

Lambda
Legal
Defense
and Education
Fund, Inc.

intermental
institute

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Studies

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February 28, 2000

Bruce N. Reed
Assistant to the President for Domestic Policy
Executive Office of the President
Second Floor, West Wing
1600 Pennsylvania Avenue, N.W.
Washington, D.C. 20500

Dear Mr. Reed:

I am forwarding to you a copy of a February 15, 2000 letter that I and several physicians with expertise in HIV recently sent to FAA Administrator Jane Garvey on the issue of the routine withholding of medical certificates from HIV positive pilots. In view of President Clinton's and Vice President Gore's public support for people with HIV and AIDS, and for the end of arbitrary discrimination against them, we are hopeful that the administration also will lend its support to the elimination of this lingering instance of the federal government's unbalanced treatment of those with HIV. We would appreciate greatly anything you are able to do to advance the consideration of this important matter.

I am available at your convenience to answer any questions you might have about the issues raised in the attached letter, and hope you will feel free to contact me. In the meantime, I thank you in advance for your assistance.

Very truly yours,

Catherine Hanssens
Director, AIDS Project

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February 15, 2000

Jane F. Garvey
Federal Aviation Administrator
Federal Aviation Administration
800 Independence Avenue, S.W.
Washington, D.C. 20591

RE: Airman medical certificate restrictions and denials for individuals with HIV and AIDS

Dear Administrator Garvey:

We are writing to you, on behalf of Lambda Legal Defense and Education Fund, Inc. and the undersigned physicians, regarding the Federal Aviation Administration's current treatment of HIV and AIDS in the granting of pilot medical certifications.¹ As you know, under current FAA policy and guidelines, individuals with a diagnosis of AIDS are not considered qualified to hold an airman medical certificate of any class, and only those HIV positive individuals with a viral load count of no greater than 1,000, a CD4+ lymphocyte count of at least 200, normal complete blood count and liver function, and no symptoms of HIV disease will be considered for a waiver and granted a medical certificate.

The FAA's guidelines reflect overly broad and largely unsupported assumptions about HIV and AIDS, and unfairly exclude otherwise qualified individuals from a career or avocation as a pilot. The guidelines must be revised if FAA policy is to be consistent with the requirements of the Rehabilitation Act of 1973, which prohibits the imposition of special medical screening criteria on individuals with disabilities when such criteria are not necessary for the safe and effective operation of the program or service in question.

While the FAA's policy has been in existence for years, the irrationality of the policy recently was illustrated through the experience of Tom Healy, who contacted Lambda after his

¹The undersigned physicians, Dr. Aaron Aronow, Dr. Robert Swenson, and Dr. Joseph Sonnabend, are specialists in, respectively, HIV and neurology, infectious disease, and the treatment of HIV/AIDS.

application for a medical certificate was denied solely because he is HIV positive. Mr. Healy originally applied for a third-class medical certificate in April, 1999; his application was denied on the basis of his HIV status by a letter from Warren S. Silberman, Manager, Aeromedical Certification Division of the Civil Aeromedical Institute, dated May 18, 1999, in which he also was advised he could request reconsideration by the Federal Air Surgeon by submitting a written request. *See* correspondence attached as Exhibit A. Shortly thereafter, he brought this issue to the attention of the Department of Transportation's Office of General Counsel and White House officials. *See* correspondence attached as Exhibit B.

Mr. Healy ultimately was successful in his appeal of this denial, and on August 19, 1999 was granted a medical certificate which is valid until October, 1999. *See* correspondence attached as Exhibit C. On September 15, 1999, Mr. Healy received another letter from Mr. Silberman advising him that, because of his history of infection with HIV and treatment with oral medications, he was ineligible for medical certification, but that he was granted "special issuance" of a third-class airman medical certificate which now expires February 29, 2000. *See* Exhibit D. The letter also advised Mr. Healy that in order to maintain uninterrupted medical certification beyond that date, he again would be required to submit a physician report, including laboratory and clinical test reports, as required for the initial waiver, in November, 1999.

We believe that the imposition of these special procedures and criteria on Mr. Healy and others in his position on the basis of disability is not necessary to ensure air safety. Because these procedures and criteria are based on assumptions rather than medical realities about HIV, and in fact cause the exclusion of qualified individuals from airman medical certificate eligibility, we further believe that they violate the Rehabilitation Act of 1973. To facilitate your consideration of this issue, we summarize below the regulations, policies, and medical considerations which bear on the treatment of pilots with HIV and AIDS. We also summarize the applicable legal standard for assessing restrictions on people with disabilities such as HIV, and recommend a course of action to remedy the problems with the current FAA policy.

FAA regulations and policies

The FAA regulations that govern medical standards and certification of pilots generally are set forth in Title 14, Part 67 of the Code of Federal Regulations (C.F.R.). Three separate subparts describe the medical standards for First-Class, Second-Class and Third-Class Airman Certificates. *See* 14 C.F.R. §§ 67.101-67.315.² The three subparts are nearly identical; each

²Third-class medical certificates are for private pilots only, have the least restrictive medical requirements and are good for three years for applicants under age 40 and for two years for those 40 and over. Second-class certificates are for commercial, non-airline duties as well as private pilot duties and

contains sections with the medical standards for vision; ear, nose, throat and equilibrium; mental illness; neurologic disorders; cardiovascular problems; and "general medical condition[s]."

There are fifteen disqualifying medical conditions specified throughout these sections of the FAA regulations.³ AIDS and HIV are nowhere specified in the regulations as disqualifying medical conditions, although it is our understanding that other conditions that are not specified in the regulations can still be disqualifying.⁴

The "general medical condition" provisions (which are cited by Dr. Warren Silberman, Manager of the FAA Civil Aeromedical Institute's Aeromedical Certification Division, in his letter of denial of certification to Thomas Healy) apply to all applicants, including those with HIV and AIDS, and the standards are the same for all three classes of certificates. See 14 C.F.R. §§ 67.113(b) and (c), 67.213(b) and (c), and 67.313(b) and (c). In pertinent part, they read:

The general medical standards for a [first, second, or third]-class airman medical certificate[s] are: . . . (b) No [] organic, functional, or structural disease, defect, or limitation that the Federal Air Surgeon, based on the case history and appropriate, qualified medical judgment relating to the condition involved, finds—(1) Makes the person unable to safely perform the duties or exercise the privileges of the airman certificate applied for or held; or (2) May reasonably be expected, for the maximum duration of the airman medical certificate applied for or held, to make the person unable to perform those duties or exercise those privileges. (c) No medication or other treatment that the Federal Air Surgeon, based on the case history and appropriate, qualified medical judgment relating to the medication or other treatment involved, finds—(1) Makes the person unable to safely perform the duties or exercise the privileges of the airman certificate applied for or held; or

would be required for crop dusters, charter pilots, corporate pilots, and others who fly commercially. They are good for one year for commercial activities and two or three years for private pilot use. First-class certificates are required for pilots of scheduled commercial passenger airliners. They have the most stringent medical requirements and are good for six months for airliner duties, one year for other commercial activities, and two or three years for private pilot duties. 14 C.F.R. § 61.23(a) and (c); see also Frequently Asked Questions Regarding Medical Certification (last modified Jan. 5, 1999) <<http://www.cami.jccbi.gov/AAM-300/amcdfaq.html>>.

³For example, bipolar disorder is listed under the mental standards, epilepsy is under the neurologic standards, and myocardial infarction is under the cardiovascular standards.

⁴We understand that there is a manual that the FAA provides to Aviation Medical Examiners (AMEs), who are private doctors designated to examine applicants for medical certification and who are trained periodically for that purpose.

(2) May reasonably be expected, for the maximum duration of the airman medical certificate applied for or held, to make the person unable to perform those duties or exercise those privileges.

14 C.F.R. §§ 67.113, 67.213, 67.313.

Applicants for any class certificate who do not meet the general requirements in those sections may apply for discretionary issuance of a certificate under § 67.401. 14 C.F.R. §§ 67.115, 67.215, 67.315. Section 67.401 provides that the Federal Air Surgeon may, in his discretion, grant an "Authorization for Special Issuance of a Medical Certificate" ("Authorization") to applicants who do not meet the general medical standards above, "if the person shows to the satisfaction of the Federal Air Surgeon that the duties authorized by the class of medical certificate applied for can be performed without endangering public safety during the period in which the Authorization would be in force." 14 C.F.R. § 67.401(a).⁵

Treatment of applicants with AIDS or HIV

According to information we received from the FAA's Aeromedical Certification Division, "[a]n individual who has the diagnosis of AIDS is not currently considered qualified to hold an airman medical certificate of any class." See Exhibit E. Thus, under the current guidelines, pilots with AIDS always are denied medical certification and these denials will be upheld throughout the FAA appeals process.

HIV positive applicants can seek a waiver and be certified if they meet specific medical standards. In order to be considered for a waiver and an airman medical certificate, an HIV positive applicant must submit the following: all hospital and medical records; a current report, preferably by a specialist in the treatment of HIV, which includes (a) the presence or absence of any indication of clinical progression of the HIV infection; (b) the presence or absence of any indication of neuropsychiatric impairment, including but not limited to, vision, hearing, motor function, attention, memory, cognition, judgment and affective disorders; (c) a listing of all therapeutic agents being utilized and the presence or absence of any adverse effects of the treatments; (d) recent determinations of viral load by polymerase chain reaction.

⁵The Federal Air Surgeon may also grant a Statement of Demonstrated Ability ("SODA") to anyone whose disqualifying condition is "static or nonprogressive and who has been found capable of performing airman duties without endangering public safety." 14 C.F.R. § 67.401(b). The primary difference between an Authorization and a SODA apparently is that an Authorization expires after a certain period, at which time the applicant must again demonstrate the ability to perform his or her duties without endangering public safety, whereas a SODA does not expire. See 14 C.F.R. § 67.401(a) and (b).

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In addition, the guidelines require that individuals with HIV satisfy the following standards in order to qualify for special issuance of a medical certificate:

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- 1) Normal cogsreen examination initially and subsequently at [12-month intervals].
- 2) Viral load not to exceed 1,000 copies per milliliter of plasma initially and not to exceed 5,000 copies per milliliter on subsequent [sic].
- 3) Normal complete blood count and normal liver function.
- 4) CD4+ lymphocyte count of 200 or greater.

Finally, the guidelines require that the applicant have no "signs, symptoms or diagnosis of AIDS."

Legal standard for assessing the validity of the FAA's treatment of pilots with HIV and AIDS

Section 504 of the Rehabilitation Act prohibits discrimination on the basis of disability by federal agencies.⁶ The Rehabilitation Act not only bars disability-based discrimination in employment, but expressly subjects the programmatic activities of the federal government to the stricture against discrimination.⁷ Discrimination under § 504 occurs when an individual with a disability who is otherwise qualified for participation in a program of a federal agency either is denied the benefits of the program or subject to discrimination under the program by the federal agency which operates the it.⁸

In order for the FAA's HIV-related criteria for medical certification to comply with the federal Rehabilitation Act of 1973, which applies to federal agencies, the criteria must reflect the restrictions necessary to ensure the safety of the airways. We take no issue with the FAA's maintenance of strict standards in this regard. However, available research and current understanding of the progression of HIV disease do not support the blanket exclusion of individuals with AIDS and all HIV positive individuals whose laboratory test results diverge from the viral load, blood count, and liver function levels required by the FAA policy, along with the general requirement that they be asymptomatic. In fact, if the CogScreen test requirement

⁶ Rehabilitation Act of 1973 § 504 (codified as amended by Rehabilitation, Comprehensive Services and Disabilities Amendments of 1978, at 29 U.S.C. § 794). The statute provides that "[n]o otherwise qualified individual with a disability in the United States...shall, solely by reason of her or his disability, be excluded from the participation in, be denied the benefits of, or be subjected to discrimination...under any program or activity conducted by an Executive agency..." *Id.*

⁷ See *Professional Pilots Federation v. Federal Aviation Administration*, 118 F.3d 758, 763 (D.C.Cir. 1996)(citing 29 U.S.C. § 794(a)).

⁸ See, e.g., *Nathanson v. Medical College of Pa.*, 926 F.2d 1368, 1380 (3rd Cir. 1991).

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Someone who is in treatment
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measures cognitive functioning necessary for piloting a plane, it is not clear why this requirement is not part of medical certification for *any* pilot applicant rather than part of a series of additional requirements imposed on individuals with HIV which, in themselves, are no measure of an individual's ability to pilot a plane safely.

Existing medical research and knowledge do not support either the automatic exclusion of every current and potential pilot with a diagnosis of AIDS, or the requirements imposed on HIV positive individuals in addition to the regular FAA medical examination required of all pilots under 14 C.F.R. § 61.23. In fact, current medical knowledge of the progression of HIV disease, and the rarity of dementia or meaningful diminishment of cognition among all but those with advanced cases of AIDS, easily support the conclusion that the FAA's current certification requirements for HIV positive applicants is rooted in stigma rather than in science.

As the undersigned doctors agree, if the FAA has identified a specific set of minimum standards for physical and neurological function which ensure that those granted medical certifications are fit to safely pilot a plane, then there should be uniformly applied tests for all applicants, and consensus as to which additional tests should be performed for *any* applicant who has an abnormality on the main evaluative measures used. Even standing alone, the criteria used to exclude individuals with HIV or AIDS is inherently inconsistent. For example, the blanket exclusion of anyone who has been AIDS-defined has no waiver for people who are doing well (with high CD4 counts, low viral loads, and no current opportunistic infections), even though their "numbers" may be higher than individuals with HIV whose CD4+ cells have dropped to 200 but no lower.

The reliance on a viral load below 1,000 copies and a minimum CD4+ count of 200 as the determinant of HIV positive person's fitness to fly is completely arbitrary. While clearly there is marked immune suppression in someone with fewer than 200 CD4+ cells regardless of the individuals outward symptoms, available data does not support an assumption that such an individual will more often than not, be unable to safely pilot a plane. Similarly, a viral load of more than 1000 copies/ml. is in itself meaningless in assessing an individual's level of cognition and physical function. Finally, the FAA's insistence on laboratory tests demonstrating an entirely normal complete blood count (CBC) and normal liver function test is unfounded. Does the FAA require that all pilots, regardless of HIV status, meet these same criteria on a biannual basis? If not, then the minor perturbations that are likely to be seen on these tests in HIV positive individuals -- typically due to their medications, and with no impact on their ability to function -- is being used to discriminate against individuals with HIV.

What is clear is that, in an attempt to come up with medical exclusion guidelines more reasonable than the earlier ban on anyone with HIV or AIDS, the FAA has instituted arbitrary markers for individuals with HIV which effectively require them to have better health and higher functioning levels than others without such a disability. There currently exist standardized tests

which quite adequately determine cognitive and motor function impairment. In view of the availability of such tests, the broad exclusion of most HIV positive pilots, and the selective application of cognitive screening requirements to these pilots — allowing other applicants with undiagnosed dementia or other functional impairments to go undetected — seems poorly tailored to legitimate public safety concerns.

Conclusion and Recommendation

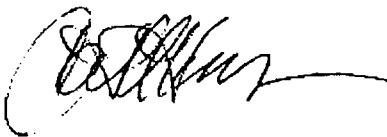
We understand the need to defer to the reasoned decision-making of the FAA in exercising its responsibility for ensuring aviation safety. However, we believe that the critically important area of aviation safety does not require arbitrary limitations on HIV positive individuals' access to medical certificates.

For far too long and far too frequently, individuals, agencies and even government officials have persisted in treating people with HIV as presumptively impaired or simply unsafe to have around. It is time for every agency of the Federal government to aggressively root out the vestiges of this discrimination in its own policies and practices.

We ask that the FAA immediately take the necessary steps to rescind the special procedures and criteria for medical certificates applicants with HIV and AIDS. We acknowledge that continuing HIV stigma, and the desirability of having broad buy-in to a change in the policy, may recommend the creation of a committee of qualified medical and legal advisors to develop certification criteria which incorporate fair, uniform measures of cognitive functioning for all certificate candidates. Lambda and the undersigned physicians hope that you will call on us for assistance and support on any such effort.

We thank you in advance for your careful consideration of this issue, and look forward to hearing from you soon.

Respectfully,



Catherine Hanssens
Director, AIDS Project
Lambda Legal Defense & Education Fund, Inc.

3 months to check

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Los Angeles, California

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Professor of Medicine & Microbiology
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Jon L. Jordan, M.D., Federal Air Surgeon
FAA Office of Aviation Medicine

Tom McSweeney, Associate Administrator for Regulation and Certification
Federal Aviation Administration

Sandra Thurman, Director
Office of National AIDS Policy

Julian Potter
Special Assistant to the President

Daniel Montoya, Executive Director
Presidential Advisory Council on HIV/AIDS

target organs
for AIDS —

brain —

short term memory
deficits
depressive nature of disease
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suicide

possible for AIDS diagnosis to
improve

Tcell 200 or less
opportunistic diseases
CMV

HART Therapy —

Some immune constitution
but not complete
they get below limit ~~time~~ of
detection

Can't make blanket statement
possible for someone to
decompensate w/in one
year

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MAR 13 2000

Ms. Catherine Hanssens
Lambda Legal Defense
and Education Fund, Inc.
120 Wall Street
New York, New York 10005

Dear Ms. Hanssens:

Administrator Garvey has asked that I respond to your letter of February 15 in which you express your concerns for applicants for airman medical certification with acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV) infection.

The Federal Air Surgeon (FAS) informs me that the guidelines developed by the Federal Aviation Administration for the medical certification of airmen with HIV related conditions were based on recommendations from nationally recognized medical specialists. Admittedly, our policy has been conservative, but it has been modified as new information and experience have demonstrated the need for less stringent restrictions.

In order to ensure aviation safety and protect the public, it is important that we follow HIV applicants through the special issuance (waiver) provision of the Federal Aviation Regulations. This provision is not exclusive to HIV applicants and is not considered discriminatory. Applicants may be considered under the special issuance provision if they do not meet the medical standards of 14 C.F.R. part 67. The regulations do not list every known disease, but give the FAS the authority to determine what other disease, defect, or limitation may make a person unable to safely perform the duties or exercise the privileges of his or her airman medical certificate for the duration of the certificate applied for or held. It is incumbent upon the FAS to specify special followup conditions he determines will best detect adverse changes in an applicant's medical

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condition before it impacts aviation safety. For example, an individual with coronary heart disease may be required to submit followup cardiovascular evaluations including interval history with reference to the cardiovascular system, treatment; general physical examination to include blood pressure, weight, funduscopic, and cardiac examinations; report of blood cholesterol and triglycerides; and electrocardiograms taken at rest and with a maximal graded exercise stress test with appropriate blood pressure and pulse responses noted including radionuclide studies if indicated. In addition, the FAS may shorten the duration of a medical certificate when appropriate. The followup requirements for an applicant are generally tailored to the specific individual with the condition and not necessarily to the condition alone. Thus, individuals with HIV are required to submit followup reports pertaining to their medical status as well. We do not require individuals with HIV to have better health or higher levels of function than other applicants. Our responsibility to the public safety requires that HIV applicants or any applicant with any condition have the equivalent health and functioning as individuals without such conditions during the period of their certification.

Cognitive function tests are not exclusive to HIV applicants. The test is applied in any condition where the normal cognition of a pilot is potentially compromised. This includes applicants with significant head injuries, strokes, alcoholism, and attention deficit disorder (ADD), in addition to those with HIV.

It has been our experience that applicants with a history of an AIDS-defining illness are at a greater risk for a debilitating recurrence of symptoms and cognitive deficits and, therefore, have not been considered eligible for airman medical certification.

We take considerable pride in the fact that as experience and advances in medicine increase our ability to stratify the risk of specific conditions, we change or modify our policies accordingly. Federal Aviation Administration guidelines are developed to provide consistent application of certification considerations and ensure that qualified individuals are not unfairly excluded from the pursuit of a

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career or avocation as a pilot. In regard to Mr. Healey, we disagree that his experience demonstrates irrationality, but it demonstrates a consistent and uniform application of our certification policy.

If you have specific recommendations regarding our HIV/AIDS guidelines, we will be pleased to consider them as we continue to re-evaluate our HIV/AIDS policy.

We appreciate your interest and concern for HIV and AIDS applicants and look forward to your contributions.

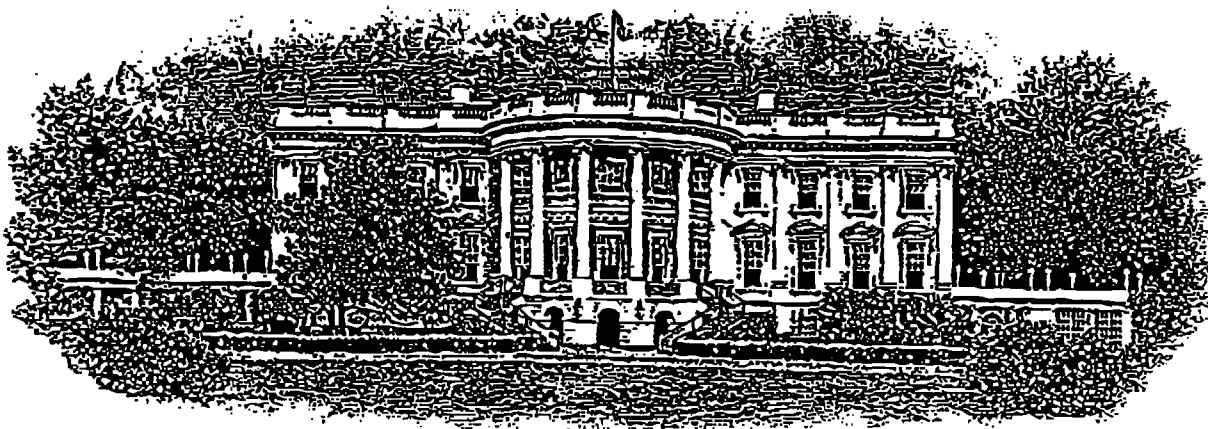
Sincerely,

ORIGINAL SIGNED BY
THOMAS E. MCSWEENEY

Thomas E. McSweeney
Associate Administrator for
Regulation and Certification

cc: AOA-3/AVR-1/AAM-1/200/300/AEA-300/Ldowney
Control No: A20000222038
Y:/aam/aam-200/00cong/Hanssens

The White House



Office of Counsel to the President

Facsimile Transmission Cover Sheet

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April 3, 2000

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Devorah Adler

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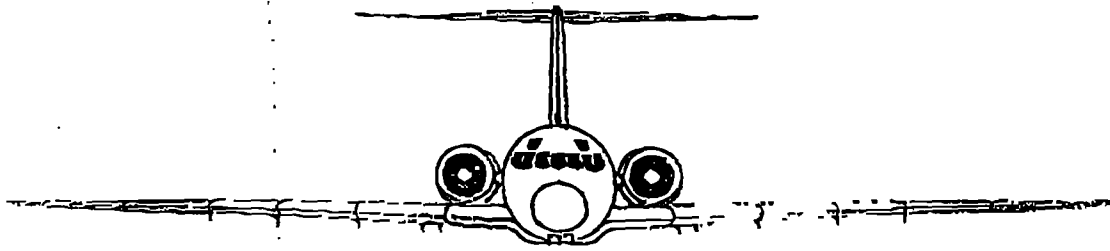
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Comments:

Excerpt from FAA
Medical examiners manual

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FEDERAL AVIATION ADMINISTRATION

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FROM: _____ JANE GARVEY
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_____ MARIE THERESE DOMINGUEZ
_____ ROCHELLE CLAYPOOLE
_____ HEATHER TOWNLEY
_____ LAJUAN EXUM
_____ SUZANNE HOLLOWAY

COMMENTS: _____

Guide for Aviation Medical Examiners

Carbohydrate Metabolism," Appendix B.)

B. The following nonendocrine general systemic findings are disqualifying for Examiner issuance of a medical certificate. Further consideration may be obtained by written appeal. Other general systemic conditions may also disqualify.

1. *Body build:* Any congenital or acquired defect that would adversely affect flying safety or endanger the individual's well-being if permitted to fly.

Although obesity in itself is not disqualifying, related conditions or diseases may be.

2. *Allergies:* Mild seasonal allergies are not disqualifying but Federal regulations require that the applicant not fly during times when symptoms are acute or medications are required.

Desensitization injections are not disqualifying if the applicant is otherwise qualified and is experiencing no residual symptoms or adverse reactions. For example, a pilot with allergic rhinitis who is experiencing only local reactions from desensitization and who requires no antihistamines or decongestant medication could be issued a medical certificate of any class if otherwise qualified and any residual symptoms of the allergy (i.e., nasal stuffiness) are transitory and mild. The Examiner should record in item 60 the period and duration of any allergic symptoms.

3. *Malignancies,* except for minor skin lesions, are disqualifying until they are adequately treated and have been evaluated by the FAA. Surgery for cancer is not disqualifying, per se, unless a radical procedure results in a significant loss of functions or processes necessary to aviation safety.

When sufficient time has elapsed for recovery from the adverse effects of the eradication procedure, the applicant may receive FAA consideration upon written request. A report from the treating physician should be submitted along with all medical and surgical records. If the applicant is found qualified, the FAA will issue a medical certificate. Followup reports may be required at specified intervals depending upon the site of the malignancy, post-operative progress, prognosis, metastases, lapse of time since surgery or related symptoms, use of medication, and other pertinent historical data.

4. *Acquired Immunodeficiency Syndrome (AIDS)* ←
Applicants for whom the diagnosis of AIDS has been established are not eligible to receive an airman medical certificate. This includes applicants who have developed AIDS-defining conditions such as pneumocystis carinii pneumonia or Kaposi's sarcoma.

Known virologic or serologic evidence of infection with Human Immunodeficiency Virus (HIV) is not, per se, a basis for refusal of certification. The presence or history of disease or the use of medications to treat AIDS or its manifestations,

Guide for Aviation Medical Examiners

however, is a basis for
disqualification. The Examiner should
obtain all pertinent medical
records and forward them with
FAA Form 8500-8 to the Aeromedical
Certification Division, AAM-300.

1ST CASE of Level 1 printed in FULL format.

OPINION OF THE OFFICE OF LEGAL COUNSEL

REVIEW OF 1988 OPINION CONCERNING THE APPLICABILITY OF
SECTION 504 OF THE REHABILITATION ACT TO
INDIVIDUALS INFECTED WITH HIV

The 1988 Office of Legal Counsel opinion accurately describes the duties imposed by section 504 of the Rehabilitation Act with respect to individuals infected with the Human Immunodeficiency Virus.

The subsequent passage of the Americans with Disabilities Act did not alter the analysis of cases arising under the Rehabilitation Act, although an amendment to section 504 now requires reference to standards set forth in the ADA. Application of the standards set forth under section 504 in any particular case requires consideration of current scientific understanding of HIV infection. Advances in the scientific understanding of HIV infection since 1988 may undermine some of the discussion in the 1988 opinion about the application of these standards to individual cases.

1994 OLC LEXIS 26; 18 Op. O.L.C. 141

July 8, 1994

CORE TERMS: Rehabilitation Act, infection, infected, reasonable accommodation, disability, memorandum, Disabilities Act, legislative history, regulation, health care, transmission, dementia, disease, scientific, patient, significant risk, potential harm, reassignment, virus, codify, reasonable medical, implementing, firefighter, construing, workplace, duties, accommodation, accurately, addressing, symptoms

ADDRESSEE:

[*1]

MEMORANDUM FOR STEPHEN R. COLGATE ASSISTANT ATTORNEY GENERAL FOR
ADMINISTRATION

OPINIONBY: JOHNSEN

OPINION:

You have asked us whether an Office of Legal Counsel Memorandum of September 27, 1988, reprinted at 12 Op. O.L.C. 264 (1988) and entitled "Application of Section 504 of the Rehabilitation Act to HIV-Infected Individuals," accurately reflects the state of the law on this issue. That memorandum concluded that Section 504 of the Rehabilitation Act, 29 U.S.C. [] 794, bars discrimination against individuals infected with the Human Immunodeficiency Virus ("HIV"), whether or not the infection has resulted in illness. Cf. School Bd. of Nassau County v. Arline, 480 U.S. 273 (1987) (holding that Section 504 bars discrimination on the basis of infection with tuberculosis, but reserving the question whether the Act applies to asymptomatic carriers of infectious diseases).

We have reviewed the 1988 O.L.C. Memorandum, and have concluded that it accurately describes the duties imposed by Section 504 of

the Rehabilitation Act with respect to individuals infected with HIV. We do, however, have a few comments to update the analysis of that Memorandum.

A. Impact of the Americans with [*2] Disabilities Act of 1990

First of all, we note that section 504 of the Rehabilitation Act has been amended to indicate that

the standards used to determine whether this section has been violated in a complaint alleging employment discrimination under this section shall be the standards applied under title I of the Americans with Disabilities Act of 1990 (42 U.S.C. 12111 et seq.) and the provisions of sections 501 through 504, and 510, of the Americans with Disabilities Act (42 U.S.C. 12201-12204 and 12210), as such sections relate to employment.

29 U.S.C. [] 794(d). n1 Because the anti-discrimination in employment provisions of the Americans with Disabilities Act ("ADA") were in large part modeled on those established in the Rehabilitation Act, and because the legislative history of the ADA reaches the same conclusions as to the reach of the Rehabilitation Act as did our 1988 Memorandum and indicates an intent to codify those conclusions as the standards for evaluating cases brought under the ADA, this amendment to Section 504 of the Rehabilitation Act for the most part reinforces rather than supplants [*3] our earlier analysis. n2 Furthermore, the ADA specifically states that, "except as otherwise provided in this chapter, nothing in this chapter shall be construed to apply a lesser standard than the standards applied under title V of the Rehabilitation Act of 1973 or the regulations issued by Federal agencies pursuant to such title." 42 U.S.C. [] 12201 (citation omitted). n3 As a general matter, therefore, the passage of the ADA requires reference to the standards set forth in that statute in litigation involving the Rehabilitation Act, but it does not alter the analysis of cases arising under the Rehabilitation Act, and indeed indicates that the interpretation of the Rehabilitation Act set forth in the 1988 Memorandum was correct.>FTNT>

n1 In addition, the term "disability" has been substituted for the term "handicap" in Section 504(a) of the Rehabilitation Act, 29 U.S.C. [] 794(a).

n2 See, e.g., H.R. Rep. No. 485, 101st Cong., 2d Sess., pt. 2, at 52-57, 67-70, 76, 149 (1990); id. pt. 3, at 29, 33-35, 40, 42, 45-46; S. Rep. No. 116, 101st Cong., 1st Sess. 22, 25-26, 31, 36, 40 (1989) (all stating that the basic anti-discrimination provisions in Title I of the ADA are modeled on those set forth in Section 504, and in some instances explicitly endorsing the interpretations of Section 504 set forth in Arline, 480 U.S. 273 (1987), and in the 1988 O.L.C. Memorandum); see also H.R. Conf. Rep. No. 596, 101st Cong., 2d Sess. (1990); Equal Employment Opportunity for Individuals With Disabilities, 56 Fed. Reg. 35726 (1991) (Supplementary Information to regulations codified at 29 C.F.R. pt. 1630) ("The format of part 1630 reflects congressional intent, as expressed in the legislative history, that the regulations implementing the employment provisions of the ADA be modeled on the regulations implementing Section 504 of the Rehabilitation Act of 1973."). [*4]

n3 The legislative history notes, for example, that the provisions of the ADA setting forth requirements for the provision of access to public accommodations by providers who do not receive federal funding are less stringent than the corresponding provisions of the Rehabilitation Act addressing the provision of access to publicly funded accommodations. E.g., H.R. Rep. No. 485, pt. 3, at

69-70. No such explicit differences exist with respect to the employment provisions of the two Acts.>ENDFN>

Specifically, the text and legislative history of the ADA confirm that:

1. HIV infection, whether or not an individual has developed any overt symptoms as a result of that infection, is a disability under the Rehabilitation Act and under the Americans with Disabilities Act. See S. Rep. No. 116 at 22-24 (listing "infection with the Human Immunodeficiency Virus" as a disability; citing the 1988 O.L.C. Memorandum for the proposition that those infected with HIV have "[a] physical or mental impairment that substantially limits one or more of the major life activities of such individual" within the meaning of both Acts; and describing disability definition generally); H.R. Rep. No. 485, [*5] pt. 2, at 51-54 (same); id. pt. 3, at 28-30 (same); see also 29 C.F.R. pt. 1630 app. at 403-05 (Interpretive Guidance to [] 1630.2(j)) (stating that HIV infection is inherently "substantially limiting" within the meaning of both Acts). Indeed, the need to protect those infected with HIV from discrimination in employment was frequently cited by those supporting the bill. See, e.g., S. Rep. No. 116 at 8, 19 (citing views of the President's Commission on the Human Immunodeficiency Virus Epidemic); 136 Cong. Rec. H2442 (daily ed. May 17, 1990) (remarks of Rep. Weiss); id. at H2479 (daily ed. May 17, 1990) (remarks of Reps. McCloskey and Waxman); id. at H4625 (daily ed. July 12, 1990) (remarks of Rep. Waxman). n4 Furthermore, both the ADA and the Rehabilitation Act include within the definition of an individual with a disability an individual who, even though he or she has no actual physical or mental impairment or history of such impairment, is regarded as having an impairment. 42 U.S.C. [] 12102(2)(C) (ADA); 29 U.S.C. [] 706(8)(B). This definition often will provide an additional basis for concluding that those infected with HIV are protected by Section 504.>FTNT>

n4 In addition, recent cases construing the Rehabilitation Act have held that HIV infection is a disability within the meaning of the Act. E.g., *Buckingham v. United States*, 998 F.2d 735 (9th Cir. 1993); *Chalk v. United States Dist. Court*, 840 F.2d 701 (9th Cir. 1988); *Roe v. District of Columbia*, 842 F. Supp. 563 (D.D.C. 1994), vacated as moot, 1994 WL 148102 (D.C. Cir. Apr. 13, 1994); *Doe v. District of Columbia*, 796 F. Supp. 559 (D.D.C. 1992); *Ray v. School Dist.*, 666 F. Supp. 1524 (M.D. Fla. 1987); *Thomas v. Atascadero Unified School Dist.*, 662 F. Supp. 376 (C.D. Cal. 1987).>ENDFN> [*6]

2. The definitions of "discrimination" and of "qualified individual" under the ADA are drawn from the definitions of these terms set forth in the Section 504 regulations. See 42 U.S.C. [][] 12111(8) (definition of "qualified individual with a disability") and 12112 (definition of "discrimination"); H.R. Rep. No. 485, pt. 3, at 32-33 ("qualified individual"); id. at 35 ("discrimination").

3. The legislative history indicates that the use of the term "direct threat" in the ADA is designed to "codify" the ruling of the *Arline* case discussed in the 1988 Memorandum. n5 The ADA indicates that an employer may raise as a defense to a claim of discrimination under the Act the argument that the employee was not otherwise qualified for the job because he or she posed a "direct threat to the health or safety of other individuals in the workplace." 42 U.S.C. [] 12113(b). The statute defines "direct threat" as a "significant risk to the health or safety of others that cannot be eliminated by reasonable accommodation," 42 U.S.C. [] 12111(3), apparently drawing on the "significant

risk" language used by the Arline Court. 480 U.S. at 287 n.16. As noted above, [*7] the legislative history indicates that this language is intended to "codify" the standard set forth in Arline. H.R. Rep. No. 485, pt. 3, at 34, 45-46; see also id., pt. 2, at 56-57, 150; H.R. Conf. Rep. No. 596 at 60; S. Rep. No. 116 at 27-28, 40. In addition, the Equal Employment Opportunity Commission has issued regulations implementing the Act that use the test set forth in Arline for evaluating the risk posed by an employee with disabilities. 29 C.F.R. [] 1630.2(r) (defining "direct threat" and requiring that employer consider "(1) the duration of the risk; (2) the nature and severity of the potential harm; (3) the likelihood that the potential harm will occur; and (4) the imminence of the potential harm"); n6 29 C.F.R. pt. 1630 app. at 410-11 (Interpretive Guidance to 29 C.F.R. [] 1630.2(r)) (employer must consider "objective, factual evidence," rather than "subjective perceptions, irrational fears, patronizing attitudes, or stereotypes," and must determine that there is a "high probability of substantial harm," rather than merely a "speculative or remote risk"). While the point is not free from doubt, the Interpretive Guidance also indicates that an employer may [*8] consider whether the individual would pose a direct threat to his or her own safety. Id.>FTNT>

n5 In addressing the issue of the effect of the risk posed by an infectious disease on an individual's qualifications for a job, Arline indicated that "[a] person who poses a significant risk of communicating an infectious disease to others in the workplace will not be otherwise qualified for his or her job if reasonable accommodation will not eliminate that risk." 480 U.S. at 287 n.16 (emphasis added). The Court stated that in making a judgment as to whether a person is qualified for a job, the employer should take into account

[findings of] facts, based on reasonable medical judgments given the state of medical knowledge, about (a) the nature of the risk (how the disease is transmitted), (b) the duration of the risk (how long is the carrier infectious); (c) the severity of the risk (what is the potential harm to third parties) and (d) the probabilities the disease will be transmitted and will cause varying degrees of harm.

Id. at 288 (quoting Brief for American Medical Association as Amicus Curiae 19; brackets in original). Furthermore, the Court argued that "in making these findings, courts normally should defer to the reasonable medical judgments of public health officials." Id. [*9]

n6 The regulation further provides that the determination whether an individual poses a direct threat

shall be based on an individualized assessment of the individual's present ability to safely perform the essential functions of the job. The assessment shall be based on a reasonable medical judgment that relies on the most current medical knowledge and/or on the best available objective evidence.

29 C.F.R. [] 1630.2(r).>ENDFN>

4. The text and legislative history of the ADA indicate that the definition of reasonable accommodation is to include the possibility of reassignment, a question that was unsettled under the Rehabilitation Act before the recent amendment. 42 U.S.C. [] 12111(9) (ADA definition of "reasonable accommodation"); S. Rep. No. 116 at 31-32 (indicating that "reasonable accommodation" under the

ADA includes the possibility of reassignment); see also Barbara A. Lee, Reasonable Accommodation Under the Americans with Disabilities Act: The Limitations of Rehabilitation Act Precedent, 14 Berkeley J. Empl. & Lab. L. 201, 206, 235-43 (1993) (arguing that for this reason, case law interpreting the Rehabilitation Act that indicates that employers need not [*10] consider reassignment to meet their duties to provide reasonable accommodation should not be relied upon as precedent in suits brought under the ADA). Because neither statute purports to list all conceivable reasonable accommodations, see 42 U.S.C. [] 12111(9) (ADA); 29 U.S.C. [] 794 (Rehabilitation Act), and because the Rehabilitation Act indicates that the standards of the ADA are to be used to determine whether the Rehabilitation Act has been violated, 29 U.S.C. [] 794(d), reassignment must be considered a possible reasonable accommodation under the Rehabilitation Act as well. See also *Buckingham v. United States*, 998 F.2d 735 (9th Cir. 1993) (Postal Service must consider, as a possible accommodation, relocating HIV-infected employee to area of country with better health care services for those infected with the virus).

5. The legislative history to the ADA clearly states that the term "undue hardship" for purposes of the ADA, and by implication Section 504, see 29 U.S.C. [] 794(d), is not to be construed as referring to the standard set forth in *Trans World Airlines, Inc. v. Hardison*, 432 U.S. 63 (1977) (construing [*11] Title VII as requiring an employer to accommodate religious beliefs only if it could be done with no more than a "de minimis" cost to the employer). n7 Rather, the ADA defines "undue hardship" as "an action requiring significant difficulty or expense." 42 U.S.C. [] 12111(10)(A). Among the factors to be considered in determining whether the difficulty or expense involved would be "significant" is the "overall financial resources" of the entity that must take the action. 42 U.S.C. [] [] 12111(10)(B)(ii) and (iii).>FTNT>

n7 See S. Rep. No. 116 at 36 (discussing *Hardison*); 29 U.S.C. [] 794(d) (stating that standards of ADA apply in Rehabilitation Act cases); H.R. Rep. No. 485, pt. 2, at 87 (provision is derived from Rehabilitation Act and should be applied consistently with provisions construing that Act); Lee, *supra*, at 206-07; Robert L. Burgdorf Jr., *The Americans with Disabilities Act: Analysis and Implications of a Second-Generation Civil Rights Statute*, 26 Harv. C.R.-C.L. L. Rev. 413, 462-63 (1991).>ENDFN>

B. Changes in Scientific Understanding

Finally, we would note that advances in the scientific understanding of HIV infection since [*12] 1988 may undermine some of the discussion in our earlier opinion about the application of these standards to individual cases. See, e.g., 1988 O.L.C. Memorandum at 15, 28, 12 Op. O.L.C. at 278, 291 (citing examples of situations in which it was thought that an individual infected with HIV might pose a direct threat to the health or safety of others).

Thus, for example, recent studies suggest that the risk of transmission from a health care worker to a patient is actually quite low. See, e.g., Centers for Disease Control and Prevention, Update: Investigations of Persons Treated by HIV-Infected Health Care Workers -- United States, 41 Morb. & Mort. Wkly Rep. 329 (May 7, 1993); National Comm'n on AIDS, Preventing HIV Transmission in Health Care Settings 7, 11-12, 15-18 (1992). n8 The Centers for Disease Control have suggested guidelines for control of transmission of the virus that reflect this information. Centers for Disease Control and Prevention, Recommendations for Preventing Transmission of Human Immunodeficiency Virus

and Hepatitis B Virus to Patients During Exposure-Prone Invasive Procedures, 40 Morb. & Mort. Wkly Rep. 1 (July 12, 1991) (No. RR-8); see also [*13] National Comm'n on AIDS, supra (discussing CDC Guidelines and other publications addressing techniques for preventing transmission of HIV in health care settings). n9>FTNT>

n8 Indeed, the Centers for Disease Control have indicated that the only documented cases of transmission from a health care worker to a patient are those involving a Florida dentist who infected six of his patients through unknown means. 41 Morb. & Mort. Wkly Rep. at 331; see also National Comm'n on AIDS, supra, at 7. As of 1993, the Centers for Disease Control had reviewed the cases of 19,036 patients treated by 57 HIV-infected health care workers. 41 Morb. & Mort. Wkly Rep. at 329.

n9 While courts typically have upheld restrictions on health care workers, see, e.g., *Bradley v. University of Tex. M.D. Anderson Cancer Ctr.*, 3 F.3d 922 (5th Cir. 1993), cert. denied, 114 S. Ct. 1071 (1994); *Leckelt v. Board of Comm'rs of Hosp. Dist. No. 1*, 909 F.2d 820 (5th Cir. 1990); *Doe v. Washington Univ.*, 780 F. Supp. 628 (E.D. Mo. 1991), the reasoning of these cases often appears to be based on outdated medical information or weak scientific analysis that greatly overstates the risks posed by such workers and thus may not apply the statute appropriately. Cf. *In re Westchester County Med. Ctr., Department of Health & Human Services, Departmental Appeals Board, Docket No. 91-504-2, Decision No. 191* (Apr. 20, 1992) (restrictions on duties of HIV-positive pharmacist violated Rehabilitation Act; federal funding to hospital terminated).

We would emphasize that the standards set forth in 29 C.F.R. [] 1630.2(r) for determining whether an individual poses a direct threat must be applied to health care workers as well as to workers in other fields. Accordingly, current medical information and consideration of the risks posed by the essential functions of the job must form the basis for a decision. In light of the current views of the Centers for Disease Control that the risks posed by HIV-infected health care workers are, in most health care settings, remote or nonexistent, we think that proper application of 29 C.F.R. [] 1630.2(r) frequently will result in a finding that the worker does not pose a direct threat.

For more general discussion of the risks posed by HIV infection in other settings, see *Chalk v. United States Dist. Court*, 840 F.2d 701 (9th Cir. 1988) (granting preliminary injunction reinstating HIV-infected junior high school teacher to classroom duties, reasoning that Chalk had "strong probability of success on the merits," of his Rehabilitation Act claim because there was no evidence to support a risk of transmission, 840 F.2d at 710); *Glover v. Eastern Neb. Community Off. of Retardation*, 686 F. Supp. 243 (D. Neb. 1988) (mandatory hepatitis B Virus ("HBV") and HIV testing of employees of agency assisting mentally retarded clients not justified; there was insufficient evidence that infection would pose a danger to others), aff'd, 867 F.2d 461 (8th Cir.), cert. denied, 493 U.S. 932 (1989).

For discussion of the risk in public safety professions, see *Roe v. District of Columbia*, 842 F. Supp. 563 (D.D.C. 1994) (limitations on activities of firefighter infected with HBV unjustified, as firefighter would not pose direct threat when performing mouth-to-mouth resuscitation; in reaching this conclusion, the court noted that hospitals generally do not bar HBV-infected employees from performing CPR), vacated as moot, 1994 WL 148102 (D.C. Cir.

Apr. 13, 1994); Doe v. District of Columbia, 796 F. Supp. 559 (D.D.C. 1992) (refusal to hire HIV-infected applicant violates Rehabilitation Act, as individual does not pose direct threat); cf. Anonymous Fireman v. City of Willoughby, 779 F. Supp. 402 (N.D. Ohio 1991) (firefighter and paramedics may be tested for HIV in light of risk).>ENDFN> [*14]

We do not attempt to review the scientific data here, but we would emphasize that a determination under the ADA, and thus by implication under Section 504, that an individual poses a "direct threat to the health or safety of other individuals in the workplace," 42 U.S.C. [] 12113(b), which is to say "a significant risk to the health or safety of others that cannot be eliminated by reasonable accommodation," 42 U.S.C. [] 12111(3) (emphasis added), must be made on an individualized basis, using the four-prong test set forth in Arline, 480 U.S. at 287-88, and adopted by the statute and regulations. See 42 U.S.C. [] 12111(3); 29 C.F.R. [] 1630.2(r) (restating definition of "direct threat" set forth in Arline); H.R. Conf. Rep. No. 596 at 60 (Section 12111(3) is intended to codify the test set forth in Arline); S. Rep. No. 116 at 27-28 (same). Furthermore, a determination that an individual poses a direct threat must be based on information about the essential functions of the particular job at stake and on current scientific information about the nature of the risks involved; speculative concerns, including unfounded and exaggerated fears [*15] of transmission risks, may not be relied upon to defend a conclusion that an individual poses a direct threat. See, e.g., 29 C.F.R. pt. 1630 app. at 410-11 (Interpretive Guidance to 29 C.F.R. [] 1630.2(r)).

Similarly, while the 1988 O.L.C. Memorandum suggested, at 15, that persons infected with HIV are subject to "dementia attack" and therefore may be unqualified for jobs in which a sudden loss of mental faculties could pose a safety risk, this discussion may be subject to misinterpretation. The discussion of hypothetical HIV-related problems in the 1988 Memorandum was not intended to be relied upon for litigation purposes, and the reference to dementia attacks was intended to refer only to the risk that an individual suffering from HIV-related dementia might occasionally be particularly severely affected. It is certainly true that an individual with symptoms of dementia, whether related to HIV or not, may not be "otherwise qualified" for certain jobs. However, neither the 1988 O.L.C. Memorandum nor any other source of which we are aware indicates that HIV-induced dementia occurs suddenly and thus would pose certain of the risks described in that memorandum. Furthermore, unpublished [*16] data compiled by the Centers for Disease Control and Prevention on June 30, 1993 indicated that less than 6% of adults known to the CDC to have AIDS were also known to have HIV-related encephalopathy, the most common cause of HIV-related neurological symptoms. See Centers for Disease Control and Prevention, Adult Female AIDS Cases by Disease: CDC AIDS Data as of June 30, 1993 (indicating that 5.1077% were affected); and Centers for Disease Control and Prevention, Adult Male AIDS Cases by Disease: CDC AIDS Data as of June 30, 1993 (indicating that 5.5688% were affected). Other sources indicate that neurological problems are most common in individuals with advanced HIV disease. E.g., Richard W. Price, et. al., The Brain in AIDS: Central Nervous System HIV-1 Infection and AIDS Dementia Complex, 239 Science 586 (Feb. 5, 1988). Accordingly, we would caution readers that an argument that an individual is not otherwise qualified for a job because of the risk of dementia, like arguments based on the risk of transmission, must be grounded in scientific evidence that such a risk exists with respect to that individual, and is relevant to the determination whether the individual [*17] is otherwise qualified for the job.

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