Maine Law Review

Volume 55
Number 2 *University of Maine School of Law Lecture Series*

Article 6

June 2003

HIV and the ADA: What is a Direct Threat?

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I. INTRODUCTION

Anne, a surgical technician at a local hospital, recently learned that she was HIV-positive. She works in the emergency room and, as a part of her job, she hands surgical instruments to doctors performing emergency surgery. It is a fast paced and unpredictable environment. Her hands often come in contact with sharp instruments. Although Anne has never put her hands into a patient's body cavity, there is a remote possibility that she may need to do so in the future. There is always a possibility, however small, that she will cut herself and come into blood-to-blood contact with a doctor or patient. The hospital learns from an anonymous source that Anne is HIV-positive and tells her that she must accept a clerical position or be fired. The administration claims that using sharp instruments and patient contact are integral components of her job and that the use of gloves will not mitigate the danger because surgical instruments can pierce gloves and blood-to-blood contact is theoretically possible. She refuses to leave her current position and is fired. Is she entitled to relief under the Americans with Disabilities Act[1] (ADA)?

The answer to this question may depend on where you live because, although the ADA prohibits discrimination based on an individual's disability, there is an exception to the prohibition against discrimination if the individual's disability poses a direct threat to the health and safety of others. In *Bragdon v. Abbott*,[2] the Supreme Court held that HIV could be considered a disability under the ADA.[3] However, the Court has not answered the question of what constitutes a direct threat. Because the Supreme Court did not resolve the direct threat matter in *Bragdon*, questions about the level of evidence necessary to establish a direct threat exist. What constitutes a risk? What does the term "significant" mean? How does one determine when a "significant risk" is present? When does reasonable accommodation eliminate the significant risk? Does the type of employment impact whether or not a significant risk exists? If so, how can a direct threat be eliminated?

Circuit courts have answered these questions differently and there is significant disagreement regarding the level of evidence necessary to prove that an HIV-positive individual poses a direct threat to the health and safety of others. On the one hand, the First and Ninth Circuits interpret significant risk to mean more than a mere theoretical possibility of transmission.[4] These courts require that a party attempting to invoke the exception provide comprehensive and objective medical evidence that there is a significant risk of transmission. However, the Fourth, Fifth, Sixth, and Eleventh Circuits approach the burden of proof from a different

1. 42 U.S.C. §§ 12101-12213 (2000).
2. 524 U.S. 624 (1998).
3. *Id.* at 655.
4. Abbott v. Bragdon, 163 F.3d 87, 90 (1st Cir. 1998); Chalk v. United States Dist. Court, 840 F.2d 701, 703 (9th Cir. 1988).

perspective and require significantly less medical evidence.[5] For these courts, a showing of a theoretical possibility of transmission is enough to invoke the direct threat exception, even if the odds of transmission are extremely small.

This Comment analyzes the protective legislation for individuals with disabilities, the legislative history, the codification of the direct threat exception, and Supreme Court precedents to show that Congress intended to enact a direct threat exception that requires strong, objective medical evidence in an effort to protect individuals with disabilities, including those who are HIV-positive, from unwarranted prejudice.

In Section II, this Comment presents an overview of the two major pieces of legislation enacted to protect individuals with disabilities from unfair prejudice, the Rehabilitation Act of 1973[6] and the Americans with Disabilities Act.[7] The overview provides definitions of important terms, such as "disability"[8] and "reasonable accommodation."[9] It examines the legislative history surrounding the enactment of the ADA, which provides insight into the intended scope of the legislation, the controversy regarding the inclusion of HIV under the definition of disability, and the decision to require that a direct threat exception be invoked only if a "significant risk,"[10] not "any risk," is present. The discussion makes clear the ambitious goals of Congress to eliminate unfair discrimination against individuals with disabilities and provide a context for the current legal environment.

Section III provides a detailed discussion of the "direct threat exception."[11] In addition to examining the definition of direct threat, this Comment takes a detailed look at a leading direct threat case, *School Board v. Arline*.[12] This case is important because, in enacting the ADA, Congress codified the direct threat standard[13] articulated in *Arline* and *Arline* continues to be cited as authority in direct threat cases.[14] This early case is also helpful because it provides evidence that the Supreme Court has traditionally required comprehensive and objective medical evidence when a party attempts to invoke a direct threat exception. This section will also explore the Supreme Court's landmark HIV decision, *Bragdon v. Abbott*.[15] This case marks the first time that the Supreme Court addressed whether HIV-positive individuals are protected under the ADA. Although the Court in *Bragdon* did not decide how much evidence is necessary to invoke the direct threat exception, this Comment analyzes the Court's examination of the medical evidence in

5. Doe v. Univ. of Md. Med. Sys. Corp., 50 F.3d 1261, 1266 (4th Cir. 1995); Bradley v. Univ. of Tex. M.D. Anderson Cancer Ctr., 3 F.3d 922, 924 (5th Cir. 1993); Estate of Mauro v. Borgess Med. Ctr., 137 F.3d 398, 407 (6th Cir. 1998); Onishea v. Hopper, 171 F.3d 1289, 1299 (11th Cir. 1999).

6. 29 U.S.C. §§ 701-796 (2000).

7. 42 U.S.C. §§ 12101-12213 (2000).

8. *Id.* § 12102(2).

9. *Id.* § 12111(9).

10. *Id.* § 12111(l)(3).

11. *Id.*

12. 480 U.S. 273, 288 (1987).

13. H.R. REP. No. 101-485(II), at 76 (1990), *reprinted in* 1990 U.S.C.C.A.N. 303, 359.

14. *E.g.*, Onishea v. Hopper, 171 F.3d 1289, 1297 (11th Cir. 1999); Estate of Mauro v. Borgess Med. Ctr., 137 F.3d 398, 400-03 (6th Cir. 1998); Doe v. Univ. of Md. Med. Sys. Corp., 50 F.3d 1261, 1265-66 (4th Cir. 1995); Bradley v. Univ. of Tex. M.D. Anderson Cancer Ctr., 3 F.3d 922, 924-25 (5th Cir. 1993); Chalk v. United States Dist. Court, 840 F.2d 701, 704-05 (9th Cir. 1988).

15. 524 U.S. 624 (1998).

the case.[16] In its decision to remand, the Supreme Court's analysis provides subtle, but important, directives to lower courts.[17] The intense scrutiny of the medical evidence by the Supreme Court provides evidence that the Court, as well as Congress, intended a direct threat standard requiring solid, objective medical evidence rather than a theoretically possible or "any risk" standard.

Section IV of this Comment examines the controversy and different levels of evidence required within the circuit courts. The First and Ninth Circuits are closely aligned with the Supreme Court's implicit directives and the legislative intent behind the ADA.[18] Four circuit courts, however, have failed to recognize the importance of the "significant risk" requirement established by Congress and the Supreme Court. Instead, the Fourth, Fifth, Sixth, and Eleventh Circuits have taken a more cautious approach to the direct threat exception as applied to HIV-positive individuals, requiring less evidence and only small odds of transmission to invoke the exception.[19]

Section V of this Comment, the conclusion, synthesizes the information set forth in the paper to provide a finding that, in order to fulfill the ambitious goals of the ADA, the direct threat exception should be invoked only when the moving party presents exacting, objective medical evidence.

II. STATUTORY OVERVIEW

A. The Rehabilitation Act of 1973

The Rehabilitation Act of 1973[20] was the first major piece of federal legislation attempting to address discrimination against individuals with disabilities. Under the Rehabilitation Act, the term "individual with a disability" means an individual "who (i) has a physical or mental impairment which for such individual constitutes or results in a substantial impediment to employment; and (ii) can benefit in terms of an employment outcome from vocational rehabilitation services provided" by the legislation.[21] Under the statute, the term "major life activities" means "a physical or mental impairment which substantially limits one or more of such person's major life activities; . . . a record of such an impairment;" or "regarded as having such an impairment."[22]

The statute deals with three major areas of federal involvement. First, the statute enacts employment requirements of nondiscrimination and affirmative action for federal employers.[23] Second, federal contractors are also required to imple-

16. *Id.* at 649-54. The Supreme Court acknowledged the congressional codification of the *Arline* test and applied this standard in its direct threat discussion. *Id.* at 649-51. The Supreme Court also looked closely at the evidence presented by both parties in the case but remanded the case because of the importance of having the most accurate, and current, medical evidence available. *Id.* at 649-54.

17. *Id.* at 653-54.

18. Abbott v. Bragdon, 163 F.3d 87, 88-90 (1st Cir. 1998); Chalk v. United States Dist. Court, 840 F.2d at 703. The Ninth Circuit decided *Chalk* before the enactment of the ADA; however, it continues to be relevant to the direct threat discussion because it employed the *Arline* test. *Id.*

19. Onishea v. Hopper, 171 F.3d at 1296-99; Estate of Mauro v. Borgess Med. Ctr., 137 F.3d at 403-04; Doe v. Univ. of Md. Med. Sys. Corp., 50 F.3d at 1266; Bradley v. Univ. of Tex. M.D. Anderson Cancer Ctr., 3 F.3d at 924-25.

20. 29 U.S.C. 701-796 (2000).

21. *Id.* § 705(20)(A).

22. *Id.* § 705(20)(B).

23. *Id.* § 791(b).

ment nondiscrimination and affirmative action in employment policies.[24] Finally, entities receiving financial assistance from the federal government, such as educational institutions, transportation, places of public accommodation, and social services, are required to implement nondiscrimination policies and provide for reasonable accommodation for individuals with disabilities.[25]

The Department of Health, Education, and Welfare issued regulations in an attempt to provide guidance to entities subject to the Rehabilitation Act.[26] In this regulation, the Department stated that "physical or mental impairment" included the following:

> (A) [A]ny physiological disorder or condition, cosmetic disfigurement, or anatomical loss affecting one or more of the following body systems: neurological; musculoskeletal; special sense organs; respiratory, including speech organs; cardiovascular; reproductive, digestive; genito-urinary; hemic and lymphatic; skin; and endocrine; or (B) any mental or psychological disorder, such as mental retardation, organic brain syndrome, emotional or mental illness, and specific learning disabilities.[27]

The department also attempted to clarify the meaning of the term "major life activities" by explaining that the term included "functions such as caring for one's self, performing manual tasks, walking, seeing, hearing, . . . learning, and working."[28]

Although the regulation helped to explain the meanings of "physical and mental impairment" and "major life activities," the regulation did not explicitly present a list of diseases and conditions covered by the Rehabilitation Act.[29] In a later explanation of the regulation, the Department listed examples of the diseases and conditions, such as "orthopedic, visual, speech, and hearing impairments, cerebral policy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, mental retardation, emotional illness, and . . . drug addiction and alcoholism," but also made clear that the list was not exhaustive.[30]

B. The Americans with Disabilities Act of 1990

The ADA was enacted in 1990 to eliminate discrimination against individuals with disabilities.[31] The purpose of the ADA was to provide a "clear and comprehensive national mandate to end discrimination against individuals with disabilities and to bring persons with disabilities into the economic and social mainstream of American life . . . ."[32] The enactment of the legislation provided enforceable standards to address "discrimination against individuals with disabilities, and to ensure that the Federal government plays a central role in enforcing these standards on behalf of individuals with disabilities."[33]

The ADA defines disability as "a physical or mental impairment that substan-

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24. *Id.* § 793.
25. *Id.* § 794.
26. *See, e.g.*, 45 C.F.R. § 84.3(j)(2) (2002).
27. *Id.*
28. *Id.*
29. *See* 45 C.F.R. pt. 84, App. A.
30. *Id.* In addition to emphasizing that the list of physical or mental impairments were not exclusive, the Department also declined to narrow the definition of handicapped person. *Id.*
31. 42 U.S.C. § 12101(b)(1) (2000).
32. H.R. REP. No. 101-485(II), at 22-23 (1990), *reprinted in* 1990 U.S.C.C.A.N. 303, 304.
33. *Id.*

tially limits one or more of the major life activities of such individual; a record of such an impairment; or being regarded as having such an impairment."[34] In order to be a "qualified individual with a disability" under the ADA, an individual with a disability must satisfy the required "skill, experience, education and other job-related requirements of the employment position" and the individual must be able to complete the essential tasks of the job "with or without reasonable accommodation."[35] The ADA does not specify particular disabilities covered under the Act due to the difficulty in constructing a comprehensive list of coverage.[36]

Congress required that the Equal Employment Opportunity Commission (EEOC) issue employment related regulations[37] in an effort to facilitate the implementation of the ADA.[38] In these regulations, the EEOC defined the terms located in the first prong of the definition, "physical or mental impairment,"[39] "major life activities,"[40] and "substantially limits."[41] These definitions are particularly important because an HIV-positive person is protected under the ADA only if he or she satisfies all three of these regulatory definitions.

Under the ADA, "physical or mental impairment" means:

> (1) 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, enitor-urinary, hemic and lymphatic, skin, and

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34. 42 U.S.C. § 12102(2).

35. 29 C.F.R. § 1630.2(m) (2002). For purposes of the ADA, reasonable accommodation means:

> (i) Modifications or adjustments to a job application process that enable a qualified applicant with a disability to be considered for the position such qualified applicant desires; or
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> (ii) Modifications or adjustments to the work environment, or to the manner or circumstances under which the position held or desired is customarily performed, that enable a qualified individual with a disability to perform the essential functions of that position; or
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> (iii) Modifications or adjustments that enable a covered entity's employee with a disability to enjoy equal benefits and privileges of employment as are enjoyed by its other similarly situated employees without disabilities.
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> (2) Reasonable accommodation may include but is not limited to:
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> (i) Making existing facilities used by employees readily accessible to and usable by individuals with disabilities; and
>
> (ii) Job restructuring; part-time or modified work schedules; reassignment to a vacant position; acquisition or modifications of equipment or devices; appropriate adjustment or modifications of examinations, training materials, or policies; the provision of qualified readers or interpreters; and other similar accommodations for individuals with disabilities.

29 C.F.R. § 1630.2(o).

36. 42 U.S.C. § 12211. The ADA does state that a person is not disabled, for purposes of the ADA, solely because of homosexuality, bisexuality, transvestism, transsexualism, pedophilia, exhibitionism, voyeurism, gender identity disorders not resulting from physical impairments, or other sexual behavior disorders; compulsive gambling, kleptomania, or pyromania; or psychoactive substance use disorders resulting from current illegal use of drugs. *Id.*

37. 42 U.S.C. § 12116.

38. 29 C.F.R. § 1630.1.

39. *Id.* § 1630.2(h).

40. *Id.* § 1630.2(i).

41. *Id.* § 1630.2(j).

endocrine; or (2) Any mental or psychological disorder, such as mental retardation, organic brain syndrome, emotional or mental illness, and specific learning disabilities.[42]

According to the EEOC, "substantially limits" means that an individual, due to his or her disability, cannot "perform a major life activity that the average person in the general population can perform," or that the individual with a disability is "significantly restricted as to the condition, manner or duration under which an individual can perform a particular major life activity" compared to the ability of an "average" person's performance of a major life activity in the same "condition, manner, or duration."[43] There are several factors to consider when evaluating whether the impairment substantially impacts a major life activity, such as "nature and severity of the impairment," the "duration, or expected duration, of the impairment," and "[t]he permanent or long term impact, or the expected permanent or long term impact of or resulting from the impairment."[44] Although the regulation does not provide an exclusive list of "substantially limiting disabilities," it does state that HIV is "inherently substantially limiting."[45]

Finally, the EEOC defined the term "major life activities."[46] "Major life activities" are "basic activities that the average person in the general population can perform with little or no difficulty."[47] Although the EEOC is not exclusive,[48] it provides examples of "major life activities," including "functions such as caring for oneself, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning, and working."[49] The definition of "major life activity" is significant because, as the Supreme Court discussed in *Bragdon v. Abbott*,[50] although HIV-positive individuals may have physical impairments, these individuals are not protected under the ADA unless the "impairment affects a major life activity."[51]

The ADA provides protection for individuals with disabilities in four major circumstances.[52] First, an individual with a disability is protected from discrimination in employment matters.[53] An employer[54] may not discriminate against a "qualified individual" with a disability "in regard to job application procedures, the hiring, advancement, or discharge of employees, employee compensation, job

42. *Id.* § 1630.2(h).
43. *Id.* § 1630.2(j).
44. *Id.* § 1630.2(j)(2)(iii).
45. *Id.* pt. 1630, App. § 1630.2(j).
46. *Id.* § 1630.2(i).
47. *Id.* pt. 1630, App. § 1630.2(i).
48. *Id.*
49. *Id.* § 1630.2(i).
50. 524 U.S. 624 (1998).
51. *Id.* at 637. In this case, the Respondent argued that HIV infection substantially limited her reproduction ability and this constituted a "major life activity." *Id.* The Supreme Court noted that given the invasive and fatal course of the disease, other HIV-positive individuals may argue that the disease substantially limits other "major life activities" but limited their discussion in this case to reproduction. *Id.* at 638.
52. 42 U.S.C. §§ 12101-12213 (2000).
53. *Id.* §§ 12111-12117.
54. An employer, for the purposes of the Act, is an individual "engaged in an industry affecting commerce who has 15 or more employees for each working day in each of 20 or more calendar weeks." *Id.* § 12111.
55. *Id.* § 12112.

training, and other terms, conditions, and privileges of employment."[55] However, an employer may defend against a charge of discrimination if he or she can prove that the individual cannot perform the job-related tasks even if "reasonable accommodations" are made or if the individual poses a direct threat to the health and safety of others.[56]

In the second component of the ADA, public entities[57] cannot deny qualified individuals the opportunity to participate in, or receive the benefits of, public services, programs, or activities.[58] The provisions regulating public entities in the ADA include both facilities and vehicles of public entities.[59]

Third, the ADA prohibits discrimination of "qualified individuals" in places of public accommodation.[60] The definition of a place of public accommodation is broad in order to ensure the Act encompassed all places open and available to the public.[61] Congress expanded the scope of federal protection to cover places of public accommodation based upon a finding that an "overwhelming majority" of individuals with disabilities did not frequent places of public accommodation be-

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56. *Id.* § 12113.

57. Under the ADA, a public entity is "(A) any State or local government; (B) any department, agency, special purpose district, or other instrumentality of a State or States or local government; and (C) the National Railroad Passenger Corporation, and any commuter authority." *Id.* § 12131.

58. *Id.* § 12132.

59. *Id.* § 12134(c).

60. For the purposes of the ADA, the following locations are places of public accommodation, if the function of these entities have an effect on commerce—

> (A) an inn, hotel, motel, or other place of lodging, except for an establishment located within a building that contains not more than five rooms for rent or hire and that is actually occupied by the proprietor of such establishment as the residence of such proprietor;
> (B) a restaurant, bar, or other establishment serving food or drink;
> (C) a motion picture house, theater, concert hall, stadium, or other place of exhibition or entertainment;
> (D) an auditorium, convention center, lecture hall, or other place of public gathering;
> (E) a bakery, grocery store, clothing store, hardware store, shopping center, or other sales or rental establishment;
> (F) a laundromat, dry-cleaner, bank, barber shop, beauty shop, travel service, shoe repair service, funeral parlor, gas station, office of an accountant or lawyer, pharmacy, insurance office, professional office of a health care provider, hospital, or other service establishment;
> (G) a terminal, depot, or other station used for specified public transportation;
> (H) a museum, library, gallery, or other place of public display or collection;
> (I) a park, zoo, amusement park, or other place of recreation;
> (J) a nursery, elementary, secondary, undergraduate, or postgraduate private school, or other place of education;
> (K) a day care center, senior citizen center, homeless shelter, food bank, adoption agency, or other social service center establishment; and
> (L) a gymnasium, health spa, bowling alley, golf course, or other place of exercise or recreation.

Id. § 12181(7). The term "commerce" is defined in the ADA as "travel, trade, traffic, commerce, transportation, or communication—(A) among the several States; (B) between any foreign country or any territory or possession and any State; or (C) between points in the same State but through another State or foreign country." *Id.* § 12181(1).

61. H.R. REP. No. 101-485(II), at 35 (1990), *reprinted in* 1990 U.S.C.C.A.N. 303, 317.

cause they did not feel welcome, did not believe that such places were safe due to past discrimination, felt self-conscious about their disabilities, and faced insurmountable architectural and structural obstacles.[62]

Finally, the ADA deals with telecommunications and common carriers.[63] The ADA requires that common carriers[64] make telecommunications relay services available to hearing-impaired and speech-impaired individuals.[65] Telecommunication relay services provide an individual with a hearing or speech impairment with the ability to "engage in communication by wire or radio with a hearing individual in a manner that is functionally equivalent to the ability of an individual who does not have a hearing impairment or speech impairment to communicate using voice communication services by wire or radio."[66]

III. THE DIRECT THREAT EXCEPTION AND *BRAGDON V. ABBOTT*

A. The Direct Threat Exception

The goal of ADA was to protect disabled individuals from unfair discrimination. In its pursuit of equity, however, Congress did not lose sight of its obligation to protect the collective interests of society. Congress provided two primary avenues to balance the potentially competing interests of individuals with disabilities and the interests of society at large.

First, Congress allows employers to implement certain "qualification standards."[67] An employer may combat a charge of discrimination if he or she can demonstrate that the "qualification standards, tests, or selection criteria that screen out or . . . otherwise deny a job or benefit to an individual with a disability has been shown to be job-related and consistent with business necessity, and such perfor-

62. H.R. REP. No. 101-485(II), at 34-35 (1990), *reprinted in* 1990 U.S.C.C.A.N. 303, 316-17. Discrimination in places of public accommodation includes denying qualified individuals the opportunity to participate or benefit from the "goods, services, facilities, privileges, advantages, or accommodations of an entity." 42 U.S.C. § 12182(b)(1)(a)(i). It is also discriminatory, under the ADA, to provide qualified individuals with a benefit that is unequal in comparison to a benefit provided to other individuals, or benefit that is separate from that provided to other individuals, unless the separation is necessary to effectively provide the benefit to the qualified individual. *Id.* § 12182(b)(1)(a)(ii)-(iii). Unless structurally impractical, places of public accommodation must also design and construct new facilities to accommodate individuals with disabilities. *Id.* § 12183(a)(1). This requirement took effect on August 26, 1990. *Id.* If a facility was constructed before the enactment of the ADA, any subsequent alterations must be designed to accommodate individuals with disabilities. *Id.* § 12183(a)(2). The ADA does not, however, require the installation of an elevator. *Id.* § 12183(b). The requirements of accommodation also apply to specific public transportation services that are provided by private entities. *Id.* § 12184.

63. 47 U.S.C. § 225 (2000).

64. "The term 'common carrier' or 'carrier' includes any common carrier engaged in interstate communication by wire or radio as defined in section 153 of this title and any common carrier engaged in intrastate communication by wire or radio, notwithstanding sections 152(b) and 221(b) of this title." *Id.* § 225(a)(1).

65. *Id.* § 225(b)(1).

66. *Id.* § 225(a)(3).

67. 42 U.S.C. § 12113(a) (2000).

68. *Id.* The regulation defines "qualification standards" as "personal and professional attributes including the skill, experience, education, physical, medical, safety and other requirements established by a covered entity as requirements which an individual must meet in order to be eligible for the position held or desired." 29 C.F.R. § 1630.2(q) (2002).

mance cannot be accomplished by reasonable accommodation."[68] The statute provides that "qualification standards" may include a "requirement that an individual shall not pose a direct threat to the health or safety of other individuals in the workplace."[69]

Second, the ADA expressly provides an exception to the prohibition on discrimination if the disability "poses a direct threat to the health or safety of others."[70] Under the statute, nothing in the Act requires:

> an entity to permit an individual to participate in or benefit from the goods, services, facilities, privileges, advantages and accommodations of such entity where such individual poses a direct threat to the health or safety of others. The term "direct threat" means a significant risk to the health or safety of others that cannot be eliminated by a modification of policies, practices, or procedures or by the provision of auxiliary aids or services.[71]

The regulation sheds some light on questions of statutory interpretation.[72] First, it makes clear that the existence of a "direct threat" is based on an individualized evaluation of "the individual's present ability to safely perform the essential functions of the job."[73] The assessment of an individual's ability is "based on a reasonable medical judgment," relying on the most current and/or best available objective medical knowledge.[74] Second, the regulation provides the following direct threat test: "In determining whether an individual would pose a direct threat, the factors to be considered include: (1) [t]he duration of the risk; (2) [t]he nature and severity of the potential harm; (3) [t]he likelihood that the potential harm will occur; and (4) [t]he imminence of the potential harm."[75]

In constructing the direct threat exception, Congress codified the standard created in the 1979 Supreme Court case, *School Board v. Arline*.[76] Arline was an elementary school teacher in Nassau County, Florida who was fired after her third relapse of tuberculosis.[77] She filed suit in federal court alleging that the school board violated § 504 of the Rehabilitation Act because she was fired due to her tuberculosis.[78] At trial, the superintendent of schools testified that Arline was, in fact, fired because of the "'continued reoccurrence of tuberculosis.'"[79] The district court found in favor of the school board.[80] The Eleventh Circuit reversed the lower court's decision, holding that a contagious disease could be covered under

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69. 42 U.S.C. § 12113(b).

70. *Id.* § 12182(b)(3).

71. *Id.*

72. 29 C.F.R. § 1630.2(r) (2002).

73. *Id.*

74. *Id.*; *see also* H.R. REP. NO. 101-485(II), at 56 (1990), *reprinted in* 1990 U.S.C.C.A.N. 303, 338. "The determination that an individual with a disability will pose a safety threat to others must be made on a case-by-case basis and must not be based on generalizations, misperceptions, ignorance, irrational fears, patronizing attitudes, or pernicious mythologies." *Id.*

75. 29 C.F.R. § 1630.2(r).

76. 480 U.S. 273 (1987). Congress codified the *Arline* decision and "the term 'direct threat' is meant to connote the full standard set forth in the *Arline* decision." H.R. REP. NO. 101-485(II), at 76 (1990), *reprinted in* 1990 U.S.C.C.A.N. 303, 359.

77. Sch. Bd. v. Arline, 480 U.S. at 276.

78. *Id.* Arline filed suit in federal court only after a state administrative proceeding denied her any relief. *Id.*

79. *Id.* (quoting testimony from superintendent of schools for Nassau County, Craig Marsh).

80. *Id.* at 277.

the Act and remanded the case for further findings to determine whether Arline was "'otherwise qualified'" for her job.[81] The Supreme Court granted certiorari and affirmed the decision of the Eleventh Circuit.[82]

The Supreme Court first held that the "fact that a person with a record of a physical impairment is also contagious does not suffice to remove that person from coverage" under the Rehabilitation Act.[83] The Supreme Court then examined whether Arline was "otherwise qualified" to be an elementary schoolteacher.[84] To evaluate the existence of health and safety risks, the Court utilized the test established in the amicus brief by the American Medical Association.[85] The Court held that in a situation involving the employment of a handicapped individual with a contagious disease, the findings of fact should be based on the following:

> 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.[86]

According to the Supreme Court, when making these findings, lower courts should typically defer to the "reasonable medical judgments of public health officials."[87] In light of these findings, the next step for the courts was to evaluate whether it was possible for an employer to reasonably accommodate the handicapped employee.[88] The Supreme Court held that an individual with tuberculosis can fall under the definition "handicapped" in the Rehabilitation Act but remanded the case to determine whether Arline was "otherwise qualified" to teach elementary school.[89]

On remand, the district court emphasized the importance of the findings of facts, which had to be based on "'reasonable medical judgments' given the state of medical knowledge."[90] The court discussed, in great detail, the low probability of transmitting tuberculosis through the air.[91] The district court also examined the

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81. Arline v. Sch. Bd., 772 F.2d 759, 765 (11th Cir. 1985).

82. Sch. Bd. v. Arline, 480 U.S. at 277.

83. *Id.* at 286.

84. *Id.* at 287.

85. *Id.* at 288 (citing Brief for American Medical Association as Amicus Curiae).

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

87. *Id.* (footnote omitted). In an "employment context, an otherwise qualified person is one who can perform 'the essential functions of the job in question.'" *Id.* at 287 n.17 (quoting 45 C.F.R. § 84.3(k) (1985)).

88. *Id.* at 288. An individual is "otherwise qualified" if he or she is able to meet "'all of a program's requirements in spite of his [or her] handicap.'" *Id.* at 287 n.17 (quoting Southeastern Cmty. Coll. v. Davis, 442 U.S. 397, 406 (1979)). Reasonable accommodation is not required if it poses an undue financial or administrative hardship on the employer or if the accommodation would not overcome the effects of an individual's handicap. *Id.*

89. *Id.* at 288-89.

90. Arline v. Sch. Bd., 692 F. Supp. 1286, 1291 (N.D. Fla. 1988).

91. *Id.* at 1287-88. Communication of the disease was extremely unlikely because when "droplet nuclei are expelled from one person, almost all, or 99.9 [percent], of the nuclei die within a second of contacting room air." *Id.* at 1288. The droplets that do survive must then reach the distal portion, or the "microscopic air space," of the lungs of a person who inhales the germs. *Id.* If a germ does reach the distal portion of a person's lungs, the body's immune system is capable of "rendering it harmless." *Id.* at 1287-88. If the immune system does not render the germ harmless, it can cause infection. *Id.* at 1288. However, only about five percent of infected

communicability of the disease in relation to the importance of medical treatment.[92] Based on an examination of the nature, duration, and severity of the risk involved, and the probability of transmission of tuberculosis, the district court held that the "risk of communication of tuberculosis by [Arline] and the risk of harm to others . . . [did] not exist" and Arline was qualified to teach elementary school.[93]

The fact intensive analysis conducted by the district court is important because Congress codified the test set forth in *Arline*.[94] This suggests that the Supreme Court signaled, in 1979, that the direct threat exception must be based on objective medical evidence, not conjecture or theoretical possibilities of transmission. Because Congress codified the *Arline* test in its enactment of the ADA direct threat exception, this provides evidence that Congress, as well as the Supreme Court, has implicitly indicated that more than a theoretical possibility of transmission is necessary to invoke the direct threat exception.

B. Bragdon v. Abbott: *HIV Can Constitute a Disability Under the ADA*

In *Bragdon v. Abbott*,[95] the Supreme Court confirmed that HIV could constitute a disability under the ADA. In 1994, the plaintiff, Sidney Abbott, disclosed her HIV status to her dentist, Randon Bragdon, on a patient registration form.[96] During the examination, Bragdon discovered that Abbott had a cavity.[97] Upon discovering the cavity, Bragdon informed Abbott that he had a "policy against filling cavities of HIV-positive patients" in his office.[98] He offered to fill the cavity at a hospital for no additional charge for his services; however, under this arrangement, Abbott would be responsible for the additional hospital fees.[99] Abbott declined the offer and filed suit under Maine law and the ADA, alleging discrimination because of her disability.[100]

The district court granted Abbott's motion for summary judgment based on a finding that Abbott's HIV infection constituted a disability under the ADA.[101] In its decision, the district court relied on an affidavit from Dr. Donald Wayne Marianos, the Director of the Division of Oral Health of the Center for Disease Control and

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individuals will experience a progression into the "disease within the first two years after infection" and only another five percent will develop the disease over the course of the individual's life. *Id.* The district court's attention to detail is important because it provides evidence that the intent of the "direct threat exception" was to provide a precise examination of the actual risk an individual who has a contagious disease poses to the health and safety of others. *Id.*

92. *Id.* at 1288-89.

93. *Id.* at 1292.

94. H.R. REP. NO. 101-485(II), at 76 (1990), *reprinted in* 1990 U.S.C.C.A.N. 303, 359.

95. 524 U.S. 624 (1998).

96. *Id.* at 628-29.

97. *Id.* at 629.

98. *Id.*

99. *Id.*

100. *Id.* Abbott sued under 42 U.S.C. § 12182 (2000). The relevant section of the statute states "no individual shall be discriminated against on the basis of disability in the full and equal enjoyment of the goods, services, facilities, privileges, advantages, or accommodations of any place of public accommodation by any person who . . . operates a place of public accommodation." *Id.* § 12182(a). The court determined that the dentist's office constituted a place of public accommodation because the term explicitly includes a "professional office of a health care provider." *Id.* § 12181(7)(F).

101. Bragdon v. Abbott, 524 U.S. at 630 (citing Abbott v. Bragdon, 912 F. Supp. 580, 585-87 (D. Me. 1995)).

Prevention (CDC).[102] The affidavit indicated that, as long as dentists take "universal precautions," it is safe to treat HIV-positive patients in a dental office.[103]

The First Circuit affirmed this decision, holding that Abbott's HIV infection was a disability, despite the fact that her infection had not advanced to the symptomatic stage.[104] The First Circuit also held that treating an HIV-positive patient in a dental office would not pose a direct threat to the health and safety of others.[105] Instead of relying on the affidavit of Dr. Marianos, the circuit court relied on the 1993 CDC Guidelines and the Policy on AIDS, HIV Infection and the Practice of Dentistry, which was published by the American Dental Association.[106]

The Supreme Court granted certiorari and focused on whether her HIV status constituted a disability under the ADA.[107] The Supreme Court affirmed the First Circuit, holding that Abbott's HIV status was a disability under the ADA.[108] The Court utilized a three-step approach in its analysis.[109] First, the Court considered whether Abbott's HIV infection constituted a "physical impairment."[110] Second, the Court examined the life activities that Abbott relied upon, reproduction and child bearing, to determine whether it was a "major life activity" under the ADA.[111] Finally, the Court combined the phrases "physical impairment" and "major life activity" to examine whether the "impairment substantially limited the major life activity."[112]

In its first step, the Court relied on the regulations interpreting the Rehabilitation Act, which were promulgated by the Department of Health, Education and Welfare (HEW), to determine whether or not HIV was a "physical impairment."[113] Because HIV is not included in the list of specific disorders that constitute physical impairment,[114] the Court had to compare the definition of "physical impairment" to the physical impact of HIV to determine whether or not asymptomatic HIV constituted a disability.[115] In assessing whether or not HIV infection was a physical impairment, the Supreme Court addressed the complexity of the disease in great detail, basing its analysis on the wealth of medical information available.[116]

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102. *Id.*

103. *Id.* (citing Abbott v. Bragdon, 912 F. Supp. at 589). The "universal precautions" are explained in the CDC's 1993 guidelines and indicate that it is safe to treat HIV-positive patients in the dental office. *Id.*

104. *Id.* (citing Abbott v. Bragdon, 107 F.3d 934, 939-43 (1st Cir. 1997)).

105. *Id.* (citing Abbott v. Bragdon, 107 F.3d at 943-48).

106. *Id.* (citing Abbott v. Bragdon, 107 F.3d at 945-46).

107. *Id.*

108. *Id.*

109. *Id.* at 631.

110. *Id.*

111. *Id.*

112. *Id.* In its construction of the statute, the Court relied upon definitions found in previous statutes, as well as interpretations from administrative agencies that had previously analyzed the matter. *Id.*

113. *Id.* at 632 (citing 45 C.F.R. § 84.3(j)(2)(i) (1997)). The Court relied on this definition heavily because HEW was the agency responsible for the implementation and enforcement of the Rehabilitation Act and the definition of physical impairment appears, without change, in the current regulation. *Id.*

114. The Court notes that one reason HIV is not included in the list of specific disorders is because HIV was not recognized as the cause of AIDS until 1983, long after the regulation was promulgated. *Id.* at 633.

115. *Id.* at 633-37.

116. *Id.* at 634-37.

The Court determined that HIV has an immediate and devastating physical impact on the infected individual and, based on this conclusion, held that "HIV infection satisfies the statutory and regulatory definition of a physical impairment during every stage of the disease" from the moment of infection, whether it is symptomatic or asymptomatic.[117]

The Court then examined whether or not Abbott's physical impairment affected a "major life activity."[118] In this case, Abbott maintained that her HIV infection limited her ability to reproduce and bear children.[119] Although the Court limited its analysis to the reproduction issue, it acknowledged that other HIV-positive parties could present legal arguments that HIV infection substantially limits other major life activities.[120] The Supreme Court agreed with the First Circuit's definition of a "major life activity," which stated "'the plain meaning of the word "major" denotes comparative importance' and 'suggests that the touchstone for determining an activity's inclusion under the statutory rubric is its significance.'"[121] The Supreme Court also agreed with the Court of Appeals's holding that reproduction fell within the definition of a "major life activity" because "reproduction and the sexual dynamics surrounding it are central to the life processes itself."[122]

The Supreme Court then considered whether Abbott's physical impairment "substantially limited [her] major life activity."[123] The Court held that Abbott's HIV infection substantially limited her capacity to reproduce in two ways. First, the Court held that an HIV-positive woman who tries to conceive a child inflicts a "significant risk" of infection on her male partner.[124] Second, the Court concluded that HIV substantially limits a woman's reproductive rights because a woman who is infected with HIV risks infecting her child during pregnancy and during child-

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117. *Id.* at 637.

118. *Id.*

119. *Id.* Although the Court limited its analysis to the reproduction issue, it did acknowledge that other HIV-positive parties could present legal arguments that HIV infection substantially limits other major life activities. *Id.*

120. *Id.*

121. *Id.* at 638 (quoting Abbott v. Bragdon, 107 F.3d 939, 940 (1st Cir. 1997)).

122. *Id.* The Supreme Court rejected Bragdon's claim that Congress intended to limit the reach of ADA to cover a person's activities only if they involve a "public, economic, or daily character." *Id.* First, the Court determined that the definition of "major life activity" did not suggest that activities outside the rubric of public, economic, or daily are not covered under the ADA. *Id.* In fact, the "breadth of the term" is contrary to such limitation. *Id.* Second, because the ADA must be consistent with the Rehabilitation Act regulations, it is necessary to look at the regulations for guidance. *Id.* The regulation provides an illustrative, but not exclusive, list of major life activities, such as "walking, seeing, hearing, speaking, breathing, learning, and working." *Id.* at 638-39 (citing 45 C.F.R. § 84.3(j)(2)(ii) (1997); 28 C.F.R. § 41.31(b)(2) (1997)). The Court determined that the regulation supports the argument that reproduction is a "major life activity" because "reproduction cannot be regarded as any less important than working and learning." *Id.* at 639. Because Bragdon did not provide a sufficient reason to support his claim that reproduction was not a major life activity, the Court upheld the Court of Appeals determination that reproduction was a "major life activity." *Id.*

123. *Id.*

124. *Id.* After reviewing the available medical data, the Court found that "[t]he cumulative results of 13 studies collected in a 1994 textbook on AIDS indicates that 20% of male partners of women with HIV became HIV-positive themselves, with a majority of the studies finding a statistically significant risk of infection." *Id.* at 640.

birth.[125] The Court listed a number of medical sources that placed the risk of transmission from mother to child between fourteen and forty percent, noting that many studies place the risk of transmission between the ranges of twenty-five to thirty percent.[126] Although a woman who is HIV-positive can conceive and bear children, the Court determined that conception and childbirth constituted a danger to the public health and that this danger met the definition of substantial limitation under the Act.[127] Because the Court held Abbott's HIV infection was a physical impairment that substantially limited a major life activity, the Court did not address whether HIV infection is per se a disability under the Act.[128] Therefore, the determination of whether or not HIV infection is a disability under the ADA is fact specific.

After holding that asymptomatic HIV may constitute a disability under the ADA, the Supreme Court examined the direct threat issue. If her condition "pose[d] a direct threat to the health or safety of others," Bragdon's refusal to treat Abbott would have been legal, even though Abbott was disabled for purposes of the Act.[129] The Supreme Court ultimately remanded the direct threat issue to the circuit court. However, before doing so, the Court set forth guidelines for the lower courts to follow and also provided signals for constructing an appropriate burden of proof structure.[130]

First, the Court outlined the guidelines for evaluating a direct threat claim. It acknowledged the need to apply the *Arline* test to determine the existence of a direct threat.[131] The Court then discussed the type of evidence necessary by stating 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."[132] Thus, as a health care professional, Bragdon had a duty to evaluate "the risk of infection based on the objective, scientific information available to him and others

125. *Id.* The Court listed a number of medical sources that placed the risk of transmission from mother to child between fourteen and forty percent, noting that many studies place the risk of transmission between the ranges of twenty-five to thirty percent. *Id.* The Supreme Court rejected Bragdon's argument that HIV infection does not substantially limit the ability of an HIV-positive woman to reproduce because of the existence of antiretroviral therapy, which can reduce the risk of perinatal transmission to approximately eight percent. *Id.* The Court held that the reduced percentage is irrelevant because the Court refused to decide that, as a matter of law, an eight percent risk of transmitting a fatal infection from mother to child is not a substantial limitation on a woman's ability to reproduce. *Id.* at 641.

126. *Id.*

127. *Id.* The decision of an HIV-infected woman to bear children also carries with it economic and legal consequences. *Id.* In its decision, the Supreme Court considered the fact that it is more expensive for an HIV-infected woman to bear a child due to the cost of antiretroviral therapy, supplemental insurance, and long-term medical expenses for a child that must be tested and, if infected with HIV, treated for the infection. *Id.* Furthermore, the Court considered the fact that some states actually forbid HIV infected individuals from engaging in sexual intercourse, regardless of consent. *Id.* (citing the following statutes: IOWA CODE §§ 139.1, 139.31 (1997); MD. CODE ANN. HEALTH-GEN. I § 18-601.1(a) (1994); MONT. CODE ANN. §§ 50-18-101, 50-18-112 (1997); UTAH CODE ANN. § 26-6-3.5(3) (Supp. 1997); *Id.* § 26-6-5 (1995); WASH. REV. CODE § 9A.36.011(1)(b) (Supp. 1998)). *See also* N.D. CENT. CODE § 12.1-20-17 (1997).

128. Bragdon v. Abbott, 524 U.S. at 641-42.

129. 42 U.S.C. § 12182(b)(3) (2000).

130. Bragdon v. Abbott, 524 U.S. at 649.

131. *Id.*

132. *Id.*

in his profession," not merely a good faith subjective belief.[133] According to the Court, a doctor's reasonableness must be considered "in light of the available medical evidence."[134] In its review of the medical evidence, the Court indicated that public health authorities, such as the U.S. Public Health Service, Centers for Disease Control, and the National Institute of Health, were particularly credible sources.[135] Although the Court deemed these sources especially important, it also indicated that an individual could contest the prevailing view by rebutting it with credible scientific evidence for "deviating from the norm."[136]

When the Court applied these standards to *Abbott*, it signaled that an intense examination of the facts, accompanied by specific, objective medical evidence, was necessary. Although the Supreme Court substantially agreed with the First Circuit's findings, there was some expression of concern. The Supreme Court called for a reexamination of the circuit court's reliance on the CDC Dentistry Guidelines and the American Dental Association Policy on HIV.[137] The Court's concern about CDC guidelines stemmed from the fact that the guidelines provided only recommended methods of preventing HIV transmission, but did not evaluate the risk of transmission.[138] The Supreme Court's uncertainty about the American Dental Association Policy on HIV arose because, even though the policy provided some objective evidence regarding the risk of transmission, the American Dental Association was a professional organization, not a public health agency.[139] The Court indicated that, in order to make a decision about the objective credibility of the organization's policy, it needed more information about the formulation of the American Dental Association's position.[140] The Court also noted that Bragdon's evidence was based on speculation and inconclusive data,[141] which was problematic because "[s]cientific evidence and expert testimony must have a traceable, analytical basis in objective fact before it may be considered on summary judgment."[142]

The Supreme Court ultimately remanded the direct threat issue for two reasons. First, the Court determined that a complete briefing on this particular issue

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133. *Id.*

134. *Id.* at 650.

135. *Id.*

136. *Id.* (referring to W. KEETON ET AL., PROSSER AND KEETON ON LAW OF TORTS § 32 at 187 (5th ed. 1984)).

137. *Id.* at 651 (citing Abbott v. Bragdon, 107 F.3d 934, 945-46 (1st Cir. 1997)).

138. *Id.* at 651-52.

139. *Id.* at 652.

140. *Id.*

141. *Id.* at 653. For example, Bragdon maintained that "the use of high-speed drills and [the] surface cooling with water created a risk of airborne HIV transmission"; however, the study that Bragdon relied on was inconclusive and expressly stated that additional research was necessary. *Id.* In addition, his own expert witness admitted that there was no evidence suggesting that HIV could be transmitted by the spray from the drill and his opinion was based only on the lack of evidence to the contrary. *Id.* Bragdon also argued that, as of September 1994, CDC identified "seven dental workers with possible occupational transmission of HIV." *Id.* at 653-54. However, this is most likely insufficient evidence because the CDC could not determine whether or not the workers contracted the HIV infection because the workers did not get tests at the appropriate time. *Id.* at 654 (citing Gooch et al., *Percutaneous Exposures to HIV-Infected Blood Among Dental Workers Enrolled in the CDC Needlestick Study*, 126 J. AM. DENTAL ASS'N 1237, 1239 (1995)).

142. *Id.* at 653 (citing Gen. Elec. Co. v. Joiner, 522 U.S. 136, 144-45, 146 (1997)).

would "help place a complex factual record in proper perspective."[143] Second, the Court believed that the resolution of the direct threat issue would be important for the "precision and comprehensiveness of the reasons given for the decision."[144] Although the Supreme Court believed that its remand would "permit a full exploration of the issue," [145] a controversy has erupted regarding the amount of evidence necessary to constitute a direct threat to the health and safety of others.

IV. DIRECT THREAT EXCEPTION IN DIFFERENT CIRCUITS

A. HIV and Direct Threat in the Circuit Courts

Circuit courts approach the direct threat exception to discrimination for HIV-positive individuals differently. First and Ninth Circuit decisions require that those trying to invoke the exception provide precise and concrete evidence of a direct threat to the health and safety of others.[146] However, the Fourth, Fifth, Sixth, and Eleventh Circuits require significantly less evidence to successfully invoke the direct threat exception to discrimination, during both the summary judgment and trial phases.[147]

B. The First Circuit

The First Circuit confronted the direct threat issue when the Supreme Court remanded *Bragdon* to resolve the question of whether Abbott's HIV status was a direct threat to the health and safety of others.[148] Focusing on Abbott's evidence, the circuit court first addressed the Supreme Court's concern regarding the 1993 CDC guidelines.[149] The court examined the history of the guidelines and analyzed the 1986 and 1987 publications.[150] The First Circuit found that the "[g]uidelines [were] competent evidence that public health authorities considered treatment of the kind that Ms. Abbott required to be safe, if undertaken using universal precautions."[151]

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143. *Id.*

144. *Id.* at 654-55. In its decision to remand this portion of the case, the Court made clear that its decision did not foreclose the possibility that the Court of Appeals would reach the same conclusion. *Id.* at 655. The Supreme Court, in its decision, was seeking clarity. *Id.*

145. *Id.*

146. *See, e.g.*, Abbott v. Bragdon, 163 F.3d 87, 90 (1st Cir. 1998); Chalk v. United States Dist. Court, 840 F.2d 701, 710-12 (9th Cir. 1988).

147. *See* Onishea v. Hopper, 171 F.3d 1289, 1299-1301 (11th Cir. 1999); Estate of Mauro v. Borgess Med. Ctr., 137 F.3d 398, 407 (6th Cir. 1998); Doe v. Univ. of Md. Med. Sys. Corp., 50 F.3d 1261, 1268 (4th Cir. 1995); Bradley v. Univ. of Tex. M.D. Anderson Cancer Ctr., 3 F.3d 922, 924 (5th Cir. 1993).

148. Bragdon v. Abbott, 524 U.S. at 654-55.

149. Abbott v. Bragdon, 163 F.3d at 89.

150. *Id.* In its assessment of the 1993 Guidelines, the First Circuit noted that the 1993 version of the universal precaution guidelines was intended to be a modification, not a retreat from earlier guidelines. *Id.* The 1987 edition explained that the "use of the universal precautions eliminates the need for additional precautions that the CDC formerly had advocated for handling blood and other bodily fluids known or suspected to be infected with bloodborne pathogens." *Id.*

151. *Id.*

Judge Selya then examined the court's earlier reliance on the American Dental Association policy.[152] In its decision to remand the direct threat issue, the Supreme Court had expressed concern that the policy may be biased if the Association relied too heavily on the ethical obligations of dentists, instead of reliable scientific evidence.[153] On remand, the circuit court received a supplemental briefing that contained information about the construction of the policy.[154] The court learned that the Association divided its scientific and ethical policies into two separate procedures, which were developed by different groups of experts and staff members.[155] The separation of the scientific and ethical research, as well as the credentials of the professionals creating the policy, provided the First Circuit with sufficient evidence to support its conclusion that the policy was scientifically valid.[156]

The circuit court held that reliance on both the policy and guidelines was proper.[157] In addition to these detailed and scientifically based sources, the First Circuit also noted that Abbott offered a plethora of other evidence in support of her position.[158] For example, she presented "several prominent experts," all indicating that her cavity could be filled safely in a private dental office, and proof that no public health agency had issued warnings disfavoring this type of treatment.[159] Upon reevaluation, the court concluded that Abbott "served a properly documented motion for summary judgment."[160]

After a careful analysis of Abbott's evidence, the court examined whether Bragdon's evidence presented sufficient evidence of a direct threat in order to create a genuine issue of material fact.[161] First, the circuit court addressed the Supreme Court's concern about the CDC's seven cases of possible HIV patient-to-dental worker transmission.[162] According to the CDC definition, the term "possible transmission" is used if a "stricken worker," who claimed to have no other possible explanation for the HIV infection, "simply failed to present himself for testing after being exposed to the virus at work."[163] Because the Supreme Court required that an "objective standard" apply when assessing the existence of a direct threat, the circuit court held that the list of seven "possible" cases of patient-to-worker transmissions did not create a genuine issue of material fact.[164]

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152. *Id.*

153. *Id.*

154. *Id.*

155. *Id.* The First Circuit revealed that the seventeen members of the Association's Council on Scientific Affairs and their staff drafted the policy relied on by the court. *Id.* The ethical policies, on the other hand, where drafted by a completely separate entity, the Council on Ethics. *Id.* Although the Association's House of Delegates approved these policies, the court determined its separate origin of policy was sufficient to establish the scientific credibility of the policy. *Id.*

156. *Id.*

157. *Id.*

158. *Id.*

159. *Id.* The court indicated that these materials alone where likely sufficient to prove that the direct threat exception did not apply in this case. *Id.*

160. *Id.*

161. *Id.*

162. *Id.* at 89-90 (citing Bragdon v. Abbott, 524 U.S. 624, 652-53 (1998)).

163. *Id.* at 90.

164. *Id.*

Second, in his supplemental briefing, Bragdon referred to forty-two "documented cases of occupational transmission of HIV to health-care workers (none of whom were dental workers)" reported by the CDC.[165] As in his initial argument, Bragdon claimed that the transmission cases were analogous to his situation because the risks faced by a dentist are similar to those faced by other health care professionals.[166] He argued that these cases should "be extrapolated to create an issue of fact as to the degree of risk" he faced as a dentist.[167] The First Circuit did not agree with Bragdon's analogy and did not believe that this evidence was substantial enough to create a genuine issue of material fact.[168] Accordingly, the circuit court upheld its prior decision that Bragdon's "evidence was insufficient without a documented showing that the risks to dentists and other health care workers [were] comparable."[169] In its decision, the circuit court noted that the Supreme Court did not challenge its position on requiring such documentation, suggesting that the Court agreed with the high bar of proof set by the First Circuit in this case.[170]

In the final section of its opinion, the First Circuit made an important observation and issued a significant piece of advice to other courts when it declared that "the state of scientific knowledge concerning this disease is evolving, and we caution future courts to 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."[171] The Supreme Court subsequently declined to grant Bragdon's petition for certiorari.[172] This provides further evidence that the Supreme Court agrees with the First Circuit's requirement that, in order to invoke the direct threat exception, the moving party must present comprehensive, objective medical evidence that a direct threat, rather than a mere theoretical possibility of transmission, exists.

C. The Ninth Circuit

In *Chalk v. United States District Court*,[173] the Ninth Circuit established an exacting standard to prove that an individual with HIV posed a direct threat to the health and safety of others. The case was decided in 1988, two years before the enactment of the ADA. It continues, however, to be important because the standards set forth for carriers of contagious diseases under the Rehabilitation Act are the same as the direct threat standard in the ADA, that is, the application of the *Arline* test.

In *Chalk*, Vincent Chalk was a certified teacher for hearing-impaired students in the Orange County Department of Education.[174] Diagnosed with AIDS in Feb-

165. *Id.*
166. *Id.*
167. *Id.*
168. *Id.*
169. *Id.* The First Circuit believed that every piece of evidence that Bragdon presented was "still 'too speculative or too tangential (or in some instances, both) to create a genuine issue of material fact.'" *Id.* (quoting Abbott v. Bragdon, 107 F.3d 934, 948 (1st Cir. 1997)).
170. *Id.*
171. *Id.*
172. Bragdon v. Abbott, 526 U.S. 1131 (1999).
173. 840 F.2d 701 (9th Cir. 1988).
174. *Id.* at 703.

ruary of 1987, Chalk was hospitalized for eight weeks. [175] When his doctor found him fit to return to work, the school department placed him on administrative leave pending a consultation with an expert.[176] The school department's expert declared that Chalk could return to work in August.[177] In August, the school department allowed Chalk to return to work, but reassigned him to an administrative position.[178] In this position, he had the option of working at the department's administrative office or from home, but the department prohibited him from teaching.[179] Although he received the same pay and benefits, the new administrative position was very different from that of a teacher in a classroom.[180] The School Department notified Chalk that if he insisted on returning to the classroom environment, it would file for declaratory relief.[181]

When Chalk refused to accept the administrative offer, the School Department filed an action in Orange County Superior Court.[182] Chalk simultaneously filed an action in federal district court for a preliminary and permanent injunction to bar the Department from excluding him from the classroom and ordering the Department to reinstate him pending trial.[183] The district court denied his motion.[184] A circuit court panel granted Chalk's motion for an expedited appeal but denied his emergency petition for a writ of mandamus.[185] Chalk then filed an injunction pending the appeal in an emergency motion.[186] The Ninth Circuit analyzed Chalk's claim under a deferential standard of review, only reversing if there was an abuse of discretion or if the lower court relied on an erroneous legal conclusion.[187]

In its analysis of Chalk's probable success on the merits, the Ninth Circuit examined the evidence in relation to the language of the Rehabilitation Act of 1973, which prohibits otherwise qualified individuals from participating in a program that receives federal financial assistance solely because the individual has a

175. *Id.*

176. *Id.* The Department hired Dr. Thomas J. Prendergast, the Director of Epidemiology and Disease Control for the Orange County Health Care Agency, to serve as its expert in determination of the matter. *Id.*

177. *Id.* at 703 n.4.

178. *Id.* at 703.

179. *Id.*

180. *Id.*

181. *Id.*

182. *Id.*

183. *Id.* at 703-04.

184. *Id.* at 704.

185. *Id.*

186. *Id.*

187. *Id.* (citing Sports Form, Inc. v. United Press Int'l, Inc., 686 F.2d 750, 752 (9th Cir. 1982); Wright v. Rushen, 642 F.2d 1129, 1132 (9th Cir. 1981); L.A. Mem'l Coliseum Comm'n v. Nat'l Football League, 634 F.2d 1197, 1200 (9th Cir. 1980)). The purpose of a preliminary injunction is to maintain the status quo during the adjudication of a case on its merits. *Id.* (citing L.A. Mem'l Coliseum Comm'n v. Nat'l Football League, 634 F.2d 1197, 1200 (9th Cir. 1980)). To meet its burden on proof, the party moving for a preliminary judgment must establish either "(1) a combination of probable success on the merits and the possibility of irreparable injury, or (2) that serious questions are raised and the balance of hardships tips sharply in its favor." *Id.* (citing L.A. Mem'l Coliseum Comm'n v. Nat'l Football League, 634 F.2d 1197, 1201 (9th Cir. 1980); Benda v. Grand Lodge of Intern. Ass'n of Machinists & Aerospace Workers, 584 F.2d 308, 314-15 (9th Cir. 1978)).

handicap.[188] The circuit court recognized that under *Arline*, the Rehabilitation Act applied to individuals with contagious diseases.[189] It then applied the direct threat test established in *Arline*.[190]

The court examined the evidence presented by Chalk in support of a preliminary injunction.[191] Chalk submitted over one hundred articles from credible medical journals, statements from five experts, and reports from the Surgeon General of the United States, the Institute of Medicine of the National Academy of Sciences, the American Medical Association, and the United States Centers for Disease Control to support his position that his AIDS/HIV status did not present a direct threat to his students.[192] The evidence he presented showed that "[e]xtensive and numerous studies have consistently found no apparent risk of HIV infection to individuals exposed through close, non-sexual contact with AIDS patients."[193] The Surgeon General's report specifically discussed the risk of transmitting the disease in a classroom environment, stating that "'[n]one of the identified cases of AIDS in the United States are known or are suspected to have been transmitted from one child to another in school, day care or foster care settings . . . [and c]asual social contact between children and persons infected with the AIDS virus is not dangerous.'"[194]

The Department, on the other hand, did not present a comparable amount of scientific evidence.[195] Instead, the Department offered only one medical witness to suggest that there was a "'probability, small though it is, that there are vectors of transmission as yet not clearly defined.'"[196] When the Department's expert, Dr. Armentrout, was asked if he had a scientific basis for his hypothesis, he stated that he did not have any "'scientific evidence that would enable me to answer that or have an opinion . . . what we [are] saying is that we haven't proved scientifically a vector.'"[197]

After reviewing the evidence presented by both Chalk and the Department, the Ninth Circuit found that the district court improperly relied upon the Department's speculation, which lacked any medical support.[198] The reliance on such speculation resulted in a failure to follow the *Arline* test and placed an impermissibly high burden of proof on Chalk.[199] The Ninth Circuit determined that "the transmission of the AIDS virus in the classroom setting was 'a mere theoretical possibility' and that exclusion of AIDS victims on that basis would violate" the Rehabilitation Act.[200] Because Chalk submitted a plethora of evidence in support of his position and the Department did not prove that transmission was anything more than a theoretical possibility, the Ninth Circuit held that Chalk demonstrated a strong probability of success on the merits and should be granted a preliminary

188. *Id.* (citing 29 U.S.C. § 794).
189. *Id.* (citing Sch. Bd. v. Arline, 480 U.S. 273, 276 (1987)).
190. *Id.* (citing Sch. Bd. v. Arline, 480 U.S. at 276).
191. *Id.* at 706.
192. *Id.* at 706-07.
193. *Id.*
194. *Id.* at 706.
195. *Id.* at 707.
196. *Id.*
197. *Id.*
198. *Id.* at 707-08.
199. *Id.* at 707.
200. *Id.* at 708.

injunction.[201]

Chalk continues to be an important decision because it provides early evidence that a standard that allows the invocation of a direct threat exception merely because there is a "theoretical possibility" of transmission is insufficient. The Ninth Circuit made this decision in 1988, at a time when the medical and legal communities knew much less about HIV. Nevertheless, the court believed that sound, objective medical evidence was required in order to prevent unfair prejudice. This exacting, objective standard should serve as a model, along with the First Circuit, of the evidence needed to invoke the direct threat exception for HIV-positive individuals.

D. The Fourth Circuit

Unlike the First and Ninth Circuits, the Fourth Circuit has not required the same heightened level of objective medical evidence. The Fourth Circuit first encountered the question of when HIV constitutes a direct threat to the health and safety of others in a 1995 case, *Doe v. University of Maryland Medical System Corp.*[202] In this case, Dr. Doe, a neurosurgeon in his third year of residency, discovered that he was HIV-positive.[203] Dr. Doe was suspended while the hospital's panel of experts examined the issue.[204] The panel ultimately recommended that Dr. Doe be permitted to return to his surgical practice and perform the same procedures, with the exception of those procedures that involved the use of exposed wire.[205] The panel further recommended that Dr. Doe be required to rigorously abide by infection control procedures, notify the hospital and patient if his blood ever contacted a patient's "non-intact skin," and that Dr. Doe provide the hospital a sample of his blood so that "if a patient claimed to have contract[ed] HIV from Dr. Doe, the DNA . . . could be compared."[206] The panel did not recommend that Dr. Doe be required to gather patient informed consents before performing surgery.[207] Despite the panel's recommendation, the hospital administrators permanently suspended Dr. Doe from his surgical practice but did offer Dr. Doe alternative residencies in nonsurgical fields.[208]

The hospital stated that it decided to revoke Dr. Doe's surgical privileges based on guidelines issued by the CDC concerning HIV-positive health care workers.[209] It is important to note, however, that the CDC's recommendations stated that HIV-

201. *Id.* at 708-09.

202. 50 F.3d 1261 (4th Cir. 1995).

203. *Id.* at 1262. In 1992, Dr. Doe was pricked with a needle while treating a person who may have had the HIV virus. *Id.* He "subsequently tested positive for [the] HIV" virus. *Id.* However, at the time of the case, it was not known whether Dr. Doe contracted the virus from the needle prick or was previously exposed to the virus. *Id.* at 1262 n.4.

204. *Id.* at 1262.

205. *Id.* The panel determined that the medical procedures that involved the use of wire presented too high a risk of transmission to patients. *Id.*

206. *Id.*

207. *Id.*

208. *Id.* at 1263.

209. *Id.* (citing Centers for Disease Control, U.S. Dep't of Health & Human Servs., *Recommendations for Preventing Transmission of Human Immunodeficiency Virus and Hepatitis B Virus to Patients During Exposure-Prone Invasive Procedures*, 40 MORBIDITY & MORTALITY WKLY. REP. 1, 3-4 (July 12, 1991) [hereinafter CDC, *Recommendations*]).

positive surgeons should not be banned from "performing most surgical procedures" as long as the surgeon strictly followed the CDC's universal precautions.[210] In order to get around the CDC's position, the hospital and the court relied heavily on the CDC's distinction between the "large class of invasive procedures," such as inserting intravenous lines, and the "limited class of 'exposure-prone' procedures, which involve greater risk of . . . skin piercing."[211] To overcome the CDC's position, the hospital and Fourth Circuit also emphasized the CDC recommendation that individual hospitals should identify their own exposure prone procedures to determine whether or not an HIV-positive surgeon should participate in the surgery.[212] In support of its position that Dr. Doe posed a direct threat to the health and safety of others, the hospital cited a skin-piercing study, which indicated that skin piercing occurs in about 6.9% of surgeries.[213] Dr. Doe attempted to rebut the accuracy and applicability of the study because it did not analyze the amount of blood-to-blood contact from skin-piercing injuries and, therefore, did not address the risk of transmitting HIV.[214] The court, however, paid little attention to Dr. Doe's efforts to create a genuine issue of material fact.

Based upon the theories above, the hospital argued that Dr. Doe posed a direct threat under *Arline* because "(1) HIV may be transmitted via blood-to-blood contact in a surgical setting; (2) Dr. Doe will always be infectious; (3) infection with HIV is invariably fatal; and (4) there is an ascertainable risk that Dr. Doe will transmit the disease during the course of his neurosurgical residency."[215] Dr. Doe acknowledged that the first three prongs of the *Arline* test weighed in favor of a direct threat finding; however, he pointed out that the risk of transmission was "so infinitesimal that it cannot, regardless of the degree of harm involved," constitute a direct threat.[216] Dr. Doe also maintained that only a spinal fusion, which involved the use of a wire, qualified as exposure prone under the CDC Recommendations.[217] He argued that because of this, reasonable accommodation was possible because Dr. Doe could perform all surgeries except the spinal fusion.[218] The Fourth Circuit did not agree with Dr. Doe and, instead, upheld the district court's grant of summary judgment for the hospital.[219]

In its decision, the Fourth Circuit reasoned that because HIV can be transmitted through blood-to-blood contact, it is possible for an HIV-positive surgeon to transmit the disease to a patient.[220] The court brushed aside the fact that, although there were known instances of HIV-positive surgeons operating on patients, there were no documented cases of HIV-positive surgeons transmitting the disease to patients.[221] Furthermore, the circuit court minimized the fact that the risk of transmission, estimated somewhere between 1 in 42,000 and 1 in 417,000, was exceedingly small.[222] The court instead chose to focus on the fact that the CDC allowed

210. *Id.* (citing CDC, *Recommendations* at 5).
211. *Id.* at 1263-64 (citing CDC, *Recommendations* at 4).
212. *Id.* at 1264 (citing CDC, *Recommendations* at 4).
213. *Id.*
214. *Id.* at 1264 n.6.
215. *Id.* at 1265.
216. *Id.* at 1266.
217. *Id.*
218. *Id.*
219. *Id.* at 1267.
220. *Id.* at 1263.
221. *Id.* at 1263 n.5.
222. *Id.*

hospitals some leeway to define "exposure prone."[223] The circuit court used this fact to determine that it was reasonable for the hospital to label Dr. Doe's responsibilities as exposure prone in order to constitute a direct threat.[224] Finally, because the risk of transmission could never be fully eliminated, the Fourth Circuit took a "cautious" approach to the direct threat rule and held that summary judgment was appropriate.[225]

This case is particularly troubling because it was decided by the grant of summary judgment. The facts presented by Dr. Doe regarding the nature of his position, the possibility of reasonable accommodation, and the admittedly small risk of transmission seem, at the very least, to create a genuine issue of material fact. The existence of some risk of transmission, such as 1 in 42,000 or 1 in 417,000, does not, in and of itself, create a direct threat.

The Fourth Circuit revisited the direct threat issue in *Montalvo v. Radcliffe*.[226] In this case, a twelve-year-old boy, Michael Montalvo, was not allowed to enroll in a traditional Japanese style martial arts school because he was HIV-positive.[227] Unlike the popular family style karate, the U.S.A. Bushidokan martial arts school focused on a combat style karate that involved significant body contact and frequent bloody injuries.[228] When Radcliffe, the program's owner, learned that Michael was HIV-positive he offered to conduct private lessons for Michael but his parents refused the proposal.[229] Instead, the family filed a discrimination suit under the Rehabilitation Act and the ADA.[230] The district court conducted a bench trial, ultimately holding that Michael's participation in the U.S.A. Bushidokan program presented a direct threat to the health and safety of others and that reasonable accommodation, by making the program softer, was not feasible.[231]

The district court relied on testimony from Radcliffe, which indicated that blood from injuries sustained during combat was "'extremely likely'" to spill onto other students and universal precautions would not eliminate such occurrences.[232] The district court relied upon this information in conjunction with expert testimony, which indicated that transmission of HIV is possible with blood-to-blood contact.[233] The court then applied the *Arline* standard and determined that Michael posed a direct threat to the health and safety of the other karate participants.[234]

The Fourth Circuit upheld the district court's holding based on the *Arline* test.[235] In its analysis, the court of appeals stated that "the gravity of one factor might well compensate for the relative slightness of another . . . [and] when the disease at risk of transmission is . . . severe and inevitably fatal, even a low probability of trans-

223. *Id.* at 1266.
224. *Id.*
225. *Id.* at 1267.
226. 167 F.3d 873 (4th Cir. 1999).
227. *Id.* at 874.
228. *Id.* The program's owner, Radcliffe, testified that, in this form of karate participants are frequently scratched or gouged and often sustain bloody lips, bloody noses, bruises, or other similar injuries. *Id.* at 875.
229. *Id.*
230. *Id.*
231. *Id.*
232. *Id.* at 876.
233. *Id.*
234. *Id.* at 878.
235. *Id.* at 879.

mission could still create a significant risk."[236]

The opinion is interesting because it states that the testimony of Radcliffe's medical expert, a private physician, "[was] not critical to the district court's factual findings since the Montalvos' expert reached essentially the same conclusion about the nature of transmitting HIV," that HIV can be transmitted by blood-to-blood contact.[237] This leads to two conclusions. First, because the court did not rely on medical opinions, its decision could not be based on "reasonable medical evidence" that Michael posed a direct threat to others.[238] This proposition is supported by the fact that the circuit court explicitly stated that it did not rely on expert testimony, which was the defendant's primary source of medical evidence. [239] Second, the intense focus on the nature of HIV led the court to neglect an important element in determining the existence of a direct threat—that the possibility of transmission be based on medical evidence. In this case, there was no medical evidence presented regarding the probability of transmitting the disease in this combat style environment. Instead, the court relied on the blanket notion that because blood-to-blood contact could transmit HIV, and because the combat can lead to blood spillage, it must be a significant risk. It failed, however, to take the necessary analytical step of assessing this risk based on the medical evidence.

The Fourth Circuit also held that no reasonable accommodation was feasible because any softening of the program would diminish its intent.[240] The court also determined that Radcliffe's offer to conduct private lessons with Michael satisfied the ADA's reasonable accommodation requirement because the ADA "does not require U.S.A. Bushidokan to abandon its essential mission and to offer a fundamentally different program of instruction."[241]

This case exemplifies the problems with relying on a more "cautious" approach to the direct threat issue in relation to HIV-positive individuals. Because the Fourth Circuit did not rely on exacting and objective medical evidence, the court substituted its interpretation of the existence of a direct threat for that of a medical expert. This is a contradiction of the directive set forth by the Supreme Court both in *Arline* and *Bragdon.*

E. The Fifth Circuit

In *Bradley v. University of Texas M.D. Anderson Cancer Center*,[242] the Fifth Circuit dealt with the issue of whether an HIV-positive surgical assistant presented a direct threat under the Rehabilitation Act of 1973.[243] Brian Bradley was a surgical assistant at the University of Texas M.D. Anderson Cancer Center and, in July of 1991, he revealed to a local newspaper that he was HIV-positive and employed by the hospital.[244] After publication of the story, the hospital reassigned him to the purchasing department as a procurement assistant.[245] Bradley sued the hospi-

236. *Id.* at 878.
237. *Id.*
238. *Id.*
239. *Id.*
240. *Id.* at 879.
241. *Id.* (citing 42 U.S.C. § 12182(b)(2)(A)(ii) (2000)).
242. 3 F.3d 922 (5th Cir. 1993).
243. *Id.*
244. *Id.* at 923.
245. *Id.*

tal claiming that the reassignment violated the Rehabilitation Act of 1973.[246] The district court granted summary judgment for the hospital.[247]

The Fifth Circuit decided this case in 1993 and the court disposed of the issue quickly and without great detail.[248] The court relied on the *Arline* test to determine whether or not Bradley was "otherwise qualified" to perform the essential functions of his job.[249] The disputed issue in the case was the probability of Bradley transmitting HIV to patients. According to the Fifth Circuit, the nature of Bradley's job created some risk because in his occupational field Bradley came within inches of patients' open wounds, placed his hands in a patient's body cavity once a day, handed "the handles of instruments to surgeons while he [held] the sharp end," and had suffered "five needle puncture wounds while on the job." [250]

Despite the findings above, the circuit court still recognized that the "risk, while present, [was] not large."[251] Like the Fourth Circuit, however, the Fifth Circuit chose to focus its attention on the CDC "exposure prone" recommendation.[252] The court used this CDC report to hold that although the risk was small, it was "not so low as to nullify the catastrophic consequences of an accident. A cognizable risk of permanent duration with lethal consequences suffice[d] to make a surgical technician with Bradley's responsibilities" a direct threat.[253] The Fifth Circuit also held that reasonable accommodation was not feasible because the hospital would be required to use another assistant to perform the essential functions Bradley could not perform.[254] The circuit court, therefore, upheld the district court's grant of summary judgment for the hospital.

The Fifth Circuit's analysis, encapsulated in a two page per curiam opinion, raises serious questions about the court's use, or lack thereof, of objective medical evidence. Although it alleges to base its decision on the probability, not the possibility, of transmission, the court focuses only on the fact that transmission is possible and only eludes to probability when it asserts that the risk of transmission is "small."[255] Unlike the Fourth and Sixth Circuits, which at least provided estimates of the probability of transmission, this court does not present any empirical evidence regarding the probability of transmission. Instead, it decides, without any real finding of facts, to equate "small" with "significant" for purposes of upholding the summary judgment. Bradley's arguments seem to indicate at least the

246. *Id.*

247. *Id.*

248. Although this case occurred before the Supreme Court's decision in *Bragdon v. Abbott*, 524 U.S. 624 (1998), this case remains good law in the Fifth Circuit and is still cited as authority in other jurisdictions that choose to utilize a less stringent evidence requirement. *E.g.*, Estate of Mauro v. Borgess Med. Ctr., 137 F.3d 398, 401 (6th Cir. 1998).

249. Bradley v. Univ. of Tex. M.D. Anderson Cancer Ctr., 3 F.3d at 924.

250. *Id.* It is interesting that the court uses the terms assistant, technician, and technologist interchangeably. In *Estate of Mauro v. Borgess Medical Center*, 137 F.3d at 404, the parties distinguished between the titles because these positions involved different responsibilities and, therefore, the probability of transmission could theoretically be different.

251. Bradley v. Univ. of Tex. M.D. Anderson Cancer Ctr., 3 F.3d at 924.

252. *Id.* (citing Centers for Disease Control, U.S. Dep't of Health & Human Servs., *Recommendations for Preventing Transmission of Human Immunodeficiency Virus and Hepatitis B Virus to Patients During Exposure-Prone Invasive Procedures*, 40 MORBIDITY & MORTALITY WKLY. REP. 1 (July 12, 1991)).

253. *Id.*

254. *Id.* at 925.

255. *Id.* at 924.

existence of a genuine issue of material fact, thus making summary judgment inappropriate.[256]

F. The Sixth Circuit

The Sixth Circuit first encountered the direct threat issue in *Estate of Mauro v. Borgess Medical Center*.[257] William Mauro was an HIV-positive operating room technician.[258] When the hospital learned of Mauro's HIV status, officials offered him an administrative position, which he refused.[259] The hospital then created a taskforce to examine the situation and ultimately terminated Mauro because officials believed his job, which allegedly required him to put his hand in a patient's body cavity, made him a direct threat to the health and safety of others.[260] Mauro filed an action against Borgess Medical Center, his former employer, alleging that the hospital violated the Americans with Disabilities Act and the Rehabilitation Act when the administration fired him.[261] The district court granted the hospital's motion for summary judgment because the court determined that Mauro "posed a direct threat to the health and safety of others."[262]

Interestingly, the district court purported to base its decision in large part on the "probability that the disease would be transmitted."[263] Instead of looking at statistical data regarding the probability of transmission, however, the court relied on Mauro's testimony that he was "'occasionally required to place his hands'" on or into the patient's incision, and that the possibility of a needle prick or sustaining a minor laceration existed.[264] The district court also believed that Mauro's expert acknowledged that a risk, but not necessarily a significant risk, existed if an operating technician put his hands onto an incision, had exposure to a needle prick, or had a minor cut.[265] Finally, the district court cited *Doe v. University of Maryland Medical System Corp.*[266] and *Bradley v. University of Texas M.D. Anderson Cancer Center*[267] as support for its finding that HIV-positive health workers posed a

256. *Id.*

257. 137 F.3d 398 (6th Cir. 1998).

258. *Id.* at 400.

259. *Id.*

260. *Id.*

261. *Id.*

262. *Id.* Mauro died prior to the Court of Appeals decision, therefore, the estate became the party in interest for the appeal. *Id.* at 400 n.3. Mauro was employed by the hospital as an operating room technician, from May of 1990 until August 24, 1992. *Id.* at 400. The hospital learned of Mauro's HIV-positive status from a telephone call from an "undisclosed source" in June of 1992. *Id.* The undisclosed caller told the hospital's human resource director that "Mauro had full blown AIDS." *Id.*

263. *Id.* (citing Mauro v. Borgess Med. Ctr., 886 F. Supp. 1349, 1352-53 (W.D. Mich. 1995)). The probability of an event occurring is the fourth prong of the *Arline* test. *Id.*

264. *Id.* (citing Mauro v. Borgess Med. Ctr., 886 F. Supp. at 1352-53). The district court also noted that Mauro sustained these types of injuries twice during his training. *Id.* However, what the district court did not consider is that Mauro was learning to be a technician during this time and it seems reasonable that a greater number of mistakes will occur during training because trainees are only beginning the learning process. *Id.* Furthermore, Mauro did not know of his HIV status and thus was not on heightened alert and may not have followed the CDC's universal precautions, two factors that could significantly reduce the risk of a needle prick or minor laceration. *Id.*

265. *Id.* at 401 (citing Mauro v. Borgess Med. Ctr., 886 F. Supp. at 1353).

266. 50 F.3d 1261 (4th Cir. 1995).

267. 3 F.3d 922 (5th Cir. 1993).

direct threat to the health and safety of others.[268] The district court granted summary judgment for the hospital.[269]

The Sixth Circuit, reviewing the summary judgment de novo, acknowledged the fact that Mauro did not have to prove that absolutely no risk existed and purported to focus on the last factor of the *Arline* test, the "probability," not possibility, of transmission.[270] The circuit court examined reports from the CDC, which recommended that most HIV-positive employees be allowed to continue with most surgical procedures.[271] Like the Fourth Circuit, however, the Sixth Circuit also relied heavily on the CDC's categorization of "exposure prone procedures."[272] Based on this CDC recommendation, a controversy ensued over how often, if ever, Mauro put his hand inside a wound. In a deposition, he indicated that he never personally had his hands inside a wound holding a retractor and only "'very, very rarely'" did he have his hands near a wound.[273] The hospital indicated that, although the need for a surgical technician to touch a wound was infrequent, it was impossible to eliminate the occasional touch because emergency situations dictated when a surgical technician needed to perform such a task.[274]

The Sixth Circuit also looked at evidence from medical experts, relying chiefly on the deposition of Dr. Davenport who stated, "even if HIV-infected health care workers followed universal precautions, methods designed to ensure that health care workers do not come into contact with blood, *some risk* of exposure existed."[275] The circuit court apparently translated "some risk" into the required "significant risk" for purposes of upholding the summary judgment. It also relied on other suspect rules of probability when it recited, as evidence for the hospital, the fact that the theoretical probability of a surgeon transmitting HIV to a patient was estimated to be between 1 in 42,000 and 1 in 420,000.[276] Focusing on this estimate was inappropriate because a surgeon places her hands in a patient far more often than a surgical technician, thus it is logical that the probability of a surgical technician transmitting HIV would be infinitesimal compared to that of a surgeon.

However, it appears that the Sixth Circuit considered the above evidence sufficient to conclude that, despite the medical evidence suggesting only that *some risk* was present, no genuine issue of material fact existed as to whether Mauro actually presented a *significant risk* to the health and safety of others. The circuit court upheld the district court's grant of summary judgment in favor of the hospital.[277]

The dissent argued that a genuine issue of material fact did exist and that the precise nature of Mauro's responsibilities as a surgical technician, especially when

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268. Estate of Mauro v. Borgess Med. Ctr., 137 F.3d at 401. The court found that these cases were indistinguishable from the case at bar, despite the fact that *Doe* involved a surgeon who likely placed his hands inside a patient's body far more often than a surgical technician. *Id.*

269. *Id.*

270. *Id.* at 403. As with most HIV and direct threat cases, the parties agreed that the first three prongs of the *Arline* test, the nature, duration, and severity of the risk, lean toward a direct threat finding, thus the majority of such cases depend on a court's analysis of the fourth prong, the probability of transmission. *Id.*

271. *Id.*

272. *Id.*

273. *Id.* at 404.

274. *Id.* at 405.

275. *Id.* (emphasis added).

276. *Id.*

277. *Id.* at 407.

read in a light most favorable to him, was certainly in dispute.[278] The dissent also criticized the majority for equating the probability of surgical technicians transmitting the disease to that of surgeons, who by "the very nature of their work enter surgical wounds with sharp instruments during virtually every procedure they perform."[279] Finally, the dissent argued that summary judgment was inappropriate because the degree of risk depends on the facts of individual cases, "not just on aggregate data about the person's contagious disease."[280] The dissent correctly exposed the majority's flawed reasoning and the problems that arise when a court employs a "theoretical risk" or "any risk" standard. As a result of the court's decision not to require detailed and objective medical evidence, Bradley was denied a trial and, ultimately, his job without the court ever adequately assessing whether a significant risk was involved. This ad hoc approach leads to unfair prejudice because HIV-positive individuals are denied employment due to a mere possibility of transmission.

G. The Eleventh Circuit

The Eleventh Circuit confronted the issue of what constitutes a direct threat in *Onishea v. Hopper*.[281] The case was brought under the Rehabilitation Act of 1973.[282] The Alabama Department of Corrections had a policy of segregating inmates who were HIV-positive from the general population.[283] Because they were separated from the general population, HIV-positive inmates were not able to participate in many programs and activities offered to inmates in the general population.[284] The plaintiffs claimed that denying HIV-positive prisoners activities available to the general population, and providing other activities separate from the general population, violated the Rehabilitation Act of 1973.[285] In an earlier proceeding, the Eleventh Circuit remanded the case to the district court to evaluate the risk of transmitting HIV in the individual programs that were unavailable to HIV-positive inmates in order to determine whether the inmates were "otherwise qualified to participate in each program."[286]

In the second trial, each party presented considerable evidence to support their arguments.[287] The plaintiffs maintained that the available medical evidence proved that the chances of transmitting HIV during prison programs were "remote at best."[288] At the time of the trial, there were no reported cases of transmitting HIV from lesbian sex, athletic injuries, stabbings, or tattooing.[289] The plaintiffs also

278. *Id.* at 408.
279. *Id.* at 409.
280. *Id.* at 411.
281. 171 F.3d 1289 (11th Cir. 1999).
282. 29 U.S.C. §§ 706-796 (2000).
283. Onishea v. Hopper, 171 F.3d at 1292. Both the men's prison at Limestone Correctional Facility and the women's prison at the Julia Tutwiler Prison for Women have special HIV-units in which HIV-positive prisoners are housed and separated from the general population. *Id.*
284. *Id.*
285. *Id.* at 1293. Litigation in this case commenced over a decade ago, prior to the enactment of the Americans with Disabilities Act, therefore, the suit was brought under the Rehabilitation Act of 1973. *Id.* at 1292.
286. *Id.* at 1293.
287. *Id.*
288. *Id.*
289. *Id.*

argued that there were "only 'sporadic' instances" of transmitting HIV from oral sex and fistfights, and certainly not in a "commonly reoccurring way."[290] Although the plaintiffs' medical expert "acknowledge[d] that anal sex and needle-sharing [were] high risk activities," the plaintiffs' evidence focused on the rarity of this type of conduct in the activities in which they wanted to participate.[291] Furthermore, because the programs were in high demand, the plaintiffs argued that inmates had every reason to "be on their best behavior," thus reducing the risk of transmission during these activities.[292] Finally, the plaintiffs argued that the high degree of surveillance during the programs made it implausible that the dangerous behavior would occur.[293]

The defendant, the correctional department, did not completely contradict the plaintiffs' testimony.[294] Instead, the correctional department introduced evidence that transmitting HIV was "theoretically possible," despite the lack of documentation, "wherever there is a large exchange of blood between an infected person and an uninfected [person]."[295] The defendants presented numerous incident reports that cited instances of inmates hiding hypodermic needles, engaging in homosexual acts, and starting fights that led to bloodshed to support their argument that there is a high risk of transmission in prison.[296] In addition, the defendants showed the possibility of transmission of contagious disease by referencing a syphilis outbreak, traceable to one inmate, which spread to eighty-six inmates within the prison.[297] Finally, the defendant compared the high number of seroconversions in fully integrated prisons to the lower seroconversions in the Alabama prison system.[298]

Although the Eleventh Circuit acknowledged that neither party presented iron-clad evidence, it nevertheless utilized the cautious direct threat test.[299] It based its decision on the district court's finding that "each case of transmission, however rare, claims at least one life," and there was a possibility that more lives could follow if the disease was transmitted from inmate to inmate.[300] The circuit court further reasoned that, "given this degree of harm, even slim odds of transmission make the risk significant."[301]

The Eleventh Circuit began its analysis with an exposition of the *Arline* test.[302] It emphasized that the word "significant" meant more than "big," stating that "we are far more likely to consider walking a tightrope to pose a significant risk if the rope is fifty feet high than if it is one foot off the ground . . . even if the odds of

290. *Id.* at 1293-94.
291. *Id.* at 1294.
292. *Id.*
293. *Id.*
294. *Id.*
295. *Id.*
296. *Id.*
297. *Id.*
298. *Id.* "Seroconversion" occurs when an inmate tests negative for HIV when he or she enters prison but later tests HIV-positive. *Id.* at 1294 n.5. Maryland experienced seroconversions at an annual rate of .41%, Nevada at .19%, and Illinois at .33%. *Id.* Alabama, on the other hand, had an all-time seroconversion rate of .0067%. *Id.*
299. *Id.*
300. *Id.* at 1295.
301. *Id.*
302. *Id.*

losing our balance are the same however far we have to fall."[303] The Eleventh Circuit followed the cautious approach taken by the Fourth, Fifth, and Sixth Circuits, claiming to balance two competing statutory policies.[304] The first policy was the need to require "evidence that the asserted risk of transmission ha[d] a sound theoretical basis" to prevent "*unfounded* fears."[305] The court then attempted to balance this with the need to protect entities bound by the Act from "*well-founded* worries that deaths can result from a ruling that an HIV-positive patient is otherwise qualified" to participate in an activity.[306] The circuit court then constructed a test in cases where the transmission of a disease inevitably leads to death. Under this test, the evidence would be sufficient to find a significant risk if it demonstrated that (1) "a certain event can occur" and (2) that "according to reliable medical opinion the event can transmit the disease."[307]

The Eleventh Circuit further held that the district court correctly ruled that the prison could not "reasonably accommodate" the HIV inmates because it was neither practical to classify inmates as high and low risk for the purpose of integration nor financially feasible to hire additional guards in order to eliminate the risk of transmission.[308] Therefore, the circuit court denied the plaintiffs' claim that reasonable accommodation was possible.

The dissent exposed several flaws in the majority's reasoning. First, it argued that the majority's blanket exclusion of HIV-positive inmates was based on the theory that "any cognizable risk of HIV transmission, no matter how infinitesimal and even if based on a wholly unlikely and speculative chain of event," had to be taken into account irrespective of the possibility of reasonable accommodation.[309] This approach fails to balance these two competing interests.[310]

Second, the dissent pointed out that the majority failed to recognize the Supreme Court's precedent concerning the "significant risk" standard.[311] The dissent looked at the Supreme Court direct threat precedent established in *Arline* and concluded that the majority improperly focused only on the third prong of the test, the severity of risk or the "potential harm to others."[312] Utilizing this prong, the majority allowed the deadly nature of the disease to "render a transmission risk significant even if the probabilities of transmission are so low as to approach zero, so long as transmission could theoretically occur," and this led to a requirement that an HIV-positive individual prove that "transmission is impossible."[313] This approach, according to the dissent, conflicts with *Arline*'s instruction to consider all four relevant factors.[314] The dissent also contended that the majority's approach was contrary to the Supreme Court's directives set forth in *Bragdon*. The

303. *Id.* at 1297.
304. *Id.* at 1298.
305. *Id.*
306. *Id.* at 1299.
307. *Id.*
308. *Id.* at 1303-04. In order to hire the additional guards needed for appropriate supervision, the Correction Department would have to spend an additional twenty-three percent of its overall budget, which the court determined was cost prohibitive. *Id.* at 1303.
309. *Id.* at 1305.
310. *Id.*
311. *Id.* at 1306-07.
312. *Id.* at 1306.
313. *Id.*
314. *Id.*

"any risk" standard established by the majority resulted in a serious failure to recognize the difference between "any risk" and "significant risk" as set forth in *Bragdon*.[315]

Third, the dissent criticized the majority's ruling because it failed to evaluate the risk of transmission in the individual prison programs, which deprived HIV-positive inmates without any meaningful assessment of risk.[316] While the dissent acknowledged that sex and needle sharing were conduits of HIV transmission, it recognized that each program presented different risk levels.[317] In this case, there was no separate analysis of the individual programs to determine whether or not the plaintiffs' were "otherwise qualified" to participate in any of the programs.[318] Instead, the district court found that the theoretical possibility of transmission, "often based on nothing more than highly speculative scenarios, justif[ied] the wholesale segregation and exclusion of HIV-positive inmates from prison programs and activities."[319] According to the dissent, this approach resulted in the discrimination of segregated inmates based solely on their HIV status, irrespective of the risk of transmission, and this was exactly what the "significant risk" standard was designed to prevent.[320]

Finally, the dissent disagreed with the majority's holding that the plaintiffs did not offer reasonable accommodation alternatives.[321] The majority upheld the district court's ruling that the addition of any extra officers would pose an undue burden on the prison system because the plaintiffs did not specify which programs they wanted integrated.[322] The dissent pointed out that this conclusion is ironic because the district court did not conduct individual inquiries for each program to assess the risk integration and the possibility of reasonable accommodations.[323]

The Eleventh Circuit applied the *Onishea* direct threat test in *Waddell v. Valley Forge Dental Associates, Inc.*[324] Waddell was employed as a dental hygienist by the Valley Forge Dental Associates.[325] He tested positive for the HIV virus in 1997.[326] Upon learning of the results, the company placed Waddell on leave to determine how to deal with the situation.[327] The company then consulted dental journals and contacted the CDC to help reach its conclusion that Waddell could not continue to work as a dental hygienist because he presented a direct threat to the health and safety of the company's patients.[328] The company offered him a clerical position, which paid about half of his dental hygienist salary.[329] When Waddell refused to accept the position, the company fired him.[330] Waddell then filed suit

315. *Id.* at 1307.
316. *Id.* at 1305.
317. *Id.* at 1307.
318. *Id.* at 1308.
319. *Id.* at 1309.
320. *Id.*
321. *Id.* at 1310-11.
322. *Id.* at 1311.
323. *Id.*
324. 276 F.3d 1275 (11th Cir. 2001).
325. *Id.* at 1278.
326. *Id.*
327. *Id.*
328. *Id.*
329. *Id.*
330. *Id.*

against Valley Forge, in which he sought relief under the ADA, Rehabilitation Act, and Georgia law.[331] The district court granted summary judgment to Valley Forge after finding that Waddell's position "entailed 'exposure prone' procedures," which made him a direct threat under the *Onishea* standard.[332]

Despite the district court's finding that the likelihood of transmission was low, the Eleventh Circuit upheld summary judgment because there was a possibility that Waddell could transmit HIV to a patient because Waddell occasionally used sharp objects while performing his job.[333] The circuit court also found that there was some chance of blood-to-blood contact between a patient and dental hygienist, even if it was theoretical and small, and this satisfied the direct threat standard established in *Onishea*.[334] Like the other circuit courts using this "cautious" approach, the Eleventh Circuit made no attempt to ascertain the actual probability of transmission. Instead, it relied on the theoretical possibility of transmission and granted summary judgment.[335] As a result of the diminished requirement of medical evidence, the HIV-positive individual was denied protection under the ADA without even the benefit of a trial.

V. CONCLUSION

When Congress passed the Americans with Disabilities Act in 1990, members had high hopes of eradicating unfair prejudice and discrimination against individuals with disabilities.[336] In order for individuals with HIV to be free from these unwarranted fears and prejudice, courts must allow a moving party to invoke the direct threat exception only if there is solid, objective medical evidence that the HIV-positive individual poses a "significant risk" to the health and safety of others. A mere theoretical possibility of transmission is insufficient. Both Congress and the Supreme Court have indicated that a more exacting standard for determining the existence of a significant risk is necessary. Two major factors support the belief that Congress intended that the direct threat exception be invoked only when the moving party presented exacting, objective medical evidence to prove the existence of a direct threat.

First, Congress explicitly codified[337] the direct threat standard set forth in *School Board v. Arline*.[338] The *Arline* test requires that courts look at more than the severity of the harm; it also requires that the courts examine the probability, not possibility, of transmitting the disease.[339] The codification of a standard that requires courts to assess the probability, rather than the mere possibility, of transmission suggests that Congress intended that a more rigorous standard be met in order to invoke the direct threat exception.

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331. *Id.*
332. *Id.* at 1278-79.
333. *Id.* at 1282-83.
334. *Id.* at 1283.
335. *Id.*
336. H.R. REP. NO. 101-485(II), at 22-23 (1990), *reprinted in* 1990 U.S.C.C.A.N. 303, 303-04.
337. H.R. REP. NO. 101-485(II), at 76 (1990), *reprinted in* 1990 U.S.C.C.A.N. 303, 359.
338. 480 U.S. 273 (1987).
339. *Id.* at 288.

Second, the definition of direct threat provides evidence that Congress intended more than an "any risk" standard. According to Congress, a direct threat is "a significant risk to the health or safety of others that cannot be eliminated by a modification of policies, practices, or procedures or by the provision of auxiliary aids or services."[340] In choosing to define direct threat by using the word "significant," in lieu of words such as any, small, or infinitesimal, Congress established its position that, in order to protect individuals from unfair discrimination, the direct threat exception should not be used just because "any risk" exists. Therefore, courts should respect Congress's desire to protect individuals with disabilities and invoke the direct threat exception only if the moving party presents a high level of evidence that establishes that an HIV-positive individual poses a "significant," not just "any," risk to the health and safety of others.

Although the Supreme Court has not explicitly stated what constitutes a direct threat, the Court has conveyed directives for lower courts to follow. First, the *Arline* case suggests that the Supreme Court conceived of invoking the direct threat exception only if the moving party presented a high level of objective medical evidence. The Supreme Court held that an individual with tuberculosis was "handicapped" under the Rehabilitation Act but remanded the case so that the lower court could thoroughly examine the objective medical evidence presented in order to determine whether Arline was "otherwise qualified" to teach.[341] The decision to remand the "otherwise qualified" component of the case provides evidence that the Supreme Court conceived of implementing a standard based on a high level of objective medical evidence.[342]

The Supreme Court's discussion of the direct threat exception in *Bragdon* provides strong evidence that the Court envisioned that the direct threat exception be invoked only when the moving party presented comprehensive, objective medical evidence.[343] First, the Court expressly recognized that the "any risk" standard is inappropriate "[b]ecause few, if any, activities in life are risk free, and the ADA does not ask whether a risk exists, but whether it is significant."[344] When the Court examined the evidence presented in the case, it signaled that an intense examination of the facts, accompanied by specific, objective medical evidence, was necessary. The Court reviewed the medical evidence presented during discovery and it emphasized the importance of the credibility of the public health authorities, such as the U.S. Public Health Service, CDC, and the National Institute of Health, which provided comprehensive and objective medical evidence.[345] The Court

340. 42 U.S.C. § 12182(b)(3) (2000).

341. Sch. Bd. v. Arline, 480 U.S. at 288.

342. It appears that the lower court also recognized the Supreme Court's intent to require a high level of objective medical evidence in order for the school board to prove that Arline was not "otherwise qualified" to teach. On remand, the lower court discussed, in great detail, the importance of the findings of facts, the breadth of the medical evidence, and the low probability of transmitting tuberculosis through the air. Arline v. Sch. Bd., 692 F. Supp. 1286, 1287-91 (N.D. Fla. 1988). The lower court also examined the nature, duration, and severity of the risk involved and the probability of transmission of tuberculosis, and held that Arline was qualified to teach elementary school. *Id.* at 1291-92.

343. Bragdon v. Abbott, 524 U.S. 624, 649 (1998).

344. *Id.* at 648 (citing Sch. Bd. v. Arline, 480 U.S. at 287; 42 U.S.C. § 12182(b)(3)).

345. *Id.* (citing Sch. Bd. v. Arline, 480 U.S. at 288; 28 C.F.R. § 36.208(c), pt. 36, App. B, p. 626 (1997)).

also recognized that Bragdon's evidence was based on speculation and inconclusive data, which was problematic because "[s]cientific evidence and expert testimony must have a traceable, analytical basis in objective fact before it may be considered on summary judgment."[346] The Court's intense scrutiny of the evidence, its statement that Bragdon's evidence was speculation, and its decision to remand suggest that the Court intended that a high level of medical evidence be presented when a direct threat exception is asserted.

Unfortunately, the majority of circuit courts have missed the signals sent by the Supreme Court and have ignored the intent of Congress to require a high level of objective medical evidence for the invocation of the direct threat exception. The Fourth, Fifth, Sixth, and Eleventh Circuits not only require little evidence to prove that an HIV-positive individual poses a direct threat to the health and safety of others, but also have granted summary judgment to the moving parties, thereby denying the disabled individual an opportunity for trial.[347] After examining the legislative history and Supreme Court precedents, it seems clear that the ADA cannot meet its vision of protecting disabled Americans from unfair discrimination if circuit courts continue to perpetuate unfounded prejudice with a loose direct threat standard. Most circuits have misconstrued the direct threat issue and, arguably, the better approach in the First and Ninth Circuits means that this issue is ripe for the Supreme Court to resolve the split.

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346. *Id.* at 653 (citing Gen. Elec. Co. v. Joiner, 522 U.S. 136, 139 (1997)).

347. *E.g.*, Waddell v. Valley Forge Dental Assoc., Inc., 276 F.3d 1275, 1284 (11th Cir. 2001); Estate of Mauro v. Borgess Med. Ctr., 137 F.3d 398, 407 (6th Cir. 1998); Doe v. Univ. of Md. Med. Sys. Corp., 50 F.3d 1261, 1267 (4th Cir. 1995); Bradley v. Univ. of Tex. M.D. Anderson Cancer Ctr., 3 F.3d 922, 925 (5th Cir. 1993).