAR WINNER
JACK NICHOLSON,
ON WHY HE IS NO
FRIEND OF
THE CONDOM,
NEW YORK POST,
MARCH 11, 1998

Thais That Bind

"The concept is to find a new way to deal with AIDS. These people cannot stay in society. Thai society has never learned to accept AIDS. They never will—it's impossible."

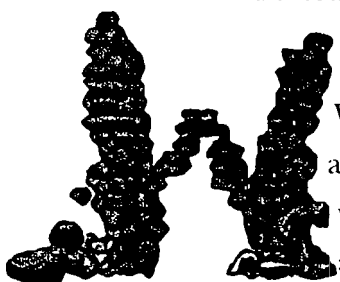
—ENGINEER-CUM-MONK ALONGKOT
TIKKOARANYO, ON HIS VISION
FOR A CHAIN OF AIDS COLONIES,
AGENCE FRANCE-PRESS,
MARCH 17, 1998

AIDS LAW

Indelicate Balance

Chipping away the ADA leaves PWAs on thin ice

BY ARTHUR LEONARD



When Congress passed the Americans With Disabilities Act (ADA) in 1990, advocates for PWAs celebrated a great victory. Congress clearly intended to protect people affected by HIV and AIDS from discrimination, or so supporters of the legislation said on the floor. ■ Unfortunately, federal court decisions by Reagan

and Bush appointees have so undermined the ADA as to have betrayed the congressional promise. For example, judges have ruled that people with HIV who have not developed physical symptoms are not included in the statute's definition of a "disability"; that people who receive disability benefits may not press employment discrimination claims; that people whose treatment restores health may not use the ADA to combat discrimination; and that HIV positive health care workers are not protected from discrimination because of the risk of transmission—however theoretical—they pose to patients.

One court recently ruled against an HIV positive grocery clerk because the employer feared he might cut himself and bleed on food. Also, a court ruled that the ADA allows an employer to place a low cap on payments for a particular medical condition, even though the inevitable effect is discrimination against people with costly conditions.

While such rulings may not represent a majority of the courts, many of these opinions came from federal appeals courts whose decisions are binding for millions of people. Why has the ADA, hailed in 1990 as a PWA charter of civil rights, produced so many terrible decisions?

When the federal and state governments began passing disability-rights laws in the 1970s, they intended to protect people with "traditional" disabilities, such as hearing or sight impairment, missing limbs and paralysis, or severe mental conditions. Their focus was on long-term or permanent conditions, not relatively brief illnesses. To express these con-

cepts, they adopted definitions that stressed severity and longevity.

The ADA requires that an individual have a mental or physical impairment that *substantially* limits a major life activity, and have a record of such an impairment or be regarded by others as having one. Major life activities include things like walking, talking, taking care of oneself and working.

To be protected by the ADA, one must be deemed "qualified"—physically and mentally able to participate, with or without "reasonable accommodations," without presenting a threat to others. Looking at this statute, some courts have decided that people with HIV who are able to function on a daily basis don't have a physical impairment. Some have ruled that the chance that people will transmit HIV "disqualifies" them. Moreover, others have ruled that anybody disabled enough to receive disability benefits could not possibly be "qualified" to work.

Most courts understand that the ADA can and should be liberally interpreted to protect those Congress intended to protect. But "strict construction" conservatives, looking for reasons to rule against a person with HIV, can find them in the strict ADA definitions. In March, the Supreme Court heard arguments in its first-ever case of HIV-related discrimination—in this instance, the appeal of a suit won by an HIV positive dental patient in Maine. By the time you read this, the court may have given us cause for a second ADA celebration, or we may be trudging back up Capitol Hill seeking a new congressional "fix" for the epidemic of AIDS discrimination. ■

THE WHITE HOUSE

Office of the Press Secretary
(Xi'an, People's Republic of China)

For Immediate Release

June 26, 1998

STATEMENT BY THE PRESIDENT

I am pleased with today's Supreme Court decision in *Bragdon v. Abbott*. This decision reinforces the protections offered by the landmark Americans With Disabilities Act for Americans living with HIV and AIDS.

The ADA was enacted with strong bipartisan support to protect Americans with disabilities from discrimination. My Administration argued successfully in this case that people with HIV are disabled whether or not they have developed the symptoms of AIDS.

I am firmly committed to protecting all Americans, including those living with HIV and AIDS, from discrimination, and ensuring that each of us can benefit from all America has to offer. Today's decision will help in fulfilling that commitment.

-30-30-30-

March 23, 1998

Supreme Court Is Set to Weigh Whether H.I.V. Is a Disability

By LINDA GREENHOUSE

WASHINGTON -- A Supreme Court case about discrimination against people who carry the virus that causes **AIDS** offers the justices a surprisingly blank slate on which to write an opinion with major implications not only for the law on the disease itself but for disability-rights law in general.

In a sense, the justices will simply be catching up with recent history when they hear arguments in the case later this month. In the 17 years since **AIDS** was first reported, the court has never decided a case about the disease or HIV. Nor have the justices yet interpreted the Americans With Disabilities Act, an 8-year-old law that in language as sweeping as it was imprecise extended federal civil-rights protection to people with disabilities.

The question before the court is whether the federal law, which prohibits discrimination on the basis of "disability" in employment, housing and public accommodations and services, applies to a person with HIV who has not developed any of the acute conditions that come under the label of **AIDS**.

The case was brought, and won in two lower federal courts, by a woman whose dentist refused to treat her in his office after she informed him that she carried the human immunodeficiency virus, or HIV.

At first glance, the question of whether the Americans With Disabilities Act covers people with asymptomatic HIV infections appears an unlikely vehicle for this first Supreme Court test of a law more identified with the image of a public building being retrofitted for wheelchair access than of a person with no visible impairment walking without assistance into a private medical office.

But far from being an anomaly, this case brings to the fore one of the most important unresolved issues under the disability law: the definition of disability.

In the 1990 law, Congress did not specify diseases or conditions. Rather, it brought people under the law's umbrella in essentially two ways, to quote the statutory language: if they have "a physical or mental impairment that substantially limits one or more of the major life activities" or if they are "regarded as having such an impairment."

Although regulations issued by the Justice Department have provided more specific guidance, explicitly identifying "HIV disease (whether symptomatic or asymptomatic)" as an example of an "impairment," the lower courts have found the definition troublesome.

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Supreme Court is set to weigh whether HIV is a Disability <http://search.nytimes.com/section/us/2000/03/23/23us01.html>

diabetes, breast cancer and various forms of mental illness are not covered by the law. The courts are divided over whether asymptomatic HIV infection is a disability.

"The utility of the statute for people with significant medical disorders is before the court right now," Wendy Parmet, a law professor at Northeastern University in Boston, said in an interview.

Ms. Parmet, one of the lawyers representing Sidney Abbott, the plaintiff in this case, said that increasingly, "courts are creating high hurdles, cutting plaintiffs off at the pass" by questioning whether a condition actually amounts to a disability. "If this were a racial discrimination case," Ms. Parmet said, "we would be discussing the nature of the discrimination, not whether the plaintiff is really black or how many black ancestors she might have had."

In the case now before the court, Bragdon vs. Abbott, No. 97-156, the 1st U.S. Circuit Court of Appeals, in Boston, applied the disability law to Ms. Abbott on the ground that her HIV-positive status had led her to conclude that she could not have children; she testified that she feared both infecting a baby and not living long enough to raise a child. She was therefore "substantially limited" in the "major life activity" of reproduction, the appeals court ruled last year.

Dr. Randon Bragdon, the dentist who refused to treat Ms. Abbott in his office, in Bangor, Maine, told her instead that he would fill her cavity in a hospital. In his appeal, Bragdon is asking the Supreme Court to rule that Ms. Abbott was not disabled when she came to his office in 1994 and that the 1990 law consequently did not apply to their interaction.

Reproduction is not a "major life activity" within the meaning of the statute, his brief argues, adding that while people who are HIV-positive may have valid reasons for forgoing parenthood, the argument that they are unable to have children "confuses moral decision-making for physical disability."

In a brief filed on the dentist's behalf, the Equal Employment Advisory Council, a group of big businesses, warns the justices that listing reproduction as a "major life activity" would mean applying the disability law to "every postmenopausal female, every impotent male" and every person who is infertile or has been surgically sterilized.

Bragdon's brief also includes an alternative argument based on an exception that Congress wrote into the law, providing that a disabled person whose condition "poses a direct threat to the health or safety of others" need not be served. He argues that courts should defer to a medical professional's judgment of whether a patient presents such a threat. "Here is the space for civil liberty among dentists," the brief states.

In briefs filed with the court, both the American Medical Association and the American Dental Association assert that HIV-positive patients may be treated safely in private offices when standard precautions against infection are taken. There is no documented case of the virus's being transmitted from a patient to a dentist or hygienist.

Although the American Medical Association supports Ms. Abbott, the American Dental Association entered the case on behalf of Bragdon to argue that reproduction is not a major life activity and that, in any event, each case of claimed disability should be evaluated individually.

It is the prospect that each plaintiff might have to not only prove that he or she

suffers from a particular condition, but to also demonstrate from scratch in each case why the condition should be considered disabling, that has mobilized a wide range of disability groups, from hemophiliacs to people with mental retardation and multiple sclerosis.

"What was intended as the broadest protection imaginable has become transformed into an obstacle course," said Chai Feldblum, a professor at Georgetown University Law Center who worked on the 1990 law as a civil-rights lobbyist and who filed a brief for the disability groups on Ms. Abbott's behalf.

Bennett Klein, who will argue the case for Ms. Abbott before the court on March 30, said, "In our view, HIV is always a disability." In an interview, he said the legislative history made clear that Congress did not intend the term "disabled" to mean "significantly debilitated or even obviously sick."

"It's not the Social Security Act, where being disabled means you can't work," said Klein, a lawyer with a Boston public-interest law firm, Gay and Lesbian Advocates and Defenders. "The assumption of Congress was that the act applied to people who were capable of working and participating in community life, and that what was preventing them from doing that was discrimination based on a health condition that affected their life in a significant way."

Even seemingly healthy people with HIV, he said, "live every day under the threat of a terminal disease" and deal with an "incredibly burdensome" schedule of taking up to 30 doses of medication a day.

Nonetheless, one imponderable element in the case is the degree to which medical advances permitting people with HIV to live longer disease-free lives have eased the atmosphere of doom surrounding the **AIDS** epidemic. In case the justices have missed the latest developments, the dental association's brief asks them to "consider, for example, the advent of protease inhibitors and their miraculous impact on the lives of persons with HIV disease."

Other Places of Interest on The Web

- ☐ [Case Summary](#) of Randon Bragdon, D.M.D v. Sidney Abbott et al. from the Legal Information Institute
 - ☐ [Supreme Court](#) Argument Calendar from the Legal Information Institute.
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March 23, 1998

White House Drug and AIDS Advisers Differ on Needle Exchange

By CHRISTOPHER S. WREN

The debate over the propriety of handing out sterile syringes to people who inject illegal drugs, to reduce the spread of **AIDS**, has reached the White House, where President Clinton's two main policy advisers on the issue have staked out opposing positions.

Their disagreement makes prospects for government financing of needle-exchange programs more unlikely when a ban on such spending, imposed by Congress in 1992, expires at the end of March.

One adviser, Sandra Thurman, the White House director of national **AIDS** policy, advocates spending on the programs as a way of saving lives by reducing the incidence of **AIDS** contracted from shared needles. But at a spirited meeting on Tuesday, the other adviser, Barry McCaffrey, the retired Army general who is the administration's director of national drug policy, ferociously opposed any government subsidy.

In a subsequent letter to Ms. Thurman, he reiterated his belief that buying clean needles for drug users would send the wrong message to young Americans who are being told that illegal drug use is wrong. The money, he said, would be better used expanding drug treatment programs.

"As public servants, citizens and parents we owe our children an unambiguous 'no use' message," McCaffrey wrote. "And if they should become ensnared by drugs, we must offer them a way out, not a means to continue addictive behavior."

His letter was leaked to some members of Congress. A copy was provided to The New York Times by someone opposed to needle exchanges.

McCaffrey's fervent opposition to paying for needle exchanges, and the esteem with which he is regarded on Capitol Hill, will probably undercut whatever support exists for exchange programs. Many members of Congress already oppose the concept or do not want to look as if they are soft on drug use in a congressional election year.

In a joint statement released on Saturday, Ms. Thurman and McCaffrey sought to play down their increasingly public differences over needle exchange. They said they agreed on other issues, like the need to make drug treatment programs more widely available.

They said they would leave it to Donna Shalala, the secretary of health and human services, to settle the needle exchange issue. Ms. Shalala, who has sided with McCaffrey on other drug policy questions, has yet to decide whether the needle exchange programs deserve government money.

are older."

"Nobody's going to stick a needle in their arm because someone hands them a needle," she said.

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The question before the court is whether the federal law, which prohibits discrimination on the basis of "disability" in employment, housing and public accommodations and services, applies to a person with HIV who has not developed any of the acute conditions that come under the label of AIDS.

The case was brought, and won in two lower federal courts, by a woman whose dentist refused to treat her in his office after she informed him that she carried the human immunodeficiency virus, or HIV.

At first glance, the question of whether the Americans With Disabilities Act covers people with asymptomatic HIV infections appears an unlikely vehicle for this first Supreme Court test of a law more identified with the image of a public building being retrofitted for wheelchair access than of a person with no visible impairment walking without assistance into a private medical office.

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"The utility of the statute for people with significant medical disorders is before the court right now," Wendy Parmet, a law professor at Northeastern University in Boston, said in an interview.

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Nonetheless, one imponderable element in the case is the degree to which medical advances permitting people with HIV to live longer disease-free lives have eased the atmosphere of doom surrounding the AIDS epidemic. In case the justices have missed the latest developments, the dental association's brief asks them to "consider, for example, the advent of protease inhibitors and their miraculous impact on the lives of persons with HIV disease."

Other Places of Interest on The Web

- Case Summary of Randon Bragdon, D.M.D v. Sidney Abbott et al. from the Legal Information Institute
 - Supreme Court Argument Calendar from the Legal Information Institute.
-

Sidney ABBOTT, et al., Plaintiffs,
Appellees,

v.

Randon BRAGDON, D.M.D.,
Defendant, Appellant.

No. 96-1643.

United States Court of Appeals,
First Circuit.

Heard Nov. 8, 1996.

Decided March 5, 1997.

HIV-positive patient brought action under Americans with Disabilities Act (ADA) and Maine Human Rights Act against dentist who refused to treat her in his office. The United States District Court for the District of Maine, Morton A. Brody, J., 912 F.Supp. 580, granted summary judgment, in favor of patient, and dentist appealed. The Court of Appeals, Selya, Circuit Judge, held, in a case of first impression, that: (1) HIV-positive status comprises "physical impairment" under ADA; (2) reproduction constitutes "major life activity" under ADA; (3) reproduction was "major life activity" under ADA for patient; (4) HIV-positive status is physical impairment that "substantially limits" fecund woman's major life activity of reproduction; (5) neither service provider nor prospective recipient of service may prove or disprove direct threat defense to ADA claim by relying on medical evidence not available when treatment was refused; (6) service provider cannot successfully contradict achieved consensus that particular disability is not a direct threat simply by proffering unsupported opinion; and (7) in September of 1994, reasonable medical judgments by public health officials, was that affording routine dental care to HIV-infected patients in office environment did not pose "direct threat" to dentist's health.

Affirmed.

1. Federal Courts 762, 766

Appellate review of district court's award of summary judgment is plenary and,

in keeping with that standard, Court of Appeals is not wedded to district court's rationale but may affirm on any alternative ground made manifest by the record. Fed. Rules Civ.Proc.Rule 56(c), 28 U.S.C.A.

2. Federal Courts ⇐766, 802

In assaying record on appeal from grant of summary judgment, Court of Appeals is guided by the same tenets that guided the lower court and is duty bound to indulge all reasonable inferences in favor of party opposing summary judgment, but must disregard improbable or overly attenuated inferences, unsupported conclusions, and rank speculation. Fed.Rules Civ.Proc.Rule 56(c), 28 U.S.C.A.

3. Civil Rights ⇐119.1

The ADA sends clear message to those who operate places of public accommodation that they may not discriminate against individuals in the full and equal enjoyment of services on the basis of a disability. Americans with Disabilities Act of 1990, § 302(a), 42 U.S.C.A. § 12182(a).

4. Civil Rights ⇐107(1), 119.1

Although dental office qualifies as place of public accommodation under Americans with Disabilities Act (ADA), ADA protects only disabled patients against discrimination. Americans with Disabilities Act of 1990, §§ 301(7)(F), 302(a), 42 U.S.C.A. §§ 12181(7)(F), 12182(a); 28 C.F.R. § 36.104.

5. Federal Courts ⇐776

Question whether patient who was infected with human immunodeficiency virus (HIV) but was asymptomatic had disability cognizable under Americans with Disabilities Act (ADA) was first and foremost a question of statutory construction which Court of Appeals would review de novo. Americans with Disabilities Act of 1990, § 302(a), 42 U.S.C.A. § 12182(a).

6. Constitutional Law ⇐70.3(3)

Statutes ⇐188

In all cases of statutory construction, court begins with words of statute, and approaches them with understanding that its role is not to set public policy but, rather, to discern legislature's will.

7. Civil Rights ⇐107(1)

Patient who asserted that she had physical or mental impairment that substantially limited one or more of her major life activities and alleged discrimination under the ADA had to prove that she had physical or mental impairment, that impairment adversely affected major life activity, and that it did so to significant extent or, more precisely, that impairment substantially limited her ability to engage in the particular major life activity. Americans with Disabilities Act of 1990, §§ 3(2), 302(a), 42 U.S.C.A. §§ 12102(2), 12182(a).

8. Civil Rights ⇐107(4)

HIV-positive status, simpliciter, whether symptomatic or asymptomatic, comprises "physical impairment" under Americans with Disabilities Act (ADA). Americans with Disabilities Act of 1990, §§ 3(2), 302(a), 42 U.S.C.A. §§ 12102(2), 12182(a); 28 C.F.R. § 36.104.

See publication Words and Phrases for other judicial constructions and definitions.

9. Civil Rights ⇐107(1)

Reproduction constitutes "major life activity" under Americans with Disabilities Act (ADA). Americans with Disabilities Act of 1990, §§ 3(2), 302(a), 42 U.S.C.A. §§ 12102(2), 12182(a).

See publication Words and Phrases for other judicial constructions and definitions.

10. Civil Rights ⇐107(1)

Touchstone for determining activity's inclusion as "major life activity" under Americans with Disabilities Act (ADA) is its significance. Americans with Disabilities Act of 1990, §§ 3(2), 302(a), 42 U.S.C.A. §§ 12102(2), 12182(a).

11. Civil Rights ⇐107(1)

In transplanting term "major life activities" from Rehabilitation Act, which used it in defining "individual with handicaps," to that of Americans with Disabilities Act (ADA), Congress specifically directed reten-

tion of original meaning. Rehabilitation Act of 1973, § 7(8)(B), 29 U.S.C.A. § 706(8)(B); Americans with Disabilities Act of 1990, §§ 3(2), 302(a), 501(a), 42 U.S.C.A. §§ 12102(2), 12182(a), 12201(a).

12. Administrative Law and Procedure

416.1

Regulation drafted with congressional oversight and approval merits particular deference.

13. Civil Rights 107(1)

Analysis under Americans with Disabilities Act's (ADA) definition of disability as a physical or mental impairment that substantially limits one or more of the major life activities of person calls for individualized inquiry into whether person is disabled, but need for case-by-case analysis of disability does not necessarily require corresponding case-by-case inquiry into connection between the person and the activity as a "major life" activity. Americans with Disabilities Act of 1990, §§ 3(2), 302(a), 42 U.S.C.A. §§ 12102(2), 12182(a); 29 C.F.R. Part 1630, App., § 1630.2(j).

14. Civil Rights 107(4)

Reproduction was "major life activity" under Americans with Disabilities Act (ADA) for woman who stated that her HIV-positive status ended her consideration of having a family. Americans with Disabilities Act of 1990, §§ 3(2), 302(a), 42 U.S.C.A. §§ 12102(2), 12182(a).

15. Civil Rights 107(4)

Eight percent risk of passing incurable, debilitating, and inevitably fatal disease to one's child is substantial restriction on reproductive activity for purposes of Americans with Disabilities Act (ADA) and, in view of reality that even if HIV-positive woman gives birth to healthy child, she probably will not live long enough to complete task of raising child to adulthood, HIV-positive status is physical impairment that "substantially limits" a fecund woman's major life activity of reproduction. Americans with Disabilities Act of 1990, §§ 3(2), 302(a), 42 U.S.C.A. §§ 12102(2), 12182(a); 29 C.F.R. Part 1630, App., § 1630.2(j).

See publication Words and Phrases for other judicial constructions and definitions.

16. Civil Rights 107(1)

Neither service provider nor prospective recipient of service may prove or disprove direct threat defense to Americans with Disabilities Act (ADA) claim by relying on medical evidence not available when treatment was refused. Americans with Disabilities Act of 1990, § 302(b)(3), 42 U.S.C.A. § 12182(b)(3).

17. Civil Rights 107(1), 240(1)

In determining whether disabled person posed direct threat to provider, so that denial of service was permissible under Americans with Disabilities Act (ADA), court must give prima facie force to views of public health authorities, but service provider may challenge those views based on contrary, properly supported, opinions voiced by other recognized experts in the field; presumption is "intermediate" presumptions, which remains available for consideration by the factfinder even after contrary evidence is introduced. Americans with Disabilities Act of 1990, § 302(b)(3), 42 U.S.C.A. § 12182(b)(3); 28 C.F.R. Part 36, App. B, § 36.208.

18. Civil Rights 107(1), 242(1)

Test for existence of "direct threat" under exception to Americans with Disabilities Act (ADA) is objective one, and service provider cannot successfully contradict achieved consensus that particular disability is not a direct threat simply by proffering unsupported opinion; despite rebuttable nature of presumption, direct threat defense may not be used to mask prejudice or unfounded fears, opposing view must be documented by competent countervailing evidence that is directly relevant, and speculative inferences, glancing statistics, unsupported conclusions, and ruminative surmise will not serve. Americans with Disabilities Act of 1990, § 302(b)(3), 42 U.S.C.A. § 12182(b)(3); 28 C.F.R. Part 36, App. B, § 36.208.

19. Civil Rights 107(4)

When HIV-positive patient visited dentist's office in September of 1994, reasonable

medical judgment by public health officials, not contradicted by other public health authorities, was that affording routine dental care, such as filling cavities, to HIV-infected patients in office environment did not pose "direct threat" to dentist's health within meaning of exception to Americans with Disabilities Act (ADA). Americans with Disabilities Act of 1990, § 302(b)(3), 42 U.S.C.A. § 12182(b)(3).

See publication Words and Phrases for other judicial constructions and definitions.

John W. McCarthy, Bangor, ME, with whom Brent A. Singer and Rudman & Winchell were on brief, for defendant.

Peter M. Sfikas, Mark S. Rubin and Jill A. Wolowitz, Chicago, IL, on brief for American Dental Ass'n, amicus curiae.

Bennett H. Klein and David G. Webbert, Augusta, ME, with whom Gay and Lesbian Advocates and Johnson, Webbert & Laubenstein were on brief, for plaintiff Sidney Abbott.

John E. Carnes, Commission Counsel, Augusta, ME, on brief for intervenor-plaintiff Maine Human Rights Commission.

Samuel R. Bagenstos, Attorney, U.S. Dept. of Justice, Washington, DC, with whom Deval L. Patrick, Assistant Attorney General, Boston, MA, and Jessica Dunsay Silver, Attorney, Washington, DC, were on brief, for intervenor-plaintiff United States of America, amicus curiae.

Robert Greenwald, Yonkers, NY, and AIDS Action Committee on brief, Boston, MA, for R.I. Dept. of Pub. Health, Bureau of Health of the Me. Dept. of Human Servs., American Pub. Health Ass'n, Ass'n of State and Territorial Dental Dirs., and Ass'n of

Though we write for simplicity's sake as if Ms. Abbott were the sole plaintiff, we note that the federal government and the Maine Human Rights Commission intervened as plaintiffs below. We note, too, that Ms. Abbott prevailed upon a parallel claim under the Maine Human Rights Act (MHRA), 5 Me.Rev.Stat. Ann. tit. 5,

State and Territorial Health Officials, amicus curiae.

Donna Levin, Boston, MA, on brief for Mass. Dept. of Pub. Health, amicus curiae.

Before SELYA, Circuit Judge, ALDRICH, Senior Circuit Judge, and STAHL, Circuit Judge.

SELYA, Circuit Judge.

In this case of first impression, the district court granted summary judgment in favor of plaintiff-appellee Sidney Abbott, an HIV-positive woman, on her claim that defendant-appellant Randon Bragdon, a dentist, violated the Americans with Disabilities Act (the ADA) by refusing to treat her in his dental office.¹ Dr. Bragdon appeals. Because we agree with the district court that Ms. Abbott is disabled within the purview of the ADA and that providing routine dental care to her (i.e., filling a cavity) would not have posed a direct threat to Dr. Bragdon's health or safety, we affirm.

I. BACKGROUND

The events giving rise to this litigation are straightforward. On September 16, 1994, Ms. Abbott arrived at Dr. Bragdon's office in Bangor, Maine for a scheduled appointment. On her patient registration form, she indicated that she was infected with the HIV virus. People may be HIV-positive for years without manifesting the set of symptoms commonly known as AIDS, and Ms. Abbott was asymptomatic at the time.

Dr. Bragdon performed a dental examination and discovered a cavity. He told Ms. Abbott that, pursuant to his infectious disease policy, he would not fill her cavity in his office, but would only treat her in a hospital setting. Though he would charge his regular fee, she would have to bear the additional cost of whatever the hospital charged for the use of its facilities. Ms. Abbott refused the

§ 4592 (West 1989). Interpretation of both the ADA and the MHRA has "proceeded hand in hand," *Soileau v. Guilford of Me., Inc.*, 105 F.3d 12, 14 (1st Cir.1997), and the parties here do not suggest any distinction between the two statutes that might affect this appeal. Consequently, we need not discuss the MHRA further.

offer and instead filed a complaint under the ADA. See 42 U.S.C. § 12182(a) (1994).

After pretrial discovery concluded, the parties cross-moved for summary judgment. The district court ruled that Ms. Abbott was substantially limited in a major life activity (reproduction) and thus was disabled for purposes of the ADA. See *Abbott v. Bragdon*, 912 F.Supp. 580, 587 (D.Me.1995). The court then concluded that the relatively routine treatment needed by Ms. Abbott could be delivered safely in Dr. Bragdon's office. See *id.* at 591. Consequently, the court granted Ms. Abbott's motion for summary judgment. See *id.* at 595-96. This appeal followed.

II. THE SUMMARY JUDGMENT STANDARD

[1] The Civil Rules authorize federal courts to grant summary judgment only when "there is no genuine issue as to any material fact and ... the moving party is entitled to judgment as a matter of law." Fed.R.Civ.P. 56(c). Confronted with a properly documented motion for *brevis* disposition, the nonmovant must establish the existence of a fact that is both genuine and material in order to ward off the entry of an adverse judgment. See *Anderson v. Liberty Lobby, Inc.*, 477 U.S. 242, 248, 106 S.Ct. 2505, 2510, 91 L.Ed.2d 202 (1986); *Garside v. Osco Drug, Inc.*, 895 F.2d 46, 48 (1st Cir.1990). Appellate review of the district court's award of summary judgment is plenary, and, in keeping with this standard, we are not wedded to the district court's rationale but may affirm on any alternative ground made manifest by the record. See *Hachikian v. FDIC*, 96 F.3d 502, 504 (1st Cir.1996).

[2] In assaying the record, we are guided by the same tenets that guided the lower court. Thus, we are duty bound to indulge all reasonable inferences in favor of the party opposing summary judgment. See *id.* This generous outlook notwithstanding, we must disregard improbable or overly attenuated inferences, unsupported conclusions, and rank speculation. See *Smith v. F.W. Morse & Co.*, 76 F.3d 413, 428 (1st Cir.1996); *Medi-*

2. The United States asserts that Ms. Abbott also is disabled under the third subset because society

na-Munoz v. R.J. Reynolds Tobacco Co., 896 F.2d 5, 8 (1st Cir.1990).

III. THE QUESTION OF DISABILITY

[3, 4] The ADA sends a clear message to those who operate places of public accommodation: you may not discriminate against individuals in the full and equal enjoyment of services on the basis of a disability. See 42 U.S.C. § 12182(a). Although a dental office qualifies as a place of public accommodation, see *id.* § 12181(7)(F); see also 28 C.F.R. § 36.104 (1996), the ADA protects only disabled patients against discrimination, and any attempt to invoke the ADA against a practicing dentist must start with an investigation into the patient's status. We turn, then, to the question of whether Ms. Abbott, who was infected with HIV but was asymptomatic, had a disability cognizable under the ADA.

[5, 6] This question is first and foremost a question of statutory construction which we review *de novo*. See *Strickland v. Commissioner, Me. Dept. of Human Servs.*, 96 F.3d 542, 545 (1st Cir.1996). In all such cases, we begin with the words of the statute, and we approach them with an understanding that our role is not to set public policy, but, rather, to discern the legislature's will. See, e.g., *United States v. Gibbens*, 25 F.3d 28, 33 (1st Cir.1994).

A. The Plaintiff's Burden.

[7] Disability is not a unitary concept under the ADA. Instead, the statute limns three subsets of disability, any one of which is sufficient to trigger the act's protections. In this regard, the ADA states:

The term "disability" means, with respect to an individual—(A) a physical or mental impairment that substantially limits one or more of the major life activities of such individual; (B) a record of such an impairment; or (C) being regarded as having such an impairment.

42 U.S.C. § 12102(2). This case, as Ms. Abbott postures it, implicates the first subset of the statutory definition.² Thus, she must commonly regards individuals who are infected with HIV as having substantially limiting impair

prove three things: first, that she has a "physical or mental impairment"; second, that this impairment adversely affects "a major life activity"; and third, that it does so to a significant extent (or, put more precisely, that the impairment "substantially limits" her ability to engage in the particular major life activity).

B. The Impairment.

[8] The plaintiff easily clears the first hurdle. We hold unhesitatingly that HIV-positive status, simpliciter, whether symptomatic or asymptomatic, comprises a physical impairment under the ADA. Regulations issued by the Equal Employment Opportunity Commission (the EEOC) implementing Title III of the ADA explicitly support this conclusion, see 28 C.F.R. § 36.104 (1996) (stating that the phrase "physical impairment" includes HIV); judicial authority buttresses this conclusion, see, e.g., *Gates v. Rowland*, 39 F.3d 1439, 1446 (9th Cir.1994); *Doe v. Garrett*, 903 F.2d 1455, 1459 (11th Cir.1990), cert. denied, 499 U.S. 904, 111 S.Ct. 1102, 113 L.Ed.2d 213 (1991); and Dr. Bragdon does not seriously advocate an antithetical view.

C. The Major Life Activity.

Moving to the second hurdle, Ms. Abbott cites reproduction as her affected major life activity. The court below accepted this assertion. See *Abbott*, 912 F.Supp. at 587. Dr. Bragdon's rebuttal is twofold. In the first place, he disputes that reproduction properly can be characterized as a major life activity. In the second place, he asserts that even if reproduction so qualifies in general, there is nonetheless an unresolved issue as to whether it qualifies in Ms. Abbott's particular case. We address each of these assertions.

[9] 1. *Reproduction Writ Large.* The question of whether reproduction in large constitutes a major life activity under the ADA is not free from doubt. The ADA itself does not define the term "major life activities," and the few available judicial precedents reveal divergent opinions. Compare *Abbott* with *Cook v. State of R.I., Dep't of Mental Health, Retard. & Hosps.*, 10 F.3d 17 (1st Cir.1993) (discussing application of the "re-

Pacourek v. Inland Steel Co., 916 F.Supp. 797, 804 (N.D.Ill.1996) (finding that reproduction is a major life activity) and *Erickson v. Board of Govs. of State Colleges*, 911 F.Supp. 316, 323 (N.D.Ill.1995) (same) and *Cain v. Hyatt*, 734 F.Supp. 671, 679 (E.D.Pa. 1990) (same) with *Krauel v. Iowa Methodist Med. Ctr.*, 95 F.3d 674, 677 (8th Cir.1996) (holding that reproduction is not a major life activity) and *Zatarain v. WDSU-Television, Inc.*, 881 F.Supp. 240, 243 (E.D.La.1995) (same). Still, it is clear that Ms. Abbott's HIV-positive status has a profound impact upon her ability to engage in intimate sexual activity, gestation, giving birth, childrearing, and nurturing familial relations. Our society has long recognized the fundamental importance of each element of this cluster of activities, and our jurisprudence reflects this bias. See, e.g., *Stanley v. Illinois*, 405 U.S. 645, 651, 92 S.Ct. 1208, 1212-13, 31 L.Ed.2d 551 (1972) (terming the rights to conceive and raise children "essential," "basic civil rights," and rights that are "far more precious ... than property rights") (citations and internal quotation marks omitted). Viewed against this backdrop, we think it is highly likely that Congress accorded comparable importance to these activities when it authored the ADA.

[10] The statute's text appears to bear out this intuition. Because the term "major life activities" is not defined in the enactment, we are obliged to construe it in accordance with its natural (that is, ordinary) meaning. See *Bailey v. United States*, — U.S. —, —, 116 S.Ct. 501, 506, 133 L.Ed.2d 472 (1995); *Smith v. United States*, 508 U.S. 223, 228, 113 S.Ct. 2050, 2053-54, 124 L.Ed.2d 138 (1993). The Court has looked to familiar dictionary definitions in similar situations. See, e.g., *Bailey*, — U.S. at —, 116 S.Ct. at 506; *Smith*, 508 U.S. at 229, 113 S.Ct. at 2054. Following that model here lends support to the classification of reproduction as a major life activity. The plain meaning of the word "major" denotes comparative importance. See, e.g., *The American Heritage Dictionary of the English Language* 1084 (3d ed.1992) (listing

garded as" language). We need not reach this contention.

"greater than others in importance or rank" as the initial definition of "major"); *Webster's Ninth New Collegiate Dictionary* 718 (1989) (defining "major" as "greater in dignity, rank, importance, or interest"). These definitions strongly suggest that the touchstone for determining an activity's inclusion under the statutory rubric is its significance—and reproduction, which is both the source of all life and one of life's most important activities, easily qualifies under that criterion.

[11] The origins of the ADA's language reinforce this conclusion. Congress lifted the term "major life activities" from the Rehabilitation Act of 1973, which used it in defining an "individual with handicaps." See 29 U.S.C. § 706(8)(B) (1988). In that milieu, the term was accorded "a broad definition, one not limited to so-called 'traditional handicaps.'" *School Bd. of Nassau County v. Arline*, 480 U.S. 273, 280 n. 5, 107 S.Ct. 1123, 1127 n. 5, 94 L.Ed.2d 307 (1987). In transplanting this combination of words from the soil of the Rehabilitation Act to that of the ADA, Congress specifically directed retention of the original meaning. See 42 U.S.C. § 12201(a) (1994). Had Congress sought to confine the definition of disability narrowly, it surely would have written new, more restrictive language instead of borrowing a descriptive phrase notable for its breadth. See *Doe v. Kohn Nast & Graf, P.C.*, 862 F.Supp. 1310, 1320 (E.D.Pa.1994). It would be wholly inconsistent with this history to hold that Congress did not envision reproduction as a major life activity.

[12] In addition to the language of the ADA and the historical antecedents of that language, we are guided by the regulations, which define "major life activities" to "mean[] functions such as caring for oneself, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning, and working." 28 C.F.R. § 36.104 (1996).³ As the regulation itself clearly indicates, this enumeration is not meant to be exclusive, and reproduction—one of the most natural of

endeavors—fits comfortably within its sweep. Furthermore, the portion of the regulations which defines physical impairments to include physiological disorders affecting the reproductive system, 28 C.F.R. § 36.104 (1996), militates in favor of the same outcome. From the scope of the latter regulation, we deduce that its drafters considered reproduction to be a major life activity—otherwise, including reproductive disorders among the regulation's roster of physical impairments would not have made much sense. See *Pa-courek*, 916 F.Supp. at 801-02.

The appellant resists this conclusion. The regulation itself includes no general adage to aid courts in determining what constitutes a major life activity, and he invites us to adopt a limiting principle which will preclude a finding that reproduction qualifies. In his view, major life activities do not embody lifestyle choices, or, as he puts it, "activities that many people decide never to do." This proposition has a modicum of decisional support. See *Krauel v. Iowa Methodist Med. Ctr.*, 915 F.Supp. 102, 106 n. 1 (S.D.Iowa 1995) ("Some people choose not to have children, but all people care for themselves, perform manual tasks, walk, see, hear, speak, breathe, learn, and work, unless a handicap or illness prevents them from doing so."), *aff'd*, 95 F.3d 674 (8th Cir.1996). In addition, courts have used other formulations en route to concluding that reproduction is unlike the activities listed in the regulation and, therefore, not a major life activity. See, e.g., *Krauel*, 95 F.3d at 677 (emphasizing that the plaintiff "has the ability to care for herself, perform manual tasks, walk, see, hear, speak, breathe, learn, and work" and is therefore not disabled); *Zatarain*, 881 F.Supp. at 243 (distinguishing reproduction from major life activities based on frequency of performance).

We do not find any of these formulations persuasive. In *Krauel*, the Eighth Circuit did not go beyond the activities explicitly included in the regulation and thus effectively treated the list as exclusive, not illustrative.

3. This phraseology is copied verbatim from 45 C.F.R. § 84.3(j)(2)(ii) (1996), a regulation implementing the Rehabilitation Act of 1973. Because that regulation was drafted with congressional oversight and approval, see *Arline*, 480 U.S. at

279-80, 107 S.Ct. at 1126-27, the definition merits particular deference. See *Consolidated Rail Corp. v. Darrone*, 465 U.S. 624, 634, 104 S.Ct. 1248, 1254-55, 79 L.Ed.2d 568 (1984).

tive. Since the plain language of the regulation counsels otherwise, we are disinclined to emulate that example. The approaches taken by the *Zatarain* court and the district court in *Krauel* are no more attractive; in contradistinction to those courts, we see no reason why an activity must be performed either frequently or universally before it can be classified as a major life activity. There is no evidence that Congress intended either frequency or universality to operate as a restriction on the definition of "major life activities." Indeed, the activities explicitly enumerated in the regulation are not wholly characterized by frequency and universality; learning—even in a broad sense—is for many adults not a part of daily life, and work is certainly not universal (as the lives of some of the very rich and some of the very poor demonstrate). The view from the other end of the spectrum bolsters this conclusion; neither lack of frequency nor lack of universality diminishes the fundamental importance of conceiving, childbearing, and raising a family.

This leaves us with the bare bones of Dr. Bragdon's thesis: that reproduction cannot be considered a major life activity because it is at bottom a lifestyle choice. That emaciated argument lacks force. To treat reproduction as a lifestyle choice, and no more, is merely an exercise in semantics. Most acts that human beings perform—or refrain from performing—have elements of volition. Speaking is undoubtedly a major life activity, but there are those (say, monks who have taken vows of silence) who choose to eschew it.

Though the question is very close, we think it must be resolved favorably to Ms. Abbott. Reproduction (and the bundle of activities that it encompasses) constitutes a major life activity because of its singular importance to those who engage in it, both in terms of its significance in their lives and in terms of its relation to their day-to-day existence. Mindful of this reality, and honoring what we believe to be Congress' intent, we hold that reproduction is a major life activity within the meaning of the ADA.

2. Reproduction Writ Small. Dr. Bragdon's fallback position is that Ms. Abbott is not disabled within the purview of the ADA

unless reproduction is a major life activity for her. He then endeavors to use this position to defeat summary judgment, maintaining that a factfinder, drawing defendant-friendly inferences from the summary judgment record, would confront a genuine issue as to whether giving birth and raising a child is so important to Ms. Abbott as to constitute one of her major life activities.

[13] The premise on which Dr. Bragdon's argument depends is of uncertain reliability. Though it is true that analysis under the first subset of the ADA's definition of disability—"a physical or mental impairment that substantially limits one or more of the major life activities of [the plaintiff]"—calls for an individualized inquiry into whether the plaintiff is disabled, see 29 C.F.R. Pt. 1630, App. § 1630.2(j) (1996) (noting in the context of the ADA's employment discrimination regulations that "[s]ome impairments may be disabling for particular individuals but not for others"); *Katz v. City Metal Co.*, 87 F.3d 26, 32 (1st Cir.1996); *Ennis v. National Ass'n of Business & Educ. Radio, Inc.*, 53 F.3d 55, 59 (4th Cir.1995), the need for this case-by-case analysis of disability does not necessarily require a corresponding case-by-case inquiry into the connection between the plaintiff and the major life activity. By way of example, it might be enough for a court to consider only whether a given impairment substantially limits a particular plaintiff without considering whether the activity is of particular import to her. Be that as it may, the question is not dispositive here (nor will it be in many cases), and the most efficient way to decide this appeal is simply to postpone a definitive answer and assume, favorably to the appellant, that a plaintiff claiming a disability under the ADA must show a nexus between her impairment and the major life activity that she asserts has been substantially limited.

[14] Even accepting *arguendo* that reproduction is not a major life activity for one with no interest in bearing children, the determination of whether reproduction is a major life activity in a particular case does not automatically become a jury question. Cf. *Medina-Munoz*, 896 F.2d at 8 (noting that even "elusive concepts such as motive or intent" sometimes can be decided on sum-

mary judgment). Here, drawing all reasonable inferences in the manner most helpful to Dr. Bragdon, a factfinder could reach no conclusion other than that reproduction, if a major life activity at all, constitutes such for Ms. Abbott. We explain briefly.

Ms. Abbott's testimony on this point is uncontradicted:

I have made the decision after I tested positive [for HIV] not to have children because of the risk of infecting the child and the risk of impairing my own immune system, and also the fact that this baby probably wouldn't have a mother after a while.

Dr. Bragdon offers no substantial rebuttal to Ms. Abbott's assertion that HIV ended her consideration of having a family, but instead asks us to doubt her sincerity. In his most telling sortie, he stresses the fact that, during her deposition, Ms. Abbott replied "no" when asked, "Are you impaired in your ability to carry out any of your life functions by the fact that you are HIV positive?" We do not believe that a party's response to a question about "life functions"—a phrase not used in ordinary parlance to refer to reproduction—can fairly be read as a direct contradiction of her unequivocal statements about her reasons for not bearing children. Dr. Bragdon has offered no other evidence suggesting that, short of her HIV infection, Ms. Abbott would have elected to remain childless. In the absence of specific discrediting evidence, a party cannot derail summary judgment by the primitive expedient of insisting that his opponent's evidence should be disbelieved. See *Grubb v. KMS Patriots, L.P.*, 88 F.3d 1, 4 (1st Cir.1996).

To say more at this point would be supererogatory. Because uncontradicted evidence establishes that reproduction is a major life activity for Ms. Abbott, the second element of her case is firmly in place.

D. The Limitation.

We turn now to the final hurdle that blocks Ms. Abbott's path. At this hurdle, the parties joust over whether Ms. Abbott's HIV

infection substantially limits her major life activity of reproduction. Under the applicable regulation, a person's major life activity is "substantially limited" if it is "restricted as to the conditions, manner, or duration under which [it] can be performed in comparison to most people." 28 C.F.R. Pt. 36, App. B § 36.104 (1996). Dr. Bragdon concedes that an HIV-positive pregnant woman faces an approximately 25% risk of transmitting the virus to her child without AZT therapy and an 8% risk of viral transmission with such therapy. He strives to persuade us, however, that there is an unresolved issue, sufficient to preclude summary judgment, as to whether HIV substantially limits Ms. Abbott's reproductive activity. In other words, he claims that on the record *sub judice*, a jury reasonably could find that the stated degree of risk does not substantially limit this infected person's ability to reproduce.

[15] We are unconvinced. No reasonable juror could conclude that an 8% risk of passing an incurable, debilitating, and inevitably fatal disease to one's child is not a substantial restriction on reproductive activity. Cf., e.g., 29 C.F.R. Pt. 1630, App. § 1630.2(j) (1996) (stating in the ADA's employment discrimination regulations that "[o]ther impairments, however, such as HIV infection, are inherently substantially limiting"). In addition, Ms. Abbott faces the unfortunate reality that even if she gives birth to a healthy child, she probably will not live long enough to complete the task of raising the child to adulthood. We thus hold that HIV-positive status is a physical impairment that substantially limits a fecund woman's major life activity of reproduction. Ms. Abbott therefore is disabled within the purview of the ADA.

We add a final observation. As we noted earlier, our mission in cases of statutory construction is to discern the legislature's intent. The result that we reach here comports with evidence in the legislative archives that Congress deemed HIV-infected individ-

uals to be disabled under the ADA. See H.R.Rep. No. 101-485(III), at 28 n.18 (1990), reprinted in 1990 U.S.C.C.A.N. 445, 451 n.18 ("Persons infected with the Human Immunodeficiency Virus are considered to have an impairment that substantially limits a major life activity, and thus are considered disabled under th[e] first test of the definition."). Moreover, the ADA's precursor, the Rehabilitation Act, had been construed by the Department of Justice (DOJ) to protect persons infected with HIV from discrimination; in enacting the ADA, Congress endorsed the DOJ's view, noting that "a person infected with [HIV] is covered under the first prong of the definition of the term 'disability' because of a substantial limitation to procreation and intimate sexual relationships." H.R.Rep. No. 101-485(II), at 52, 1990 U.S.C.C.A.N. 303, 334; see also S.Rep. No. 101-116, at 22 (1989). This legislative history thus independently bolsters our conviction that Ms. Abbott is disabled under the ADA.

IV. THE DIRECT THREAT QUESTION

Under the ADA, a place of public accommodation must extend its services to all disabled persons without reference to their disabilities, subject to certain carefully circumscribed exceptions. See 42 U.S.C. § 12182(a). By virtue of one such exception, a covered service provider need not deal with an individual who "poses a direct threat to the health or safety of others." 42 U.S.C. § 12182(b)(3). The term "direct threat" is defined by the statute; in this context it contemplates the existence of "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." *Id.*⁴

Dr. Bragdon seeks safe harbor under this exception, asserting that requiring him to treat Ms. Abbott would pose a direct threat to his health. His argument envisions that

to fill Ms. Abbott's cavity, he would need to inject a local anesthetic into her mouth and drill the decayed tooth. These procedures, he says, create an undue risk of HIV transmission both through needlestick and through the spattering of blood and bloody saliva.

A court's goal in conducting a direct threat analysis under the ADA is to achieve a responsible balance, protecting service providers and other places of accommodation from enforced exposure to unacceptable health and safety risks while at the same time protecting disabled individuals from discrimination that is rooted in prejudice or baseless fear. See *Arline*, 480 U.S. at 287, 107 S.Ct. at 1130-31. EEOC regulations drawn from the Court's seminal opinion in *Arline* guide this analysis:

In determining whether an individual poses a direct threat to the health or safety of others, a public accommodation must make an individualized assessment, based on reasonable judgment that relies on current medical knowledge or on the best available objective evidence, to ascertain: the nature, duration, and severity of the risk; the probability that the potential injury will actually occur; and whether reasonable modifications of policies, practices, or procedures will mitigate the risk.

28 C.F.R. § 36.208(c) (1996); see also *Arline*, 480 U.S. at 287-88, 107 S.Ct. at 1130-31 (discussing essentially the same factors).

Of course, any inquiry along these lines depends in one sense on what information permissibly may be weighed in the balance and in another sense on the extent to which particular kinds of evidence should be assigned extra weight (or, perhaps, decretory significance). Thus, before evaluating the medical evidence proffered by the parties, we must determine (1) the relevancy, if any, of subsequent medical knowledge (that is, medical evidence not available in September 1994 when Dr. Bragdon refused to treat Ms. Abbott), and (2) the degree of deference, if any, due the judgments of public health officials.

⁴ It is important to note that Dr. Bragdon does not argue that his offer to treat Ms. Abbott in a hospital setting is a practice modification that would eliminate the claimed threat to his health. He did not endeavor to prove in the court below

that hospital treatment was significantly safer than office treatment, and he makes no such argument to us. He argues instead that he had no duty to treat her in his office and that his offer

A. The Evidentiary Time Line.

[16] The first of these excursions need not detain us. The applicable regulations instruct that a judgment on the presence or absence of a direct threat must be predicated on "current medical knowledge or on the best available objective evidence," 28 C.F.R. § 36.208(c) (1996) (emphasis supplied), and, hence, point unwaveringly toward confining medical evidence to that available at the time a dentist or other health-care professional refuses to treat. This principle—that neither the service provider nor the prospective recipient of the service may prove or disprove the direct threat defense by relying on medical evidence not available when treatment was refused—is sound policy. Under such a regime, the service provider retains the opportunity to prove that he made an appropriate determination of the existence of a direct threat based on the evidence available when he made the decision to withhold his services. This is sound policy because, while health-care providers can be expected to maintain a working knowledge of currently accepted thinking in their fields, they cannot be expected to anticipate either future scientific advances or the emerging wisdom of public health organizations. In short, by holding covered service providers to an objective standard featuring the best evidence available at the time they refuse to render treatment to disabled persons, the ADA holds the delicate balance between sometimes conflicting rights steady and true.

This approach is also scrupulously fair. To punish providers when they satisfy an objective standard based on the best evidence available at the time of their decisions would be to punish them for a lack of clairvoyance. By the same token, to hold providers harmless after they have refused treatment based on nothing more than unfounded

to treat her in a hospital was gratuitous (and, therefore, legally irrelevant). Dr. Bragdon claims the right to deny entirely routine dental treatment to patients with HIV, and his defense must stand or fall on the correctness *vel non* of that thesis. It is only that claim which we consider here. Thus, this case does not address whether it is illegal under the ADA for dentists to take additional precautions when treating HIV-infected patients.

trepidation would run at cross-purposes with the central theme of the ADA. Fundamental fairness insists that providers in such circumstances ought not to be entitled to rely on subsequent understandings to shield them from the condign consequences of discriminatory conduct.⁵ Cf. *McKennon v. Nashville Banner Pub. Co.*, 513 U.S. 352, —, 115 S.Ct. 879, 885, 130 L.Ed.2d 852 (1995) (holding that an employer in an employment discrimination case may not justify its conduct based on evidence that did not motivate it at the time of the employment decision); *North Shore Univ. Hosp. v. Rosa*, 86 N.Y.2d 413, 633 N.Y.S.2d 462, 465, 657 N.E.2d 483, 486 (1995) (evaluating conduct alleged to be discriminatory under state law based on accepted medical practice at the time of the alleged infraction).

B. The Degree of Deference.

[17] The second threshold determination involves the degree of deference due the medical judgments of public health authorities. The government joins Ms. Abbott in arguing for a rule which, if embraced, would cede great deference to those authorities. They posit that, in the absence of dissent among public health authorities, a service provider should be bound to accept the expressed collective judgment of those authorities unless he can demonstrate that this judgment is medically unreasonable. In contrast, Dr. Bragdon asseverates that, at least in the case of a service provider who is himself a skilled professional (such as a doctor or dentist), a court should defer to the provider's judgment, as long as it appears to have been reasonable in light of then-current medical knowledge.

The question of deference pivots on language in *Arline*, where Justice O'Connor, writing for the Court, stated that in making factual findings of the sort that are necessary to inform the inquiry into the existence *vel non* of a direct threat, "courts normally should defer to the reasonable medical judg-

5. Few rules are without exception in extreme cases. One can conceive of situations in which, after a medical professional refused treatment but before trial, there might occur some medical breakthrough or stunning new CDC pronouncement that overwhelmingly vindicated the professional's fears. Especially because decisions in ADA cases have some forward-looking impact, we do not rule out the possibility that later occurring events might occasionally be pertinent. But nothing in the present record suggests any

ments of public health officials." 480 U.S. at 288, 107 S.Ct. at 1131. In crafting regulations applicable to the ADA, the EEOC treated this passage from *Arline* as gospel. See 28 C.F.R. Pt. 36, App. B § 36.208 (1996) (remarking that the direct threat regulations "codify] the standard first applied by the Supreme Court in [*Arline*]").

We agree that the deference due public health officials must flow from the quoted passage—but acknowledging the hegemony of *Arline* does not signal automatic victory for Ms. Abbott and the government. The "defer entirely" formulation that they urge upon us is totally unprecedented; we have found no case in which the views of public health authorities are treated with the solicitude that Ms. Abbott and the government invite. If adopted, this formulation would come close to making a consensus among public health authorities unchallengeable by other medical evidence and, consequently, unreviewable by the courts. Nothing in *Arline* demands such obsequious obeisance to public health authorities or indicates an intention on the Court's part to consign the medical judgments of private physicians to some evidentiary Siberia. Instead, the Court quite clearly left the details of deference for another day. See, e.g., *Arline*, 480 U.S. at 288 n. 18, 107 S.Ct. at 1131 n. 18 ("This case does not present, and we do not address, the question whether courts should also defer to the reasonable medical judgments of private physicians . . .").

Because we are unprepared to say that medical wisdom resides exclusively in public health authorities, we reject the idea of a conclusive presumption. The applicable regulations state that "[s]ources for 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." 28 C.F.R. Pt. 36, App. B § 36.208 (1996) (emphasis supplied). This list is plainly illustrative, not exhaustive, and the use of the verb "include" indicates to us that other sources of medical knowledge are within the pale. The statute, the suggestion implicit in

post hoc scientific revelation warranting a departure from the usual rule.

In *United States v. Jessup*, 757 F.2d 378, 381-84 (1st Cir.1985), then-Judge Breyer distinguished "bursting bubble" presumptions (which

the regulations, and the teachings of the Court are best synthesized by fashioning a rule which gives prima facie force to the views of public health authorities, but which permits a service provider to challenge those views based on contrary, properly supported opinions voiced by other recognized experts in the field (e.g., research studies published in peer-reviewed journals). Such a rule accords a meaningful degree of respect to the views of public health authorities, particularly when those views are unanimous. But the rule draws a distinction between respect and absolute capitulation. Under it, the conclusions of public health authorities may be rebutted by persuasive evidence adduced from other recognized experts in a given field.⁶

[18] Treating the presumption of correctness which attaches to the collective judgment of public health authorities as rebuttable will not, as the government intimates, sabotage the statutory scheme. Because the test for the existence *vel non* of a direct threat remains an objective one, a service provider cannot successfully contradict an achieved consensus simply by proffering an unsupported opinion. This ensures that, despite the rebuttable nature of the presumption, the direct threat defense may not be used to mask prejudice or unfounded fears. Rather, to frame a genuine issue, an opposing view must be documented by competent countervailing evidence that is directly relevant. Speculative inferences, glancing statistics, unsupported conclusions, and ruminative surmise will not serve.

C. Applying the Standard.

[19] We turn next to a review of the medical evidence that was available when Ms. Abbott visited Dr. Bragdon's office in September 1994. By then, both the United States Centers for Disease Control and Prevention (CDC) and the American Dental Association (the Association) had spoken to the issue of the health risk to dental workers from patients infected with HIV. The Association's 1991 *Policy on AIDS, HIV Infection and the Practice of Dentistry* stated that:

vanish when contrary evidence is introduced) from "intermediate" presumptions (which remain available for consideration by the factfinder even after contrary evidence is introduced). The presumption here is of the latter stripe.

Current scientific and epidemiologic evidence indicates that there is little risk of transmission of infectious diseases through dental treatment if recommended infection control procedures are routinely followed. Patients with HIV infection may be safely treated in private dental offices when appropriate infection control procedures are employed.

In 1993, the CDC updated its earlier guidelines and specified a compendium of infection control procedures, known as the "universal precautions," for use by dental workers treating HIV-positive patients. See CDC, *Recommended Infection-Control Practices for Dentistry*, 1993 (the Recommendations). The CDC took the position that, when implemented, the prescribed precautions "should reduce the risk of disease transmission in the dental environment." *Id.* at 3. While the guidelines do not state explicitly that no further risk-reduction measures are desirable or that routine dental care for HIV-positive individuals is safe, those two conclusions seem to be implicit in the guidelines' detailed delineation of procedures for office treatment of HIV-positive patients. See *United States v. Morvant*, 898 F.Supp. 1157, 1166 (E.D.La. 1995) (concluding that "the universal precautions as prescribed by the CDC are universally accepted as 'reasonable modifications' of practices that will significantly mitigate the risk [of HIV transmission from patient to dentist]").⁷ Tellingly, no public health authority has suggested that it is unsafe to provide routine dental care to HIV-positive patients in a private office environment. We find, therefore, that Ms. Abbott adduced competent evidence of reasonable medical

7. In support of her motion for *brevis* disposition, Ms. Abbott also presented testimony from Dr. Donald Wayne Marianos, director of the Division of Oral Health at the CDC. Dr. Marianos stated categorically that "[n]o infection control procedures beyond the use of universal precautions are necessary when providing routine dental care to persons with HIV and AIDS." He also declared that "[t]he CDC does not recommend the use of infection control procedures beyond those cited in [the Recommendations] for the provision of routine dental treatment to persons with HIV or AIDS" and that "the risk of HIV transmission from patient to provider [in such circumstances] is so low as to be unquantifiable." Dr. Marianos' testimony is of limited value to us in assess-

judgments by public health officials, not contradicted by other public health authorities, to the effect that affording routine dental care (such as filling cavities) to HIV-infected patients in an office environment does not pose a direct threat to the dentist's health.

The next question is whether Dr. Bragdon has produced sufficient countervailing evidence that filling Ms. Abbott's cavity in an office setting would have constituted a direct threat to his health. In an endeavor to create a genuine issue of material fact, he cites eight sources of information which he argues show that rendering the necessary treatment in his office would have jeopardized his health.⁸ We examine these sources to determine if any of them, individually or in the aggregate, justify denying summary judgment to Ms. Abbott.

1. Dr. Bragdon notes that the Food and Drug Administration (the FDA) recommended in 1992 that persons who have had contact with a patient's blood through needlestick, non-intact skin, or mucous membranes refrain from donating blood for a year. This recommendation is clearly insufficient to demonstrate a direct threat to Dr. Bragdon. To safeguard the integrity of the blood supply, the FDA may seek to avoid minute risks and take unusual precautions even in the absence of actual evidence of danger. It is not surprising, therefore, that the FDA issued its recommendation without making any finding that there was a significant risk of contracting HIV from contact of the type and kind described. In contrast, to determine whether there is a direct threat within the purview of the ADA, an inquiring court must gauge the nature, duration, and

ing the medical evidence available to Dr. Bragdon inasmuch as the record contains no evidence that the CDC had publicly taken so explicit a position as of September 1994.

8. Although Dr. Bragdon presented material from a retained expert, Dr. Sanford Kuvin, he does not claim that Dr. Kuvin's testimony was based on medical knowledge available to him on the date he declined to treat Ms. Abbott, and his brief discusses Dr. Kuvin's testimony in a separate section devoted to the possibility that evidence available after September of 1994 might be relevant to the issue. To clinch the point, Dr. Kuvin's testimony itself relies on a number of sources not available until 1995 and beyond.

severity of the risk.⁹ The FDA's recommendation does not advance this inquiry.

2. Dr. Bragdon refers to a CDC report documenting forty-two incidents of transmission of HIV to health-care workers and seven possible transmissions to dental workers. We deem this data insufficient to warrant depriving Ms. Abbott of summary judgment. Evidence of HIV transmission to health-care workers outside the dental field does not prove a direct threat to a practicing dentist in the absence of any evidence showing that the magnitude of risk to a dentist is comparable to the risk to other health-care workers in other settings. Nor is such an equivalency obvious; health-care workers in, say, emergency rooms may be exposed to much larger needles and more copious quantities of blood than are common in routine dental practice.

Generalities about health-care workers aside, Dr. Bragdon 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. See *Smith*, 76 F.3d at 428 (noting that unsupported speculation must be disregarded at summary judgment); *Medina-Munoz*, 896 F.2d at 8 (similar).

3. Dr. Bragdon brandishes a CDC report telling of the transmission of HIV from a Florida dentist to his patients. But neither the CDC report nor any other proffered evidence establishes transmission of HIV from a patient to a dental worker. The difference is meaningful. Dentists have the advantage of equipping and staffing their offices and dictating the precautionary procedures that will be utilized during patient encounters. In contrast, patients have no way of assuring that any particular risk-reduction measures, much less the universal precautions recommended by the CDC, are introduced. Given that dentists are in a superior position to patients in terms of pro-

tecting against infection, a single report of dentist-to-patient infection cannot reasonably be taken to suggest a direct threat to dentists from their patients' infections.

4. The high-speed drills that dentists use when filling cavities may also generate aerosol mists of water, blood, and bloody saliva. Using this datum as a springboard, Dr. Bragdon jumps to the conclusion that a study by researchers at the Stanford Medical School, raising concerns about transmission of HIV when dentists perform aerosol generating procedures, is sufficient to defeat summary judgment. See Gregory K. Johnson and William S. Robinson, *Human Immunodeficiency Virus-1 (HIV-1) in the Vapors of Surgical Power Instruments*, 33 *Journal of Medical Virology* 47 (1991). By its own characterization, however, the Johnson-Robinson paper is too conjectural to raise a genuine issue of material fact as to whether filling Ms. Abbott's cavity would constitute a direct threat to Dr. Bragdon's health. The paper notes that it "do[es] not quantitate the risk of HIV transmission ... by such aerosols," and that "the large body of epidemiologic data on prevalence of HIV infections ... would suggest that transmission by aerosols is not common." *Id.* at 49.

5. Dr. Bragdon points out that the CDC did not state that it was medically unwise to take additional precautions with persons known to be HIV-positive. This observation, while true, gains him little ground. Such silence on the part of the CDC is at best equivocal; it does nothing to prove that there is any risk to a dentist in treating HIV-positive patients. Because the inference that Dr. Bragdon seeks to draw from the CDC's silence is wholly conjectural, it cannot figure in the summary judgment calculus.¹⁰ See *Smith*, 76 F.3d at 428.

6. Dr. Bragdon adverts to the Association's report that the risk to health-care workers is greater than the risk to patients. At the same time, he notes, federal courts have found a significant risk of HIV trans-

9. Then, too, the stakes are different. The only foreseeable loss from what may be an overabundance of caution on the FDA's part is some small quantity of donated blood. Surrendering to stereotypes and unfounded fears when dealing with disabled persons, however, will subvert Congress' intent in enacting the ADA.

10. In all events, it is implicit in the 1993 CDC guidelines that no risk-reduction steps beyond the universal precautions are necessary to ensure the safety of dentists providing routine dental care to HIV-positive individuals. See *supra* p. 945-46.

mission from health-care workers to patients. See, e.g., *Bradley v. University of Tex. M.D. Anderson Cancer Ctr.*, 3 F.3d 922, 924 (5th Cir.1993) (per curiam), *cert. denied*, 510 U.S. 1119, 114 S.Ct. 1071, 127 L.Ed.2d 389 (1994); *Doe v. Washington Univ.*, 780 F.Supp. 628, 633 (E.D.Mo.1991). Dr. Bragdon seeks to lace these findings together to support a conclusion that the risk to him from treating Ms. Abbott is also significant. The tie does not bind; this combination produces far too much of a generalization to have any force in the much narrower contours of this case.

Moreover, the federal cases involving transmission of HIV from health-care workers to patients are inapposite not only because of the asymmetry of control of risk-reduction measures between health-care workers and patients, *see supra*, but also because the cited cases spring from a context in which any risk at all to patients is deemed unacceptable. See *Washington Univ.*, 780 F.Supp. at 633 ("It is the stated goal of the medical profession to heal, and its secondary axiom, if healing is not possible, is not to harm.") Therefore, these cases do not support a reasoned inference that rendering routine care to a dental patient infected with HIV constitutes a direct threat to the dentist's health.

7. Dr. Bragdon states that although he did his best to comply with the universal precautions, he still sustained sharp injuries on a regular basis. We believe that this kind of anecdotal evidence by a dentist who is not an expert on infectious disease is inadequate to block summary judgment. See *Medina-Munoz*, 896 F.2d at 8 (noting that summary judgment may be granted when opposing evidence is not significantly probative). Although courts need not defer slavishly to the judgments of public health officials, *see supra* Part IV(B), we believe it would be inconsistent with *Arline* were courts to credit lay testimony on matters of public health. See *Arline*, 480 U.S. at 287-88, 107 S.Ct. at 1130-31 (emphasizing the need to protect the handicapped from unfounded fears).

8. Dr. Bragdon cites a study reporting that compliance with the universal precautions would reduce needlestick exposures by only 62%. See Edward S. Wong et al., *Are Universal Precautions Effective in Reducing*

the Number of Occupational Exposures Among Health Care Workers?, 265 *Journal of the American Medical Association* 1123, 1126 (1991). This statistic says nothing about the initial baseline degree of danger of treatment in the absence of the universal precautions and thus is impuissant to prove that a dentist using the CDC's precautions is directly threatened by treating an HIV-positive patient.

At this point, we have reviewed all the proof relevant to direct threat that Dr. Bragdon claims was available to him in September of 1994. Each piece of evidence is too speculative or too tangential (or, in some instances, both) to create a genuine issue of material fact. This ends our item-by-item explication of the record.

We next consider whether these eight proffers, in cumulation, possess greater probative force. This can occur when items of evidence, each insufficient in itself to prove a particular point, complement each other, like interlocking pieces of a jigsaw puzzle, in such a way that they together demonstrate some material fact. Thus, had Dr. Bragdon cited separate sources of evidence demonstrating (a) the likelihood of dental needlestick and (b) the likelihood of a dentist contracting HIV from a needlestick, these items together possibly would have been adequate to defeat summary judgment on the direct threat defense. Or, had he proffered several items of evidence that each showed a small risk to the health or safety of others, the aggregate effect of these items might have sufficed to prove a significant risk and thus to thwart summary judgment.

Despite the fact that Dr. Bragdon did not explicitly make a "cumulative proof" argument, we have spontaneously reviewed the record with this thought in mind. Having done so, we are satisfied that the evidentiary proffers canvassed above, insufficient in themselves, are likewise insufficient in combination to call into legitimate question the lower court's entry of summary judgment. In making this evaluation, we emphasize that, under the ADA, a service provider like Dr. Bragdon is not entitled to demand absolute safety; he can rely upon the direct threat defense only in response to significant risks. Here, Dr. Bragdon has failed to pres-

ent meaningfully probative evidence that treating Ms. Abbott would have posed a medically significant risk to his health or safety.

V. CONCLUSION

For the reasons indicated, we rule that Ms. Abbott's HIV positive status is a physical impairment which substantially interferes with her major life activity of reproduction, and that she is therefore disabled within the meaning of the ADA. Inasmuch as Dr. Bragdon has failed to produce sufficient evidence to establish a triable issue on his direct threat defense, the entry of summary judgment in Ms. Abbott's favor must stand.

Under ordinary circumstances, we would go no further. Here, however, we believe that more should be said. It is sometimes convenient to think of cases as involving conduct that may be categorized in terms of polar extremes: reasonable or unreasonable, praiseworthy or blameworthy, good or evil. But, given the complexities of the society in which we live, many decisions resist such facile classification into black-or-white dichotomies. Such cases are better characterized in varying shades of gray.

This is such an instance. The litigants' positions are understandable in human terms and impartial observers can empathize with both parties. Still, on the facts of record, the defendant's refusal to render routine dental care to an HIV-positive patient offends a duly enacted federal statute and thus cannot be tolerated by a court of law.

Although we do what we must, we are not blind to the difficulty of the choices that the ADA compels health-care professionals such as Dr. Bragdon to make. We also recognize that cases of this kind are necessarily fact-sensitive; had the patient required more invasive treatment or had the dentist proffered stronger evidence of a direct threat, the result may well have differed. In the same vein, presented with other facts and circumstances in a future case, perhaps reflecting dramatic improvements in medical science that substantially reduce the likelihood of transmitting HIV through reproduction, we

might well reach a different conclusion than the one that we reach today. Such an ebb and flow is to be expected, because this is the very nature of the inquiry that the ADA mandates. We therefore caution future courts not to read our words more broadly than the context admits; our decision today eschews a blanket rule and instead demands case-by-case inquiry into a service provider's responsibilities to treat HIV-positive patients.

Affirmed.



UNITED STATES, Appellee,

v.

Thomas D'ANDREA, Defendant—
Appellant.

No. 95-2105.

United States Court of Appeals,
First Circuit.

Heard Sept. 11, 1996.

Decided March 5, 1997.

Defendant was convicted in the United States District Court for the District of Rhode Island, Ronald R. Lagueux, Chief Judge, of bank fraud and making false statements to federally insured financial institution, and he appealed. The Court of Appeals, Torruella, Chief Judge, held that: (1) government's reference to "straw borrowers" to show that defendant owed credit union millions of dollars from loans obtained using others' names was probative for rebuttal purposes; (2) use of forgery to obtain credit union loan was part of same scheme or plan as fraudulent efforts to obtain loan from bank for which defendant was convicted and was "relevant conduct" for sentence-

HIV LAW & POLICY STUDY

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***Media Briefing After Supreme Court HIV/AIDS and Disability Case:
Are People with HIV Protected from Discrimination?***

Washington, DC—On Monday, March 30, the HIV Law and Policy Study of the Georgetown University Law Center will provide media availability to legal and policy experts on **Bragdon v. Abbott**, a case that will be argued before the Supreme Court that morning. The event will be held at the Stewart Mott House, adjacent to the Court, 122 Maryland Avenue, NE, Washington, DC, following oral argument and any questions posed outside the Supreme Court. Lunch will be available at 12 noon; comments will begin at 12:15.

Various legal and policy experts, as well as lawyers who participated in the case directly and through the filing of amicus briefs, will be available to provide their reactions to questions raised at oral argument and will discuss their views on the legal issues and policy implications of the case.

Bragdon v. Abbott is the first case the Supreme Court will hear involving the Americans with Disabilities Act (ADA) and also the first case it will hear involving HIV/AIDS. The case may have widespread implications for antidiscrimination protections for all people with disabilities, as well as for medical and public health responses to the HIV/AIDS epidemic.

Media availability on March 30 will include:

- Bennett Klein, Counsel of Record for Ms. Abbott and AIDS Law Project Director of Gay & Lesbian Advocates & Defenders
- Wendy Parmet, Co-Counsel for Ms. Abbott and Northeastern Professor of Law
- Gary Buseck, Executive Director of Gay & Lesbian Advocates & Defenders
- Timothy Westmoreland, Senior Advisor to the Kaiser Family Foundation on HIV/AIDS Issues and Project Director of the HIV Law and Policy Study
- Chai Feldblum, Georgetown Professor of Law and Counsel of Record of an amicus brief on behalf of 59 disability, civil rights, and religious groups
- Andrew Imparato, General Counsel of the National Council on Disability
- Catherine Hanssens, AIDS Project Director of the Lambda Legal Defense and Education Fund, Inc. and Counsel of Record of an amicus brief on behalf of 16 groups and individuals representing medical, dental, nursing, and public health professionals
- Janis Spire, Executive Director of the Elizabeth Glaser Pediatric AIDS Foundation

The HIV Law and Policy Study is a project of the Federal Legislation Clinic of Georgetown University Law Center. The project is supported by the Henry J. Kaiser Family Foundation of Menlo Park, California.

Lunch will be served.

###

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A project supported by the Henry J. Kaiser Family Foundation, Menlo Park, CA

IN THE
Supreme Court of the United States

OCTOBER TERM, 1997

RANDON BRAGDON, D.M.D.,

Petitioner,

— v —
SIDNEY ABBOTT, *et al.*,

Respondents.

ON WRIT OF CERTIORARI TO THE UNITED STATES
COURT OF APPEALS FOR THE FIRST CIRCUIT

**BRIEF OF INFECTIOUS DISEASES SOCIETY OF AMERICA;
NATIONAL ALLIANCE OF STATE AND TERRITORIAL AIDS
DIRECTORS; ASSOCIATION OF STATE AND TERRITORIAL
DENTAL DIRECTORS; AMERICAN ASSOCIATION OF DENTAL
SCHOOLS; COUNCIL OF STATE AND TERRITORIAL
EPIDEMIOLOGISTS; AMERICAN NURSES ASSOCIATION;
ASSOCIATION OF NURSES IN AIDS CARE; NATIONAL
ASSOCIATION OF PUBLIC HOSPITALS AND HEALTH
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AS AMICI CURIAE IN SUPPORT OF RESPONDENT**

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INTEREST OF THE *AMICUS CURIAE*

This *amicus curiae* brief is submitted by the Infectious Diseases Society of America; National Alliance of State and Territorial AIDS Directors; Association of State and Territorial Dental Directors; American Association of Dental Schools; Council of State and Territorial Epidemiologists; American Nurses Association; Association of Nurses in AIDS Care; National Association of Public Hospitals and Health Systems; American Public Health Association; Association of Reproductive Health Professionals; John G. Bartlett, M.D.; James W. Curran, M.D., M.P.H.; John C. Fletcher, Ph.D., M.Div.; June E. Osborn, M.D.; Merle A. Sande, M.D.; Brian Wispelwey, M.S., M.D. ("Medical, Dental, Nursing and Public Health Professionals").¹ Medical, Dental, Nursing and Public Health Professionals play central roles in treating people with Human Immunodeficiency Virus ("HIV") disease and in protecting the public from the further spread of HIV and Acquired Immune Deficiency Syndrome ("AIDS"). The statements of interest of *amici* are included in the appendix to this brief.

This Court's rulings on the scope of the protections provided for those infected with HIV by the Americans with Disabilities Act ("ADA") will have a profound effect not only on individuals living with the virus, but also on public health efforts to combat the HIV epidemic. Medical, Dental, Nursing and Public Health Professionals have a central interest in ensuring that the Court understands the nature of HIV disease; how the virus is transmitted; and the threat which HIV discrimination, and the erosion of laws

¹ This brief has been authored in its entirety by undersigned counsel for the *amici*. No person or entity, other than the named *amici* and their counsel, made any monetary contribution to the preparation or submission of this brief.

prohibiting it, pose to the public health as well as to the health of those infected with the virus.

By written consent of the parties,² *amici curiae* Medical, Dental, Nursing and Public Health Professionals submit this brief in support of Respondent Sidney Abbott.

SUMMARY OF ARGUMENT

The ADA prohibits discrimination against any individual with "a physical or mental impairment that substantially limits one or more of the major life activities of such individual." 42 U.S.C. § 12102(2) (1996). Infection with HIV meets this statutory definition.

HIV infection indisputably is an impairment. There is no period of time when the virus remains latent, and from the point of infection, HIV ravages the immune system and the ability to avoid disease. HIV also substantially limits major life activities of virtually every infected person. HIV is transmissible from infection until death, a fact which necessarily has a profound effect on human intimacy and procreative activities and which feeds the irrational fear and discrimination which confronts people who are infected.

A ruling by this Court that the ADA does not cover all persons with HIV infection would seriously undermine the nation's fight against the epidemic. A decision to deny protection to HIV-infected individuals who are without visible symptoms of disease, or who are unable to prove that they would have a child if uninfected, would be a powerful disincentive to get tested, seek medical attention, and secure the knowledge necessary to avoid infecting others. The pattern of discrimination against persons with HIV demonstrates that the unfounded fear of infection, not the

stage of disease, fosters discrimination; denial of protection for those in the earlier stages of HIV will legitimize, and likely increase, the too prevalent pattern of medical providers' refusals to treat those in need of care.

The argument that an HIV-infected patient poses a direct threat of infecting a dentist is completely at odds with scientific and medical knowledge. The risk of transmission of HIV in dental care is negligible, and all but eliminated by the consistent use of universal precautions which have been recommended by the Centers for Disease Control and Prevention and required by the Occupational Safety and Health Administration since the 1980's.

Judicial deference to the judgment of Petitioner, or any individual health care professional who refuses to treat patients with HIV because of concern that he might become infected, is unwarranted and in conflict with professional standards which treat such behavior as unethical. Deference to the unsupported opinion of an individual physician, dentist or other health care professional, rather than to the overwhelming consensus of public health officials charged with control of an epidemic, would jeopardize the public health and hinge the medical care access of those with HIV on the willingness of providers to overcome the irrational fear of a stigmatized disease.

ARGUMENT

I. FROM THE ONSET OF INFECTION, HIV IS A SERIOUS MEDICAL IMPAIRMENT.

HIV infection is a medical impairment. It always causes "loss or abnormality of psychological, physiological or anatomical structure or function." *Stedman's Concise Medical Dictionary for the Health Professions* 434 (3d ed. 1997). It is a remarkably complex retrovirus with a

² Letters of consent from all parties have been filed separately with the Clerk of the Court.

"profound pathogenicity," i.e., ability to cause disease. 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). While the description of the earliest stage of HIV disease as "asymptomatic" is established in medical parlance, it is a construct to describe this stage rather than a medical reality.

From the outset, the virus targets those "T cells" (CD4+ helper T cell lymphocytes) which activate and regulate components of the immune system's response. Silvija I. Staprans & Mark B. Feinberg, *Natural History and Immunopathogenesis of HIV-1 Disease*, in *The Medical Management of AIDS*, *supra*, at 29, (5th ed.). The virus infects T cells, uses the cell's own genes to manufacture new viruses that infect other cells, and destroys increasing numbers of T cells in the process. Greene, *supra*; Staprans & Feinberg, *supra*, at 29. HIV targets those T cells which "may be the most essential in maintaining normal immune function," as well as cells which ingest pathogens and other harmful substances (bacteria, viruses and dead tissue). Staprans & Feinberg, *supra*, at 29. HIV triggers other disease processes not directly linked to immune system collapse, such as wasting (emaciation) and dementia. Department of Health and Human Services, National Institutes of Health, Report of the NIH Panel to Define Principles of Therapy of HIV Infection, at 18, (1997) [hereinafter "1997 NIH Panel Report"]; Greene, *supra*, at 19-20; Staprans & Feinberg, *supra*, at 34.

As noted recently by an expert panel convened by the National Institutes of Health:

HIV infection is always harmful, and true long-term survival free of clinically significant immune dysfunction is unusual.

...Only about 2 percent or less of HIV-infected persons seem to be able to contain HIV replication to extremely low levels and maintain stable CD4+ T-cell counts within the normal range for lengthy periods ..., and many of these individuals display laboratory evidence of immune system damage.

1997 NIH Panel Report, *supra*, at 4 (reference omitted).

After the first signs of infection, a person who has tested HIV-positive³ may be outwardly asymptomatic for years. However, the virus continues to spread throughout the body. "Although a period of clinical latency occurs in most individuals after acute infection, there is clearly not a period of virological or immunological latency." 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 Volberding & Mark A. Jacobson eds., 1998). Recent studies conclusively demonstrated that the infected person hosts a very high level of continuous "virologic mayhem" -- daily and massive production of HIV virus, matched with massive destruction of T cells and generation of new cells attempting to replace them. Greene, *supra*, at 21; Riddler & Mellors, *supra*, at 49-50.

Even in patients who are in early stages of HIV disease, the virus is causing a wide variety of laboratory abnormalities, including anemia, platelet deficiencies, and other blood deficiencies. Margaret A. Fischl, *An Introduction to the Clinical Spectrum of AIDS*, in *Textbook of AIDS*

³ The commonly-used HIV tests detect antibodies for the virus in the individual's blood. When blood tests are positive for HIV antibodies, the individual has "seroconverted" and is termed HIV seropositive or HIV-positive. John Bartlett, *Medical Management of HIV Infection*, at 15 (1997 ed.).

Medicine 149, 150 (Samuel Broder et al. eds., 1994). Many patients suffer persistent dermatologic abnormalities, including scabies, psoriasis that is difficult to control, and a variety of bacterial and fungal infections. Michael S. Saag, *Clinical Spectrum of Human Immunodeficiency Virus Diseases*, in AIDS: Etiology, Diagnosis, Treatment and Prevention 203, 206 (Vincent T. DeVita et al. eds., 4th ed. 1997). Moreover, even outwardly asymptomatic patients are at increased risk for a number of potentially very serious medical conditions including mycobacterium tuberculosis, syphilis, acute and chronic hepatitis, toxoplasma gondii, and pneumocystis carinii pneumonia. Fischl, *supra*, at 150-51. In most infected persons, HIV infection progresses to severe immunodeficiency and AIDS⁴ -- the "susceptibility to opportunistic infections, malignancies, neurologic diseases, and wasting, eventually leading to death." 1997 NIH Panel Report, *supra*, at 4.

II. FROM THE ONSET OF INFECTION, HIV SUBSTANTIALLY LIMITS A RANGE OF CENTRAL ACTIVITIES IN THE LIVES OF INFECTED INDIVIDUALS.

HIV profoundly alters the lives of those who are infected, forcing them to forego, or alter, several important life activities in a way that is profoundly different from that of persons without HIV-compromised immune systems.

⁴ Under Center for Disease Control and Prevention criteria, AIDS is diagnosed when a patient has one or more of a series of opportunistic infections or other diseases resulting from severe immunodeficiency, or when the patient's T cell count falls below 200 per cubic millimeter of blood (with normal T cell counts in the range of 1000). CDC, 1993 *Revised Classification System for HIV Infection and Expanded Surveillance Case Definition for AIDS Among Adolescents and Adults*, 41 MMWR RR-17 (1992).

Those infected with HIV must contend with the need to take precautions during every sexual encounter, and with the knowledge that the decision to bear a child risks transmission of a typically fatal illness to both the child and the other parent. Many must take medications in difficult regimens with often debilitating side effects. The need for proximity to medical professionals who treat HIV, and the inability to vaccinate against a number of potentially serious illnesses, limits travel and the ability to interact safely with others. The HIV-positive person also must live with chronic concerns about others' knowledge of his or her health status, social stigma and shame, the fear and reality of discrimination, and deep uncertainty about the future. Individually and in combination, these factors make it substantially more difficult for a person with HIV to care for himself and to take part in the full range of interactions with others, including sexual intimacy.

A. HIV Infection Substantially Interferes With The Ability to Care for Oneself.

Appropriate medical management of HIV disease includes all stages of disease, from initial infection through AIDS. Fischl, *supra*, at 149-58. It is important that patients with HIV infection "have their care optimized and disease progression slowed by a combination of monitoring, preventive therapy, and well-timed intervention with antiretroviral agents." Michael Clement & Harry Hollander, *Initial Evaluation of and Health Care Maintenance for the HIV-Infected Adult*, in *The Medical Management of AIDS* 130, 138 (Merle A. Sande & Paul A. Volberding, eds., 4th ed. 1995).

Physicians counsel patients with HIV infection to set their personal health care as a new priority in their lives. Lynda S. Doll & Beth A. Dillon, *Counseling Persons*

Seropositive for Human Immunodeficiency Virus Infection and Their Families, in *AIDS: Etiology, Diagnosis, Treatment and Prevention*, *supra*, 533, 534-38. In addition to medications typically prescribed to slow the progression of the disease, a physician will start the patient on prophylactic medications as immune system damage increases to prevent certain kinds of opportunistic infections, even if the patient is still relatively asymptomatic. Clement & Hollander, *supra*, at 109.

In 1996 and 1997, new antiretroviral therapies were approved by the Food and Drug Administration which, at least to date, are proving very effective in controlling disease progression in many patients. *See, e.g.*, Paul A. Volberding, *Protease Inhibitors Vindicated*, 350 *Lancet* SIII 10 (1997). The two major developments have been the introduction of new drugs, called protease inhibitors; and the adoption of "combination therapy" – the use of several antiretroviral drugs in combination. There are solid scientific reasons to believe that these combination therapies will benefit not only patients with more advanced HIV disease, but also many patients who are outwardly asymptomatic, and this therapy has been recommended for both. 1997 NIH Panel Report, *supra*, at 7; Steven F. Deeks & Paul A. Volberding, *HIV-1 Protease Inhibitors*, in *AIDS Clinical Review 1997-1998* 145, 174-75 (Paul A. Volberding & Mark A. Jacobson eds., 1998).

While the new therapies have saved lives, even after initiation of treatment the immune system does not completely recover, and significant damage caused by HIV likely is irreversible. Deeks & Volberding, *HIV-1 Protease Inhibitors*, *supra*, at 174-75. They also are burdensome, require substantial changes in each patient's diet and eating schedule, and typically require some scheduling accommodation in a range of settings, including work. These therapies "require[] strict adherence to complicated dosing regimens," Deeks & Volberding, *supra*, at 147. Because of

the danger of developing drug resistance, patients must strictly comply with the prescribed dosing regimen. 1997 NIH Panel Report, *supra*, at 12. The medications must be taken several times a day, usually at very specific intervals. Deeks & Volberding, *HIV-1 Protease Inhibitors*, *supra*, at 176. Some pills must be taken with high-calorie meals, some in a fasting state, and at least one requires aggressive hydration to prevent a build-up in the kidney. *Id.* Some of these medications require refrigeration, *id.*, which makes them more difficult to take at work and restricts activities away from home. Many patients find it impossible to comply with such a regimen for the rest of their lives, and as a result multiple drug resistance develops. Volberding, *Protease Inhibitors Vindicated*, *supra*, at SIII 10; *see* Deeks et al., *HIV-1 Protease Inhibitors*, J.A.M.A. 145, 152 (1997) (questioning whether "patients outside of a monitored research setting [can] comply with complicated regimens").

In addition, the medications commonly produce a number of side effects, sometimes very debilitating. Deeks & Volberding, *HIV-1 Protease Inhibitors*, *supra*, at 177. The side effects include severe nausea and abdominal pain, diarrhea, fatigue, weakness, anorexia, headaches, taste disturbances, and various laboratory abnormalities. *Id.*

Not only do many patients require some adjustment of work schedules in order to take medications under the prescribed conditions and to adjust to side effects, but the demanding nature of antiretroviral regimens may impose significant restrictions on a patient's ability to travel. HIV-positive persons must consider avoiding locations where there is not ready access to HIV medical expertise, and they cannot be immunized against several potentially deadly diseases.⁵

⁵ Vaccinations using live virus or bacteria are contraindicated for patients with HIV infection. Such vaccines include measles, mumps and rubella (MMR), varicella-zoster, BCG and yellow fever. Bartlett, *supra*

Although the new antiretroviral therapies are an exciting advance in HIV disease management, the virus has not been defeated, nor has HIV been transformed from a fatal to a manageable, chronic illness. Unfortunately, there also are significant numbers of patients for whom the new therapies do not appear to work or who develop resistance to these therapies. Deeks et al., *HIV-1 Protease Inhibitors*, *supra*, at 150-51; Volberding, *Protease Inhibitors Vindicated*, *supra*. Perhaps most important, these medications are too new for physicians to know whether the drugs will be effective in fighting disease progression in the long term. Deeks & Volberding, *HIV-1 Protease Inhibitors*, *supra*, at 179.

HIV threatens more than one's physical health, and many persons newly diagnosed with HIV suffer from severe emotional stress. Doll & Dillon, *supra*, at 534; Bartlett, *supra* n.2, at 213; Paul A. Volberding, *How to Tell Patients They Have HIV Disease*, in *The AIDS Knowledge Base 2.6-1, 2.6-2* (P.T. Cohen et al., eds., 2nd ed. 1994). Multiple psychosocial stressors persist through all stages of their illness. Lisa Capalini, *HIV Disease: Psychosocial Issues and Psychiatric Complications*, in *The Medical Management of AIDS*, *supra*, at 289, (4th ed.). One medical commentator describes this impact of HIV as follows:

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.

Id. at 296 (reference omitted). The depression and anxiety experienced by persons living with HIV often is exacerbated by medications that themselves cause depression and anxiety. *Id.*, at 296, 305. Medical care providers, including *amici*, who have cared for large numbers of persons with HIV disease frequently have seen the damaging effects of depression and anxiety, social stigma, and experiences of discrimination on their patients' health.

B. HIV Infection Substantially Limits Human Intimacy, Sexual Activity, Procreation and Parenting.

The HIV-positive person faces substantial and irreversible obstacles to all forms of intimacy. Most patients with HIV fear that disclosure of their condition will result in stigmatization, rejection by family, friends and co-workers, and discrimination. Doll & Dillon, *supra*, at 535. Stigmatization and discrimination are such important factors that the individual's primary physician or other health care provider are urged to "ask the patient who else knows of his or her seropositivity and review issues of confidentiality related to landlords, employers, insurance, and health care agencies." Laura A. Worth and Jeffrey H. Burack, *Outpatient Management of HIV Infection*, in *The AIDS Knowledge Base 4.3-1, 4.3-19* (2nd ed.). Stigma and discrimination are a significant source of depression and anxiety in many patients, Doll & Dillon, *supra*, at 535, as is others' fear of infection, even through casual contact. The reality of HIV discrimination creates a painful dilemma for many HIV-infected persons. Most are understandably cautious about to

n.2, at 55-60.

whom they disclose their diagnosis, but disclosure is necessary for the infected person to obtain health care and social support. *Id.* at 534.

A person with HIV lives with the reality that unprotected sex not only endangers his or her partner, but also may subject the patient to increased health risks if he or she is exposed to other diseases particularly dangerous for those with HIV, or contracts a new strain of the virus. Worth & Burack, *supra*, at 4.3-18.

Medical professionals often recommend that an infected person not engage in procreative sexual activity because an HIV-infected woman considering pregnancy and childbirth faces several additional risks. First, there is a significant risk that the virus will be transmitted from mother to child – while the child is in the womb, during labor or delivery, or through breast-feeding. Daniel V. Landers & Maureen T. Shannon, *Management of Pregnant Women With HIV Infection*, in *The Medical Management of AIDS*, 459, 461 (5th ed.). Even if the mother takes AZT during pregnancy and childbirth, in accord with current recommendations to reduce the possibility of HIV transmission to her child, the risk of transmission to the child is reduced only from approximately 25 percent to approximately eight percent. *Id.* at 462; Bartlett, *supra* n.2, at 68; Ann J. Melvin and Lisa M. Frankel, *Pediatric HIV Disease: New Developments in Treatment and Prevention*, in *AIDS Clinical Review* 1997/1998, 109, 112-13. Apart from the risk that the child might be infected, there is the real risk that the use of AZT monotherapy will produce drug-resistant virus that reduces the mother's own treatment options and that can be passed on to her newborn. Landers & Shannon, *supra*, at 459-61. Finally, uncertainty about their own life expectancy, and their reduced ability to care for themselves and their children, leads some women to decide not to conceive, or to abort when they learn they are pregnant and are HIV-positive. Doll & Dillon,

supra, at 536.

III. A RULING THAT ASYMPTOMATIC HIV INFECTED PERSONS ARE NOT PROTECTED UNDER THE ADA WOULD UNDERMINE PUBLIC HEALTH GOALS IMBEDDED IN THE ACT, BY DISCOURAGING ASYMPTOMATIC PERSONS FROM BEING TESTED, OBTAINING RISK-REDUCTION COUNSELING, AND OBTAINING ESSENTIAL MEDICAL TREATMENT.

In *School Board of Nassau County v. Arline*, 480 U.S. 273 (1987), this Court recognized that legal protections against discrimination directed towards those with transmissible illnesses are vital to an effective public health policy in our democracy:

[B]ecause the [Rehabilitation] Act requires employers to respond rationally to those handicapped by a contagious disease, the Act will assist local health officials by helping remove an important obstacle to preventing the spread of infectious diseases: the individual's reluctance to report his or her condition.

Id. at 286 n.15. This principle is particularly applicable to HIV. Antidiscrimination laws protecting all persons with HIV are critical to the nation's fight against the epidemic.

Voluntary HIV testing and counseling are key to controlling the spread of the disease. People who test HIV-positive routinely are counseled to avoid activities that pose a high risk of infecting others. Doll & Dillon, *supra*, at 536. "The earlier the infected person is detected, the earlier he or she may be advised of [his or her] contagious state and

counseled on how to avoid further transmission of this lethal virus." American Medical Association, *Prevention and Control of Acquired Immunodeficiency Syndrome: An Interim Report*, 258 JAMA 2097, 2102 (1987). Encouraging early awareness of HIV infection thus is critical to protecting public health.

Early detection of HIV disease also is critical to effective treatment. A patient's risk of developing many HIV-related opportunistic infections can be greatly reduced by prophylactic medications. As discussed in Part II.A, *supra*, many infected persons should be receiving antiretroviral therapy before they develop advanced HIV disease, and perhaps as soon as possible after infection.⁶

Fear of discrimination is a significant disincentive to undergo HIV testing and to seek medical care. The pervasive and powerful stigma associated with HIV and AIDS, and the justified fear of encountering discrimination, keep many persons from being tested to learn their HIV status. *The National AIDS Strategy* (Office of National AIDS Policy, Washington, D.C.), 1997, at 10, 23. Physicians, hospitals, public health agencies and community-based HIV/AIDS service organizations frequently encounter individuals who have delayed being tested for HIV, or who have delayed seeking medical treatment, counseling and other support services for months or years, because they fear discrimination.

Prior to enactment of the ADA, medical authorities pointed out the correlation between protections against HIV

⁶ Early medical intervention also is extraordinarily cost-effective, both for patients and for the public which must absorb the costs of care for uninsured, or publicly insured, individuals. "Just a few cents worth of medicine a day can prevent *Pneumocystis carinii* pneumonia, a disease that has catastrophic health consequences and costs." *Costs High for Failure to Get Treatment for PCP - Pneumocystis Carinii Pneumonia*, AIDS Weekly 10 (June 12, 1995).

discrimination and effective implementation of public health policy. A report of the Institute of Medicine of the National Academy of Sciences found that

fear of discrimination is a major constraint to the wide public acceptance of many potentially effective public health measures. Public health programs will be most effective if they are accompanied by clear and strict sanctions to prevent unwarranted discrimination against those who are infected with HIV or who are at risk of infection.

Institute of Medicine, National Academy of Sciences, *Confronting AIDS: Directions for Public Health, Health Care, and Research: Update 63* (1988). See also 1987 AMA Report, 258 JAMA at 2102 (1987) (American Medical Association report declaring that antidiscrimination laws should cover all HIV-positive persons to encourage HIV counseling and testing.)

In the legislative history of the ADA, Congress likewise observed that eradicating HIV discrimination has a significant public health dimension:

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

H.R. Rep. No. 101-485, pt. 2, at 31 (1990), *reprinted in* 1990 U.S.C.C.A.N. 303, 313 (quoting the 1988 Report of the

President's Commission on the Human Immunodeficiency Virus Epidemic). In testimony to Congress, Admiral James Watkins, Chair of the President's Commission, elaborated:

HIV-related discrimination is impairing this nation's ability to limit the spread of the epidemic....Public health officials will not be able to gain the confidence and cooperation of infected individuals or those at risk for infection if such individuals fear that they will be unable to retain their jobs and their housing, and that they will be unable to obtain the medical and support services that they need because of discrimination based on a positive HIV antibody test.⁷

Petitioner and his *amici* argue that an HIV-positive person subjected to discrimination has no remedy under the ADA unless he or she has visible symptoms of HIV infection and can prove other substantial impacts in his or her own life. Any disability test excluding some individuals with HIV would create a ruinous incentive for people to avoid testing, counseling, and medical treatment.⁸ The significance of

⁷ *Americans with Disabilities Act of 1988: Joint Hearing on S.2345 Before the Subcomm. on the Handicapped of the Senate Comm. on Labor and Human Resources and the Subcomm. on Select Education of the House Comm. on Education and Labor*, 100th Cong. 39-40 (1988) (statement of Adm. James Watkins), reprinted in 2 House Comm. on Education and Labor, 100th Cong., 2d Sess., *Legislative History of Public Law 101-336, The Americans with Disabilities Act*, at 967-68 (1990).

⁸ This reluctance to undergo testing probably would be exacerbated in jurisdictions requiring the reporting to public health authorities of positive HIV tests. Proponents of HIV names reporting base their position on the assumption that all persons testing positive are legally protected from discrimination. *E.g.*, Robert Steinbrook, *Battling*

potential discrimination to a decision to have an HIV test is so well recognized that some states require that individuals considering a test be explicitly informed of the risks of discrimination. *E.g.*, Conn. Gen. Stat. § 19a-582(d) (1997); Md. Regs. Code tit. 10, § 52.08.04 (1997); N.Y. Pub. Health § 2781(1) (Consol. 1997). In addition, as noted above (Part II. A), while antiretroviral therapies are recommended for many outwardly asymptomatic people, the decision to initiate therapy requires people with HIV to weigh the health benefits of treatment against the risk of possible discovery of their condition. Dosing requirements make combination therapy difficult for an employee who fears disclosure of her condition in the workplace, and health insurance claims also can alert the employer to a patient's health status. Once initiating therapy, an employee who varies a prescribed dosing regimen (to avoid revealing that he is on medication) risks developing drug-resistant virus.

Discrimination in health care is particularly damaging to efforts to combat the HIV epidemic. It not only results in denial of specific services, but also creates distrust of health care professions and institutions, and further fosters a reluctance by persons with HIV disease to seek medical care. After all, had Ms. Abbott not known, or volunteered, her HIV infection status, Dr. Bragdon would have filled her cavity, and this case would not now be before the Court. Given the importance of early diagnosis and treatment, and the fact that people with HIV experience discrimination as a consequence of unfounded fears about their infection rather than the stage of their illness, it is illogical and inconsistent with critical public health goals to base the protections against health care

HIV on Many Fronts, 337 N. Engl. J. Med. 779 (1997); Lawrence Gostin et al., *National HIV Case Reporting for the United States - A Defining Moment in the History of the Epidemic*, 337 N. Engl. J. Med. 1162, 1165 (1997).

discrimination on whether symptoms of HIV disease are visible.

The ability of persons with HIV to rely on adequate dental care is important to maintaining their overall medical and psychological health. *Regular Dental Care Can Have Psychological and Physical Benefits*, AIDS Alert at 1 (Nov., 1993). HIV-positive patients generally have a greater incidence of complications from minor dental problems than those without HIV, and some untreated dental conditions can become sufficiently serious to interfere with health-related necessities of eating and taking medication. Michael Glick, *Intraoral Manifestations Associated With HIV Disease*, in *Dental Management of Patients with HIV* 153, 154-57 (Michael Glick ed., 1994).

The need for reliable quality health care, and the fear that this care will be denied, is a source of considerable anxiety for those who are HIV-positive. *E.g.*, Mauro A. Montoya, *If I Tell You, Will You Treat Me?*, 27 J. Marshall L. Rev. 363 (1994). As observed in a collaborative guide on public health, dental practice and HIV, "HIV-infected persons face sometimes insurmountable barriers...in finding health care providers willing to treat them." *Guide to Public Health Practice: HIV and the Dental Community* (Association of State and Territorial Dental Directors & Association of State and Territorial Health Officials, Washington, D.C.) (March, 1989) (J.A. at 125).

Several studies of dental professionals' attitudes conducted over the last decade suggest that patients' fears of discrimination are not unfounded. For example, in a 1991 study of dental students, 75% said that dentists have an obligation to treat patients with HIV, and 62% said that they would treat them in their own practices although 53% said that they would not treat patients with HIV if they had a choice. Eric S. Solomon, et al., *Issues in the Dental Care Management of Patients with Bloodborne Infectious*

Diseases: An Opinion Survey of Dental School Seniors, 55 J. Dental Educ. 594 (1991); Scott Burris, *Dental Discrimination Against the HIV-Infected: Empirical Data, Law and Public Policy*, 13 Yale J. on Reg. 1, 11-15 (1996) ("Dental Discrimination"). Recent surveys still indicate both that a significant number of dentists are unwilling to treat patients who are HIV-positive, and that a significant number of persons with HIV encounter dental professionals who are unwilling to treat them. Burris, *Dental Discrimination*, *supra*, at 11-20.⁹

IV. THE RISK OF HIV INFECTION THROUGH DENTAL OR MEDICAL CARE IS

⁹ Lingering fears of patients with HIV, and consequent discrimination, has not been restricted to the dental profession. A survey of 951 neonatologists nation-wide found that many would withhold costly medical treatments from babies born to HIV-positive mothers, even if they had no idea whether the baby actually was infected with HIV. *In Brief...HIV Babies*, 10 AIDS Policy & Law 12 (1995). In the same study, a substantial number of doctors said that they would withhold life-saving treatment of babies even without confirmation of their actual serostatus. Only 25% stated that they would provide such care to babies known to be HIV infected. *Id.* Another survey of health professionals treating critically ill newborns at six New York City hospitals found that a significant number of those polled would be less likely to recommend aggressive treatment of a seriously ill infant with HIV than they would for a critically ill infant with no evidence of HIV exposure. Betty W. Levin et al., *Treatment Choices for Infants in the Neonatal Intensive Care Unit at Risk for AIDS*, 265 J.A.M.A. 2976, 2976-80 (1991). *See also* Ferdinand Christian, Jr. et al., *Open-Heart Surgery in an HIV-Positive Patient*, 10 AIDS Patient Care and STDs 210, 211 (1996) (discussing "a reluctance among surgeons and especially cardiothoracic surgeons to operate on HIV-positive patients"); C. Lewis & M.D. Montgomery, *Primary Care Physicians' Refusal to Care for Patients Infected with HIV*, 156 Western J. Med. 36 (1992) (almost half of those physicians surveyed reported an unwillingness to treat HIV-positive patients).

**NEGLIGIBLE AND DOES NOT JUSTIFY A
REFUSAL TO TREAT A PATIENT WITH HIV
DISEASE.**

The vehicles of HIV transmission have been well established since the mid-1980's: blood and blood products, semen, cervical and vaginal secretions, and breast milk. Staprans & Feinberg, *supra*, at 29. See Bartlett, *supra* n.2, at 2-3, 9-11 (giving breakdown of transmission routes). Dental workers face virtually no risk of acquiring HIV through occupational exposure to these bodily fluids. Despite the millions of dental procedures that have been performed since the first reported case of AIDS in 1981, there has been no documented case of occupational transmission of HIV to a dental worker. CDC, *Occupational Exposure to HIV, Information for Health-Care Workers* (visited January 25, 1998) <<http://www.cdc.gov/ncidod/hip/faq.htm>; Sara Babich, D.D.S. & Ronald P. Burakoff, D.M.D., *Occupational Hazards of Dentistry*, New York State Dental Journal 27, October 1997, at 26, 27.¹⁰ Since the mid-1980's, seroprevalence surveys of dentists in selected cities and at American Dental Association annual meetings, and seroprevalence studies of dental assistants and dental hygienists in selected cities, have documented HIV infection rates of zero or almost zero. Ruthanne Marcus & David M.

¹⁰ See also, *Facts About AIDS for the Dental Team* (Council on Dental Therapeutics, American Dental Association, Chicago, Illinois), October 1988, at 5-6 citing N.M. Flynn et al., *Absence of Antibody Among Dental Professionals Exposed to Infected Patients*, 146 West. J. Med. 439 (1987) (255 dental workers with frequent HIV-positive patients, none HIV-positive), and Robert S. Klein et al., *Low Occupational Risk of Human Immunodeficiency Virus Infection Among Dental Professionals*, 318 N.Eng.J.Med. 86, 88 (1988) (1,309 dental workers, many practicing in areas with high prevalence of HIV infection, only one dentist tested positive but no occupational exposure to HIV could be documented).

Bell, *Occupational Risk of Human Immunodeficiency Virus Infection in Health Care Workers*, in AIDS: Etiology, Diagnosis, Treatment and Prevention, *supra*, at 645, 647-48.

Dentists, like other health care providers, are required to adhere to universal precautions for all patients to avoid exposure to bloodborne pathogens. The term "universal precautions" refers to a set of infection control practices under which health care workers assume that all blood and certain body fluids are potentially infectious and thus always take precautions to prevent direct exposure to these fluids. Universal precautions include basic barrier techniques (i.e. protective attire such as gloves, eyewear, masks, and gowns), careful handling of sharp instruments, safe disposal of all "sharps," use of surface disinfectants, and autoclaving or other methods of sterilizing instruments. Chris H. Miller, *Infection Control*, 40 Dental Clinics of North America 437, 439-54 (1996); CDC, *Recommended Infection-Control Practices for Dentistry*, 35 MMWR 237, 238-41 (1986); CDC, *Recommended Infection-Control Practices for Dentistry*, 1993 42 MMWR RR-8, 1, 3-9 (1993); OSHA, 29 C.F.R. § 1910.1030(d) (1997)(effective March 6, 1992). This is necessary because it is impossible to identify all patients who may be infectious. See Charles E. Barr, *Practical Considerations in the Treatment of the HIV-Infected Patient*, 38 Dental Clinics of North America 404, 420 (1994). Universal precautions can be easily and effectively implemented in the dental office.¹¹

It is, therefore, inaccurate and misleading for *amicus*

¹¹ A decade ago, the American Dental Association noted that patients with HIV infection may be safely treated in private dental offices when appropriate infection control procedures are employed. *Facts about AIDS for the Dental Team*, *supra* n.10, at 15. It has reiterated this position to this Court. (Brf. *Amicus Curiae* American Dental Association in Supp. of Pet'r at 1-2 n.2.)

Promina to state that a 0.3% risk that a doctor or dentist caring for an HIV-positive patient will contract HIV. (Bragdon *Amicus Curiae* of Promina Northwest Health System in Supp. Of Pet's at 12-13.) The statistic Promina selected is: the risk of actual transmission to infected blood following percutaneous exposure (e.g., through accidental needlestick or laceration of the skin by another sharp object). Ruthanne Marcus & David M. Bell, *Occupational Risk*, *supra*, 645, 648; Barbara F. Gooch et al., *Percutaneous Exposures to HIV-Infected Blood Among Dental Workers Enrolled in the CDC Needlestick Study*, 126 J. Am. Dent. Ass'n 1237 (1997). In other words, there is a 99.7% probability that the unlikely occurrence of a needlestick or puncture wound, which delivers HIV-infected blood into the body, will *not* lead to infection. CDC, *Occupational Exposure to HIV*, *supra*. The overall risk faced by any doctor or dentist is very much smaller than 0.3%, since most health care providers never experience percutaneous injuries involving HIV-infected blood. Moreover, the estimated 0.3% risk *if* a health care worker suffers a needlestick or other puncture wound exposing him or her to HIV-infected blood is based on studies of all health care workers. The risk posed by a percutaneous injury to a dentist or other dental professional is much much smaller, and involve extremely small quantities of blood and minor injuries to the dental worker. Gooch, *supra*, at 1239-40.

Because universal precautions clearly work, the CDC unequivocally has stated that health care workers should not deny treatment to HIV-positive patients. CDC, *Recommendations for Prevention of HIV Transmission in Health-Care Settings*, 36 MMWR 2S, 15S (1987). Petitioner thus defies both well-established scientific evidence, and the findings and recommendations of our nation's leading public health officials, when he contends that dental care of an HIV-positive patient poses any significant risk to him.

V. THE ADA DOES NOT CONTEMPLATE JUDICIAL DEFERENCE TO A HEALTH CARE PROVIDER'S PERSONAL OPINION, UNSUBSTANTIATED BY OBJECTIVE EVIDENCE, THAT AN HIV-POSITIVE PATIENT IS UNSAFE TO TREAT.

Petitioner in effect seeks an exemption from his burden under the ADA to document the existence of a direct threat because of his professional status as a dentist. *Amicus curiae* Promina Northwest Health System similarly argues that "[h]ealth care service providers are unique and deserve special protection under the ADA." (Brf. *Amicus Curiae* of Promina Northwest Health System at 2.) Such an extraordinary level of deference to a defendant who has refused treatment on the basis of a patient's HIV status is inconsistent with the statute, with this Court's decision in *Arline*, and with the ethical standards of the dental and medical professions. There is no particular profession or level of training that automatically immunizes an individual from the prejudices that have long haunted the disabled and particularly those with infectious diseases, such as the plaintiff in *Arline* and the Respondent in this case.

Title III of the ADA covers, among many other types of public accommodations, "a...professional office of a health care provider [or] hospital." 42 U.S.C. § 12181 (7) (A). Nothing in the statute -- or this case -- requires that a health care institution or provider modify professional standards which govern their services. No health care professional is required to provide a patient with care that is medically inappropriate, outside the scope of the practitioner's area of competence, or that the practitioner would not provide to a patient without HIV.

However, when a provider denies services to a person with HIV because of fear of the risk posed by the person to

the provider or others, a single test for determining the legitimacy of the refusal applies to medical and non-medical providers alike. A "direct threat" exists if and only if the defendant proves "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)(1996). This is an objective test; a finding of "direct threat" must be "based on reasonable judgment that relies on current medical knowledge or on the best available objective evidence..." 28 C.F.R. § 36.208(c)(1997)(Department of Justice regulations). "Sources for 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." *Id.* at, App.B. § 6.208(c). *Amici* concur with the court below that "properly supported opinions voiced by other recognized experts in the field (e.g., research studies published in peer-reviewed journals)" also are relevant. *Abbott v. Bragdon*, 107 F.3d 934, 945 (1st Cir. 1997).

The ADA's direct threat test, and the Justice Department's regulations, are based on this Court's rulings in *Arline*. After noting that persons with contagious diseases frequently have suffered from irrational fear and misapprehension, 480 U.S. at 284, the Court declared that, in adopting the Rehabilitation Act, Congress intended "to replace such reflexive reactions...with actions based on reasoned and medically sound judgment." *Id.* at 285. If "those accused of being contagious...never have the opportunity to have their condition evaluated in light of medical evidence...they would be vulnerable to discrimination on the basis of mythology -- precisely the type of injury Congress sought to avoid." *Id.* (footnote omitted). Therefore "courts normally should defer to the reasonable medical judgments of public health officials." *Id.* at 288 (footnote

omitted). This reasoning is entirely applicable to the Petitioner's reflexive reaction to HIV in this case, and particularly appropriate when the risk assessment involves possible transmission of contagious diseases -- both the area of expertise and the special responsibility of officials charged with protection of the public health. Nowhere in *Arline* does this Court suggest that deference is due to a doctor who is a defendant in a case challenging the discriminatory refusal to provide medical care, and who has a clear personal interest in the outcome of the litigation.

Since *Arline*, a number of lower federal courts have addressed cases of discrimination by health care professionals against persons with HIV or other disabilities. Those cases have recognized the need to distinguish bona fide medical opinion from pretext masquerading as medical judgment. In *Sumes v. Andres*, 938 F.Supp. 9 (D.D.C.1996), for example, an obstetrician refused to treat a hearing impaired pregnant woman with a fever, arguing that she was "high risk" and that he was not qualified to treat deaf people. The court held that "a provider may not withhold medical benefits solely based on a participant's disability, but may act only pursuant to a bona fide medical reason." *Id.* at 11.

Similarly, in a case challenging the denial of an ear operation for an HIV-positive patient, the court in *Glanz v. Vernick*, 756 F.Supp. 632, 638 (D.Mass. 1991) found that a rule affording initial deference to a defendant doctor's judgment in such circumstances would "enable doctors to offer merely pretextual medical opinions to cover up their discriminatory decisions." In *Howe v. Hull*, 873 F.Supp. 72 (N.D. Ohio 1994), a man with AIDS sought emergency care at a local hospital, but the attending physician refused to admit him, claiming a suspicion that the plaintiff had a rare medical condition that they were not equipped to treat; the court found that this explanation was a pretext.

The claims of Petitioner and *amicus* Promina

Northwest Health System that health care professionals should be able to make their own decisions about risk, without following expert knowledge, are inconsistent with the nature of the dental and medical professions. A health care professional necessarily assumes a small degree of personal risk, *see* 107 F.3d at 948 ("a service provider like Dr. Bragdon is not entitled to demand absolute safety"), and dental and medical ethics recognize both that refusing care to HIV-positive patients is unethical, and that treatment of patients with HIV is not particularly risky:

Since 1988, the Association has taken the specific position that refusal to treat a patient because that patient has or may have an infectious disease such as AIDS is unethical ... Education on universal precautions and barrier techniques is the most effective means to dispel unwarranted fears among health care professional and the public.¹²

A physician may not ethically refuse to treat a patient whose condition is within the physician's current realm of competence solely because the patient is seropositive for HIV. Persons who are seropositive should not be subjected to discrimination based on fear or prejudice.¹³

¹² *Position Paper on Acquired Immune Deficiency Syndrome* (American Association of Oral and Maxillofacial Surgeons, Rosemont, Illinois), Sept. 1991 (J.A. 111).

¹³ *Code of Medical Ethics* (American Medical Association, Chicago, Illinois), 1996-1997 ed., § 9.131 (first issued in 1992). The AMA's Principles of Medical Ethics state that "when an epidemic prevails, a physician must continue his labors without regard to the risk to

Dental Health care workers have an ethical obligation to provide dental care to HIV-infected individuals, or those perceived to be at risk of HIV infection, in the same manner as they would to other patients . . . HIV seropositivity is not sufficient cause for referral.¹⁴

It appears, however, that some health care providers equate prohibitions against discriminatory denial of care with an attempt of government to impose an affirmative obligation on providers to treat everyone who crosses their office threshold. As a committee of dental professionals observed in a practitioners' guide to AIDS & Dentistry:

Some dentists are confused about the meaning of non-discrimination when it comes to the provision of dental care. It does not mean that the private practitioner has no choice regarding whom he or she chooses to treat. It does mean that there are some conditions upon which a practitioner may not base his or her treatment decisions.

Dentists retain the right to refuse to take patients for a wide variety of reasons. Civil rights laws, however,

his own health." *Ethical issues Involved in the Growing AIDS Crisis* (Council on Ethical and Judicial Affairs of the American Medical Association, Chicago, Illinois), Sept. 1988, at 1-2 *citing Principles of Medical Ethics* (American Medical Association, Chicago, Illinois), 1955.

¹⁴ *Guide to Public Health Practice: HIV and the Dental Community* (Association of State and Territorial Dental Directors & Association of State and Territorial Health Officials, Washington, D.C.) (J.A. at 125-26).

prohibit grounding that refusal upon the prospective patient's belonging to certain groups. No practitioner today would quarrel with the idea that it would be unethical as well as illegal to refuse to treat all blacks or all women. Similarly, AIDS civil rights law, specifically, and physical handicap rights laws, generally, prohibit practitioners from basing their care decisions upon the fear and prejudice which can be associated with physical handicaps, particularly contagious diseases.¹⁵

As noted in testimony on behalf of the American Dental Association to the President's Commission on the HIV epidemic on the issue of HIV-positive individuals' access to treatment:

For the dental profession to respond in such a manner that "obligations to self-interest" override obligations to patients would be the beginning of the erosion of professional ethics and the trust that society has placed in the health professions. This trust is given legal sanction through the conferring of licenses to practice dentistry and moral sanction through the conferring of elevated status which dental and medical professionals enjoy in the community by reason of their special knowledge, skills and expertise.

Vincent C. Rogers, D.D.S., M.P.H., Testimony for the American Dental Association to The President's Commission

¹⁵ *AIDS & Dentistry: A Discussion Leader's Guide*, (Dental Steering Committee, AIDS Education and Training Center for Southern CA, Los Angeles, California) 1991 at 28.

on the HIV Epidemic (Jan. 14, 1988) at 5.¹⁶

Clearly then, while it is the opinion of *amici* here that the majority of health care workers respond professionally and skillfully in their treatment of HIV-positive patients, the provision of care to such patients, and interpretation of the ADA, cannot rest on the assumption that there will be sufficient accessible providers with "[c]ourage, conscience and calling," as Petitioner Bragdon's *amicus* Promina suggests (Br. *Amicus Curiae* of Promina Northwest Health System at 14), to allow care of the HIV-positive patient to remain the option of the individual provider. If one dentist or health care worker can deny treatment on "professional judgment" about risk of infection that runs counter to the overwhelming consensus of public health authorities, other medical experts, and professional ethical standards, then logically all may do so. A ruling that accommodates such judgments would virtually ensure that fewer health care providers will shoulder an increasing caseload of HIV-positive patients, and that significant numbers of men, women and children with HIV will forego the early medical intervention that reflects the standard of care necessary to

¹⁶ Indeed, in its *amicus* brief to this Court, the American Dental Association notes that its own ethical policies provide that "a decision not to provide treatment to an individual because the individual has AIDS or is HIV seropositive based solely on that fact, is unethical," and that "in Association communications on this issue, members be reminded that a patient's HIV/AIDS status is not a justification for refusal of treatment." *Amicus Curiae* Brief of the American Dental Association at 1-2 n.2. The American Dental Association argues, nonetheless, that the ADA should be interpreted not to cover all HIV-positive persons. Such an interpretation not only would be incorrect and harmful to the public health, but also would provide little if any meaningful guidance for dentists or other health care workers, who would be left not knowing when the ADA and similar laws govern their conduct and when they do not.

preserve health and stem further transmission.

Finally, creation of a "health care professional's exception" to the ADA in determining whether a particular patient poses a direct threat to the provider will have ramifications that extend beyond the health care needs of the affected individual patient. If a dentist or other health care provider is permitted to refuse treatment to persons with HIV or other infectious disease based on the provider's exaggerated fear of infection, communicable diseases of significant threat to the general public will go untreated and will pose an unnecessarily increased risk to the public.

CONCLUSION

For the reasons stated above, the Medical, Dental, Nursing and Public Health Professionals who have joined in this *amicus* brief respectfully submit that the decision below should be affirmed.

Respectfully submitted,

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Dated: February 6, 1998

APPENDIX

APPENDIX

The Infectious Diseases Society of America represents over 5,000 physicians, scientists and other health professionals dedicated to excellence in patient care, research and public health disease prevention and education in the field of infectious diseases. Infectious diseases is a board certified subspecialty of internal medicine and pediatrics. The majority of persons with AIDS in this country receive care from infectious diseases physicians.

The National Alliance of State and Territorial AIDS Directors (NASTAD) is the only national public health organization in the United States that focuses exclusively on the HIV/AIDS epidemic. Founded in 1992, the organization represents the chief HIV/AIDS program administrators in each state and territorial health departments who are responsible for managing federally-funded and state-funded HIV/AIDS prevention, health care and housing programs in every state. NASTAD members administer HIV prevention and surveillance programs funded by the Centers for Disease Control and Prevention. The organization's members also are responsible for administering programs which serve the medical care, AIDS drug assistance and supportive service needs of a significant number of the low-income, uninsured individuals with HIV/AIDS in the nation. NASTAD believes that discrimination against individuals with HIV infection represents a serious barrier to achieving federal, state and local goals in reducing the spread of HIV and in providing compassionate and effective health care services to individuals who are HIV-infected. As an organization, and as a collection of public health professionals focused on preventing the occurrence of HIV and providing health services to those who are infected, NASTAD is deeply concerned about the very real threat to the public's health

posed by discrimination against individuals with HIV infection.

The Association of State and Territorial Dental Directors (ASTDD) is a non-profit volunteer organization formed as an affiliate of the Association of State and Territorial Health Officers in 1948. ASTDD membership consists of the Chief Dental Public Health Officer of the State Health Department or equivalent public health agency, of the states, territories, or possessions of the United States. The purpose of this association is to consider policies and recommendations of public or private agencies pertaining to the practice of dental public health, which may impact the administration of dental public health programs at the state level, and to adopt policies for the guidance of its members. The ASTDD endorses the recommendations of the U.S. Public Health Service, the Centers for Disease Control and Prevention, and the Code of Ethics of the American Dental Association with respect to the treatment of HIV-positive patients in the private dental office.

American Association of Dental Schools (AADS) represents all 55 dental schools in the United States, as well as advanced education, hospital, and allied dental education institutions. It is within these institutions that future practitioners, educators, and researchers are trained; significant dental care provided; and the majority of dental research conducted. AADS is the only national organization that speaks exclusively for dental education.

Council of State and Territorial Epidemiologists (CSTE) is a professional association of 400 epidemiologists in U.S. states and territories working together to detect, prevent, and control conditions of public health significance. CSTE supports treatment by medical providers of HIV

infected persons and believes that routine dental care should not be denied to such patients. Universal precautions employed consistently are known to protect patients and health care workers, including dentists, from transmission of HIV. CSTE advocates that the public health interest is best served by intolerance of discriminatory refusals to treat HIV infected persons.

The American Nurses Association (ANA), a national labor and professional organization for registered nurses, consists of 53 state and territorial constituent organizations with approximately 180,000 members. The issue before this court directly involves not only the protection of individuals who are HIV-positive under the Americans with Disabilities Act (ADA) but has significant ramifications for the provision of early intervention and treatment of HIV. ANA has been at the forefront in advocating for the protection of patient confidentiality and in assuring all individuals full access to health care treatment.

Association of Nurses in AIDS Care (ANAC) is a national nursing organization committed to the individual and collective professional development of nurses involved in the delivery of care to persons infected or affected by the human immunodeficiency virus (HIV), and to promoting the health, welfare, and rights of all HIV-infected persons. ANAC recognizes that it is a moral, legal, and professional responsibility of nurses to care for persons with HIV infection.

National Association of Public Hospitals and Health Systems (NAPH) represents over 100 metropolitan area safety net hospitals and health systems nationwide. NAPH member institutions serve a large proportion of the nation's HIV/AIDS populations in both inpatient and outpatient

settings. In addition to providing medical care to persons with HIV and AIDS, NAPH has historically supported and advocated for the rights of these persons.

American Public Health Association (APHA) is a national organization devoted to the promotion and protection of personal and environmental health. Founded in 1872, APHA is the largest public health organization in the world, with over 50,000 members. It represents all disciplines and specialties in public health. APHA also publishes a technical report series dealing with various aspects of the HIV epidemic through the American Journal of Public Health, as well as numerous books related to HIV and state-of-the-art research.

Association of Reproductive Health Professionals (ARHP) is an interdisciplinary medical professional association composed of obstetricians/gynecologists and other physicians, advanced practice clinicians, researchers, educators, and other professionals in reproductive health. ARHP, founded in 1963, has an organizational mission to educate health care professionals and the public on family planning, contraception and other reproductive health issues including sexually transmitted diseases, HIV/AIDS, urogenital disorders, abortion, menopause, cancer prevention/detection, sexual health, and infertility. ARHP opposes restricting the ADA's anti-discrimination protections to those diagnosed with AIDS, and supports the principle that patient care should be a health care provider's primary concern.

John G. Bartlett, M.D., is Professor of Medicine and Chief of the Division of Infectious Diseases at the Johns Hopkins University School of Medicine in Baltimore, Maryland. Dr. Bartlett has authored over 600 medical articles

or chapters and eleven books including the principal physician handbook, Medical Management of HIV (in several editions, most recently 1997). Prior to joining the faculty at John Hopkins, Dr. Bartlett was a professor at the University of California and Tufts University School of Medicine.

James W. Curran, M.D., M.P.H., is Professor of Epidemiology and Dean of the Rollins School of Public Health of Emory University. Dr. Curran was the Coordinator for the Task Force on Kaposi's sarcoma (an AIDS-related cancer) beginning in 1981 and continued as a leader at the Centers for Disease Control and Prevention's (CDC) HIV/AIDS Division until 1995. He currently serves as the CDC liaison for the Association of Schools of Public Health, and chairs the Social Factors Reference subcommittee of the American Public Health Association Policy Committee.

John C. Fletcher, Ph.D., M. Div., was Emily Davie and Joseph S. Kornfeld Professor of Biomedical Ethics at the School of Medicine, and Director of the Center for Biomedical Ethics, University of Virginia, from 1987 until 1997. He also served as the Hospital Ethicist at the University of Virginia Health Services Center. Dr. Fletcher was Chief of the Bioethics Program at the Warren G. Magnuson Clinic Center, National Institutes of Health, from 1977 to 1987. Dr. Fletcher has published extensively in medical ethics and bioethics, and is the author, with Dr. Brian Wispelwey, of *AIDS and Ethics* in Textbook of AIDS Medicine (Samuel Broder et al. Eds., 1st ed. 1994, 2d ed. 1998).

June E. Osborn, M.D., a pediatrician and a virologist, is the former Chair of the Congressional National Commission on AIDS (1989 to 1993) and of the World Health Organization's Global Commission on AIDS (1988 to

1992). Now Professor of Emerita at the University of Michigan School of Public health and Medical Schools, Dr. Osborn began working as a medical school faculty member in 1966, and became Dean of the School of Public Health at the University of Michigan from 1984 to 1993.

Merle A. Sande, M.D., holds and is Chairman of the Department of Internal Medicine, The Clarence M. and Ruth N. Birrer Presidential Endowed Chair in Internal Medicine, at the University of Utah. The author of more than 200 scholarly articles, Dr. Sande also is co-editor of the textbook, The Medical Management of AIDS (now in its fifth edition). An infectious disease specialist, Dr. Sande worked as Chief of Medical Services at San Francisco General Hospital when AIDS cases first appeared at the epidemic's beginning in the United States in the early 1980's through 1996.

Brian Wispelwey, M.S., M.D., is an Associate Professor of Internal Medicine (Infectious Diseases), at the University of Virginia in Charlottesville, Virginia, where he serves as the Director of the AIDS and Infectious Diseases Clinic at the University of Virginia Health AIDS Education Program for Health Care Providers, with Dr. Fletcher, Dr. Wispelwey co-authored *AIDS and Ethics* in Textbook of AIDS Medicine.

IN THE
Supreme Court of the United States
OCTOBER TERM, 1997

RANDON BRAGDON, D.M.D.,
v. *Petitioner,*
SIDNEY ABBOTT, *et al.,*
Respondents.

On Writ of Certiorari to the
United States Court of Appeals
for the First Circuit

**BRIEF OF THE AMERICAN MEDICAL ASSOCIATION
AS AMICUS CURIAE IN SUPPORT OF RESPONDENTS**

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QUESTIONS PRESENTED

Amicus curiae will address the following questions:

Does an individual with early, or "asymptomatic," HIV disease have a "disability" within the meaning of the Americans with Disabilities Act?

Under the Americans with Disabilities Act, should a court defer to a health care practitioner's subjective judgment about the presence of a "direct threat" of infection posed by an individual who seeks treatment in the office of that practitioner, when the overwhelming weight of scientific evidence demonstrates that any such risk is insignificant?

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IN THE
Supreme Court of the United States

OCTOBER TERM, 1997

No. 97-156

RANDON BRAGDON, D.M.D.,
v. *Petitioner,*
SIDNEY ABBOTT, *et al.,*
Respondents.

On Writ of Certiorari to the
United States Court of Appeals
for the First Circuit

BRIEF OF THE AMERICAN MEDICAL ASSOCIATION
AS *AMICUS CURIAE* IN SUPPORT OF RESPONDENTS

INTEREST OF *AMICUS CURIAE*

This case calls upon the Court to revisit the framework, established in *School Bd. v. Arline*, 480 U.S. 273 (1987), for evaluating claims of discrimination by persons who suffer from an infectious disease.¹ Specifically, this case presents two important questions: First, does a person with early HIV disease, sometimes called "asymptomatic HIV disease," have a "disability" as that term is defined

¹ Pursuant to Rule 37.6 of the Rules of this Court, *amicus* states that no counsel for a party authored this brief in whole or in part, and that no person or entity other than *amicus* and its counsel made any monetary contribution to the preparation or submission of this brief. Pursuant to Rule 37.3 of the Rules of this Court, the parties have consented to the filing of this brief, and the consent letters have been filed with the Clerk of the Court.

in the Americans with Disabilities Act ("the Act" or "the ADA")? Second, to what extent should courts defer to a health care practitioner's subjective judgment about the presence of a "direct threat" of infection in a particular practice setting? As the nation's largest organization of physicians, *amicus* American Medical Association ("AMA") has a vital interest in both questions.

The AMA's nearly 300,000 member physicians are regularly called upon to care for persons with infectious diseases, including early HIV disease. The AMA and its members thus have a substantial interest in ensuring that these patients receive treatment that reflects informed and medically reasonable judgments about the risks of infection. To that end, for more than a decade, the AMA has sponsored extensive efforts to ascertain the facts about HIV disease and its transmission and to disseminate those facts to physicians and the public.

Most notably, in an ethical opinion adopted in 1992, the AMA confirmed, specifically in the context of HIV disease, a physician's age-old ethical obligation to treat patients with a communicable disease. AMA, *Code of Medical Ethics* § 9.131 (1996-97 ed.), AMA *Amicus* App. 1a. This opinion, embraced after extensive debate and analysis, holds that "[a] physician may not ethically refuse to treat a patient whose condition is within the physician's current realm of competence solely because the patient is seropositive for HIV," and that "[p]ersons who are seropositive should not be subjected to discrimination based on fear or prejudice." *Id.* This duty to treat is further reinforced by an additional ethical opinion that "physicians who offer their services to the public may not decline to accept patients because of race, color, religion, national origin, or any other basis that would constitute invidious discrimination" (*id.* § 9.12, AMA *Amicus* App. 1a)—an opinion that the AMA, in educational materials addressing the physician's legal obligations under the ADA, has made clear forbids refusal to treat patients with HIV. These ethical opinions have been widely dissemi-

nated by the AMA, have been cited in numerous judicial opinions and journal articles, and are the subject of extensive and continuing AMA efforts and initiatives aimed at public awareness and continuing physician education.

The AMA believes that the medical considerations underlying its position regarding the ethical obligation of physicians to treat individuals who are HIV+ are highly relevant to the proper resolution of this case. The plain medical fact is that HIV disease, even in its early stages, has profound effects on a person's health. HIV-infected individuals require access to routine medical services. Moreover, the general consensus of medical opinion, both in 1994 and today, is that there is no significant risk of transmission of HIV from patient to practitioner arising out of the delivery of routine care in the medical or dental office by a practitioner who takes certain straightforward "universal precautions." In these circumstances, it is not medically appropriate to refuse to provide such care in an office setting to individuals with early HIV disease.

MEDICAL BACKGROUND

We begin with a discussion of infectious diseases generally and, in particular, important aspects of HIV disease. This discussion includes both the progression of HIV disease from infection through its severe stages and the risks of HIV transmission from patients to health care workers and specifically to dentists. In analyzing the nature, duration, severity, and risks of HIV transmission, we focus on data from the 1994 time frame, *i.e.*, the time when respondent Abbott was denied treatment, because, as the court of appeals correctly concluded, "neither the service provider nor the prospective recipient of the service may prove or disprove the direct threat defense by relying on medical evidence not available when treatment was refused." Pet. App. 18a.

A. Infectious Diseases in the United States

Each year, millions of Americans contract infectious, or communicable, diseases.² See Centers for Disease Control & Prevention ("CDC"), 46 Morbidity and Mortality Weekly Report ("MMWR") 1259 (Jan. 1998) (table 1) (year-end figures for select diseases). More than 200 different infectious diseases have been identified, including hepatitis, lyme disease, meningitis, pneumonia, tetanus, tuberculosis, and HIV disease. See *Control of Communicable Diseases in Man* ix-xv (A. Benenson ed., 15th ed. 1990). The consequences of contracting an infectious disease vary widely, ranging from minor irritation to paralysis or death. In some cases, a person with an infectious disease may have no outwardly apparent symptoms at all.

B. Human Immunodeficiency Virus and HIV Disease

The condition known as acquired immunodeficiency syndrome ("AIDS") was first reported to the CDC in 1981. See CDC, *Pneumocystis Pneumonia—Los Angeles*, 30 MMWR 250 (1981). In 1983, HIV, the pathogen responsible for AIDS, was identified. As more information about the nature and continuous progression of the HIV disease process accumulated, the term AIDS "became outdated from a clinical perspective." Michael S. Saag, *Clinical Spectrum of Human Immunodeficiency Virus Diseases*, in *AIDS: Etiology, Diagnosis, Treatment and Prevention* 203, 203 (Vincent T. DeVita, Jr. et al. eds., 4th ed. 1997) (hereinafter "Saag"). In current usage, "AIDS" is primarily an epidemiological category

² The words "infectious" and "communicable" are often used interchangeably. An "infectious disease" or "communicable disease" refers to a disease that is capable of being transmitted to others at some time. When someone is currently capable of transmitting a disease to others, he or she is referred to as being "infectious" or "contagious," or (less frequently) "communicable." *Dorland's Illustrated Medical Dictionary* 359, 372, 888 (28th ed. 1994).

that is used to track the number of new cases of persons with advanced HIV disease, rather than a clinical term that is relevant to patient care. *Id.*

HIV is a human virus that can infect and replicate in numerous types of human cells. Paul A. Volberding, *Clinical Spectrum of HIV Disease*, in *AIDS: Etiology, Diagnosis, Treatment and Prevention* 123, 124 (Vincent T. DeVita, Jr. et al. eds., 3d ed. 1992) (hereinafter "Volberding"). Certain immune-system T-cells—those with a molecule known as CD4—are particularly susceptible to HIV infection. *Id.* Infected T-cells (T-cells that are "CD4+") eventually die, and as the number of such cells decreases, the body's ability to fight infection also decreases. The infected individual's CD4+ cell count is thus "the best predictor of the [individual's] relative risk for developing HIV-related opportunistic diseases" at any given time. Saag at 203. As a result, HIV disease is viewed as progressing in stages that correspond to a range of CD4+ cell levels in the patient. *Id.* at 203-04; Volberding at 126.

1. *Progression and Effects of HIV Disease*

HIV disease begins with infection by HIV. There are three basic routes of HIV transmission: (1) invasive exposure to blood, blood products, or other infectious bodily fluids, as in individuals who share contaminated needles for intravenous drugs or who receive contaminated blood; (2) prenatal or perinatal exposure (i.e., from mother to infant)³; and (3) intimate sexual contact with a partner who is HIV+. Volberding at 127; Anthony S. Fauci & H. Clifford Lane, *The Acquired Immunodeficiency Syndrome (AIDS)*, in *Harrison's Principles of Internal Medicine* 1392, 1393 (Eugene Braunwald et al. eds., 11th ed. 1987).

³ HIV may also be transmitted postnatally from mother to infant through breast milk. Committee on Pediatric AIDS, *Human Milk, Breastfeeding, and Transmission of Human Immunodeficiency Virus in the United States*, 96 *Pediatrics* 977, 977 (1995).

"HIV infection induces a disease process that is continuous and progressive." Volberding at 125. There is, in fact,

a single, continuous disease process beginning with the initial exposure to the infectious agent and terminating in the advanced forms of immune deficiency, with death resulting from the complex interactions between the HIV infection itself and the secondary opportunistic infections and malignancies.

Id. at 126. With advances in treatment, increasing numbers of patients with HIV are surviving longer, but the disease is generally fatal. See Saag at 208 ("it appears inevitable that all patients with HIV-1 infection will ultimately succumb to their disease"). Apart from a number of HIV-related gynecological manifestations, "there is little gender difference in opportunistic processes and HIV disease progression." Rebecca Clark, *Clinical Manifestations and the Natural History of Human Immunodeficiency Virus Infection in Women*, in *Medical Management of AIDS in Women* 115, 115 (Deborah Cotton & D. Heather Watts eds., 1997); see also Howard L. Minkoff & Jack A. DeHovitz, *Care of Women Infected With the Human Immunodeficiency Virus*, 266 JAMA 2253, 2255-56 (Oct. 23/30, 1991) ("There is no specific evidence that non-gynecologic opportunistic manifestations of HIV disease differ between men and women.").

The median time from estimated initial HIV infection to the development of symptoms of advanced HIV disease is roughly 10 to 12 years. Saag at 209; Volberding at 129. Importantly, the rate at which HIV disease progresses varies widely from person to person. The reasons for this variability are not well understood. According to Saag, "the rate of disease progression is quite variable, with some individuals progressing to AIDS within months of the initial infection and others remaining free of AIDS-defining conditions for more than 15 to 20 years (i.e., long-term nonprogressors)." Saag at 209; see also Volberding at 129 (same). Accordingly, "[f]or any HIV-1-

infected individual," however, "the likelihood of the disease progression is difficult to predict." Saag at 203.

The first stage of HIV disease is known as "acute retroviral syndrome" or "acute seroconversion syndrome." Volberding at 127-28; Saag at 204-05. This complex of symptoms generally begins two to six weeks after initial infection. Saag at 204. The symptoms, which include fevers, lymphadenopathy (*i.e.*, chronic abnormal enlargement of the lymph nodes), pharyngitis, and diffuse skin rash, most closely resemble acute mononucleosis or a severe case of the flu. Volberding at 127. Most symptoms resolve within 14 to 21 days, Saag at 205, but lymphadenopathy often persists throughout early HIV disease, Volberding at 127. These symptoms are indicative of HIV's direct and immediate attack on the cells of the immune system. After the HIV cell attaches to the CD4 receptor on a lymph cell, its membrane fuses with that of the lymph cell and its viral genetic material is injected into the host. Volberding at 124. The host can then become a factory for the production of more copies of HIV's genetic material, and these copies spread to other cells. *Id.* Indeed, within two to four weeks after initial infection, high levels of circulating HIV are detectable. Within one to three weeks after the onset of acute retroviral syndrome, HIV antibodies are detectable. Saag at 205.

The second stage of HIV disease is known as early, or asymptomatic, HIV disease. It is characterized by a CD4+ count of 500 to 750 cells/mm³. *Id.* at 205; Volberding at 126 (Table 9-1). This is the longest stage of HIV disease, with a typical duration of 10+ years. Volberding at 126 (Table 9-1, line 3). Lymphadenopathy is the only typical symptom that is readily apparent to the patient, and it usually persists from the time of acute seroconversion. Saag at 205-06; Volberding at 128. A consistent pattern of irregularities in the blood and immune symptoms can also be detected with laboratory tests. Volberding at 128. Finally, a range of dermatological abnormalities and oral lesions are not uncommon during

this phase. Saag at 206. This stage of the disease requires consistent monitoring and routine medical care to prevent, so far as is practicable, the onset of opportunistic infections. Volberding at 130-31.

As was noted above, CD4+ cell count is the most important marker of the disease's progression, and it declines steadily throughout early HIV disease. As HIV continues its attack on the immune system, a person with HIV experiences "an insidious, progressive decline in CD4+ cells (40 to 80 cells/mm³ per year)." *Id.* at 207. Without antiretroviral therapy, there is "an enormously high degree of viral production throughout all stages of infection," depriving the immune system of any respite from HIV's assault. *Id.* at 206.

As the CD4+ count drops below 500 cells/mm³, the individual is likely to pass from the asymptomatic to the symptomatic stage of HIV disease. *Id.* at 207; Volberding at 126 (Table 9-1). Symptomatic HIV disease can range in duration, from a brief period ending in death to a number of years. Volberding at 126 (Table 9-1). Symptoms at this stage include night sweats, chronic diarrhea, fever, weight loss, fatigue, and more frequent or severe skin and oral lesions. Saag at 207; Volberding at 131-32. Indeed, "[n]early every organ system in the body can be affected," and "the effect of symptoms on the patient ranges from minimal to devastating." Volberding at 131. When an individual with HIV reaches the final stages of the disease, CD4+ counts fall below 200 cells/mm³ and continue to decline. Opportunistic infections such as *pneumocystis carinii* pneumonia, encephalitis, and B-cell lymphoma begin to appear. Saag at 207; Volberding at 133. When CD4+ counts drop below 50 cells/mm³, an increasing array of opportunistic infections must be treated. Saag at 208. Brain disorders and involuntary weight loss, or "wasting," are also common at this stage. *Id.*

With aggressive antiretroviral therapy and prophylactic treatments designed to fend off opportunistic infections,

this stage of the disease can be managed for some time despite the profound immunosuppression brought about by HIV. Saag at 207-09; Volberding at 133-34. Nevertheless, deaths at this late stage of HIV disease remain common. Saag at 208. As one authority has put it,

the diagnosis of terminal-stage HIV-1 disease is usually based on an inability to control the symptoms of disease, because no treatments are available for the particular disorder or, more commonly, because available treatments become ineffective.

Id. at 208-09.

The effects of HIV disease are not limited to the clinical effects already discussed. Individuals who have learned that they are HIV+ must adapt to a daunting new personal circumstance:

HIV leads to a deterioration of the patient's health, requires ongoing medical and subspecialty care, results in frequent hospitalizations, can be painful, often requires embarrassing and invasive procedures, and usually leads to premature death. It also disrupts the patient's ability to engage in usual activities such as school or work and has a devastating psychologic and emotional effect on the individual and his or her family.

Sandra Y. Lewis *et al.*, *Pediatric and Family HIV: Psychosocial Concerns Across the Continuum of Disease*, 31 *Nursing Clinics N. Am.* 221, 221 (Mar. 1996). It is not difficult to recognize that, in light of this harsh reality, "HIV is the most feared disease in our society." Jimmie C. Holland *et al.*, *Psychiatric and Psychosocial Aspects of HIV Infection*, in *AIDS: Etiology, Diagnosis, Treatment and Prevention* 347, 347 (Vincent T. DeVita, Jr. *et al.* eds., 3d ed. 1992) (hereinafter "*Holland et al.*"). And the realization that HIV has transformed—and almost certainly severely shortened—one's life, "can be accompanied by profound feelings of shock, disbelief, depression, loneliness, hopelessness, personal grief, guilt, anger, and fear." Margaret A. Chesney & Susan Folkman, *Psycho-*

logical Impact of HIV Disease and Implications for Intervention, 17 *Psychiatric Clinics N. Am.* 163, 163 (Mar. 1994).

Indeed, individuals with early HIV disease typically must confront a number of psychosocial issues that affect their quality of life. These include:

- (1) disclosing their serostatus to significant others;
- (2) seeking meaning in living with an HIV diagnosis;
- (3) making critical decisions about safer sexual behavior and drug use, reproductive choices, and custody planning for children;
- (4) adopting healthy coping strategies;
- (5) seeking social support;
- (6) managing social distancing in relationships; and
- (7) coping with the uncertainty of the disease course.

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, Jr. et al. eds., 4th ed. 1997). These challenges not only touch every major area of life activity, but they significantly limit the individual's ability to proceed with daily life without regard to the HIV disease. See *id.* at 534-38 (detailed review of each issue). See also AMA, *HIV Blood Test Counseling: Physician Guidelines* 3-5 (2d ed. 1993).

Finally, the unpredictable rate at which HIV progresses heightens the psychological impact and anguish of being diagnosed with the disease. "[U]ncertainty becomes the central issue of daily life as each body sensation is analyzed for evidence of progression or new infection." Holland et al. at 348. The fact that HIV disease may suddenly and rapidly progress to an advanced and debilitating stage severely complicates planning and making decisions about work and family life.

2. HIV Transmission in the Health Care Setting

The principal means of HIV transmission in the health care setting is exposure to the blood, blood products, or

other infectious bodily fluids of a person with HIV. The primary risk of transmission from a patient to a health care practitioner comes from percutaneous exposure, such as a needlestick or a cut with a sharp object.⁴ See generally David M. Bell, *Human Immunodeficiency Virus Transmission in Health Care Settings: Risk and Risk Reduction*, 91 Am. J. Med. 3B-294S (1991 Supp. 3B).

a. *Transmission.*—Since the first reported case of occupationally transmitted HIV infection in the health care setting occurred in 1983, the public health community has collected and analyzed epidemiological data to estimate the risk of HIV infection from patients to health care practitioners, including dentists. See David K. Henderson *et al.*, *Risk for Occupational Transmission of Human Immunodeficiency Virus Type 1 (HIV-1) Associated With Clinical Exposures*, 113 *Annals Internal Med.* 740, 740 (Nov. 15, 1990). Data have been collected in different ways. All of which indicates that the risk of HIV transmission from a patient to a dentist is not significant, as long as easily followed universal precautions are used.

First, public health authorities have created a "passive surveillance" system for collecting and tracking reports of HIV transmission from patient to health care worker. In 1991, the CDC began tracking the number of health care workers who report occupationally acquired HIV infection. Ruthanne Marcus & David M. Bell, *Occupational Risk of Human Immunodeficiency Virus Infection in Health Care Workers*, in *AIDS: Etiology, Diagnosis, Treatment and Prevention* 645, 645 (Vincent T. DeVita, Jr. *et al.* eds., 4th ed. 1997) (hereinafter "Marcus & Bell"). As of December 1994, the CDC's surveillance data specific to health care workers showed 42 documented cases and 91 possible cases of HIV infection involving

⁴ In some circumstances (not including routine dental procedures for a patient with HIV disease), infections may be transmitted by cutaneous exposure (such as a splash on the skin), or mucocutaneous exposure (such as exposure to the mucous membranes of the sinus).

patient care.⁵ *Id.* at 646. None of the documented cases involved a dental practitioner. *Id.* As of June 1997, the number of documented cases of HIV transmission from patient to health care practitioner had risen to 52, but, as before, none of the health care practitioners was a dentist. CDC, *HIV/AIDS Prevention: Facts About Surveillance of Health Care Workers With HIV/AIDS* (Aug. 1997). Given the number of dental procedures performed across the country each year, the lack of a single documented case of HIV transmission from patient to dentist strongly indicates that the risk of such transmission is not significant.⁶

Researchers also have conducted a number of long-term prospective cohort studies that assess the likelihood that a health care worker will become HIV+ after a documented percutaneous exposure to HIV-infected blood. "These studies," published in 1994 or earlier, "have consistently indicated that the risk of acquiring HIV infection after a percutaneous exposure to HIV-infected blood is approximately 0.3%," *i.e.*, 3 in 1,000. Marcus & Bell at 648. This figure of 3 in 1,000 is not, as some have implied, a measure of the risk that a dentist who treats a patient

⁵ A "documented case" involves a health care worker's documented conversion from HIV seronegative to HIV seropositive status in connection with a known percutaneous, mucous membrane, or skin exposure. Marcus & Bell at 646. A "possible case" involves a health care worker who reported an occupational exposure to HIV and who had no identifiable behavioral or transfusion risks, but for whom there is no documented proof that, prior to the occupational exposure, the worker did not have HIV. *Id.*

⁶ The CDC also has other data linking HIV disease and employment. As of December 31, 1994, the CDC had received reports of 304,651 adults with AIDS for whom employment information was available. Of these people, 14,591 (or 4.8%) had been employed in health care settings. In the workforce as a whole, by comparison, approximately 6.7% of workers are employed in health services. In other words, according to 1994 data, health care workers were "not overrepresented among reported cases of AIDS." Marcus & Bell at 645.

with HIV will become infected with HIV. Rather, that figure must be multiplied by the likelihood that the dentist will be exposed to HIV-infected blood or other fluid through a percutaneous injury in the first place. For dentists, such injuries occur infrequently—on average, once every four months.⁷ Moreover, as Marcus & Bell indicate, this 0.3% risk estimate of practitioner HIV infection after exposure to infected blood includes many different types of injuries from source patients at various stages of HIV disease. *Id.* Factors unique to dentistry might tend to lower this estimate. For example, because the needles used to administer local anesthetic are of a smaller bore than those used for many medical procedures, *e.g.*, to draw blood, sticks from such needles will expose dentists to smaller amounts of infected blood. Stephen E. Gruninger *et al.*, *Human Immunodeficiency Virus Type 1 Infection Among Dentists*, 123 J. Am. Dental Ass'n 57, 62-63 (Mar. 1992). It is therefore "difficult . . . to rationalize how accidental needlesticks could be a significant HIV transmission route in the dental operator." *Id.* at 62.

b. Universal Precautions.—The CDC promulgated recommendations based on universal precautions in 1987. Elizabeth A. Bolyard & David M. Bell, *Universal Precautions in the Health Care Setting*, in *AIDS: Etiology, Diagnosis, Treatment and Prevention* 655, 656 (Vincent DeVita, Jr. *et al.* eds., 4th ed. 1997). The principle of universal precautions assumes that blood, certain bodily fluids, and tissues of *all* patients must be considered infectious and treated accordingly. *Id.* at 656. The CDC

⁷ The baseline rate of needlestick injuries among dentists has steadily declined during the era of universal precautions. Data from 1993 indicate that, at that time, dentists suffered a percutaneous injury roughly once every four months. Jennifer L. Cleveland *et al.*, *Occupational Blood Exposures in Dentistry: A Decade in Review*, 18 Infect. Control & Hosp. Epidemiol. 717, 720 (Oct. 1997) ("the rate of percutaneous exposures among U.S. dentists decreased steadily from approximately one injury per month in 1986 to one injury every 4 months in 1993"). Given the decline from 1986 to 1993, however, the baseline rate may well be even lower today.

has promulgated and continually updated guidelines based on universal precautions, both for general health care settings and for specialized areas of practice, including dentistry.⁸ *Id.* at 656-57. The core practices of universal precautions ("UP") can be readily summarized:

UP emphasizes the use of appropriate barrier precautions (e.g., gloves, gowns, and facial protection) routinely to prevent mucocutaneous blood contact. The precautions also emphasize the need for prevention of percutaneous injuries through care in the use of needles and other sharp instruments and during disposal of these devices, including the use of conveniently placed sharps disposal units. Proper handwashing, linen and waste handling, and disinfection and sterilization of instruments and other reusable equipment are recommended.

Id. at 657. These practices focus on limiting the health care worker's exposure to blood-borne pathogens such as HIV.

The application of universal precautions to the field of dentistry is straightforward. For example, according to the CDC, "medical gloves (latex or vinyl) always must be worn by [dental health care workers] when there is a potential for contacting blood, blood-contaminated saliva, or mucous membranes." CDC, *Recommended Infection-Control Practices for Dentistry*, 1993 42 MMWR RR-8, at 3 (May 28, 1993), Pet. App. 185a. Likewise, "[c]hin-length plastic face shields or surgical masks and protective eyewear should be worn when splashing or spattering of blood or other body fluids is likely, as is common in dentistry." *Id.*, Pet. App. 186a; see also Jennifer L. Cleveland & Donald W. Marianos, *Special Considerations for Dentistry*, in *AIDS: Etiology, Diagnosis, Treatment and Prevention* (Vincent T. DeVita, Jr. et al. eds., 4th ed. 1997)

⁸ See, e.g., CDC, *Recommended Infection-Control Practices for Dentistry*, 1993, 42 MMWR RR-8 (May 28, 1993), Pet. App. 181a-189a.

(discussing infection control practices for dentistry). As the CDC states, "[w]hen implemented, these recommendations should reduce the risk of disease transmission in the dental environment." *Recommended Infection Control* at 1 (summary), Pet. App. 181a. Significantly, the CDC guidelines do not suggest that the risks of HIV transmission are reduced by performing routine medical or dental procedures in hospital, rather than office, settings.

Petitioner notes that these public health guidelines contain no "definitive statement of the significance of the risk to dentists." (Pet. 21.) This criticism is misplaced. The universal precautions guidelines are not intended to provide an exhaustive report of epidemiological data or a static risk estimate. The data regarding the quantum of risk, already reviewed in detail above, are readily available in peer-reviewed journals accessible to petitioner and all other interested health care workers.

Given petitioner's focus on the possibility of HIV infection from aerosolized pathogens (Pet. 16, 19-20), it is useful to focus on epidemiological evidence on this subject. Marcus & Bell recently summarized the evidence regarding aerosol transmission as follows:

Although inhalation of particles of aerosolized blood may pose a theoretical risk of blood borne pathogen transmission, *no case of such transmission has been documented*. Transmission of blood borne pathogens by aerosols would require generation of aerosolized particles of blood, the presence of infective blood borne pathogens in these aerosolized particles, and the deposition of a sufficient number of infective blood particles in the respiratory tract or on the mucous membranes of a susceptible host to cause infection. . . . Aerosolized HIV has been detected in laboratory studies, although these studies should not be interpreted to mean that HIV is aerosolized in a clinical setting or that HIV is transmitted by this route. . . . Until further research is conducted, the possibility of occupational transmission of HIV

through aerosolized blood should be considered theoretical.

Marcus & Bell at 651 (emphasis added); see also David M. Bell, *Human Immunodeficiency Virus*, *supra*, at 3B-298S ("There are no known instances of transmission of a blood-borne pathogen by aerosol in a clinical setting."). Any "theoretical" risk of transmission should not alter the conclusion that, on the basis of all known data, there is no significant risk of HIV transmission from patient to dentist during routine dental care provided in accordance with universal precautions.

The American Dental Association's policy statements reflect the absence of significant risk to dentists in providing routine dental care in an office setting using universal precautions. According to the relevant policy statement, first promulgated in 1988 and renewed in 1991, "there is little risk of transmission of infectious diseases through dental treatment if recommended infection control procedures are routinely followed." American Dental Ass'n, *Policy on AIDS, HIV Infection and the Practice of Dentistry* (1991), J.A. 225. Further, according to the ADA, "[p]atients with HIV infection may be safely treated in private dental offices when appropriate infection control procedures are employed." *Id.* (emphasis added).

3. Ethical Obligation to Treat Infected Patients

Finally, the duty to treat patients with communicable diseases, and more broadly, the recognition that the practice of medicine requires physicians to accept the risk of transmission of those diseases, is a cornerstone of medical ethics. See, e.g., Ezekiel Emanuel, *Do Physicians Have An Ethical Obligation To Treat Patients With AIDS?*, 318 N. Eng. J. Med. 1686 (1988). In ethical opinions adopted and disseminated well before the facts of this case arose, the AMA has confirmed that physicians may not ethically refuse to treat a patient solely because that patient is seropositive for HIV. AMA, *Code of Medical Ethics*, § 9.131 (1996-97 ed.), AMA *Amicus App.* 1a-2a; see *id.* § 9.12, AMA *Amicus App.* 1a.

SUMMARY OF ARGUMENT

The ADA reflects a national commitment to ensure that no individual is treated unfairly because of a disability and, in particular, to ensure that no person is denied access to health care services because of a medically unreasonable judgment based upon an actual, historical, or perceived disability. The ADA was enacted against the backdrop of this Court's seminal holding, in *School Bd. v. Arline*, 480 U.S. 273 (1987), that persons with contagious diseases may be considered handicapped within the meaning of section 504 of the Rehabilitation Act of 1974. The ADA's broad definition of disability confirms Congress's agreement with this Court that "society's accumulated myths and fears about disability and disease are as handicapping as are the physical limitations that flow from actual impairment," and that "contagiousness" is particularly likely to give rise to the "public fear and misapprehension" that often leads to discrimination. 480 U.S. at 284 (footnote omitted). It is therefore critical under the ADA, as it was under the Rehabilitation Act, to ensure that decisions about access to health care for individuals who are disabled within the meaning of the Act are based upon "reasonable medical judgments." *Id.* at 288; see, e.g., 42 U.S.C. 12101(a)(3) (Act needed to remedy discrimination against the disabled in "health services").

I.

The Act defines "disability" in three ways. Two of these are relevant here. First, the Act defines a "disability" as an impairment that substantially limits a major life activity. The term also includes being "regarded as" having such an impairment.

Respondent Abbott is covered by both statutory definitions. First, even where outward symptoms have not manifested, a diagnosis of infection with HIV typically affects every aspect of a person's life and substantially limits mul-

multiple life activities. Second, petitioner Bragdon denied respondent access to the routine dental care that he offered to others solely on the basis of respondent's HIV infection. He thus regarded her HIV infection as a physical impairment that substantially limited her eligibility to obtain health care—a crucial aspect of “caring for one’s self” that has long been recognized as a major life activity. Thus, the court of appeals correctly concluded that respondent has a “disability” within the meaning of the ADA.

II.

The Act permits a place of public accommodation to deny services to an individual where “such individual poses a direct threat to the health or safety of others.” In *Arline*, this Court concluded that, in the context of the possible transmission of an infectious disease such as tuberculosis or HIV, assessing the presence of a “significant health and safety risk[]”, 480 U.S. at 287, entails an inquiry “based on reasonable medical judgments given the state of medical knowledge.” *Id.* at 288 (quoting *AMA Arline Amicus Br.* at 19). Accordingly, although courts ordinarily should accord substantial deference to a reasonable medical or dental judgment regarding the presence of a health or safety risk, such deference is appropriate only when it is “reasonable” and consistent with “the state of medical knowledge.” *Id.*

Here, there was a firm consensus among both private and public health care professionals about the absence of a significant risk of transmission in the treatment context at issue. In these circumstances, petitioner Bragdon’s contrary judgment cannot be regarded as reasonable. See *General Elec. Co. v. Joiner*, 118 S. Ct. 512 (1997). Moreover, the deference ordinarily shown to a professional judgment is unwarranted where, as here, the practitioner whose judgment contravenes the consensus view was directly involved in the case, did not obtain an independent, medically reasonable opinion before refusing to treat re-

spondent in his office, and did not adhere to an important ethical tenet of his profession.

ARGUMENT

I. GIVEN THE STATE OF MEDICAL KNOWLEDGE AND PRACTICE IN 1994, RESPONDENT HAD A "DISABILITY" AS DEFINED BY THE ACT

The Act defines a "disability" in two ways that are relevant here. First, a "disability" is "a physical or mental impairment that substantially limits one or more of the major life activities of [the] individual." 42 U.S.C. § 12102(2)(A). Second, a "disability" includes "being regarded as having such an impairment," *i.e.*, a physical or mental impairment that substantially limits one or more of a person's major life activities. 42 U.S.C. § 12102(2)(C). Given the facts about HIV as they were known in 1994, virtually all persons suffering from early HIV disease, including respondent Abbott, should be found to have a disability under the first definition. In addition, petitioner's refusal to treat respondent solely on the basis of her early HIV disease demonstrates that he regarded her as having a substantially limiting impairment, bringing this case within the alternative definition of "disability."

A. Persons With Early HIV Disease Have An Impairment That Likely Substantially Limits Many Major Life Activities

The court of appeals' conclusion that HIV, "whether symptomatic or asymptomatic, comprises a physical impairment under the ADA" (Pet. App. 6a) is fully consistent with the current state of medical knowledge about HIV disease. See pages 5-9, *supra*. Petitioner has not challenged that conclusion in this Court. Indeed, to suggest otherwise would conflict with established medical facts about the nature and progression of HIV disease.⁹

⁹ See also 28 C.F.R. § 36.104 (1997) (DOJ regulations implementing the Act's public accommodations provisions, defining "physical

Petitioner challenges, instead, the lower courts' conclusion that reproduction—"intimate sexual activity, gestation, giving birth, childrearing, and nurturing familial relations," (Pet. App. 7a)—is a "major life activity" for purposes of the definition of "disability."¹⁰ To focus exclusively on reproduction as *the* major life activity substantially limited by HIV, however, is to ignore much of the profound impact of HIV disease. Even asymptomatic HIV disease has a debilitating effect on many other major life activities. These include life-shaping decisions such as what education to pursue, what family and financial obligations to assume, what employment opportunities to seek or to forgo and, at bottom, how to spend the limited time left to live. It is simply inconsistent with human experience to say that HIV disease, which profoundly affects a person's ability to plan for and engage in a host of basic life activities, does not substantially limit them.¹¹

Recognizing that HIV infection can have a substantial effect on major life activities of virtually all those who are

impairment" as, *inter alia*, "HIV disease (whether symptomatic or asymptomatic)"; 45 C.F.R. § 84.3(j)(2) (1997) (HHS regulations implementing the Rehabilitation Act, defining "physical impairment" as, *inter alia*, a physiological disorder of the hemic and lymphatic systems). HIV disease attacks and impairs the body's immune system relentlessly from the moment of infection.

¹⁰ *Amicus* concurs with the court of appeals' conclusion that reproduction encompasses a cluster of life activities of profound scope and widely recognized importance, and is comparable to the life activities identified by regulation as "major." See 28 C.F.R. § 36.104 (1997) ("The phrase *major life activities* means functions such as caring for one's self, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning, and working."); 45 C.F.R. § 84.3(j)(2)(ii) (1997) (*same*).

¹¹ The impact of HIV infection on these basic life decisions is made all the more profound and intractable by the unpredictable nature of the clinical course of an individual person's HIV disease. The variability in life expectancy for someone infected with HIV is such that no individual can know whether he or she will live for 10 or 15 years or more—or die within months or a few years. See page 6-7, *supra*.

infected is fully consistent with the nature and purpose of the Act. The Act is intended to prevent discrimination against disabled individuals in arenas as diverse as employment, 42 U.S.C. § 12112(a), entitlement to government services, *id.* § 12132, and access to public accommodations such as health care services, *id.* 12182(a). See *id.* § 12101(a)(3) ("discrimination against individuals with disabilities persists in such critical areas as . . . health services"). In order to achieve this far-reaching goal, Congress patterned the Act's definition of "disability" on the Rehabilitation Act's broad definition of "handicap," expressly invoking Rehabilitation Act statutory and regulatory standards for interpreting the ADA. See 42 U.S.C. § 12201 (requiring adherence to Rehabilitation Act standards). The Rehabilitation Act's definition of "handicap" had itself been expanded in 1974, one year after its original enactment. See *Arline*, 480 U.S. at 278. Congress had concluded that its forerunner, restricted to limitations on employability,

was too narrow to deal with the range of discriminatory practices in housing, education, and health care programs which stemmed from stereotypical attitudes and ignorance about the handicapped.

Id. at 287 n.3.

This history confirms that the "major life activities" criterion that Congress chose to define "disability," while necessary to provide some limits on the broad scope of an Act that otherwise would cover all "impairments," was never intended to become a linguistic obstacle course that would defeat the Act's fundamental remedial purpose for individuals with serious, irreversible, life-threatening medical conditions. To the contrary, Congress intended to give "disability," like the predecessor term "handicap," a broad definition so that the civil rights protection that it intended to afford all disabled Americans in fact would be available to them. See 42 U.S.C. § 12101(b)(2) (Act's purposes include "provid[ing] clear, strong, consistent, enforceable standards addressing discrimination").

The *Arline* decision, on which the Act is significantly based, further reinforces the appropriateness of construing the statutory term "disability" to encompass a disease with the characteristics of early HIV disease. *Arline* suggests that meritless claims are to be winnowed out less by narrowly construing the definition of who is handicapped than by a careful analysis of whether an individual is otherwise qualified for relief. See 480 U.S. at 285 ("the definition of 'handicapped individual' is broad, but only those individuals who are both handicapped *and* otherwise qualified are eligible for relief") (emphasis in original). Indeed, this Court's holding in *Arline*—that "[a]llowing discrimination based on the contagious effects of a physical impairment would be inconsistent with the basic purpose of" the Rehabilitation Act (*id.* at 284)—is perforce true with respect to the basic purpose of the more far-reaching Americans with Disabilities Act.

For this reason, the Act should be construed to "ensure that [disabled] individuals are not denied jobs or other benefits," such as equal access to basic medical care, "because of the prejudiced attitudes or the ignorance of others" with respect to their disabilities. *Id.* HIV disease is both contagious and generally fatal—a combination of attributes with a unique potency for prompting irrational and discriminatory responses. To construe the Act to deny protection to those with this disease because of a perceived inadequate impact on major life activities would unjustly narrow the scope of this landmark legislation.

B. Persons With Early HIV Disease Are Likely To Be Regarded As Having An Impairment That Substantially Limits Many Major Life Activities

The Act also includes a definition of "disability" that protects persons who are not currently suffering from an impairment that substantially limits a major life activity. In particular, the third subsection of 42 U.S.C. § 12102(2) defines having a "disability" as "being regarded as having such an impairment," whether or not such impairment

presently exists. 42 U.S.C. § 12102(2)(C). In 1994, as the lower courts correctly discerned, respondent Abbott did have an impairment that substantially limited her major life activities. Furthermore, petitioner himself regarded her as having such an impairment, thus bringing her within the scope of the Act's protection by virtue of Section 12102(2)(C).

The basis for petitioner's refusal to provide respondent routine dental care in his office was unquestionably her HIV disease. Petitioner regarded respondent as having an impairment because she was HIV+. The question, therefore, is whether his refusal to provide dental care in his office substantially limited a major life activity.

For two independent reasons, obtaining needed health care is a crucial element of one of the "major life activities" covered by the Act. First, both HHS's Rehabilitation Act regulations and the Justice Department's public accommodations regulations expressly place "caring for one's self" at the top of the list of illustrative "major life activities." See note 10, *supra* (quoting regulations). Obtaining health care services, including routine dental care, is surely a primary component of caring for one's self. Indeed, obtaining such care is especially important for persons suffering from a progressive immunosuppressive disorder such as HIV disease, for whom infection from untreated conditions can pose serious additional risks. See pages 7-8, *supra*.

Second, Congress expressly included the "professional office of a health care provider" among the Act's list of public accommodations that are forbidden to discriminate on the basis of disability. 42 U.S.C. § 12181(7)(F). By treating the provision of health care services as a public accommodation, Congress made plain its view of the critical importance of obtaining access to health care. See also 42 U.S.C. § 12101(a)(3) (finding that "health services" are a "critical" area in which discrimination on the basis of disability persists). For this reason as well, obtaining health care may properly be covered as a major life ac-

tivity. *Cf. Arline*, 480 U.S. at 283 n.10 ("working" is a major life activity because the Act forbids employment discrimination).

Accordingly, petitioner's refusal to treat respondent on the basis of her HIV disease means that respondent has a "disability" under the Act's "regarded as" prong and thus triggers review of the medical reasonableness of that refusal. As this Court observed in *Arline*, by amending the definition of "handicap" to include the "regarded as" component, "Congress acknowledged 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." 480 U.S. at 284 (footnote omitted); see *id.* at 284-85 & nn.4-13. These important truths, recognized by this Court more than a decade ago, should guide the Court's interpretation of the ADA, which is designed to remedy discrimination on the basis of disability.

II. ALTHOUGH COURTS ORDINARILY SHOULD DEFER TO THE REASONABLE MEDICAL JUDGMENTS OF PRIVATE HEALTH CARE PROFESSIONALS, PETITIONER'S JUDGMENT WAS NOT MEDICALLY REASONABLE AND THEREFORE IS NOT ENTITLED TO DEFERENCE

Even though respondent was unquestionably disabled within the meaning of the ADA, the question remains whether filling her cavity would have posed "a direct threat" to petitioner's "health or safety." See 42 U.S.C. § 12182(b)(3). The Act defines "direct threat" as "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." *Id.* The Act thus requires an inquiry not into whether *all* risk may be eliminated, but whether all *significant* risk may be eliminated.

Decisions about the presence of a "direct threat" of infection must be based, not on prejudice or stereotypes, but on reasonable medical judgments.¹² Under the Act, therefore, a health care professional need do no more—and no less—than make a medically reasonable decision about whether and how to treat a contagious patient in light of available epidemiological data and guidelines regarding the significance of and means of reducing the risk of transmission. On this issue, petitioner asserts that the court of appeals erred in not deferring to his assessment of the significance of the risk. See Petitioner's Merits Br. 42-44.

In *Arline*, this Court held that, when assessing the significance of risks related to infectious disease, "courts normally should defer to the reasonable medical judgments of public health officials." 480 U.S. at 288. There is no reason, under the ADA, to deviate from this presumption for cases involving matters—such as infectious disease—that are particularly the province of public health officials. The CDC's guidelines, for example, typically reflect a consensus view of both public and private medical authorities, and therefore should be accorded deference in applying the ADA. This case, however, poses the question left open in *Arline* regarding the extent to which deference also may be due to the judgments of private health care practitioners. See *Arline*, 480 U.S. at 288 n.18.

Ordinarily, substantial deference should be given to employment or accommodation decisions that are genuinely

¹² See 28 C.F.R. § 36.208(c) (1997) ("In determining whether an individual poses a direct threat to the health or safety of others, a public accommodation must make an individualized assessment, based on reasonable judgment that relies on current medical knowledge or on the best available objective evidence, to ascertain: the nature, duration, and severity of the risk; the probability that the potential injury will actually occur; and whether reasonable modifications of policies, practices, or procedures will mitigate the risk.") (emphasis added). Cf. *Arline*, 480 U.S. at 288 (listing the same factors for assessing risk).

and rationally founded upon a reasonable, private, medical judgment. See, e.g., *AMA Arline Amicus Br.* at 21-22 n.16; *Kampmeier v. Nyquist*, 553 F.2d 296, 299 (2d Cir. 1977) (upholding school board decision to exclude students with vision in only one eye from contact sports because officials "relied on [a reasonable] medical opinion that [the] children . . . [were] not qualified."). Indeed, in disability cases not involving matters of public health, there typically will be no definitive public health guidance available, and so the opinions of private physicians or dentists will inevitably be at issue. These professionals are generally well-qualified to make judgments regarding potential threats to health or safety posed in various scenarios.

More specifically, in cases involving infectious diseases, the parties should not be precluded from relying on private medical opinions when those opinions are medically reasonable and satisfy established standards for expert testimony. This conclusion is fully consistent with the core principle established in *Arline*, that assessments of the significance of risk should be "based on reasonable medical judgments given the state of medical knowledge" concerning the "nature," "duration," "severity," and "probability" of transmission of the disease. *Arline*, 480 U.S. at 288 (quoting *AMA Arline Amicus Br.* at 19). Thus, for example, where a party can show that there is no single consensus but rather a range of reasonable views within the medical profession concerning a disputed issue,¹³ then, at the very least, that party should be permitted to present to a factfinder the evidence supporting the party's position. Indeed, where, for example, a physician, alleged to have violated the Act, demonstrates that he or she obtained or made a reasonable medical judg-

¹³ This could be the case, for example, when a particular disease is too new for a public health consensus to have formed, when new treatments have been developed but only preliminarily tested, or when substantial research calls materially into question the bases for existing guidelines.

ment, that fact normally should be dispositive that there has been no violation of the Act.

In this case, however, the judgment of petitioner Bragdon was not reasonable and should be given no deference. First, that judgment was inconsistent with the consensus among public and private health authorities in 1994 that providing routine dental care to patients infected with HIV in a dentist's office posed no significant risk of harm to the dentist if universal precautions were followed. The CDC guidelines in place in 1994 on this point were fully consistent with, and explicitly supported and amplified by, the guidance provided and widely disseminated by both the American Dental Association, and more generally, by the AMA. See, e.g., J.A. 225; AMA *Amicus* App. at 1a-2a. Where a consensus exists that there is "little risk" to providing a particular treatment to a patient with a particular type of infection (J.A. 225), private deviations from that view should be deemed presumptively unreasonable.

Second, petitioner did not rely on any substantial scientific evidence in support of his position. As this Court recently reemphasized in the context of admissibility determinations, *all* expert testimony must be scrutinized with an eye toward determining whether the opinions proffered actually draw any support from the underlying scientific proof:

Trained experts commonly extrapolate from existing data. But nothing in either *Daubert* or the Federal Rules of Evidence requires a district court to admit opinion evidence which is connected to existing data only 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 opinion proffered.

General Elec. Co. v. Joiner, 118 S. Ct. 512, 519 (1997). The court of appeals' detailed analysis of the evidence petitioner offered to defend his refusal to treat respondent identified numerous "analytical gap[s]" between underlying data and the view sought to be supported. Only

after the court found all this evidence wanting, considered separately and cumulatively, (Pet. App. 22a-29a), did it finally conclude, consistent with the principles in *Joiner*, that petitioner "failed to present meaningfully probative evidence that treating Ms. Abbott would have posed a medically significant threat to his health or safety." *Id.* at 30a.

Third, deference is less appropriate where, as here, a party seeks to invoke it in defense of his own unilateral action. Notably, petitioner did not attempt, contemporaneously with the event at issue, to seek out an independent private medical opinion concerning the degree of risk posed by treating respondent. This failure is significant, for the question as left open in *Arline* contemplated a scenario in which an employer had sought out an independent private medical opinion. See *Arline*, 480 U.S. at 288 n.18 ("This case does not present, and we do not address, the question whether courts should also defer to the reasonable medical judgments of private physicians on which an employer has relied.") (emphasis added). Here, in contrast, petitioner's actions were based on his own judgment in an area—treatment of HIV-infected patients—where he had no special claim to expertise and thus where an unfounded fear might distort his judgment.

Finally, and most fundamentally, petitioner's claim to deference is irreconcilable with his categorical refusal to provide health care to respondent.¹⁴ This is not a case in which a practitioner has sought, consistent with reasonable medical judgment, to modify his practices and procedures in order to minimize personal risk while still reasonably accommodating his patient's needs.¹⁵ Petitioner's attempt

¹⁴ The court of appeals noted that petitioner did not attempt to prove that the hospital treatment he proposed was significantly safer than routine office treatment, but instead claimed "the right to deny entirely routine dental treatment to patients with HIV." Pet. App. 16a n.4.

¹⁵ There certainly will be cases in which a health care worker may seek to take additional precautions when treating a patient with a

to defend his absolute position by appealing to the AMA's ethical principle that physicians shall be "free to choose whom to serve" (see Petitioner's Merits Br. 45 n.34, quoting AMA Principle VI) is misguided. The AMA's ethical opinions make clear that this broad principle is bounded by the ethical duty not to refuse treatment to patients on the ground that such treatment would pose some personal risk to the physician. See AMA, *Code of Medical Ethics* §§ 9.12, 9.131 (1996-97 ed.), AMA *Amicus* App. 1a-2a. Indeed, the duty to treat despite some personal risk is inherently a part of what makes medicine a profession rather than a commercial trade—it is "constitutive" of what it means to be a medical professional. See Ezekiel Emanuel, *Do Physicians Have An Obligation To Treat Patients With AIDS?*, 318 N. Eng. J. Med. 1686, 1686-87 (1988). If deference is due to a professional judgment, it can only be because that judgment was made consistent with the critical tenets that separate a profession from a trade. A judgment that conflicts with those tenets is necessarily not a "professional" one, and therefore cannot merit deference.

* * * *

To many in our society, HIV disease raises the specter of an irreversible death sentence, and a protracted and horrible death at that. Fear of contracting this disease can be so great that it provokes decisions based on misinformation and prejudice—and thereby leads to discriminatory conduct without medical justification. It is precisely for this reason that the Americans With Disabilities Act should be construed, in complete harmony with the dictates of medical ethics, to prohibit arbitrary limitations

communicable disease: such precautions would be appropriate if they do not unduly burden the ability of the patient to get needed care and if they reflect a medically reasonable and good faith effort to accommodate the patient's needs as well as the health care worker's reasonable concerns for personal health and safety. In such a situation, there should ordinarily be no basis for a finding of discrimination, but that is not this case.

on the access of an individual to health care because that individual is seropositive for HIV. Based on the overwhelming weight of scientific authority, the long-established standards of the medical and dental professions, and the manifest intent of Congress, respondent should not have been denied dental treatment in the dentist's office.

CONCLUSION

For the foregoing reasons, the judgment of the court of appeals should be affirmed.

Respectfully submitted,

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February 6, 1998

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APPENDIX A

**CODE OF MEDICAL ETHICS:
CURRENT OPINIONS WITH ANNOTATIONS
AMERICAN MEDICAL ASSOCIATION**

Opinion 9.12—Physician-Patient Relationship: Respect for Law and Human Rights. The creation of the physician-patient relationship is contractual in nature. Generally, both the physician and the patient are free to enter into or decline the relationship. A physician may decline to undertake the care of a patient whose medical condition is not within the physician's current competence. However, physicians who offer their services to the public may not decline to accept patients because of race, color, religion, national origin, or any other basis that would constitute invidious discrimination. Furthermore, physicians who are obligated under preexisting contractual arrangements may not decline to accept patients as provided by those arrangements. (I, III, V, VI)

Issued July 1986.

Updated June 1994.

[Council on Ethical and Judicial Affairs, American Medical Association, *Code of Medical Ethics: Current Opinions With Annotations* 152 (1996-97 ed.).]

Opinion 9.131—HIV-Infected Patients and Physicians. A physician may not ethically refuse to treat a patient whose condition is within the physician's current realm of competence solely because the patient is seropositive for HIV. Persons who are seropositive should not be subjected to discrimination based on fear or prejudice.

When physicians are unable to provide the services required by an HIV-infected patient, they should make appropriate referrals to those physicians or facilities equipped to provide such services.

A physician who knows that he or she is seropositive should not engage in any activity that creates an identi-

2a

fied risk of transmission of the disease to others. A physician who has HIV disease or who is seropositive should consult colleagues as to which activities the physician can pursue without creating risk to patients. (I, II, IV)

Issued March 1992 based on the report "Ethical Issues in the Growing AIDS Crisis," issued December 1987 (*JAMA*. 1988; 259: 1360-61).

Updated June 1996.

[Council on Ethical and Judicial Affairs, American Medical Association, *Code of Medical Ethics: Current Opinions with Annotations* 157 (1996-97 ed.).]

APPENDIX B

**PRINCIPLES OF MEDICAL ETHICS I, II, IV & VI
AMERICAN MEDICAL ASSOCIATION**

- I. A physician shall be dedicated to providing competent medical service with compassion and respect for human dignity.
- II. A physician shall deal honestly with patients and colleagues, and strive to expose those physicians deficient in character or competence, or who engage in fraud or deception.
- IV. A physician shall respect the rights of patients, of colleagues, and of other health professionals, and shall safeguard patient confidences within the constraints of the law.
- VI. A physician shall, in the provision of appropriate patient care, except in emergencies, be free to choose whom to serve, with whom to associate, and the environment in which to provide medical services.

[Council on Ethical and Judicial Affairs, American Medical Association, *Code of Medical Ethics: Current Opinions With Annotations* xiv (1996-97 ed.).]

No. 97-156

In The
Supreme Court of the United States
October Term, 1997

RANDON BRAGDON, D.M.D.

Petitioner,

SIDNEY ABBOTT, ET AL.

Respondents

On Writ Of Certiorari
To The United States Court Of Appeals
For The First Circuit

BRIEF OF SENATORS HARKIN, JEFFORDS
AND KENNEDY AND OF REPRESENTATIVES
HOYER, OWENS AND WAXMAN AS AMICI CURIAE
IN SUPPORT OF RESPONDENTS

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INTEREST OF AMICI CURIAE*

The following Senators and Congressmen were primary authors and sponsors of the Americans with Disabilities Act and are leaders in shaping this nation's disability policy. Amici have an interest in ensuring that the fundamental principles of the ADA are not eroded by overly restrictive interpretations of the term "disability," which result in condoning the discriminatory practices the ADA was intended to prohibit.

Senator Tom Harkin was the chief sponsor and a principal author of the ADA. As Chair of the Subcommittee on Disability Policy of the Senate Committee on Labor and Human Resources, and floor manager, he was involved in all aspects of the passage of the ADA.

Congressman Steny H. Hoyer was the lead House co-sponsor of the ADA. He led the House passage of the legislation and was intimately involved in all aspects of its consideration.

Senator James M. Jeffords has authored or contributed to every piece of legislation affecting federal disability policy since 1974, including amendments to Section 504 of the 1973 Rehabilitation Act, and the ADA. He is currently the Chair of the Senate Labor and Human Resources Committee.

Senator Kennedy, a principal author of the ADA, was the Chair of the Senate Committee on Labor and Human Resources during its passage, and is now Ranking Minority Member. He has been a leader on HIV/AIDS issues, including assuring coverage in the ADA.

Congressman Major R. Owens was Chair of the Subcommittee on Select Education of the Committee of Education and Labor during the deliberations on the ADA and was involved in all deliberations in the House.

Congressman Henry A. Waxman was an original co-sponsor of the ADA, and Chair of the House Commerce Subcommittee on Health and the Environment during its passage. He has been a

* The parties have consented to the filing of this brief.

Counsel for a party did not author this brief in whole or in part. No person or entity, other than the *Amicus Curiae*, its members, or its counsel made a monetary contribution to the preparation and submission of this brief.

leader in promoting public health and civil rights legislation for people with HIV infection.

SUMMARY OF THE ARGUMENT

Although couched in an argument rejecting "per se" coverage of persons with asymptomatic HIV infection under the American with Disabilities Act, Petitioner and his amici are actually asking this Court to hold that these individuals are never protected from discrimination under the ADA. This result threatens the very core of the ADA, which is meant to ensure that people with physical or mental impairments are not denied an equal opportunity to contribute to and participate in community life based on myths, fears, and stereotypes about disability.

Petitioner's argument that individuals with asymptomatic HIV infection are not "substantially limited in a major life activity" relies on an overly restrictive and unfounded interpretation of the plain language of the statute and contradicts unequivocal Congressional intent to protect persons with both symptomatic and asymptomatic HIV infection from adverse treatment that is not based on objective medical fact.

The substantially limited language as carried over from Section 504 of the 1973 Rehabilitation Act was understood to distinguish "trivial impairments" from those that significantly impact a person's life. HIV infection clearly has a significant impact on the life of those diagnosed with this debilitating fatal disease.

Moreover, Congress did not limit the definition of disability to those with substantially limiting impairments. Petitioner and his amici simply ignore the third prong of the disability definition "regarded as" – which was designed precisely to ensure that individuals with stigmatic conditions which invoke negative reactions in others would not be "vulnerable to discrimination on the basis of mythology . . . precisely the type of injury Congress sought to prevent." *School Board of Nassau County v. Arline*, 480 U.S. 273, 284 (1987).

In order to ensure that individuals with disabilities would have their conditions "evaluated in light of medical evidence . . ." *Arline* at 285, Congress adopted this Court's formulation of "direct

threat" in *Arline*. Since this case, like *Arline*, involves the risk of contagion, deference to public health officials is appropriate. There is nothing in the language or legislative history of the ADA which justifies deference to private health care providers who are defendants or on whom a defendant has relied.

ARGUMENT

I. THE DEFINITION OF DISABILITY IS BROAD IN ORDER TO ACHIEVE THE NON-DISCRIMINATION GOALS OF THE ADA

In its extensive deliberations on the Americans with Disabilities Act (ADA),¹ Congress heard testimony from a wide range of people with different disabilities about the many types of discrimination that limit equal opportunity to education, employment, public accommodations, and public services.² Congress also reviewed authoritative governmental,

¹ The Senate Committee on Labor and Human Resources and the Senate Subcommittee on the Handicapped held five hearings on the bill. On September 7, 1989, the bill passed the Senate with overwhelming support by a vote of 76 to 8. In the House, over 20 hearings were held before four House committees subcommittees. The House and Senate Conference Committee convened twice. The conference bill passed by an overwhelming majority in both the House (by a vote of 377 to 28) and the Senate (by a vote of 91 to 6). The ADA was signed by President Bush on July 26, 1990.

² For example:

. . . A young woman who has cerebral palsy told the Senators about a local movie theater that would not let her attend because of her disability. . . .

. . . A Vietnam veteran who had been paralyzed during the war and came home using a wheelchair testified that . . . [he] could not get a job because of discrimination.

. . . A woman testified that, when she lost her breast to cancer, she also lost her job and, as a person with a history of cancer, could not find another one. Parents whose small child

public health, and census reports which studied the status of people with disabilities, which all concluded that comprehensive civil rights legislation was necessary to combat pervasive discrimination against people with disabilities.³

Congress found that "discrimination against individuals with disabilities persists in such critical areas as employment, housing, public accommodations, education, transportation, communication, recreation, institutionalization, *health services*, voting, and access to public services," 42 U.S.C. § 12101(a)(3) (emphasis added), and that the purpose of the ADA is "to provide a clear and comprehensive national mandate for the elimination of discrimination against individuals with disabilities." 42 U.S.C. § 12101(b)(1).

Congress recognized that discrimination takes a variety of forms – outright exclusion, lack of access, application of outmoded eligibility criteria, and attitudinal barriers based on "false presumptions, generalizations, misperceptions, patronizing attitudes, ignorance, irrational fears and pernicious mythologies." H.R. Rep. No. 101-485, pt. 2, at 30, 1990 U.S.C.C.A.N. at 311; S. Rep. No. 101-116, at 7.

Comprehensiveness was the hallmark of the Americans with Disabilities Act. As stated by then Attorney General Thornburgh, on behalf of President Bush:

One of the (the ADA bill's) most impressive strengths is its comprehensive character. Over the last 20 years, civil rights laws protecting disabled

had died of AIDS testified about how they could not find an undertaker who would bury their child. . . .

Arlene Mayerson, *The History of the ADA, in Implementing the Americans with Disabilities Act: Rights and Responsibilities of All Americans*, 17, 23 (Lawrence O. Gostin & Henry A. Beyer eds., 1993) (citations omitted). For a review of testimony, see H.R. Rep. No. 101-485, pt. 2, at 28-49 (1990), reprinted in 1990 U.S.C.C.A.N. 303, 310-31; S. Rep. No. 101-116, at 5-20 (1989).

³ The Committee Reports cite a variety of reports relied on by Congress. See H.R. Rep. No. 101-485, pt. 2, at 28, 1990 U.S.C.C.A.N. at 310; S. Rep. No. 101-116, at 6.

persons have been enacted in piece-meal fashion. Thus, existing Federal laws are like a patchwork quilt in need of repair. There are holes in the fabric, serious gaps in coverage that leave persons with disabilities without adequate civil rights protections.

H.R. Rep. No. 101-485, pt. 2, at 48, 1990 U.S.C.C.A.N. at 330; S. Rep. No. 101-116, at 19.

Congress' intent was to ensure that all decisions based on disability, present, past, or perceived, were guided by facts, not myths, fears, and stereotypes. As stated by Senator Dole:

We have included in this legislation all people with all disabilities, no matter how misunderstood because that is what this bill is about – replacing misunderstanding with understanding.

136 Cong. Rec. S9695 (daily ed. July 13, 1990) (statement of Sen. Dole).

Petitioner's argument that, in passing the ADA, Congress intended to condone discrimination against an individual with asymptomatic HIV infection based on unfounded fear of contagion, threatens the very core of the ADA. With the advance of medical technology, many individuals with a variety of disabilities from epilepsy to schizophrenia are or will become asymptomatic.⁴ To argue that Congress intended to strip them of anti-discrimination protection for this reason is not only illogical, but also totally ignores Congress' recognition that disability status alone often invokes discrimination.⁵ Congress was well aware that people with HIV infection, whether symptomatic or not, face pervasive discrimination due to fear of contagion. The history of the ADA demonstrates that Congress saw this type of discrimination as the same as, not

⁴ It is for this reason that the Committee Reports and authoritative agency regulations require limitations to be assessed without regard to mitigating measures. See H.R. Rep. No. 101-485, pt. 2, at 52, 1990 U.S.C.C.A.N. at 333; S. Rep. No. 101-116, at 23; 29 C.F.R. Pt. 1630, App., § 1630.2(j).

⁵ See discussion of "regarded as" prong, *infra* pp. 13-22.

different from, the types of discrimination faced by people with a wide variety of disabilities.

In determining who would be protected by the ADA, Congress adopted the definition of “handicap” under Section 504 of the Rehabilitation Act of 1973.⁶ A “disability” is defined with respect to an individual in three ways:

- (A) a physical or mental impairment that substantially limits one or more of the major life activities of such individual;
- (B) a record of such an impairment; or
- (C) being regarded as having such an impairment.

42 U.S.C. § 12102(2).⁷

This Court reviewed the history of the Section 504 definition in *School Board of Nassau County v. Arline*, 480 U.S. 273 (1987). Prior to 1974, the definition of handicap was tied directly to employability. *See id.* at 279 n.3. As noted in *Arline*, the definition was expanded in 1974 to address “the range of discriminatory practices in housing, education, and health care programs, which stemmed from stereotypical attitudes and ignorance about the handicapped.” S. Rep. No. 93-1297, at 16, 37-38, 50, *cited in Arline* at 279 n.3.

The agency responsible for promulgating the Section 504 regulations, concluded that a specific list of conditions, which would constitute handicaps, was not possible because it would be difficult to ensure the “comprehensiveness of any such list.” 45 C.F.R. Pt. 84, App. A, p. 310 (1985) *cited in Arline*, 480 U.S. at 280 n.5. Moreover, in response to comments that the definition was unreasonably broad, the agency found that

⁶ As explained in the Committee Reports, “[n]o change in definition or substance is intended nor should be attributed to the change in phraseology [from the term “handicap” to “disability.”].” H.R. Rep. No. 101-485, pt. 2, at 51, 1990 U.S.C.C.A.N. at 332; S. Rep. No. 101-116, at 21. *See also* H.R. Rep. No. 101-485, pt. 3, at 26 (1990), *reprinted in* 1990 U.S.C.C.A.N. 445, 449.

⁷ This definition is often referred to as a three-prong definition. As discussed *infra*, Congress also carved out specific exclusions to the definition of disability in the ADA. *See* p. 22.

the broad regulatory definition “is inherent in the statutory definition.” *Arline*, 480 U.S. at 280 n.5.

As this Court stated in *Arline*, “the definition of ‘handicapped individual’ is broad, but only those individuals who are both handicapped *and* otherwise qualified are eligible for relief.” *Id.* at 285. This Court emphasized that without a broad definition of disability, individuals with disabilities would never have the opportunity to have their qualifications objectively evaluated, leaving them “vulnerable to discrimination on the basis of mythology – precisely the type of injury Congress sought to prevent.” *Id.*

As argued below, Congress intended people with HIV infection, symptomatic or not, to be protected against discrimination based on fear of contagion. The substantially limited language carried over from Section 504 was understood to distinguish “trivial impairments” from those that significantly impact a person’s life. H.R. Rep. No. 101-485, pt. 2, at 52, 1990 U.S.C.C.A.N. at 334; S. Rep. No. 101-116, at 23. No one could seriously argue that HIV infection does not have a significant impact on the life of those diagnosed with this debilitating fatal disease.⁸

Moreover, Congress did not limit the definition to those with present substantially limiting impairments. Rather, Congress recognized that in order to achieve its purpose, the ADA needed to protect those who were not currently substantially limited but who have a history of a disability or whose physical or mental condition invoked negative reactions in others.⁹ *See* 42 U.S.C. § 12102(2)(b)-(c).

⁸ In addition, any argument that Congress intended to exclude individuals with asymptomatic HIV infection from coverage under the ADA is belied by the plain language of the statute. The language of the ADA, itself, demonstrates that Congress knew how to exclude disabilities from ADA coverage when it wished to do so. *See discussion infra* p. 22.

⁹ For example, as pointed out in *Arline*, “irrational fears or prejudice on the part of employers or fellow workers” . . . make it difficult for former cancer patients to secure employment.” *Arline*, 480 U.S. at 284.

As Petitioner states in his brief, this Court has “[o]ver and over . . . stressed that ‘[i]n expounding a statute, we must not be guided by a single sentence or member of a sentence, but look to the provisions of the whole law, and to its object and policy.’ ” Pet. Brief at 27, *quoting United States Nat’l Bank of Or. v. Indep. Ins. Agents of N. America*, 508 U.S. 439, 455 (1993). That said, Petitioner proceeds to apply a hyper-technical and incomplete interpretation to the definition of disability that would wholly defeat Congressional purpose and intent in passing the ADA. It is absolutely impossible to read the language and legislative history of the ADA and come to the conclusion that Congress condoned adverse treatment of people with HIV infection without reference to medical reality.

Petitioner’s attempt to cast his argument as a mere rejection of “per se” coverage is misleading. Under Petitioner’s case-by-case approach, individuals with asymptomatic HIV infection would always lose because according to Petitioner asymptomatic HIV infection, by definition, does not substantially limit major life functions. Pet. Brief at 3. In other words, Petitioner and his amici argue for “per se” non-inclusion of persons with asymptomatic HIV infection.

The “per se” characterization is a misnomer, in any case. People with certain disabling conditions will always be covered by the first “substantially limited” prong, not because the analysis is discarded, but because the condition itself is inherently substantially limiting. Moreover, an individual who has a physical or mental condition that is stigmatized and results in adverse treatment is covered by the third “regarded as” prong. Therefore, a person with HIV infection, who like Ms. Abbott, experiences discrimination because of fear of contagion is covered by the ADA. This is what Congress intended – this is the only way that the Congressional purpose to prohibit actions based on myths, fears, and stereotypes can be realized. Any other result would do violence to the “object and

(*quoting* 123 Cong. Rec. 13515 (1977) (statement of Sen. Humphrey)). See “Regarded As” argument, *infra* pp. 13-22.

policy” of the ADA. *United States Nat’l Bank of Or.*, 508 U.S. at 455.

II. HIV INFECTION FALLS WITHIN THE PLAIN LANGUAGE OF THE STATUTORY DEFINITION OF “DISABILITY”.

While the Petitioner apparently concedes that HIV infection is an impairment, Petitioner argues that asymptomatic HIV infection can never be a disability under the ADA. This argument would nullify not only the unequivocal intent of Congress, but also all agency regulations implementing the statute. Moreover, in Petitioner’s attempt to persuade the Court that Congress condoned discrimination against people with HIV infection based on contagion, unless they are symptomatic, Petitioner fails to acknowledge the full definition of disability, including the “regarded as” prong of the definition. Whether under the first prong or the third prong, it is clear that people who face discrimination based on HIV status are covered by the ADA.

A. HIV Infection Falls Within the First Prong of the Definition of Disability Because HIV Infection – Symptomatic or Asymptomatic – Substantially Limits Major Life Activities.

As noted above, the first prong of the definition of “disability” defines the term as a “physical or mental impairment that substantially limits one or more . . . major life activities.” 42 U.S.C. § 12102(2)(a). The term “major life activities” must be interpreted broadly enough to encompass the full range of disability experiences intended to be covered by the ADA. As repeatedly stated in the Committee Reports, the purpose of the substantial limitation language was to distinguish “trivial” impairments.

Persons with minor, trivial impairments, such as a simple infected finger, are not impaired in a major life activity. A person is considered an individual with a disability for purposes of the first prong of the definition when the individual’s important life

activities are restricted as to the conditions, manner, or duration under which they can be performed in comparison to most people.

H.R. Rep. No. 101-485, pt. 2, at 52, 1990 U.S.C.C.A.N. at 334; S. Rep. No. 101-116, at 23.

As anyone diagnosed with HIV infection knows, and as Congress was well aware, a positive HIV test changes everything.¹⁰ Numerous legislators stated their understanding of the pervasive effect of an HIV diagnosis. In the words of Senator Kennedy:

People with HIV disease are individuals who have any condition along the full spectrum of HIV infection – asymptomatic HIV infection, symptomatic HIV infection or full-blown AIDS. These individuals are covered under the first prong of the definition of disability in the ADA, as individuals who have a physical impairment that substantially limits a major life activity. . . . [A]lthough the major life activity that is affected at any point in the spectrum by the HIV infection may be different, there is a substantial limitation of some major life activity from the onset of HIV infection.

136 Cong. Rec. S9696 (daily ed. July 13, 1990) (statement of Sen. Kennedy); *accord* 136 Cong. Rec. H4623 (daily ed. July 12, 1990) (statement of Rep. Owens); *id.* at H4624 (statement of Rep. Edwards); *id.* at H4626 (statement of Rep. Waxman).

Petitioner's argument is nothing more than a rehashing of the argument presented to and rejected by this Court in *Arline*. In that case, the petitioner argued that an adverse decision based on fear of contagion was not disability-based

¹⁰ From the moment of contraction, HIV-infected individuals must pay constant and diligent attention to developing proper sleep and eating patterns, regulating weight in anticipation of future possible weight loss, avoiding dangerous activities that might threaten others with exposure to the virus, and avoiding exposure that might result in reactivation of prior infections for which the individual has a compromised ability to respond. Moreover, all life decisions are influenced greatly by the known progressive and fatal nature of the disease.

discrimination because it was not based on “real or perceived diminution of an individual’s capabilities.” *Arline*, 480 U.S. at 281 n.6. Supporting the petitioner, the government argued that since it is possible for a person to be capable of spreading a disease without having a “physical impairment,” discrimination based on contagion could never be disability-based discrimination. The government in *Arline* incorrectly used asymptomatic HIV infection as such an example. *See id.* at 282 n.7. Since that time, the unanimous opinion of public health officials, Congress, and the implementing agencies is that HIV infection is an impairment. *See* S. Rep. No. 101-116, at 22; 29 C.F.R. Pt. 1630, App., § 1630.2(j). Petitioner has conceded this point. Pet. Brief at 18. Therefore, the words of *Arline* apply with equal force here.

We do not agree with Petitioners that, in defining a handicapped individual under § 504, the contagious effects of a disease can be meaningfully distinguished from the disease’s physical effects on a claimant in a case such as this. [Respondent’s] contagiousness and her physical impairment each resulted from the same underlying condition. . . . It would be unfair to allow [Petitioner] to seize upon the distinction between the effects of a disease on others and the effects of a disease on a patient and then use that distinction to justify discriminatory treatment.

480 U.S. at 282.

Finally, contrary to Petitioner’s claim, there is no reason in the language of the ADA not to recognize reproduction as a major life activity. Congress did not intend the term to be restrictive, or to give certain types of disabilities preference over others because of the major life function affected. Indeed, a finding that reproduction or intimate sexual activities are *not* major life activities will thwart the will of Congress.

The Committee Reports repeatedly cite with approval a memorandum written by the Office of Legal Counsel of the

Department of Justice interpreting Section 504 and its application to individuals with HIV infection:¹¹

As noted by the U.S. Department of Justice, . . . a person infected with the Human Immunodeficiency Virus is covered under the first prong of the definition of the term "disability" because of a substantial limitation to procreation and intimate sexual relationships.

H.R. Rep. No. 101-485, pt. 2, at 52, 1990 U.S.C.C.A.N. at 334 (citing OLC Memorandum at 9-11). See also H.R. Rep. No. 101-485, pt. 3, at 28 n.18, 1990 U.S.C.C.A.N. at 451; S. Rep. No. 101-116, at 22. Since it is clear that Congress and the Department of Justice concluded that sex and reproduction are major life activities, and everyone involved in the legislation was aware of this, Petitioner and his amici's contrary view is not persuasive.¹²

The agencies charged with implementing the ADA have also concluded that HIV infection substantially limits major

¹¹ Memorandum of Office of Legal Counsel to the President Regarding Application of Section 504 of the Rehabilitation Act to HIV-Infected Individuals, 1988, reprinted in *Americans with Disabilities Act of 1988: Hearings on S. 933 Before the Senate Comm. on Labor and Human Resources*, 101st Cong. 338-366 (1989) [hereinafter OLC Memorandum]. The Petitioner cites to an earlier D.O.J. memorandum, concluding that HIV is not a "handicap" under 504. Pet. Brief at 22 n.15. What Petitioner fails to convey, however, is that the Cooper memorandum cited was actually the background for the Government's position in *Arline*, which was rejected by this Court. See *Arline*, 480 U.S. at 282 n.7.

¹² As explained by Justice Breyer:

[A] fairly common function of legislative history [is] explaining specialized meanings of terms or phrases in a statute which were previously understood by the community of specialists (or others) particularly interested in a statute's enactment.

Stephen Breyer, On the Uses of Legislative History in Interpreting Statutes, 55 S. Cal. L. Rev. 845, 853 (1992).

life activities.¹³ See the Department of Justice Title III implementing regulations, 28 C.F.R. Pt. 35, App. A, § 35.104, and the Equal Employment Opportunity Commission ["EEOC"] Title I implementing regulations, 29 C.F.R. Pt. 1630, App., § 1630.2(j). See also 28 C.F.R. § 36.104; *id.* at Pt. 36, App. B, § 36.104.

Petitioner's argument that "[a]symptomatic HIV-infection is not a substantial physical limitation on [the] ability to have intimate sex and/or reproduce," Pet. Brief at 13, is quite astounding. The risk of transmitting HIV to offspring is real and substantial. In the words of the First Circuit, "[n]o reasonable juror could conclude that an 8% risk of passing an incurable, debilitating, and inevitably fatal disease to one's child is not a substantial restriction on reproductive activity." *Abbott v. Bragdon*, 107 F.3d 934, 942 (1st Cir. 1997).

B. HIV Infection Falls Within the Third Prong of the Definition of Disability.

In arguing that HIV is not a disability under the ADA, Petitioner ignores the "regarded as" prong of the ADA definition of disability. Even if this Court does not find asymptomatic HIV infection to be a disability under the first prong of the definition, it is clear that the "regarded as" prong of the definition, as explained in *Arline*, was enacted precisely to address the type of discrimination faced by Ms. Abbott in this case. There is no dispute that Petitioner's reason for not treating Ms. Abbott was fear generated by her impairment.¹⁴

¹³ The DOJ and EEOC regulations are entitled to judicial deference. See *Chevron U.S.A., Inc. v. Natural Resources Defense Council, Inc.*, 467 U.S. 837, 844-45 (1984) ("[c]onsiderable weight should be accorded to an executive department's construction of a statutory scheme it is entrusted to administer . . ."); *Consolidated Rail Corp. v. Darrone*, 465 U.S. 624, 634 (1984) ("This Court generally has deferred to contemporaneous regulations issued by the agency responsible for implementing a congressional enactment.").

¹⁴ As argued above, Congress considered HIV infection to be substantially limiting. However, for purposes of the "regarded as" analysis

A review of the legislative history leaves no doubt that Congress intended the “regarded as” prong to prohibit discrimination based on *disability status*. As this Court stated in *Arline*,¹⁵

[t]o combat the effects of erroneous but nevertheless prevalent perceptions about the handicapped, Congress expanded the definition of “handicapped individual” so as to preclude discrimination against “[a] person who has a record of, or is *regarded as having an impairment [but who] may at present have no actual incapacity at all.*”

480 U.S. at 279 (emphasis added).¹⁶

Quoting from the *Arline* decision, the ADA Committee Reports adopt the rationale articulated by this Court as follows:

By amending the definition of “handicapped individual” to include not only those who are actually physically impaired, but also those who are regarded as impaired and who, as a result, are substantially limited in a major life activity, Congress acknowledged that *society’s accumulated myths and fears about disability and disease are as handicapping as are the physical limitations that flow from actual impairment.*

Arline, 480 U.S. at 284 (emphasis added), *cited in* H.R. Rep. No. 101-485, pt. 2, at 53, 1990 U.S.C.C.A.N. at 336; S. Rep. No. 101-116, at 24.

it is sufficient that Petitioner adversely reacted to her impairment, which Petitioner does not dispute.

¹⁵ See *supra* note 6. Congress adopted the definition of disability from the definition of handicap under Section 504.

¹⁶ The Court specifically noted that the previous definition was “too narrow to deal with the range of discriminatory practices in housing, education, and *health care programs* which stemmed from stereotypical attitudes and ignorance about the handicapped.”

Arline, 480 U.S. at 279 n.3 (citing S. Rep. No. 93-1297, at 16, 37-38, 50) (emphasis added).

As reflected in the Committee Reports, Congress intended to adopt the long-standing definition of the “regarded as” prong under Section 504, as follows:

(iv) “Is regarded as having an impairment” means

(A) has a physical or mental impairment that does not substantially limit major life activities but that is treated by a [covered entity] as constituting such a limitation;

(B) has a physical or mental impairment that substantially limits major life activities only as a result of the attitudes of others toward such impairment; or

(C) has none of the impairments defined in [prong 1] but is treated by a [covered entity] as having such an impairment.

H.R. Rep. No. 101-485, pt. 3, at 29, 1990 U.S.C.C.A.N. at 452, *citing* 45 C.F.R. § 84.3(j)(2)(iv), (incorporated in ADA regulations at 29 C.F.R. at 1630 App. A § 1630.2(1) (1997)). See also H.R. Rep. No. 101-485, pt. 2, at 53, 1990 U.S.C.C.A.N. at 336; S. Rep. No. 101-116, at 23.

Subsection (B) is intended to cover stigmatic impairments, such as HIV infection, which invoke reactions based on ignorance, fear, and stereotypes. As this Court recognized in *Arline*,

Few aspects of a handicap give rise to the same level of public fear and misapprehension as contagiousness.

* * *

The Act is carefully structured to replace such reflexive reactions to actual or perceived handicaps with actions based on reasoned and medically sound judgments: the definition of “handicapped individual” is broad, but only those individuals who are

both handicapped *and* otherwise qualified are eligible for relief.

480 U.S. at 284-85.¹⁷

While conceding “regarded as” coverage on one hand, Petitioner undercuts coverage by arguing that an individual defendant would need to regard the infection as affecting a “pertinent” major life activity. Pet. Brief at 18. In Petitioner’s formulation, this would be impossible, because it would be extremely unlikely that a person with asymptomatic HIV infection would be adversely treated because the defendant viewed her as substantially limited in walking, breathing, hearing, etc. Rather, the adverse treatment would be based on fear of contagion, as in this case.

Petitioner’s interpretation of the “regarded as” prong makes a mockery of Congressional intent. Under his formulation, a school board would be free to exclude a child with asymptomatic HIV infection from school on the mistaken belief that the child would infect classmates, so long as the school board did not view the child as substantially limited in a “pertinent life activity.” The numerous statements of members expressing outrage about the plight of Ryan White and other children with HIV infection belie such an assertion.¹⁸

Likewise, it makes no sense for Petitioner to argue that Ms. Abbott is not covered under the “regarded as” prong of the definition because he did not perceive her to be limited in a “pertinent major life activity.” Petitioner viewed Ms. Abbott

as substantially limited in the ability to receive routine medical care. Petitioner would like to have it both ways. He cannot refuse treatment based on her medical condition and then come to court and argue that he did not regard her medical condition as “substantially limiting” enough to bring her under the protection of the ADA. This argument simply ignores the language and purpose of the “regarded as” prong.

Petitioner’s example of “Magic” Johnson and Greg Louganis as super-heroes who could not possibly be “disabled,” Pet. Brief at 3-4, misses the whole purpose of the “regarded as” prong of the disability definition. The ADA recognizes that many people with physical or mental impairments are extremely capable, but are stymied in their efforts to participate in society because of the views of others. If “Magic” Johnson or Greg Louganis were denied medical services or entrance to a restaurant because of the unfounded fear of HIV transmission, it would be irrelevant whether they could win gold medals at the Olympics. That is the whole point of the “regarded as” prong, to assure that people have an opportunity to be judged on their merits, not on the misguided perceptions or prejudices of others.

Congress noted the particular importance of the “regarded as” prong of the definition for those with “stigmatic conditions.” H.R. Rep. No. 101-485, pt. 2, at 53, 1990 U.S.C.C.A.N. at 336; S. Rep. No. 101-116, at 24. The most commonly cited example of a person covered by the “regarded as” prong in the legislative history is a “burn victim.” H.R. Rep. No. 101-485, pt. 2, at 53, 1990 U.S.C.C.A.N. at 336; H.R. Rep. No. 101-485, pt. 3, at 30, 1990 U.S.C.C.A.N. at 453; S. Rep. No. 101-116, at 24. Again, Congressional intent would be subverted if Petitioner could turn down all burn victims and then argue that he did not view them as substantially limited in “pertinent major life activities,” *i.e.*, the ability to walk, hear, see, etc.

In fact, discrimination against many of the disabilities that Congress intended to cover would be condoned by Petitioner’s logic. As this Court noted in *Arline*,

Even those who suffer or have recovered from such noninfectious diseases as epilepsy or cancer have

¹⁷ In *Arline* this Court interpreted Section 504 without any explicit references in the legislative history to contagious diseases. Any concerns of the *Arline* dissent in this regard are not applicable here because Congress made its intent to cover individuals with HIV infection under the ADA explicit. See 480 U.S. at 289-90; see also *infra* pp. 23-26 (discussing legislative history concerning HIV infection).

¹⁸ See, e.g., 136 Cong. Rec. S7442 (daily ed. June 6, 1990) (Ronald Reagan: “We Owe It to Ryan”); 136 Cong. Rec. H2479 (daily ed. May 17, 1990) (statement of Rep. McCloskey); *id.* at H2480 (statement of Rep. McDermott); *id.* at H2481 (statement of Rep. Jontz).

faced discrimination based on the irrational fear that they might be contagious.

480 U.S. at 284. According to Petitioner, individuals with epilepsy or cancer, who are not substantially limited in a "pertinent life activity" could be turned away because of fear of contagion. This inequity was condemned in *Arline*:

Allowing discrimination based on the [perceived] contagious effects of a physical impairment would be inconsistent with the basic purpose of § 504, which is to ensure that handicapped individuals are not denied . . . benefits because of the prejudiced attitudes or the ignorance of others.

Id.

There can be no doubt that people with HIV infection are substantially limited as a result of the attitudes of others. As the Commissioner to the National Commission on AIDS stressed in his testimony before Congress, "[r]emember, Ryan White, denied entry to school. The Ray family, burned from their home. A woman with AIDS denied entry with her children to a public swimming pool. A bright young attorney forced into poverty because he was fired from his job." *Americans with Disabilities Act of 1989: Hearings Before the House Subcomm. on Civil and Constitutional Rights and Comm. on the Judiciary*, 101st Cong., 1st Sess. 171 (1989) (statement of Rev. Scott Allen, Commissioner, National Commission on AIDS). Social exclusion of this nature most certainly materially limits major life activities. See *Cain v. Hyatt*, 734 F. Supp. 671, 678 (E.D. Pa. 1990) ("HIV-positive individuals are unjustifiably and 'widely stereotyped as indelibly miasmatic, untouchable, physically and morally polluted.'").¹⁹

¹⁹ See also *Harris v. Thigpen*, 941 F.2d 1495, 1521 (11th Cir. 1991) (HIV-infected prisoners are "categorically separated from virtually all aspects of general population institutional life"); *Austin v. Pennsylvania Dep't of Corrections*, 876 F. Supp. 1437, 1465 (E.D. Pa. 1995) (noting that in addition to impairing multiple body systems, HIV infection substantially limits major life activities "by . . . the fear it inspires in others"); *Doe v. District of Columbia*, 796 F. Supp. 559, 565 (D.D.C. 1992) (Defendant

Members of Congress recognized the importance of HIV coverage to combat the stigma attached to the disease, particularly fear of contagion:

With this measure, we call for an end to finger pointing and fear mongering about AIDS. We know with great certainty how this disease is and is not transmitted. There is no scientific or medical reason to shun people with AIDS or HIV disease.

135 Cong. Rec. S10789 (daily ed. Sept. 7, 1989) (statement of Sen. Kennedy).

Perhaps nothing better illustrates the purpose of the "regarded as" prong of the definition of disability than the floor debates on the Chapman amendment. Under this proposal, food-handling employees diagnosed with an infectious disease would have been exempt from certain provisions of the ADA.²⁰ According to Representative Chapman, the proponent of the amendment:

the bill as currently drafted will not provide an employer the flexibility to move an employee out of food-handling position [sic] if that employee were diagnosed as having an infectious or contagious disease such as AIDS. The reality is that many Americans would refuse to patronize any food

testified that he " 'would be crazy' not to take the public's fear of HIV and AIDS into account."); *Cain v. Hyatt*, 734 F. Supp. 671, 680 (E.D. Pa. 1990) ("The particular associations AIDS shares with sexual fault, drug use, social disorder, and with racial minorities, the poor, and other historically disenfranchised groups accentuates the tendency to visit condemnation upon its victims"); *Doe v. Dolton Elementary School Dist. No. 148*, 694 F. Supp. 440, 444 (N.D. Ill. 1988) ("Surely no physical problem has created greater public fear and misapprehension than AIDS."); *Ray v. School Dist. of DeSoto County*, 666 F. Supp. 1524, 1535 (M.D. Fla. 1987) ("The Court recognizes the concern and fear which is flowing from this small community . . . However, the Court may not be guided by such community fear. . . .").

²⁰ See H.R. Conf. Rep. No. 101-596, at 61 (1990), reprinted in 1990 U.S.C.C.A.N. 565, 570.

establishment if an employee were known to have a communicable disease.

136 Cong. Rec. H2478 (daily ed. May 17, 1990) (statement of Rep. Chapman).

From the start, Representative Chapman admitted that there was no evidence that AIDS could be transmitted in the process of handling food. *See id.* The whole debate centered on the fact that restaurants would lose patrons because of the erroneous belief that the disease could be transmitted through food. *See id.* In arguing against the amendment, Representative McDermott stated:

. . . the amendment is not about the reality of contagious disease. It is about the fear of contagious disease. Let us be honest: It is about the fear of AIDS.

* * *

A few years ago, a school board in Indiana told Ryan White that he could not go to school with other children. It was not that the school officials thought Ryan would infect the others, they said, it was that some parents were afraid he would. That school system made a policy decision in response to fear and prejudice. By the time Ryan White died last month, everyone knew better.

136 Cong. Rec. H2480 (daily ed. May 17, 1990) (statement of Rep. McDermott).

The Bush Administration agreed.

Dr. Sullivan, the Secretary of Health stated: 'Any policy based on fears and misconceptions about HIV will only complicate and confuse disease control efforts without adding any protection to public health. We need to defeat discrimination rather than to submit to it.'

136 Cong. Rec. S9686 (daily ed. July 13, 1990) (statement of Sen. Harkin).

In conference, the Chapman Amendment was replaced with a provision that rejected decisions based on "false perceptions" requiring decisions about food handling to be based

on "valid scientific and medical analysis and using accepted public health methodologies. . . ." H.R. Conf. Rep. No. 101-596, at 62, 1990 U.S.C.C.A.N. at 570. As stated by Senator Hatch, the author of the substitute amendment, "this does away with people's fears and it says let science govern, which is the only way to do it." 136 Cong. Rec. S9538 (daily ed. July 11, 1990) (statement of Sen. Hatch).²¹

The debates and resolution of the Chapman amendment make no sense in Petitioner's view of HIV coverage. According to the Petitioner's circular analysis, a restaurant owner could not only transfer but also fire an individual with HIV infection who handled food, so long as the owner did not regard the infection as affecting a "pertinent life activity." Pet. Brief at 18. Yet in defeating the Chapman amendment, Congress expressly rejected such actions by restaurant owners.

People with both symptomatic and asymptomatic HIV infection are equally situated, vis-a-vis contagion. As evidenced by the debates concerning the Chapman amendment, Congress intended that a person with HIV infection, whether or not symptomatic, who is turned away because of fear of contagion be given an opportunity to have the adverse treatment evaluated under objective standards pursuant to the ADA. Nothing could better exemplify the "object and policy"

²¹ *See also* 136 Cong. Rec. H4623 (daily ed. July 12, 1990) (statement of Rep. Owens) ("[T]he original amendment offered by Congressman Chapman responded to public fear and misperception regarding people with HIV diseases by legitimizing those fears. . . . I am pleased that we have arrived at an acceptable resolution of this issue, particularly because the ADA offers such critical protection to people with HIV disease in a range of areas."); *id.* at H4624 (statement of Rep. Edwards). Without a doubt, there is fear and misperception regarding the threat posed by people with Acquired Immune Deficiency Syndrome (AIDS) and other forms of Human Immunodeficiency Virus (HIV) disease. But the proper response to such fear and misperception is not to legitimize them by allowing such false perceptions to determine who can hold certain jobs. Rather, the proper response is that taken in the Hatch amendment, which the conferees have adopted.").

of the "regarded as" prong of the definition. *United States Nat'l Bank of Or.*, 508 U.S. at 455.

C. HIV Infection is Not One of the Conditions Explicitly Excluded from the Statutory Definition of Disability Under the ADA.

In perhaps the most disingenuous argument presented by Petitioner, Petitioner argues that Congress rejected HIV coverage because "HIV infection is nowhere mentioned in the legislation passed after extensive debate." Pet. Brief at 26 n.18.

As stated above, the ADA adopted the approach taken in the Rehabilitation Act, which rejected listing specific conditions because of the "difficulty of ensuring the comprehensiveness of any such list." 45 C.F.R. Pt. 84 App. A, p. 310 (1985), *cited in Arline*, 480 U.S. at 280 n.5. However, while the ADA does not list exemplary conditions or diseases that fit within the disability definition, the statute does list those conditions that do *not* constitute a disability under the ADA.²² These examples show that Congress clearly knew how to exempt certain conditions or diseases from coverage under the ADA when it so desired. Moreover, in light of the abundant testimony before Congress on the subject of HIV and AIDS, it speaks volumes that the exemptions cited in the statute do not include mention of HIV infection. Not only did Congress choose not to exclude asymptomatic infection from coverage, it made certain that the exclusions would not affect HIV coverage.

The following colloquy between Senators Helms and Harkin could not be clearer.

²² Under 42 U.S.C. § 12208, being a transvestite is not a disability. Similarly, under 42 U.S.C. § 12211(a), "homosexuality and bisexuality are not impairments and as such are not disabilities." Section 12211(b) further clarifies conditions that do not qualify as disabilities, including transsexualism, exhibitionism, compulsive gambling, pyromania, and "psychoactive substance use disorders resulting from current illegal use of drugs." 42 U.S.C. § 12211(b).

MR. HELMS: I do not understand why, for example, you went down the road of including in your definitions people who are HIV positive, because 85 percent or more of the HIV positive people in this country are known to be drug users or homosexual or both. [sic]

MR. HARKIN: Then I respond to the Senator that they are not covered under this bill on the basis of their homosexuality or drug use.

MR. HELMS: The Senator better read his committee report, because it says they are covered.

MR. HARKIN: They are covered on the basis of their HIV infection but not on the basis of being current drug users.

135 Cong. Rec. S10768 (daily ed. Sept. 7, 1989) (statements of Sens. Helms and Harkin).

The Judiciary Report reiterates this understanding: Individuals who are homosexual or bisexual and are discriminated against because they have a disability, such as infection with the Human Immunodeficiency Virus, are protected under the ADA. The Committee specifically rejected amendments to exclude homosexuals with certain disabilities from coverage.

H.R. Rep. No. 101-485, pt. 3, at 75, 1990 U.S.C.C.A.N. at 498.

III. THE LEGISLATIVE HISTORY OF THE ADA MAKES CLEAR THAT CONGRESS INTENDED HIV INFECTION TO BE A COVERED "DISABILITY" UNDER THE ACT.

Congressional intent to cover people with both symptomatic and asymptomatic HIV infection is unambiguous. Congress repeatedly affirmed this intent – in both the Committee Reports and the floor statements – in order to ensure that people with HIV disease were not subject to discrimination based on fear or ignorance.

First, the Committee Reports confirm Congress' intent to use the standards and interpretations under Section 504,

including this Court's discussion of the definition of "disability" in *Arline*. Prior to enactment of the ADA, the agency responsible for implementing Section 504²³ and all courts addressing the issue concluded that HIV infection was a covered "handicap." See *infra* note 27. It is well established that when Congress adopts a new law incorporating sections of a prior law, Congress is presumed to be aware of prior judicial interpretations and to adopt them in re-enacting statutory language. See *Lorillard v. Pons*, 434 U.S. 575, 580-81 (1978). See also *Keene Corp. v. United States*, 508 U.S. 200, 212-13 (1993) (where Congress re-enacts a statute that had been given a consistent judicial interpretation, such re-enactment generally includes the settled judicial interpretation).²⁴

Congress knew that Section 504 was a powerful tool to combat discrimination based on fear and ignorance of HIV transmission. For example, in the 1980s children with HIV infection who had been terrorized by their community and excluded from school,²⁵ and a child who had been put in a glass enclosure in the back of the classroom,²⁶ were able to use Section 504 to combat myths, fears, and stereotypes about

²³ Enforcement of Nondiscrimination on the Basis of Handicap in Department of Justice Programs, 48 Fed. Reg. 55996 (1983) (codified at 28 C.F.R. Pt. 39).

²⁴ This is most compelling here, as the ADA states that: "Nothing in the ADA shall be construed to provide a lesser standard than the standard applied under Title V of the Rehabilitation Act." 42 U.S.C. § 12201(a).

²⁵ *Ray v. School District of DeSoto County*, 666 F. Supp. 1524 (M.D. Fla. 1987). As stated by the *Ray* Court, "[t]he reality is that the Ray boys have already been dealt a hand not to be envied by anyone. The boys at their young ages are having to face two potentially life-threatening diseases. This is more than most people face in their entire adult lives. Denial of the opportunity to lead as normal an educational and social life as possible is adding insult to injury." *Id.* at 1535.

²⁶ *Martinez v. School Board of Hillsborough County*, 861 F.2d 1502, 1504 (11th Cir. 1988).

HIV infection. In fact, no court even considered the proposition that HIV infection may not be a covered handicap under Section 504.²⁷

Congress not only relied on prior interpretations of Section 504, however; it expressly endorsed the conclusion of the Department of Justice memorandum that Section 504 applies to individuals infected with HIV.²⁸ In addition, it endorsed the recommendation of the Presidential Commission on the HIV Epidemic that HIV-infected individuals be covered under anti-discrimination legislation:

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 HEV [sic] epidemic and will leave HIV-infected individuals isolated and alone.

* * *

Comprehensive Federal anti-discrimination legislation, which prohibits discrimination against persons with disabilities in the public and private sectors, including employment, housing, public accommodations and participation in government programs should be enacted. All persons with symptomatic or asymptomatic HIV infection should be clearly included as persons with disabilities who are covered by the anti-discrimination protections of this legislation.

²⁷ See, e.g., *Doe v. Garrett*, 903 F.2d 1455, 1459 (11th Cir. 1990) (holding that infection with AIDS constitutes a handicap under Rehabilitation Act), *cert. denied*, 499 U.S. 904 (1991); *Leckelt v. Board of Comm'rs of Hosp. Dist. No. 1*, 909 F.2d 820, 825 (5th Cir. 1990) (assuming that HIV infection is an impairment protected by Section 504); *Chalk v. United States Dist. Court, Central Dist. of Cal.*, 840 F.2d 701, 705 (9th Cir. 1988) (assuming AIDS comes within Section 504).

²⁸ See discussion *supra* pp. 11-12.

H.R. Rep. No. 101-485, pt. 2, at 31, 48, 1990 U.S.C.C.A.N. at 313, 330 (citing *Report of the Presidential Comm. on the Human Immunodeficiency Epidemic*, June 1988, at 123); S. Rep. No. 101-116, at 8, 19.

Finally, as quoted throughout this brief, the record is replete with floor statements expressing the intent that HIV be a covered disability. *See supra* pp. 10, 19-21, 23. As the debates over the Chapman amendment make vividly clear,²⁹ even those who didn't approve of HIV coverage understood that the ADA prohibited discrimination on the basis of HIV infection, symptomatic or asymptomatic.³⁰

IV. IN DETERMINING WHETHER AN INDIVIDUAL POSES A DIRECT THREAT UNDER THE ADA, COURTS SHOULD NOT DEFER TO PRIVATE HEALTH CARE PROVIDERS.

At the core of the ADA is the requirement that any adverse decision based on disability be judged by objective fact. Perhaps the most invidious stereotype faced by people with disabilities throughout the ages has been that they pose a danger to others. As noted by this Court in *Arline*, "[t]he isolation of the chronically ill and of those perceived to be ill or contagious appears across cultures and centuries, as does the development of complex and often pernicious mythologies about the nature, cause, and transmission of illness." 480 U.S. at 284 n.12 (citations omitted).

In order to ensure that individuals with disabilities were not assumed to be a danger without objective facts, Congress created the "direct threat" defense. 42 U.S.C. § 12182(b)(3). This defense protects people with disabilities from unfounded

²⁹ *See* discussion *supra* pp. 19-21.

³⁰ In the words of one opponent of the ADA, "[W]ith the adoption of this act we are instantaneously going to bring within the definition of disabled person across this land every HIV carrier in America, every person with AIDS. Now that is not what my definition of disability should be including." 136 Cong. Rec. H4621 (daily ed. July 12, 1990) (statement of Rep. Dannemeyer).

adverse actions, while at the same time recognizing legitimate concerns for public safety. *See* H.R. Rep. No. 101-485, pt. 2, at 56-57, 1990 U.S.C.C.A.N. at 338-39; H.R. Rep. No. 101-485, pt. 3, at 45-46, 1990 U.S.C.C.A.N. at 468-69; S. Rep. No. 101-116, at 27.

This is not, however, a case that calls upon this Court to speculate about how a generally expressed Congressional intent would apply to the situation presented here. The exact issue presented in the third question certified in this case was decided by Congress when it enacted the direct threat defense based on the standard articulated in *Arline*.³¹ *Arline* directly addressed the standard to be used in cases where the threat posed is infection. In those cases, the Court held that the question of whether a person with a disability poses a direct threat must be evaluated objectively given the state of medical knowledge, and that

[i]n making these findings, courts normally should defer to the reasonable medical judgments of public health officials.

480 U.S. at 288. *See also id.* at 286 n.15.

While this Court also noted that *Arline* did not present, and it therefore did not address, the question of whether courts should also defer to the reasonable medical judgments of private physicians on which an employer has relied, *see id.* at 288 n.18, this reference must be to the medical judgments of private physicians on matters *other* than the risk posed by a contagious disease. Otherwise, the Court's twice-mentioned statement that courts should defer to judgments of public health officials on issues of contagion would make little sense. Thus, Petitioner's attempt to construe *Arline* as leaving

³¹ *Section 101(8) - Direct Threat*

The Committee intends to codify the direct threat standard used by the Supreme Court in *School Board of Nassau County v. Arline*.

H.R. Rep. No. 101-485, pt. 3, at 34, 1990 U.S.C.C.A.N. at 457. *See also* H.R. Rep. No. 101-485, pt. 2, at 56-57, 1990 U.S.C.C.A.N. at 338-39; S. Rep. No. 101-116, at 27, 40.

open the question presented here is unsupportable. A rule cannot provide simultaneous deference to public health officials and employers' private physicians or physician defendants on the same determinations, because such judgments may conflict, as in this case.³²

Nothing in the ADA or its legislative history supports the conclusion that Congress intended to create a different standard for private health care providers. Indeed, discrimination by health care providers against people with disabilities was one of the very harms the ADA was enacted to address.³³ Adopting the findings of a report by the U.S. Commission on Civil Rights, Congress concluded that discrimination against people with disabilities "persists in such critical areas as . . . medical treatment." H.R. Rep. No. 101-485, pt. 2, at 31, 1990 U.S.C.C.A.N. at 312; S. Rep. No. 101-116, at 8.

There is no principled way to distinguish between cases where the health care provider is a defendant and those where the defendant relies on a doctor as the basis for an adverse decision. Congress explicitly rejected giving deference to defendants' doctors. As stated in the House Committee on Education and Labor Report:

[A]ny determination by a company physician can be challenged by evidence from the complainant's physician. Company doctors often are unfamiliar with certain disabilities and assume that there are barriers to employment which, in fact, do not exist. The complainant's own physician often has more knowledge about the effects of the disability on the individual being considered.

³² While it is not necessary to address the open question in this case, it should be noted that Congress's intent to cover doctor's offices in the same manner as other public accommodations is clear from the legislative history. As argued *infra*, deference to medical doctor defendants, or to defendants' doctors, was explicitly rejected.

³³ Offices of health care providers are specifically covered. See 42 U.S.C. § 12181(7)(I).

H.R. Rep. No. 101-485, pt. 2, at 73, 1990 U.S.C.C.A.N. at 356.³⁴

Moreover, the refusal by dentists and other health care providers to treat individuals with HIV was explicitly mentioned in the legislative history as an area of discrimination that the ADA was intended to remedy:

The public accommodations title of the ADA will also offer necessary protection for people with HIV disease. This title prohibits discrimination in such areas as doctors' offices, *dentists' office* [sic], lawyers' offices, and various other service providers. *These are areas of society in which, unfortunately, people with HIV disease have faced discrimination.*

136 Cong. Rec. H4623 (daily ed. July 12, 1990) (statement of Rep. Owens) (emphasis added).

The test adopted by Congress, which is reflected in the U.S. Department of Justice's regulations implementing Title III, does not leave health care providers or any other places of public accommodation without recourse. As noted by the First Circuit in this case, the deference afforded to public health officials under the ADA's "direct threat" standard is not absolute. Petitioner and other defendants, whether health care providers or not, are free to come forward and challenge the views of public health officials "based on contrary, properly supported opinions voiced by other recognized experts in the

³⁴ Petitioner's reference to the legislative history statement that "nothing in this legislation is intended to prohibit a physician from providing the most appropriate medical treatment in the physician's judgment," is incomplete and therefore misleading. Pet. Brief at 43, quoting S. Rep. No. 101-116, at 63. This sentence goes on to state that the ADA does not prohibit a physician from: "referring an individual with a disability to another physician when the physician would make a referral of an individual *who does not have a disability*." S. Rep. No. 101-116, at 63 (emphasis added). By using such limiting language, Congress made clear that where a health care provider refuses to treat a patient on the basis of her disability and would not have made the same referral to an individual without a disability, a question of discrimination arises. It is undisputed that the reason for rejection here was the Respondent's disability.

field (e.g., research studies published in peer-reviewed journals)." *Abbott*, 107 F.3d at 945. Defendants, for example, may choose to put forth evidence demonstrating that the reports and opinions of public health officials on which a plaintiff relies are out of date, or reflect stereotypes about people with disabilities. The Petitioner's failure to put forth sufficient evidence to rebut the Guidelines of the U.S. Centers for Disease Control and the policy of the American Dental Association, both of which conclude that with use of universal precautions patients with HIV can be treated in dentists' offices without significant risk, *id.* at 948, does not support the application of a weaker standard for health care providers. This demonstrates why the uniform standard intended by Congress is needed.

CONCLUSION

For the foregoing reasons, the judgment of the Appeals Court should be affirmed.

Respectfully submitted,

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