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### **Quantifying a Direct Threat: Risks That Health Care Providers Must Take While Treating Infectious Patients - Bragdon v. Abbott**

Deborah L. Slowata

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# Casenote

## **Quantifying a Direct Threat: Risks That Health Care Providers Must Take While Treating Infectious Patients — *Bragdon v. Abbott***

### I. Introduction

In 1998, the Supreme Court's decision in *Bragdon v. Abbott*<sup>1</sup> established that a person with an HIV infection is protected as a disabled person under the Americans with Disabilities Act ("ADA"),<sup>2</sup> even when the disease is in its asymptomatic stage. The Court, however, was not able to determine, based on the evidence adduced at trial, whether there was any triable issue of fact regarding the significance of the risk for medical caregivers treating the HIV infected patient. Specifically, the Court failed to determine the significance of the risk for a dentist treating an HIV infected patient in his or her office, and whether that risk would allow the dentist to escape liability under the ADA.

In *Bragdon*, the Supreme Court considered two issues raised by the defendant, Randon Bragdon, on appeal from a summary judgment in favor of the plaintiff, Sidney Abbott, for a violation of the ADA. The Court first determined that Ms. Abbott, who had been diagnosed with HIV but was asymptomatic, met the statutory definition of disabled, and, therefore, was protected from discrimination under the ADA.<sup>3</sup> The second issue was whether Dr. Bragdon's refusal to treat Ms. Abbott was exempted from the ADA because the act of providing treatment

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1. *Bragdon v. Abbott*, 524 U.S. 624 (1998).

2. See Americans with Disabilities Act of 1990, 42 U.S.C. § 12101 (1990).

3. See *Bragdon v. Abbott*, 524 U.S. at 630-31.

under normal office conditions was a "direct threat" to Dr. Bragdon's health.<sup>4</sup>

The unresolved issue, which had formed the basis for the remand in *Bragdon*, was the determination of the precise risks of providing health care to people who are infected with HIV, and whether these risks are substantial enough to create a triable issue of fact. To date, public health officials have concentrated on developing guidelines for risk reduction. However, while officials claim the risks are low, they have not provided health care workers with an objective assessment from which a worker could make a reasonable judgment as to whether a direct threat exists.<sup>5</sup> This note will discuss the evolution and policy behind the ADA and the meaning of the *Bragdon* decision in light of the current state of scientific knowledge.

## II. Background

### A. *The Rehabilitation Act of 1973*

The ADA and the earlier Rehabilitation Act of 1973<sup>6</sup> attempt, in many respects, to fulfill a similar public policy. The Rehabilitation Act, and its more recent amendments, were the manifestation of Congress' belief that disabled people were a growing part of the population, comprised one of the most disadvantaged groups in society, and had rights that needed protection.<sup>7</sup> These rights included the ability to "(A) live independently, (B) enjoy self-determination, (C) make choices, (D) contribute to society, (E) pursue meaningful careers, and enjoy full inclusion and integration in the economic, political, cultural and educational mainstream of American society."<sup>8</sup> The purpose of the statute was to implement this policy by empowering disabled people to maximize these rights.<sup>9</sup> The Rehabilitation Act attempted to provide this empowerment by state-of-

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4. *Id.* at 648.

5. See *Recommendations for Prevention of HIV Transmission in Health-Care Settings* (visited Nov. 6, 1998) <<http://www.cdc.gov/epo/mmwr/preview/mmwrhtml/00023587.htm>>.

6. See Rehabilitation Act of 1973, P.L. No. 93-112, § 1, 87 Stat. 355 (1973).

7. See Rehabilitation Act of 1973, 29 U.S.C. § 701(a) (1998).

8. *Id.*

9. See Rehabilitation Act of 1973, 29 U.S.C. § 701(b) (1998).

the-art vocational rehabilitation programs, independent living facilities, research, and training.<sup>10</sup>

Congress wanted the federal government to take a leadership role<sup>11</sup> by providing incentives under the Rehabilitation Act to:

- (1) Develop and implement comprehensive and continuing State plans for meeting the current and future needs for providing vocational rehabilitation services to handicapped individuals and to provide such services for the benefit of such individuals, serving first those with the most severe handicaps, so that they may prepare for and engage in gainful employment;
- (2) Evaluate the rehabilitation potential of handicapped individuals;
- (3) Conduct a study to develop methods of providing rehabilitation services to meet the current and future needs of handicapped individuals for whom a vocational goal is not possible or feasible so that they may improve their ability to live with greater independence and self-sufficiency;
- (4) Assist in the construction and improvement of rehabilitation facilities;
- (5) Develop new and innovative methods of applying the most advanced medical technology, scientific achievement, and psychological and social knowledge to solve rehabilitation problems and develop new and innovative methods of providing rehabilitation services to handicapped individuals through research, special projects, and demonstrations;
- (6) Initiate and expand services to groups of handicapped individuals (including those who are homebound or institutionalized) who have been underserved in the past;
- (7) Conduct various studies and experiments to focus on long neglected problem areas;
- (8) Promote and expand employment opportunities in the public and private sectors for handicapped individuals and to place such individuals in employment;
- (9) Establish client assistance pilot projects;
- (10) Provide assistance for the purpose of increasing the number of rehabilitation personnel and increasing their skills through training; and
- (11) Evaluate existing approaches to architectural and transportation barriers confronting handicapped individuals, develop new

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10. *See id.*

11. *See id.*

such approaches, enforce statutory and regulatory standards and requirements regarding barrier-free construction of public facilities and study and develop solutions to existing architectural and transportation barriers impeding handicapped individuals.<sup>12</sup>

Thus, the Rehabilitation Act sought to establish broad goals which the federal government could seek to achieve through various programs, in cooperation with the states and the private sector.<sup>13</sup> The Rehabilitation Act has much to do with the development of opportunities for the handicapped, but there is little in the Rehabilitation Act itself that protects the rights of handicapped people.<sup>14</sup> At the end of the Rehabilitation Act, however, there is a provision that addresses discrimination against handicapped employees by employers who are recipients of Federal Grants. Section 504 provides:

[n]o otherwise qualified handicapped individual in the United States, [as defined in the statute], shall, solely by reason of his handicap, be excluded from the participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance.<sup>15</sup>

It is this section, and its interpretation by the courts, that laid the foundation for the standards that are applied to *Bragdon* and the cases that precede it.

The Rehabilitation Act in general, and Section 504 in particular, are important to the decision in *Bragdon* for two reasons. First, the ADA provides that, unless otherwise specified, it shall not be construed to "apply a lesser standard of protection than the standards applied under title V of the Rehabilitation Act of 1973 . . . or the regulations issued by Federal agencies pursuant to such title."<sup>16</sup> Second, in *School Board of Nassau County, Florida v. Arline*<sup>17</sup> (a case decided under the Rehabilitation Act), the Supreme Court defined the standard that it would later use in *Bragdon*, for assessing whether an otherwise discriminatory action would be exempted from the

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12. Rehabilitation Act of 1973, Pub. L. No. 93-112, § 2, 87 Stat 355 (1973).

13. *See id.*

14. *See id.* For example, the Rehabilitation Act as originally enacted did not provide for the protection of handicapped people against discrimination except regarding participation in federally funded programs and activities.

15. Rehabilitation Act of 1973, Pub. L. No. 93-112 § 504, 87 Stat. 355 (1973).

16. Americans with Disabilities Act of 1990, 42 U.S.C. § 12201 (1998).

17. *School Board of Nassau County, Florida v. Arline*, 480 U.S. 273 (1987).

ADA because of the significant risk of infection from a communicable disease.<sup>18</sup>

In *Arline*, the respondent was a teacher who had taught in an elementary school in petitioner's school district between 1966 and 1979.<sup>19</sup> Ms. Arline had been hospitalized for tuberculosis in 1957, but her disease remained in remission for the next twenty years.<sup>20</sup> In 1977, Arline was found to have active tuberculosis in her bloodstream. Subsequent cultures, in March 1978, and November 1978, also tested positive.<sup>21</sup> At the end of the 1978-1979 school year, Arline was discharged from her job. The record on appeal showed that the petitioner had not dismissed Arline because of any wrongdoing, but rather because of the recurrence of tuberculosis.<sup>22</sup>

The respondent brought suit against the petitioner for discriminatory termination of her employment due to her disability, in violation of the Rehabilitation Act.<sup>23</sup> After trial, the district court held in favor of the defendant school board on all counts.<sup>24</sup> The court reasoned that a contagious disease, such as tuberculosis, did not meet the definition of "handicap" under the Rehabilitation Act, and that because of an overriding policy to protect the public from contagious diseases, the school board was not required to accommodate her in another position.<sup>25</sup>

On the plaintiff's appeal, the circuit court was not persuaded by the trial court's determination that tuberculosis was not a disability because the Rehabilitation Act was not intended to cover communicable diseases.<sup>26</sup> They chose instead to look at the plain statutory construction of Section 504 of the Rehabilitation Act, and the regulations promulgated by the Department of Health and Human Services implementing Section 504.<sup>27</sup> The circuit court reversed the lower court's decision, concluding that

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18. *See id.* at 274.

19. *See id.* at 276.

20. *Id.*

21. *Id.*

22. *Arline*, 480 U.S. at 275.

23. *Id.*

24. *See Arline v. School Board of Nassau County*, 772 F.2d 759, 761 (11th Cir. 1985).

25. *Id.*

26. *Id.* at 764.

27. *Id.*

tuberculosis was a disability under the Rehabilitation Act, and remanded the case to the district court to more carefully assess the risks of allowing an elementary school teacher with tuberculosis to remain in her position.<sup>28</sup> From this decision, the school board appealed.<sup>29</sup>

The Supreme Court addressed two questions: (1) should a person with tuberculosis be considered a "handicapped person" under the Rehabilitation Act, and, if so, (2) is a person with tuberculosis "otherwise qualified" to teach elementary school as defined in the Rehabilitation Act?<sup>30</sup> The Court established that the test to be used to determine if a person is disabled under the Rehabilitation Act must be taken from the statutes and regulations considered together. A person is defined as handicapped if he or she: "(i) has a physical or mental impairment which substantially limits one or more of such person's major life activities, (ii) has a record of such impairment, or (iii) is regarded as having such an impairment."<sup>31</sup>

The Court further looked to the regulations from the Department of Health and Human Services to provide definitions for two key terms.<sup>32</sup> "Physical impairment [is defined] as '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.'<sup>33</sup> The regulations also define "major life activities" which are "functions such as caring for one's self, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning, and working."<sup>34</sup>

Using this statutory framework, the Court determined that Arline was physically impaired (physiological disorder of the respiratory system), and that this impairment was serious enough to substantially limit one or more major life activities.<sup>35</sup>

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28. *Id.*

29. *See* Arline, 480 U.S. at 277.

30. *Id.* at 275.

31. *Id.* at 279 (quoting 29 U.S.C. § 706(7)(B)).

32. *Id.* at 279.

33. *Id.* at 280 (quoting 45 CFR § 84.3(j)(2)(i)).

34. Arline, 480 U.S. at 280 (quoting 45 CFR § 84.3(j)(2)(ii)).

35. *Id.* at 281.

This determination, taken in conjunction with her hospitalization for tuberculosis (record of impairment), established that Arline was “handicapped” under the Rehabilitation Act definition.<sup>36</sup>

The Court then turned to the question of whether Arline was “otherwise qualified” to remain employed as an elementary school teacher.<sup>37</sup> The Court recognized that this question could only be answered by “conduct[ing] an individualized inquiry and mak[ing] appropriate findings of fact.”<sup>38</sup> Where a person’s qualification for employment rests on a question of risks from contagious disease, the Court was concerned that this inquiry balance the “goal of protecting handicapped individuals from deprivations based on prejudice, stereotypes, or unfounded fear, while giving appropriate weight to such legitimate concerns . . . as avoiding exposing others to significant health and safety risks.”<sup>39</sup>

The Court adopted the recommendation of the American Medical Association,<sup>40</sup> and determined that the inquiry should include:

[F]indings 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 that the disease will be transmitted and will cause varying degrees of harm.<sup>41</sup>

“In making these findings, courts normally should defer to the reasonable medical judgments of public health officials.”<sup>42</sup>

### B. *The Americans with Disabilities Act of 1990*

The ADA greatly expands the level of antidiscrimination protection given in Section 504 of the Rehabilitation Act.<sup>43</sup>

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36. *Id.*

37. *Id.* at 287.

38. *Id.*

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

40. *Id.* at 288.

41. *Id.* (quoting Brief for American Medical Association as Amicus Curiae 19).

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

43. See Americans with Disabilities Act of 1990, 42 U.S.C. §§ 12101-189 (1998). Title I proscribes employment discrimination, Title II proscribes discrimi-



While the Rehabilitation Act focuses on providing opportunities for the handicapped, the ADA focuses on the elimination of discrimination.<sup>44</sup> The ADA was enacted based on Congress' findings:

- (1) some 43,000,000 Americans have one or more physical or mental disabilities, and this number is increasing as the population as a whole is growing older;
- (2) historically, society has tended to isolate and segregate individuals with disabilities, and, despite some improvements, such forms of discrimination against individuals with disabilities continue to be a serious and pervasive social problem;
- (3) 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;
- (4) unlike individuals who have experienced discrimination on the basis of race, color, sex, national origin, religion, or age, individuals who have experienced discrimination on the basis of disability have often had no legal recourse to redress such discrimination;
- (5) individuals with disabilities continually encounter various forms of discrimination, including outright intentional exclusion, the discriminatory effects of architectural, transportation, and communication barriers, overprotective rules and policies, failure to make modifications to existing facilities and practices, exclusionary qualification standards and criteria, segregation, and relegation to lesser services, programs, activities, benefits, jobs, or other opportunities;
- (6) census data, national polls, and other studies have documented that people with disabilities, as a group, occupy an inferior status in our society, and are severely disadvantaged socially, vocationally, economically and educationally;
- (7) individuals with disabilities are a discrete and insular minority who have been faced with restrictions and limitations, subjected to a history of purposeful unequal treatment, and relegated to a position of political powerlessness in our society, based on characteristics that are beyond the control of such individuals and resulting from stereotypic assumptions not truly indicative of the

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nation in access to public services, and Title III proscribes discrimination in public accommodations and services operated by private entities.

44. *See id.*

individual ability of such individuals to participate in, and contribute to, society; . . . .<sup>45</sup>

Congress determined that the "Nation's proper goals . . . are to assure equality of opportunity, full participation, independent living, and economic self-sufficiency" for people with disabilities.<sup>46</sup>

The purpose of the ADA was:

- (1) to provide a clear and comprehensive national mandate for the elimination of discrimination against individuals with disabilities;
- (2) to provide clear, strong, consistent, enforceable standards addressing discrimination against individuals with disabilities;
- (3) to ensure that the Federal Government plays a central role in enforcing the standards established in this Act on behalf of individuals with disabilities; and
- (4) to invoke the sweep of congressional authority, including the power to enforce the fourteenth amendment and to regulate commerce, in order to address the major areas of discrimination faced day-to-day by people with disabilities.<sup>47</sup>

Unlike the Rehabilitation Act, the scope of the ADA was not limited to recipients of federal funding. For employment discrimination, the ADA covered any "employer, employment agency, labor organization, or joint labor-management committee."<sup>48</sup> The ADA also prohibited discrimination by public accommodations. Included in the definition of "public accommodation" were: (1) places of lodging (excluding small, owner occupied inns); (2) restaurants and bars; (3) places of entertainment; (4) convention centers, meeting halls, and places of public gathering; (5) retail sales and rental stores; (6) service establishments (including professional offices of health care providers); (7) public transportation stations; (8) museums, libraries and galleries; (9) schools; (10) social service establishments; and (11) places for exercise and recreation.<sup>49</sup>

The ADA defined "disability" in a similar manner to "handicapped" as defined under the Rehabilitation Act. A disability,

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45. *Id.*

46. *Id.*

47. *Id.*

48. See Americans with Disabilities Act of 1990, § 42 U.S.C. § 12111-112.

49. See *id.* § 12181.

with respect to an individual, is "(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 impairment; or (C) being regarded as having such an impairment."<sup>50</sup> The ADA specifically allows a public accommodation to refuse to serve a disabled person if it would create an unreasonable risk.<sup>51</sup> Section 302 provides:

[N]othing in this title 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.<sup>52</sup>

"The term 'direct threat' means a significant risk to the health or safety of others that cannot be eliminated by a modification of policies, practices, or procedures or by the provision of auxiliary aids or services."<sup>53</sup> Congress did not specify the standards to be applied for assessing "direct threat." The House Committee on the Judiciary, by use of the term, "intend[ed] to codify the direct threat standard used by the Supreme Court in *School Board of Nassau County v. Arline*."<sup>54</sup>

### C. *HIV and the ADA - Public Policy Concerns*

Although people who suffer from Human Immunodeficiency Virus (HIV) are not given specific protection under the ADA, the legislative history gives a fairly clear indication that Congress intended them to be protected.<sup>55</sup> As early as 1988, as part of hearings on the ADA hearings, the Senate Committee on Labor and Human Resources entered into the record an administrative legal analysis of the impact that the *Arline* decision would have on people with HIV under Section 504 of the Rehabilita-

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50. *Id.* § 12102.

51. *See id.* § 12182.

52. *Id.*

53. Americans with Disabilities Act of 1990, § 42 U.S.C. § 12182.

54. H.R. REP. NO. 101-485(III), at 34 (A&P 1990).

55. *See id.*; see also *Americans with Disabilities Act of 1989: Hearings on S. 933 Before the Comm. on Labor and Human Resources and the Subcomm. on the Handicapped*, 101st Cong. n.29 (1989).

tion Act.<sup>56</sup> Douglas W. Kmiec, Acting Assistant Attorney General, attempted to extrapolate from *Arline* the manner in which people with HIV would be affected.<sup>57</sup>

Mr. Kmiec testified:

We believe that symptomatic HIV-infected individuals are handicapped under section 504. For these individuals; the disease has progressed to the point where the immune system has been sufficiently weakened that a disease such as cancer or pneumonia has developed, and as a result, the individual is diagnosed as having clinical AIDS. Because of the substantial limiting effects these clinical symptoms have on major life activities, such a person is an 'individual with handicaps' for purposes of section 504.<sup>58</sup>

Mr. Kmiec then turned to the question of asymptomatic HIV which he believed *Arline* left unanswered.<sup>59</sup> He relied on an analysis provided by Surgeon General C. Everett Koop to conclude that people with asymptomatic HIV would meet the "physical impairment" test under the Rehabilitation Act.<sup>60</sup> Surgeon General Koop described the progress of the HIV disease:

HIV infection is the starting point of a single disease which progresses through a variable range of stages. In addition to an acute flu-like illness, early stages of the disease may involve subclinical manifestations i.e., impairments and no visible signs of illness. The overwhelming majority of infected persons exhibit detectable abnormalities of the immune system.<sup>61</sup>

From this analysis, Surgeon General Koop concluded:

[F]rom a purely scientific perspective, persons with HIV infection are clearly impaired. They are not comparable to an immune carrier of a contagious disease such as Hepatitis B. Like a person in the early stages of cancer, they may appear outwardly healthy but are in fact seriously ill.<sup>62</sup>

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56. See *Americans with Disabilities Act of 1989: Hearings on S. 933 Before the Comm. on Labor and Human Resources and the Subcomm. on the Handicapped*, 101st Cong. 342-50 (1989).

57. See *id.*

58. See *id.* at 342.

59. See *id.* at 344.

60. *Id.*

61. *Americans with Disabilities Act of 1989: Hearings on S. 933 Before the Comm. on Labor and Human Resources and the Subcomm. on the Handicapped*, 101st Cong. 345 (1989).

62. *Id.*

Mr. Kmiec then addressed the question of whether asymptomatic HIV limits a "major life activity" as required by the Health and Human Services (HHS) regulations.<sup>63</sup> He recognized that the courts might have some difficulty finding that a person with asymptomatic HIV was limited because "such individuals would not appear at first glance to have disabling physical effects from their infection that substantially affect the type of life activities listed in the HHS regulations."<sup>64</sup>

Mr. Kmiec believed, however, that a strong argument could be made for inclusion of people with HIV primarily because of the limitations that HIV infection places on reproduction:

Based on the medical knowledge available to us, we believe that it is reasonable to conclude that the life activity of procreation — the fulfillment of the desire to conceive and bear healthy children — 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. Because of the infection in their system, they will be unable to fulfill this basic human desire. There is little doubt that procreation is a major life activity and that the physical ability to engage in normal procreation — procreation free from the fear of what the infection will do to one's child — is substantially limited once an individual is infected with the AIDS virus.

This limitation — the physical inability to bear healthy children — is separate and apart from the fact that asymptomatic HIV-infected individuals will choose not to attempt procreation. The secondary decision to forego having children is just one of many major life decisions that we assume infected individuals will make differently as a result of their awareness of their infection.<sup>65</sup>

In the final stages of debate on the ADA, treatment of HIV infected people became one of the last two remaining issues in the conference committee.<sup>66</sup> At issue was an amendment by Representative Chapman that would have carved out an exception in the ADA for special treatment of food handlers with communicable diseases.

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63. *Id.* at 346.

64. *Id.*

65. *Id.* at 347-48.

66. *See* 136 CONG. REC. H4611 (1990).

On May 17, 1990, Representative Chapman offered an amendment to Section 103 that would exempt food handlers with infectious diseases from protection under the ADA if their employer made reasonable accommodations for assignment to another job.<sup>67</sup> By this amendment, Representative Chapman was allowing the possibility that public perception and economic considerations, rather than scientific judgment, might determine whether a person with a communicable disease could be denied employment.<sup>68</sup> Representative Chapman told the House that the amendment was necessary because many people would refuse to patronize a food establishment if they knew that someone with an infectious disease was handling food. He was concerned that this could have serious consequences to the establishment, resulting in the possible loss of the business and the jobs associated with it.<sup>69</sup>

Representative Chapman's concerns were not primarily due to the risks that HIV infected people working in food handling positions might communicate their disease to the public. To the contrary, he disavowed such a belief when he told the House that the Centers for Disease Control and Prevention (CDC) had not found one case in over 130,000 where AIDS was transmitted by a food handler.<sup>70</sup>

Representative McDermott rose in opposition to the amendment, and articulated Congress' clear intent not to allow discrimination based on public perception. Representative McDermott made a clear distinction between an exemption based on scientifically sound health concerns, and one based on unreasonable fear:

In medical school, I was trained to protect my patients from disease, to use the best medical knowledge to protect the public health. So was the gentleman from Georgia, Dr. Rowland. If

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67. See 136 CONG. REC. D623, H2478 (1990). The Chapman Amendment provided that "It shall not be a violation of this Act for an employer to refuse to assign or continue to assign any employee with an infectious or communicable disease of public health significance to a job involving food handling, provided that the employer shall make reasonable accommodation that would offer an alternative employment opportunity for which the employee is qualified and for which the employee would sustain no economic damage."

68. See *id.*

69. See *id.*

70. See *id.*

either of us believed for one second that this amendment would do anything to protect the public against any disease, we would support it.

But 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.

Never mind that we spend millions of dollars on public education about how AIDS is and is not transmitted. Never mind what the American Medical Association says, or Dr. Roper of CDC, or former Surgeon General Koop, or Dr. Rowland, or what everyone on this floor knows.

As long as anybody in our country remains ignorant, this amendment says, as long as anyone is still afraid, the food service industry may cater to that ignorance and fear.

But that is all right, we are told, because the infected food handler will be given another job, at the same pay, away from the food. In a restaurant, I suppose that means washing dishes or working the cash register. Then, what if someone says: "Maybe you can get AIDS from a dish, or from handling a dollar bill?" Will we have to come back and amend this act again?<sup>71</sup>

The Chapman amendment was passed by the House of Representatives by a vote of 199 ayes and 187 noes.<sup>72</sup>

During Senate debate on the ADA conference report, Dr. Sullivan, Secretary of Health, testified that the inclusion of any provision, such as the Chapman amendment, which allowed an unreasonable restriction on food handlers with HIV, would be harmful to disabled people.<sup>73</sup>

Sullivan 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.<sup>74</sup>

The Bush administration's concerns were echoed by The Association of State and Territorial Health Officials:

The appropriate response to public fear is ongoing education, not legitimizing further discrimination in the statute. For these rea-

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71. 136 CONG. REC. D623, H2480 (1990).

72. See 136 CONG. REC. D623, H2483 (1990).

73. See 136 CONG. REC. S9684 (1990).

74. *Id.*

sons, the Chapman amendment is not only unnecessary, but is counterproductive.<sup>75</sup>

The Senate conferees agreed, noting that "persons with disabilities, including those with infectious diseases and infections, should be judged on the basis of their qualifications and the facts applicable to them and not on the basis of fear, ignorance, and prejudice."<sup>76</sup>

The general consensus was that the decisions made about direct threat exemptions for certain people with communicable diseases in general, and HIV in particular, should be based on knowledge of how these diseases are transmitted.<sup>77</sup> The conferees accepted a substitute provision from Senator Hatch that

requires that the Secretary of Health and Human Services review all infectious and communicable diseases which may be transmitted through the handling of the food supply; publish a list of those diseases which are transmitted through the handling of the food supply; publish methods by which such diseases are transmitted; and widely disseminate such information regarding the list of diseases and their modes of transmissibility to the general public. . . .<sup>78</sup>

This provision is embodied in Title I of the ADA.<sup>79</sup>

The Senate debate about the Chapman amendment provided some indication that some members of Congress presumed that people infected by HIV might be considered disabled under the ADA.<sup>80</sup> Senator Kennedy discussed how important the ADA would be for people with HIV:

Since the beginning of the HIV epidemic, public health officials have talked about the importance of antidiscrimination protection for people with HIV disease. I am extremely pleased that in passing the ADA, the Congress has taken such action. I would like to discuss briefly the important protections that the ADA will offer to people with HIV disease in a range of areas. 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

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75. *Id.*

76. *Id.*

77. *See id.*

78. 136 CONG. REC. S9684 (1990).

79. *See* Americans with Disabilities Act of 1990, 42 U.S.C. § 12113 (1998).

80. *See* 136 CONG. REC. S9696 (1990).



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. Although 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.

Discrimination against people with HIV disease has, unfortunately, been one of the tragic hallmarks of this epidemic. A recent study by the AIDS project of the American Civil Liberties Union, 'Epidemic of Fear,' documents in detail a range of discrimination cases that have occurred over the past decade across the country.<sup>81</sup>

Senator Kennedy did not just see the ADA as providing HIV infected people with protection against job discrimination, but believed that it would apply to Title III as well, and that under current medical judgment, discrimination would be unnecessary:

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' offices, lawyers' offices, and various other service providers. Of particular importance, title III prohibits the use of eligibility criteria that screen out, or tend to screen out, people with disabilities, unless such criteria can be shown by the public accommodation to be necessary for the provision of its services or goods. Thus, for example, a doctor or dentist could not require that a person demonstrate that he or she was not HIV-infected; for example, by requiring that the individual take an HIV test, unless meeting that criterion was necessary to provide services to that individual. Under current medical and scientific judgments, including current CDC guidelines, there is no reason to require proof of HIV-negativity in any public accommodation setting. Thus, title III will finally offer needed protection to individuals with HIV disease.<sup>82</sup>

#### D. *Risks of HIV Infection to Health Care Workers*

By their rejection of the Chapman amendment, it seems clear that Congress was unwilling to yield to any "direct threat" exemptions based on fear of contagion rather than scientific

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81. *Id.*

82. *Id.* at S9697.

judgment. Congress codified the *Arline* "direct threat" standard into the ADA,<sup>83</sup> but as the Court held in *Bragdon*, it remains to be determined whether it would be reasonable for a health care provider, such as a dentist, to refuse to treat an HIV infected patient in a normal office setting.<sup>84</sup>

The Center for Disease Control ("CDC") publishes recommendations for safety precautions that health care providers should follow to reduce the risk of infection from HIV.<sup>85</sup> The 1987 "Recommendations for Prevention of HIV Transmission in Health-Care Settings" (CDC Recommendations) indicate:

The increasing prevalence of HIV increases the risk that health-care workers will be exposed to blood from patients infected with HIV, especially when blood and body-fluid precautions are not followed for all patients. Thus, this document emphasizes the need for health-care workers to consider ALL patients as potentially infected with HIV and/or other blood-borne pathogens and to adhere rigorously to infection-control precautions for minimizing risk of exposure to blood and body fluids of all patients.<sup>86</sup>

The CDC recommends that risks of HIV be minimized by the use of "Universal Precautions" which are applied to all patients regardless of whether their HIV status is known.<sup>87</sup> The CDC Recommendations of Universal Precautions consist of a six-step procedure that promotes the use of barrier protection, proper handling of scalpels and needles, and conditions under which health care workers should not expose themselves to the risk of HIV.<sup>88</sup>

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83. See H.R. REP. NO. 101-485(III), at 34 (1990).

84. See *Bragdon v. Abbott*, 524 U.S. at 649.

85. See *Recommendations for Prevention of HIV Transmission in Health-Care Settings*, (visited Nov. 6, 1998) <<http://www.cdc.gov/epo/mmwr/preview/mmwrhtml/00023587.htm>>.

86. *Id.*

87. See *id.*

88. See *id.* The CDC recommendations provide that

1. All health-care workers should routinely use appropriate barrier precautions to prevent skin and mucous-membrane exposure when contact with blood or other body fluids of any patient is anticipated. Gloves should be worn for touching blood and body fluids, mucous membranes, or non-intact skin of all patients, for handling items or surfaces soiled with blood or body fluids, and for performing venipuncture and other vascular access procedures. Gloves should be changed after contact with each patient. Masks and protective eyewear or face shields should be worn during procedures that are likely to generate droplets of blood or other body fluids to prevent exposure of mucous membranes of the mouth, nose, and

Beyond the general Universal Precautions recommended for all health care workers, the CDC Recommendations suggest additional precautions for dentists. The CDC Recommendations warn dental workers that:

[b]lood, saliva, and gingival fluid from ALL dental patients should be considered infective. Special emphasis should be placed on the following precautions for preventing transmission of blood-borne pathogens in dental practice in both institutional and non-institutional settings.<sup>89</sup>

The CDC Recommendations advise dentists to take special precautions to shield themselves from blood and saliva, to sterilize equipment, and cover surfaces that are hard to clean.<sup>90</sup>

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eyes. Gowns or aprons should be worn during procedures that are likely to generate splashes of blood or other body fluids.

2. Hands and other skin surfaces should be washed immediately and thoroughly if contaminated with blood or other body fluids. Hands should be washed immediately after gloves are removed.

3. All health-care workers should take precautions to prevent injuries caused by needles, scalpels, and other sharp instruments or devices during procedures; when cleaning used instruments; during disposal of used needles; and when handling sharp instruments after procedures. To prevent needlestick injuries, needles should not be recapped, purposely bent or broken by hand, removed from disposable syringes, or otherwise manipulated by hand. After they are used, disposable syringes and needles, scalpel blades, and other sharp items should be placed in puncture-resistant containers for disposal; the puncture-resistant containers should be located as close as practical to the use area. Large-bore reusable needles should be placed in a puncture-resistant container for transport to the reprocessing area.

4. Although saliva has not been implicated in HIV transmission, to minimize the need for emergency mouth-to-mouth resuscitation, mouthpieces, resuscitation bags, or other ventilation devices should be available for use in areas in which the need for resuscitation is predictable.

5. Health-care workers who have exudative lesions or weeping dermatitis should refrain from all direct patient care and from handling patient-care equipment until the condition resolves.

6. Pregnant health-care workers are not known to be at greater risk of contracting HIV infection than health-care workers who are not pregnant; however, if a health-care worker develops HIV infection during pregnancy, the infant is at risk of infection resulting from perinatal transmission. Because of this risk, pregnant health-care workers should be especially familiar with and strictly adhere to precautions to minimize the risk of HIV transmission.

89. *Id.*

90. See *Recommendations for Prevention of HIV Transmission in Health-Care Settings* (visited Nov. 6, 1998) <<http://www.cdc.gov/epo/mmwr/preview/mmwrhtml/00023587.htm>>. The CDC guidelines for dentists provide:

1. In addition to wearing gloves for contact with oral mucous membranes of all patients, all dental workers should wear surgical masks and protective eyewear or

The CDC acknowledges that a risk of HIV infection from patient to health care worker exists.<sup>91</sup> In July, 1997, the CDC published a paper, *Facts About The Human Immunodeficiency Virus and Its Transmission*, with a stated purpose of "correct[ing] a few misconceptions about HIV."<sup>92</sup> The report advises that "[i]n the health care setting, workers have been infected with HIV after being stuck with needles containing HIV-infected blood or, less frequently, after infected blood contacts the worker's open cut or splashes into a mucous membrane (e.g., eyes or inside of the nose)."<sup>93</sup> As of December, 1997, the CDC reported 186 cases of health care workers (of which 7 were dentists) who had either a documented or possible occupational transmission of HIV after percutaneous or mucocutaneous exposure to HIV.<sup>94</sup>

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chin-length plastic face shields during dental procedures in which splashing or spattering of blood, saliva, or gingival fluids is likely. Rubber dams, high-speed evacuation and proper patient positioning, when appropriate, should be utilized to minimize generation of droplets and spatter.

2. Handpieces should be sterilized after use with each patient, since blood, saliva, or gingival fluid of patients may be aspirated into the handpiece or waterline. Handpieces that cannot be sterilized should at least be flushed, the outside surface cleaned and wiped with a suitable chemical germicide, and then rinsed. Handpieces should be flushed at the beginning of the day and after use with each patient. Manufacturers' recommendations should be followed for use and maintenance of waterlines and check valves and for flushing of handpieces. The same precautions should be used for ultrasonic scalers and air/water syringes.

3. Blood and saliva should be thoroughly and carefully cleaned from material that has been used in the mouth (e.g., impression materials, bite registration), especially before polishing and grinding intra-oral devices. Contaminated materials, impressions, and intra-oral devices should also be cleaned and disinfected before being handled in the dental laboratory and before they are placed in the patient's mouth. Because of the increasing variety of dental materials used intra-orally, dental workers should consult with manufacturers as to the stability of specific materials when using disinfection procedures.

4. Dental equipment and surfaces that are difficult to disinfect (e.g., light handles or X-ray-unit heads) and that may become contaminated should be wrapped with impervious-backed paper, aluminum foil, or clear plastic wrap. The coverings should be removed and discarded, and clean coverings should be put in place after use with each patient.

91. See *The Human Immunodeficiency Virus and Its Transmission* (last modified July, 1997) <[http://www.cdc.gov/nchstp/hiv\\_aids/pubs/facts/transmis.htm](http://www.cdc.gov/nchstp/hiv_aids/pubs/facts/transmis.htm)>.

92. *Id.*

93. *Id.*

94. See 9 CENTERS FOR DISEASE CONTROL AND PREVENTION, *HIV/AIDS Surveillance Report* No 2, 21 (1997).

## III. Bragdon v. Abbott

A. *Facts*

In *Bragdon*, the plaintiff Sidney Abbott, visited the dental office of the defendant Dr. Randon Bragdon in September, 1994, for a dental appointment.<sup>95</sup> At the time of her visit, she revealed to Dr. Bragdon that she was infected with HIV.<sup>96</sup> During the course of her dental exam, Dr. Bragdon discovered a cavity.<sup>97</sup> He informed Ms. Abbott that his "infectious disease policy" precluded filling cavities of HIV-infected patients in his office.<sup>98</sup> He suggested that as an alternative, he would be willing to perform the procedure in a hospital for no additional fee if Ms. Abbott would bear the cost of the hospital facilities.<sup>99</sup>

At the time of her visit, Ms. Abbott had been infected with the HIV virus for years.<sup>100</sup> During that time, her infection was asymptomatic, and she was apparently healthy despite the virus that was multiplying in her bloodstream.<sup>101</sup>

B. *The Holding*1. *U.S. District Court for Maine*

Sidney Abbott filed suit in the Federal District Court of Maine, alleging that Dr. Bragdon violated her rights under the ADA and the Maine Human Rights Act (MHRA) when he refused to treat her in his office.<sup>102</sup> The United States Government and the MHRC intervened as plaintiffs, and all parties moved for summary judgment.<sup>103</sup> The trial court granted summary judgment for the plaintiffs, and denied summary judgment for the defendant.<sup>104</sup>

The court articulated the issues before it: "With respect to the ADA, the Parties dispute (1) whether Plaintiff's asymptomatic HIV constitutes a disability under the statute, and (2)

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95. See *Abbott v. Bragdon*, 912 F. Supp. 580, 584 (D. Me. 1995).

96. See *id.*

97. See *id.*

98. See *id.*

99. See *id.*

100. See *Abbott v. Bragdon*, 912 F. Supp. at 584.

101. See *id.*

102. See *id.*

103. See *id.*

104. See *id.*

whether treatment of Plaintiff in Defendant's office poses a direct threat to the health and safety of others such that Defendant may lawfully refuse such treatment."<sup>105</sup> The court reasoned that a summary judgment is appropriate "when the moving party demonstrates the absence of a genuine issue of material fact, and that it is entitled to judgment as a matter of law."<sup>106</sup> The non-moving party may defeat the motion if, he or she can, through the use of "affidavits, admissions, deposition testimony and answers to interrogatories . . . set forth specific facts establishing a genuine issue for trial."<sup>107</sup>

The court set forth three elements that must be satisfied to sustain a violation of Title III of the ADA: (1) that the defendant's office is a place of public accommodation, (2) that plaintiff is disabled as defined in the ADA, and (3) that treatment of plaintiff in defendant's office would not pose a direct threat to the health and safety of others.<sup>108</sup> The first element was not in dispute.<sup>109</sup>

The court found that the plaintiff was disabled, as defined in the ADA, as a matter of law.<sup>110</sup> It applied the standards articulated in the ADA: an individual is disabled when he or she has "(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 impairment; or (C) being regarded as having such an impairment."<sup>111</sup>

The court relied on regulatory guidelines to determine that HIV, whether symptomatic or asymptomatic, is a physical impairment.<sup>112</sup> It then turned to the question of whether asymptomatic HIV substantially limits a major life activity of an individual who has it.<sup>113</sup> The court held that reproduction was a major life activity, and that HIV limited reproduction because

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105. *See Abbott v. Bragdon*, 912 F. Supp. at 584.

106. *Id.*

107. *Id.*

108. *See id.* at 585.

109. *Id.*

110. *See Abbott v. Bragdon*, 912 F. Supp. at 587.

111. *Id.* at 585 (quoting 42 U.S.C § 12102(2)).

112. *Id.*

113. *See id.* at 585-86.

of the added risk that exists for childbearing for a woman with HIV.<sup>114</sup>

The court then turned to the question of whether treatment of the plaintiff in the defendant's office posed a direct threat to the health or safety of the defendant. To answer this question, the court looked again to the regulations, and also to the decision in *Arline*.<sup>115</sup> The standard the court used was whether Dr. Bragdon's decision was supported by current medical judgment of a public health official.<sup>116</sup> The court found Dr. Bragdon's statistical conclusions too speculative to sustain a summary judgment.<sup>117</sup> The court accepted the testimony offered by the plaintiff from Wayne Marianos, Director of Oral Health for the CDC, who participated in the creation of the CDC infectious disease transmission prevention guidelines for dentists.<sup>118</sup>

Dr. Marianos testified that "when implemented, the CDC Recommendations reduce the already low risk of disease transmission in the dental environment, from . . . patient to dental health care worker."<sup>119</sup> The court found this testimony persuasive as to providing an assessment of "reasonable medical judgment of a public health official."<sup>120</sup> The court also rejected the defendant's assertion that the cases where restrictions on HIV infected health care workers was held not to violate the ADA argued in favor of the application of the direct threat exemption in this case. The court reasoned that because Dr. Bragdon both took the risk and controlled the means of risk reduction, his safety was under his control; unlike the patients who have no means of protecting themselves against a less diligent HIV infected health care worker.<sup>121</sup> The court went on to conclude that "treatment of plaintiff in [defendant's] office poses no direct threat to the health or safety of others."<sup>122</sup> Dr. Bragdon ap-

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114. *See id.* at 586-87.

115. *See Abbott v. Bragdon*, 912 F.Supp. at 587.

116. *See id.*

117. *See id.* at 589.

118. *Id.*

119. *Id.*

120. *Abbott v. Bragdon*, 912 F.Supp. at 591.

121. *See id.* at 590-91.

122. *See id.*

pealed to the First Circuit Court of Appeals which affirmed the trial court's decision.<sup>123</sup>

## 2. *First Circuit Court of Appeals*

The court of appeals agreed with the trial court's reasoning on all issues. However, the court of appeals took a more comprehensive look at the "direct threat" evidence than the trial court had in its opinion. First, the court considered the evidence presented by the plaintiff, and, unlike the trial court, did not find Dr. Marianos' testimony "compelling."<sup>124</sup> It also refuted the relevance of eight "sources of information" that Dr. Bragdon proffered to show that treatment in the office would be dangerous.<sup>125</sup> The court found that "[e]ach piece of evidence is too speculative or too tangential . . . to create a genuine issue of material fact [to overcome a motion for summary judgment.]"<sup>126</sup>

The court was persuaded by two factors. First, it was impressed by CDC guidelines for universal precautions which, when implemented, would reduce the risk of infection.<sup>127</sup> Although the report did not say that treating a patient under the guidelines would be safe, or that no further risk-reduction measures might make it more safe, the court inferred these conclusions.<sup>128</sup> Second, the court was influenced by an American Dental Association (Dental Association) policy report stating that patients with the HIV infection could be safely treated in a

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123. See *Abbott v. Bragdon*, 107 F.3d 934 (1st Cir. 1997).

124. *Id.* at 946, n.7.

125. See *id.* at 946-48. Dr. Bragdon used the following in support of his position: (1) an FDA recommendation that "persons who have contact with a patient's blood through needlestick, non-intact skin or mucous membranes refrain from donating blood for a year"; (2) a CDC report that documented 42 incidents of HIV transmission to health care workers, including possibly seven dentists; (3) a CDC report of a dentist who transmitted HIV to his patients; (4) a Stanford Medical School report that raises concerns of HIV transmission by high speed drills; (5) that "the CDC did not state that it was medically unwise to take additional precautions" with HIV infected patients; (6) that the risk to health care workers from patients is documented to be greater than to patients from health care workers, yet courts have found that restricting health care workers with HIV is not discrimination; (7) that Dr. Bragdon sustained sharp injuries on a regular basis; and (8) a study that shows that universal precautions only reduces needlestick exposures by 62%.

126. *Abbott v. Bragdon*, 107 F.3d at 948.

127. See *id.* at 945-46.

128. See *id.*



dentist's office.<sup>129</sup> The court of appeals, therefore, affirmed the decision of the trial court.<sup>130</sup>

### 3. *The United States Supreme Court*

Dr. Bragdon appealed the circuit court decision to the Supreme Court.<sup>131</sup> The Court agreed with the lower courts that Abbott's HIV infection is considered a disability under the ADA, but the judgment was vacated and remanded because the court was concerned that Dr. Bragdon's assertion of a "direct threat" had not been disproved as a matter of law.<sup>132</sup> Justice Kennedy delivered the opinion of the Court.<sup>133</sup>

The Court first examined the definition of disability under the ADA 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 impairment; or being regarded as having such impairment."<sup>134</sup>

The Court limited its consideration to the elements of (A) above, and performed a three step analysis: (1) is respondent's HIV infection a physical impairment? (2) is reproduction a major life activity under the ADA? and (3) does HIV substantially limit the major life activity?<sup>135</sup> The Court noted that "[t]he ADA's definition of disability is drawn almost verbatim from the definition of 'handicapped individual' included in the Rehabilitation Act of 1973, . . . and the definition of 'handicap' contained in the Fair Housing Amendments Act of 1988."<sup>136</sup> The ADA required that the Court not apply a lesser standard than those applied under the Rehabilitation Act, and the Court concluded that Congress intended that regulatory interpretations under the Rehabilitation Act should still be followed.<sup>137</sup>

The Court determined that while HIV was not among the disorders included as a physical impairment in the regulatory commentary, it met the regulatory definition of a physical im-

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129. *See id.* at 946.

130. *See id.* at 949.

131. *See Bragdon v. Abbott*, 524 U.S. at 628.

132. *See id.* at 655.

133. *See id.* at 628.

134. *Id.* at 630.

135. *See id.* at 631.

136. *Bragdon v. Abbott*, 524 U.S. at 631-32.

137. *See id.* at 632.

pairment, which includes "(A) any physical disorder or condition . . . affecting one or more of the following body systems: neurological; musculoskeletal; special sense organs; respiratory, including speech organs; cardiovascular; reproductive, digestive, genito-urinary; hematic and lymphatic; skin; and endocrine."<sup>138</sup> The Court concluded that HIV is a physiological disorder "with a constant and detrimental effect on the infected person's hemic and lymphatic systems from the moment of infection."<sup>139</sup>

Having determined that HIV was a physical impairment, the Court then considered whether a major life activity had been substantially impacted.<sup>140</sup> Abbott, the respondent, claimed that reproduction was the major life activity affected by her HIV infection, and her decision not to bear children was due to the increased risks, to both mother and child, caused by the virus. The Court confined its evaluation to the record on appeal.<sup>141</sup>

The Court rejected the petitioner's argument that the ADA was intended to apply to activities having a "public, economic, or daily character."<sup>142</sup> They concluded, instead, that reproduction, and the sexual dynamics surrounding it, met the definition of a major life activity under the ADA.<sup>143</sup>

The final consideration was whether Abbot's HIV infection substantially limited her ability to reproduce.<sup>144</sup> The court determined that HIV limited the respondent's ability to reproduce in two ways: (1) a woman infected with HIV who attempts to conceive imposes a significant risk of transmitting the disease to her partner, and (2) has a 25% risk of transmitting the disease to her child during gestation.<sup>145</sup>

The petitioner conceded the existence of the risk of transmission of HIV to the child, but argued that it could be reduced to 8% through the use of anti-retroviral therapy.<sup>146</sup> The Court

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138. *Id.* at 633.

139. *Id.* at 637.

140. *See id.*

141. *Bragdon v. Abbott*, 524 U.S. at 638.

142. *Id.* at 639.

143. *See id.*

144. *See id.* at 639.

145. *See id.* at 639-40.

146. *Bragdon v. Abbott*, 524 U.S. at 640.

responded: “[i]t 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.”<sup>147</sup> The Court further noted that “[w]hen significant limitations result from the impairment, the definition is met even if the difficulties are not insurmountable.”<sup>148</sup>

The Court agreed with the courts below that no triable issue of fact remained on the question of disability, and that the respondent was disabled, as defined by the ADA, by her HIV infection.<sup>149</sup> The Court declined to address the question of “whether HIV is a per se disability under the ADA.”<sup>150</sup> The Court did, however, discuss substantial administrative and judicial authority for considering symptomatic and asymptomatic HIV disabilities under the ADA.<sup>151</sup>

The Court considered only one other question from Dr. Bragdon’s petition: “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?”<sup>152</sup>

Dr. Bragdon could lawfully have refused to treat Ms. Abbott in his office if her HIV infection “posed a direct threat to the health or safety of others.”<sup>153</sup> The Court looked to the ADA for the definition of direct threat.<sup>154</sup> The statute 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.”<sup>155</sup>

The direct threat provision in the ADA stems from the Court’s holding in *Arline*,<sup>156</sup> and the Court recognized that it provides a balance between protecting people with disabilities

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147. *Id.* at 641.

148. *Id.*

149. *See id.*

150. *Id.* at 642.

151. *See Bragdon v. Abbott*, 524 U.S. at 642-47.

152. *Id.* at 648 (quoting petition for certiorari).

153. *Id.* (quoting 42 U.S.C. § 12182(b)(3)).

154. *Id.* at 648.

155. *Id.* at 648-49.

156. *See School Board of Nassau County v. Arline*, 480 U.S. 273.

and protecting others from significant health risks, such as those from contagious diseases.<sup>157</sup> The *Arline* decision established that (1) a risk must be significant, the fact that it exists is not enough; (2) the existence of the risk must be determined from the position of the person refusing the accommodation; (3) the risk assessment must be based on objective, scientific information available to him; and (4) the views of public health authorities carry special weight and authority, but are not conclusive.<sup>158</sup>

The Court concluded that the First Circuit was correct when it declined to rely on Dr. Marianos' testimony.<sup>159</sup> Similarly, the First Circuit correctly discounted, as lacking scientific basis, Dr. Bragdon's testimony regarding the enhanced safety of treating Ms. Abbott in a hospital.<sup>160</sup>

The Court was concerned, however, that the First Circuit might have placed undue reliance on the CDC Recommendations for Universal Precautions because "they do not assess the level of risk."<sup>161</sup> The Court also believed that the First Circuit placed undue reliance on Dental Association Policy because it is a professional association, not a scientific organization, and its assessments might be based on a combination of risk assessment and professional responsibility.<sup>162</sup>

While the Court expressed doubts that petitioner had "advanced evidence sufficient to raise a triable issue of fact,"<sup>163</sup> the Court acknowledged that it did not have enough evidence from the record and briefs provided to resolve the question fully.<sup>164</sup> The Court, therefore, remanded the question of direct threat back to the First Circuit, noting that "[r]esolution of the issue will be of importance to health care workers not just for the result but also for the precision and comprehensiveness of the reasons given for the decision."<sup>165</sup>

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157. See *Bragdon v. Abbott*, 524 U.S. at 649.

158. See *id.* at 649-50.

159. See *id.* at 650.

160. See *id.* at 650-51.

161. *Id.* at 651-52.

162. *Bragdon v. Abbott*, 524 U.S. at 652.

163. *Id.* at 653.

164. See *id.*

165. *Id.* at 654-55.

Justice Stevens concurred, joined by Justice Breyer.<sup>166</sup> The Justices both believed that petitioner had not raised a triable issue of fact, and would have preferred that the decision of the First Circuit had been affirmed.<sup>167</sup> However, the concurring Justices realized that they could not obtain a majority for their position.<sup>168</sup> Because they otherwise agreed with Justice Kennedy's reasoning, they concurred.<sup>169</sup>

Justice Ginsburg also concurred.<sup>170</sup> Justice Ginsburg stated that the HIV infection "inevitably pervades life's choices: education, employment, family and financial undertakings."<sup>171</sup> As such, HIV, whether symptomatic or asymptomatic, is a disability under the ADA. Justice Ginsburg also agreed that, because of the importance of this issue to all health care workers, a remand was an appropriately cautious action.<sup>172</sup>

Chief Justice Rehnquist, joined by Justice Scalia, Justice Thomas and, in part, Justice O'Connor, concurred in the judgment in part and dissented in part.<sup>173</sup> The Justices, except Justice O'Connor, believed that the respondent had not established that HIV limited her life activity of reproduction.<sup>174</sup> The Justices looked to evidence that Ms. Abbott did not consider herself impaired, and there was no evidence that she intended to bear children.<sup>175</sup> They noted that the First Circuit also erred in establishing that reproduction is a "major life activity" under the ADA.<sup>176</sup> Further, the dissent argued that the majority failed to demonstrate a connection between reproduction and the listed (although not exhaustive) activities illustrated in the Act.<sup>177</sup> In addition, the dissent argued that respondent's decision not to have children is a choice, not a limitation. She still would be

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166. *Id.* at 655.

167. *Bragdon v. Abbott*, 524 U.S. at 655-56.

168. *See id.* at 656.

169. *See id.*

170. *See id.* at 656.

171. *Id.*

172. *See Bragdon v. Abbott*, 524 U.S. at 656.

173. *See id.*

174. *Id.*

175. *See id.* at 659.

176. *Id.*

177. *See Bragdon v. Abbott*, 524 U.S. at 659.

able, if she so chose, to have sexual intercourse, give birth and rear a child.<sup>178</sup>

Justice O'Connor joined in the remainder of the opinion.<sup>179</sup> The other dissenting Justices agreed with the remand to the First Circuit, but did not understand the Court's instructions.<sup>180</sup> When assessing "direct threat" under the ADA, the views of politically appointed public health officers should be given no special weight or authority, such views must stand on their own.<sup>181</sup> The dissent stressed that the Court erred when it did not give proper credence to the petitioner's evidence, which was sufficient to avoid a summary judgment.<sup>182</sup> Justice O'Connor concurred in part and dissented in part.<sup>183</sup> In addition, Justice O'Connor was of the opinion that the act of giving birth is not a major life activity per se because it is not the same as those activities represented in the statute.<sup>184</sup>

#### 4. *First Circuit Court of Appeals on Remand*

In December, 1998, the First Circuit Court of Appeals reheard the case to address the issues raised by the Supreme Court. The First Circuit affirmed its original holding in favor of the plaintiff, Sidney Abbott.<sup>185</sup> To reach this holding, the First Circuit ordered supplemental briefing, and considered a new round of oral arguments.<sup>186</sup>

The First Circuit looked first to the CDC guidelines to determine whether they, in fact, stated that it would be safe for a health care worker to treat a patient without taking further precautions.<sup>187</sup> The First Circuit noted that the CDC guidelines, issued in 1993, "updated earlier versions issued in 1986 and 1987 respectively."<sup>188</sup> The 1986 edition stated that the use of universal precautions were effective for preventing the trans-

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178. *See id.* at 660-61.

179. *Id.* at 657.

180. *Id.* at 662.

181. *See id.* at 662-63.

182. *See Bragdon v. Abbott*, 524 U.S. at 663.

183. *Id.* at 664.

184. *See id.* at 664-65.

185. *See Abbott v. Bragdon*, 163 F.3d 87, 90 (1st Cir. 1998).

186. *Id.* at 88.

187. *Id.* at 89.

188. *Id.*

mission of HIV.<sup>189</sup> The 1987 edition reduced the level of precautions previously recommended, and stated that no additional precautions need be taken beyond those in the revised guidelines.<sup>190</sup> The First Circuit held that these earlier statements by the CDC did provide the risk assessment that the Supreme Court required, and noted that “[n]either the parties nor any of the amici have suggested that the 1993 rewrite was intended to retreat from these earlier risk assessments, and we find no support for such a position in the Guidelines’ text.”<sup>191</sup>

The first circuit next addressed the weight they had given to the Dental Association Policy.<sup>192</sup> Upon review of a “cornucopia of information regarding the process by which the [Dental Association] Policy was assembled,”<sup>193</sup> the court learned that the Dental Association uses separate committees to develop scientific policies (such as the guidelines on which the plaintiff relied) and ethical policies.<sup>194</sup> This separation, the First Circuit reasoned, was enough to dispel the Supreme Court’s concern that the Dental Association report was based on professional ethics rather than scientific conclusions.<sup>195</sup> Based on these conclusions, the First Circuit held that Ms. Abbott had met her burden for summary judgment.<sup>196</sup>

The First Circuit then reconsidered whether the CDC’s statement of seven “possible” transmissions of HIV to dental workers provided Dr. Bragdon with a triable issue of fact.<sup>197</sup> The First Circuit determined that the CDC used the word “possible” simply to indicate cases where an occupational origin of the infection was unknown rather than suspected.<sup>198</sup> Further,

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189. *See id.*

190. *See Abbott v. Bragdon*, 163 F.3d at 89.

191. *Id.*

192. *See Abbott v. Bragdon*, 524 U.S. 641, 651-52.

193. *Abbott v. Bragdon*, 163 F.3d at 89.

194. *See id.* *See also Brief of the Amicus Curiae: The American Dental Association in Support of Sidney Abbott, et al.* (last modified Sept. 29, 1998) <<http://www.ada.org/prac/position/brag2-4.html>>. The ADA Science Council, assessing data provided by the CDC, concluded that “the risk of occupationally acquiring HIV-infection through the practice of dentistry is so low as to be almost undetectable.”

195. *See Abbott v. Bragdon*, 163 F.3d at 89.

196. *Id.*

197. *See id.* at 90.

198. *Id.*

the First Circuit determined that this definition of "possible" was documented in scientific literature, and available to Dr. Bragdon in September, 1994.<sup>199</sup> The First Circuit held that this clarification, in conjunction with the required "objective standard", dispelled the Supreme Court's concern that the existence of a possibility of infection might raise a triable issue of fact.<sup>200</sup>

Finally, the First Circuit reconsidered whether the "42 documented cases of occupational transmission of HIV to [non-dental] health-care workers" could support Dr. Bragdon's claim by extrapolation.<sup>201</sup> The First Circuit determined that there was insufficient evidence of comparable risks between dentists and other health-care workers to allow such an inference.<sup>202</sup> The First Circuit concluded that Dr. Bragdon's arguments were "too speculative or too tangential . . . to create a genuine issue of material fact."<sup>203</sup>

In conclusion, the First Circuit emphasized that their determination was case-specific.<sup>204</sup> They cautioned that "[t]he state of scientific knowledge concerning [HIV] is evolving and . . . future courts [should] consider carefully whether future litigants have been able, through scientific advances, more complete research, or special circumstances, to present facts and arguments warranting a different decision."<sup>205</sup>

#### IV. Analysis

In *Bragdon v. Abbott*, the Court took a cautious approach that left many questions unresolved. The Court declared Sidney Abbott disabled under the ADA by virtue of the limitation that her HIV infection caused on her ability to reproduce.<sup>206</sup> The Court stopped short, however, of saying that the HIV infection is a disability under the ADA per se.<sup>207</sup>

The Court did give a strong indication that it would answer this final question in the positive. It cited opinions from the Of-

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199. *Id.*

200. *See Abbott v. Bragdon*, 163 F.3d at 90.

201. *Id.*

202. *See id.*

203. *Id.* at 90 (quoting *Abbott v. Bragdon*, 107 F.3d at 948).

204. *See id.* at 90.

205. *Abbott v. Bragdon*, 163 F.3d at 90.

206. *See Bragdon v. Abbott*, 524 U.S. at 641.

207. *See id.* at 642.



fice of Legal Counsel, interpretations by the Department of Justice, interpretations from regulatory agencies, legislative history, and court opinions to conclude that the Rehabilitation Act and the ADA were intended to protect people with asymptomatic HIV from infection.<sup>208</sup> The weight of these authorities, the Court says, "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."<sup>209</sup> The Court is unwilling to call asymptomatic HIV a disability per se in this case, but there is a clear indication that it might be inclined to do so in the future.

As a result, the Court's decision leaves two possibilities for future dispute: (1) would an otherwise unimpaired person with asymptomatic HIV, for whom reproduction was not an issue, still be considered disabled by her disease? and (2) does the ADA now apply to someone who is otherwise healthy, but unable to reproduce for other reasons, such as infertility? The early answer to the second question, which is beyond the scope of this note, is that courts may not be willing to extend *Bragdon* to include all cases of infertility.<sup>210</sup>

With regard to the "direct threat" question, the Court does not take us far beyond *Arline*.<sup>211</sup> The Court applied the statutory standard for assessing whether a direct threat exists, which is whether the threat is "a significant risk to the health or safety of others that cannot be eliminated by a modification of policies, practices or procedures or by the provision of auxiliary aids or services."<sup>212</sup> The Court then reiterated its holding in *Arline* that 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."<sup>213</sup>

What is new from this decision is the quality of evidence that the Court is willing to accept, as a matter of law, to deter-

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208. *See id.* at 642-47.

209. *Id.* at 647.

210. *See McGraw v. Sears, Roebuck & Co.*, 21 F. Supp. 2d 1017, 1021 (D. Minn. 1998) (declining to extend *Bragdon* to consider a woman with early menopause as disabled under the ADA).

211. *See Bragdon v. Abbott*, 524 U.S. at 648-49.

212. *Id.*

213. *Id.* at 649.

mine whether it is unreasonable for a dentist to refuse to treat an HIV infected patient in his office. The respondent relied successfully in the courts below on the prevention guidelines provided by the CDC as evidence that treating her was not a significant risk.<sup>214</sup> The First Circuit was willing to infer from these guidelines that if Dr. Bragdon had followed them, there would not have been a significant risk to his health.<sup>215</sup> The Supreme Court was unwilling to make such an inference, and concluded "... the Guidelines do not necessarily contain explicit 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 risk."<sup>216</sup>

If, as Dr. Bragdon argued in the trial court, the "quantification of risk may be impossible,"<sup>217</sup> then health care providers are forced to operate based on an unknown risk.<sup>218</sup> The First Circuit followed the standards of *Arline* for risk assessment based on objective information. The assessment should consider: "(1) the nature, duration, and severity of the risk; (2) the probability that the potential injury will actually occur; and whether reasonable modifications of policies, practices or procedures will mitigate the risk."<sup>219</sup>

The First Circuit suggested that Dr. Bragdon might have overcome summary judgment had he provided evidence that could have been assessed by these standards, such as "sources of evidence demonstrating (a) the likelihood of a dental needlestick and (b) the likelihood of a dentist contracting HIV from a needlestick."<sup>220</sup> It is possible, therefore, that Dr. Bragdon might have been able to develop an argument from sources such as the CDC, which has reported HIV seroconversion (transmission) for percutaneous exposure at .3%,<sup>221</sup> coupled with data on dental needlestick frequency.

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214. See *Abbott v. Bragdon*, 107 F.3d at 946.

215. *Id.*

216. *Bragdon v. Abbott*, 524 U.S. at 651-52.

217. *Abbott v. Bragdon*, 912 F. Supp. at 588.

218. See *Abbott v. Bragdon*, 107 F.3d at 943.

219. *Id.*

220. *Id.* at 948.

221. See Centers for Disease Control and Prevention, *Case Control Study of HIV Seroconversion in Health-care Workers after Percutaneous Exposure to HIV-*

Dr. Bragdon failed to provide evidence that the risks to dentists were similar to the risks to health-care workers in general. If, in the future, a dentist were able to show that he or she is at a risk comparable to a surgeon, he or she could find support in scientific literature to indicate a lifetime risk as high as 10%.<sup>222</sup>

Those who would consider the legal duty of a dentist to treat HIV patients in his or her office to be settled law would do well to consider the caution given by the First Circuit on remand. While the risk of HIV infection may be small, the devastating consequences should it occur<sup>223</sup> may resonate with a jury. It might be possible, because of scientific advances or better research, for a dentist to defeat a future motion for summary judgment and have the ability to convince a jury that the risk, based on objective scientific evidence, is sufficient to obtain the "direct threat" protection of the ADA.

## V. Conclusion

Does *Bragdon v. Abbott*<sup>224</sup> establish the right of asymptomatic HIV patients to be treated no differently by their dentists than patients who do not suffer from the disease? The Court clearly answered in favor of the presumption, absent a clear showing of a direct threat to the dentist by objective scientific evidence, that a patient with HIV may not be treated differently under the ADA.<sup>225</sup> However, the Court also left open the possibility that new (or better-defined) scientific information could yield a different result.<sup>226</sup>

It was plainly the intent of Congress to provide protection against discrimination for those who suffer from HIV. However, Congress was not willing to impose a duty on dentists or

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*infected Blood - France, United Kingdom, and United States, August 1994-January 1998*, 275 JAMA 4 (1996).

222. See James G. Wright et. al., *Mechanisms of Glove Tears and Sharp Injuries Among Surgical Personnel*, 266 JAMA 12 (1991).

223. See 9 CENTERS FOR DISEASE CONTROL AND PREVENTION, *HIV/AIDS Surveillance Report* 2, 13 (1997). The CDC indicates a mortality rate of over 90% for adult and adolescent cases diagnosed in 1987 and prior. Of a total of 633,000 cases reported through December, 1997, 61% (385,968) had died.

224. *Bragdon v. Abbott*, 524 U.S. at 624.

225. *Id.* at 649.

226. *Id.*

other health care providers to take unreasonable risks to their own safety. Thus, they included the direct threat exception to equal accommodation under the ADA.<sup>227</sup>

Should a health care provider, such as Dr. Bragdon, be able to establish the existence of an unreasonable risk despite the use of universal precautions, it is likely that the issues in *Bragdon v. Abbott* could arise again.<sup>228</sup> Should this occur, either the courts or Congress will be called upon to decide, as a matter of public policy, whose rights, those of the patient or those of the doctor, will be protected.

*Deborah L. Slowata\**

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227. See Americans with Disabilities Act of 1990, 42 U.S.C. § 12182 (1998).

228. See *Abbott v. Bragdon*, 107 F.3d at 949.

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