



1995

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### Recommended Citation

Patricia M. Bailey, *Significant Risk Concept Justifies Practice Restrictions of an HIV-Infected Surgeon*, 40 Vill. L. Rev. 687 (1995).

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1995]

## Notes

### "SIGNIFICANT RISK" CONCEPT JUSTIFIES PRACTICE RESTRICTIONS OF AN HIV-INFECTED SURGEON

*Scoles v. Mercy Health Corp.*

#### I. INTRODUCTION

Congress enacted the Rehabilitation Act of 1973<sup>1</sup> (Rehabilitation Act) and the Americans with Disabilities Act<sup>2</sup> (ADA) to protect individuals with

1. 29 U.S.C. §§ 701-797b (1994). Section 504 of the Rehabilitation Act of 1973 provides that "[n]o otherwise qualified individual with a disability . . . shall, solely by reason of her or his disability, be excluded from the participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving [f]ederal financial assistance . . ." *Id.* § 794(a). Section 504 of the Rehabilitation Act provides disabled individuals with their greatest statutory protection against discrimination prior to the enactment of the Americans with Disabilities Act (ADA). Jill Cohen, *Access to Medical Care for HIV-Infected Individuals Under the Americans With Disabilities Act: A Duty to Treat*, 18 AM. J.L. & MED. 233, 237 (1992).

2. 42 U.S.C. §§ 12101-12213 (1988 & Supp. V 1993). The ADA provides that "[n]o covered entity shall discriminate against a qualified individual with a disability because of the disability of such individual in regard to job application procedures, the hiring, advancement, or discharge of employees, employee compensation, job training, and other terms, conditions, and privileges of employment." *Id.* § 12112(a). In the late 1980s, the National Council on Disability, an independent federal agency that gives recommendations to Congress on the disabled, recommended the enactment of comprehensive legislation in order to eliminate further discrimination against individuals with disabilities. Statement by President George Bush Upon Signing S. 933, 26 WEEKLY COMP. PRES. DOC. 1165 (July 30, 1990) [hereinafter Statement]. In response, Congress introduced a bill that later was enacted as the Americans With Disabilities Act of 1990. *Id.* Senator Lowell Weicker of Connecticut and Senator Tom Harkin of Iowa sponsored the original bill in the Senate. 134 CONG. REC. S5106-07 (daily ed. Apr. 28, 1988). The House of Representatives considered a similar bill. 134 CONG. REC. E1307 (daily ed. Apr. 29, 1988). After negotiations with congressional sponsors in September of 1989, the Bush administration agreed to endorse a new Senate version. Eileen P. Kelly & Robert J. Aalberts, *Americans With Disabilities Act: Undue Hardship for Private Sector Employers?*, 41 LAB. L.J. 675, 675-76 (1990).

On September 7, 1989, the Senate passed the bill, but the House of Representatives continued its debate. 135 CONG. REC. S10,803 (daily ed. Sept. 7, 1989). The debate in the House centered around the Department of Health and Human Services' (HHS) concern over the large numbers of employees affected by the AIDS epidemic and other contagious diseases. *See* 136 CONG. REC. H4614-30 (daily ed. July 12, 1990) (stating disapproval regarding treatment of HIV-positive individuals in food handling industry). The concern focused on whether individuals could transmit contagious diseases by personal contact or food handling. Kelly & Aalberts, *supra*, at 675-76. A compromise on this issue was reached that required HHS to publish a list of diseases that could be transmitted by handling food. *Id.* at 676. Because the weight of scientific opinion indicated that AIDS could not be

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disabilities or handicaps from discrimination.<sup>3</sup> It was not until recently, however, that these acts covered individuals infected with the Human Immunodeficiency Virus (HIV) and Acquired Immunodeficiency Syndrome (AIDS).<sup>4</sup> Although HIV and AIDS fall within the Rehabilitation Act's and

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transmitted through casual contact, it was unlikely that AIDS would appear on the HHS list. *Id.* The Senate passed the amended version of the ADA on July 11, 1990 and the House passed it the following day. 136 CONG. REC. S9556 (daily ed. July 11, 1990); 136 CONG. REC. H4614 (daily ed. July 12, 1990). President George Bush signed the ADA into law on July 26, 1990. Statement, *supra*, at 1165. This law was viewed as a "declaration of independence for the disabled and the most sweeping civil rights law in a quarter century." Kelly & Aalberts, *supra*, at 684.

3. See 29 U.S.C. § 701(b) (stating that purpose of the Rehabilitation Act is to "empower individuals with disabilities to maximize employment, economic self-sufficiency, independence, and inclusion and integration into society through . . . the guarantee of equal opportunity"); 42 U.S.C. § 12101(b) (stating that one purpose of ADA is to provide a "comprehensive . . . mandate for the elimination of discrimination against individuals with disabilities"); Sidney D. Watson, *Eliminating Fear Through Comparative Risk: Docs, AIDS and the Anti-Discrimination Ideal*, 40 BUFF. L. REV. 739, 764, 768 (1992) (noting that Congress enacted Rehabilitation Act to enable handicapped people to achieve full productive capability, to foster their self-sufficiency and independence, and to integrate them into society; and emphasizing that ADA was intended to expand scope of protection for individuals with disabilities well beyond that provided in Rehabilitation Act); Donald J. Olenick, Note, *Accommodating the Handicapped: Rehabilitating Section 504 After Southeastern*, 80 COLUM. L. REV. 171, 172-76 (1980) (noting that Rehabilitation Act was designed to enable handicapped persons to achieve their full productive capability, foster their self-sufficiency and independence, and integrate them into community).

4. See, e.g., *Gates v. Rowland*, 39 F.3d 1439, 1446 (9th Cir. 1994) (explaining that regulations implementing ADA include, as physical or mental impairment, HIV virus whether symptomatic or asymptomatic (citing 28 C.F.R. § 35.104(4)(1)(ii) (1994)); *id.* (holding that person infected with HIV is individual with handicap within meaning of Rehabilitation Act); *Harris v. Thigpen*, 941 F.2d 1495, 1522-24 (11th Cir. 1991) (stating that for limited purposes of appeal, HIV infected prisoners had satisfied threshold criterion of demonstrating "handicap" within meaning of Rehabilitation Act); *Leckelt v. Board of Comm'rs of Hosp. Dist. No. 1*, 909 F.2d 820, 825 (5th Cir. 1990) (assuming for purposes of appeal that seropositivity to HIV antibodies was impairment protected under Rehabilitation Act and that officials treated plaintiff as though he had impairment); *Chalk v. United States Dist. Ct.*, 840 F.2d 701, 705 n.6 (9th Cir. 1988) (ruling that teacher diagnosed with AIDS was handicapped under Rehabilitation Act); *Support Ministries for Persons With AIDS, Inc. v. Village of Waterford*, 808 F. Supp. 120, 130-31 (N.D.N.Y. 1992) (noting that legislative history of ADA indicates that HIV infection is specifically included in ADA's definition of "disability"); *Doe v. District of Columbia*, 796 F. Supp. 559, 568 (D.D.C. 1992) (holding that based on his HIV status, "Doe" was individual with handicaps under Rehabilitation Act because he had physical impairment that substantially limited major life activities such as procreation, sexual contact and normal social relationships); *Casey v. Lewis*, 773 F. Supp. 1365, 1370 (D. Ariz. 1991) (explaining that courts have held that persons who are HIV-positive are handicapped persons to which § 504 of Rehabilitation Act applies); *Glanz v. Vernick*, 756 F. Supp. 632, 635 (D. Mass. 1991) (noting that defendants did not dispute that HIV-positive status is handicap for purposes of Rehabilitation Act); *Doe v. Dolton Elementary Sch. Dist. No. 148*, 694 F. Supp. 440, 443-44 (N.D. Ill. 1988) (holding that elementary school student infected with AIDS was entitled to preliminary injunction that allowed him to return to school because court found student was likely to prevail in establishing that he was handicapped under Rehabilitation Act); *Thomas v. Atascadero Unified Sch. Dist.*, 662 F.

the ADA's protective scope, there is one potentially debilitating limitation on the HIV-infected individual's recovery: the Rehabilitation Act and

Supp. 376, 379-81 (C.D. Cal. 1987) (explaining that child infected with HIV was "handicapped person" within meaning of § 504 of Rehabilitation Act and child was "otherwise qualified" to attend regular kindergarten classes).

The Supreme Court left open the question of whether asymptomatic carriers of a disease such as AIDS could be considered "handicapped" under the Rehabilitation Act. See *School Bd. v. Arline*, 480 U.S. 273, 282 n.7 (1987) ("[W]e . . . do not reach, the questions whether a carrier of a contagious disease such as AIDS could be considered to have a physical impairment, or whether such a person could be considered, solely on the basis of contagiousness, a handicapped person as defined by the [Rehabilitation] Act."). However, with regard to the ADA, the legislative history clearly indicates that asymptomatic carriers of AIDS are considered "disabled" for purposes of the Act. See 28 C.F.R. § 35.104(4)(1)(ii) (1995) (stating that phrase "physical or mental impairment includes . . . HIV disease (whether symptomatic or asymptomatic)"). Several legislators commented directly upon the issue of whether asymptomatic HIV-positive people are protected by the ADA. Congressman Owens of New York stated, "[p]eople with HIV disease are individuals who have any condition along the full spectrum of HIV infection-asymptomatic HIV infection, symptomatic HIV infection or full blown AIDS. These individuals are covered under the first prong of the definition of disability in the ADA." 136 CONG. REC. H46,223 (daily ed. July 12, 1990). Senator Kennedy of Massachusetts, co-sponsor of the bill, agreed, 136 CONG. REC. S9696 (daily ed. July 13, 1990), as did Representative Waxman, "[a]s medical knowledge has increased, specialists in the field increasingly recognize that there exists a continuum of disease among those who are HIV infected. All such individuals are covered under the first prong of the definition of disability in the ADA." 136 CONG. REC. H4646 (daily ed. July 12, 1990).

AIDS is a fatal disease that develops after a person becomes infected with the HIV. Centers for Disease Control, *AIDS and Human Immunodeficiency Virus Infection in the United States: 1988 Update*, 38 MORBIDITY AND MORTALITY WKLY. REP., May 12, 1989, at 1 [hereinafter CDC 1989]. AIDS was first identified in the early 1980s. Watson, *supra* note 3, at 744. By February 30, 1991, 167,803 cases of AIDS were reported in the United States and 106,361 people had already died. *Id.* An individual may be infected with HIV but not have AIDS. Mireya Navarro, *AIDS Definition Is Widened to Include Blood Cell Count*, N.Y. TIMES, Aug. 8, 1991, at D21-22. An individual has AIDS when he or she tests positive for HIV antibodies and has an accompanying opportunistic infection or a cancer that characteristically attacks individuals with immune systems suppressed by HIV. *Id.* A person infected with HIV who does not manifest any of the infections or cancers typically associated with AIDS, nonetheless has AIDS when her T-cell count (immune system cells destroyed by the virus) decrease to 200 or fewer cells per cubic millimeter of blood. *Id.*

AIDS has no known cure and treatment of its outward symptoms does not reverse the immunodeficiency. *Update: Acquired Immunodeficiency Syndrome — United States, 1981-88*, 261 JAMA 3147, 3147-48 (1990). The FDA has approved an antiviral drug called zidovudine (formerly AZT) for the treatment of AIDS patients. Paul A. Volberding et al., *Zidovudine in Asymptomatic Human Immunodeficiency Virus Infection*, 322 NEW ENG. J. MED. 941, 941 (1990). Zidovudine delays the development of full-blown AIDS in HIV-positive persons who are asymptomatic or mildly symptomatic, but who have reduced immune cell counts. David K. Henderson & Julie L. Gerberding, *Prophylactic Zidovudine After Occupational Exposure to the Human Immunodeficiency Virus: An Interim Analysis*, 160 J. INFECTIOUS DISEASES 321, 322-23 (1989). Although this drug has extended the working careers of many HIV-infected individuals, it can cause severe side effects, such as anemias and copenias, which require constant monitoring. *Id.*

ADA only protect an HIV-infected individual if he or she does not pose a "significant risk" to others.<sup>5</sup> As a result, the "significant risk" concept has particular significance in the context of HIV-infected health care workers in that the allowable amount of risk that HIV-positive health care workers can pose to patients is determinative of whether these individuals can ever have a viable claim of discrimination under these acts.<sup>6</sup>

Of particular importance for professionals within the United States Court of Appeals for the Third Circuit's jurisdiction is *Scoles v. Mercy Health Corp.*,<sup>7</sup> in which the United States District Court for the Eastern District of Pennsylvania considered the risk posed by a surgeon infected with HIV.<sup>8</sup> In *Scoles*, the court decided whether the Rehabilitation Act or the ADA protected Dr. Paul Scoles, an HIV-positive orthopedic surgeon, against discrimination by his employer, Mercy Health Corporation (Mercy Health).<sup>9</sup> The court determined that Dr. Scoles presented a "significant risk" to his patients and thus, the Rehabilitation Act and the ADA did not protect him from Mercy Health's actions.<sup>10</sup> Before appealing the case to the Third Circuit, however, Dr. Scoles and Mercy Health reached a private settlement, leaving the issue unresolved and giving little guidance to hospitals

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5. See Rehabilitation Act of 1973, 29 U.S.C. § 794 (1994) (protecting individuals with handicaps as long as they are "otherwise qualified," which courts interpret to mean as long as they do not pose "significant risk" to others); ADA, 42 U.S.C. §§ 12111(3), 12113(a)-(b) (1988 & Supp. V 1993) (explaining that it is defense to discrimination that application of qualification standards that denies job or benefit to individual was job-related and consistent with business necessity; such qualification standards include requirement that individual shall not pose "direct threat" to health or safety of others with "direct threat" defined as "significant risk" to health or safety of others that cannot be eliminated by reasonable accommodation).

6. For a discussion of the importance of the probability of the risk factor to HIV-infected health care workers, see *infra* notes 158-60 and accompanying text. The risk of HIV transmission from doctor to patient became a serious concern in 1990, when the Centers for Disease Control obtained the report of a possible transmission from a Florida dentist, Dr. David Acer, to a patient, Kimberly Bergalis. Christine Huebner, Note, *Mandatory Testing of Health-Care Workers for AIDS: When Positive Results Lead to Negative Consequences*, 37 N.Y.L. SCH. L. REV. 339, 339 (1992). After this initial report, four other individuals reported HIV transmission from Dr. Acer. *Id.* The possibility of doctor-patient HIV transmission "has prompted heated debates in the medical community over the need for greater precautions to be taken during health-care worker/patient interactions." *Id.*

7. 887 F. Supp. 765 (E.D. Pa. 1994).

8. For a discussion of the facts of *Scoles*, see *infra* notes 92-108 and accompanying text.

9. *Scoles*, 887 F. Supp. at 768. For a discussion of the protection provided by the Rehabilitation Act, see *infra* notes 34-43, 49-51 and accompanying text. For a discussion of the protection provided by the ADA, see *infra* notes 44-51 and accompanying text.

10. *Id.* at 772. For a discussion of the "significant risk" standard applied in *Scoles*, see *infra* notes 109-54 and accompanying text. For a discussion of the *Scoles* court's holding, see *infra* notes 155-77 and accompanying text.

regarding the proper treatment of HIV-positive physicians and HIV-infected health care professionals regarding their job security.<sup>11</sup>

This Note will discuss the *Scoles* decision and examine the different actions courts have taken when confronted with issues concerning HIV-infected health care workers.<sup>12</sup> Part II of this Note will analyze the standards developed regarding the determination of "significant risk" under the Rehabilitation Act and the ADA.<sup>13</sup> Part III of this Note will examine the facts leading up to Dr. Scoles' discrimination complaint against Mercy Health.<sup>14</sup> Part IV will analyze the court's opinion and its reasoning with regard to the risk of transmission of the HIV virus from health care workers to patients.<sup>15</sup> Finally, Part V will consider the repercussions of *Scoles* and conclude that as a result of this case, the Rehabilitation Act and ADA will only protect HIV-infected health care workers in limited situations.<sup>16</sup>

## II. BACKGROUND

In *Scoles*, the district court discussed whether Mercy Health violated the Rehabilitation Act and the ADA when it required Dr. Scoles to disclose his HIV-positive status to patients and obtain the patients' informed consent before performing invasive surgical procedures.<sup>17</sup> In an effort to understand the *Scoles* court's reasoning, Section A of the background will discuss the purposes behind the Rehabilitation Act and the ADA.<sup>18</sup> Moreover, Section B will discuss the scope of the protection available under both Acts.<sup>19</sup> Finally, Section C will discuss the application of the "significant risk" limitation to recent HIV employment discrimination cases focusing specifically on HIV-infected health care workers.<sup>20</sup>

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11. See Shankar Vedantam, *Settlement Reached in AIDS Suit*, PHILA. INQUIRER, Feb. 8, 1995, at B2. The secret settlement was announced on Wednesday, February 8, 1995 and the details of the settlement remained confidential. *Id.*

12. For a discussion of the *Scoles* decision, see *infra* notes 109-54 and accompanying text. For a discussion of the different actions courts have taken regarding HIV-infected health care workers, see *infra* notes 63-89 and accompanying text.

13. For a discussion of the "significant risk" standard, see *infra* notes 17-91 and accompanying text.

14. For a discussion of the facts of *Scoles*, see *infra* notes 92-108 and accompanying text.

15. For a detailed discussion of the court's analysis and holding, see *infra* notes 109-77 and accompanying text.

16. For a discussion of the impact of the *Scoles* decision, see *infra* notes 178-80 and accompanying text.

17. *Scoles v. Mercy Health Corp.*, 887 F. Supp. 765, 768-72 (E.D. Pa. 1994).

18. For a discussion of the purposes behind the Rehabilitation Act and the ADA, see *supra* note 3 and accompanying text.

19. For a discussion of the scope of the protection available under the Rehabilitation Act and the ADA, see *infra* notes 21-51 and accompanying text.

20. For a discussion of the application of the "significant risk" limitation to recent cases, see *infra* notes 52-91 and accompanying text.

A. *Purpose Behind the Rehabilitation Act and the ADA*

HIV-infected employees are protected by two federal anti-discrimination statutes: the Rehabilitation Act<sup>21</sup> and the ADA.<sup>22</sup> Congress enacted the Rehabilitation Act to promote the self-sufficiency and independence of handicapped people, thus hoping to foster their integration into society.<sup>23</sup> Section 504 of the Rehabilitation Act prohibits any recipient of federal financial assistance, including both public and private entities, from discriminating against individuals with disabilities who are "otherwise qualified" for the position.<sup>24</sup> Although not expressly provided for in the Act, individuals may enforce the statute and its implementing regulations through a private right of action.<sup>25</sup> The remedies available to a private plaintiff who proves intentional discrimination include retrospective and prospective equitable relief.<sup>26</sup>

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21. 29 U.S.C. §§ 701-795(i) (1994). Section 504 of the Rehabilitation Act provides: "No otherwise qualified individual with a disability . . . shall, solely by reason of her or his disability, be excluded from the participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance . . ." *Id.* § 794.

22. 42 U.S.C. §§ 12101-12213 (1988 & Supp. V 1993). For the text of the general rule prohibiting discrimination against HIV-infected employees, see *supra* note 2.

23. S. REP. NO. 1297, 93rd Cong., 1st Sess. 16 (1974). Congress expanded the definition of "handicapped individual" in 1974 to include:

[A]ny person who (i) has a physical or mental impairment which substantially limits one or more of such person's major life activities, (ii) has a record of such impairment, or (iii) is regarded as having such an impairment.

29 U.S.C. § 706(7)(B) (1988 & Supp. 1992), amended by 29 U.S.C. § 706(8)(A) (1994). This definition reflected Congress' attempt to protect handicapped people from discrimination stemming from prejudice and "archaic attitudes and laws." S. REP. NO. 1297, 93rd Cong., 1st Sess. 50 (1974). It also recognized that "the American people are simply unfamiliar with and insensitive to the difficulties confront[ing] individuals with handicaps." *Id.*

24. See 29 U.S.C.A. § 794(a) (1994) (prohibiting recipients of federal financial assistance from discriminating against individuals because of their disabilities); see also *School Bd. v. Arline*, 480 U.S. 273, 288 (1987) (defining four factors to determine "otherwise qualified" condition). The elements of a cause of action under § 504 are: (1) the plaintiff is a "handicapped person" under the Rehabilitation Act; (2) the plaintiff is "otherwise qualified" to perform the job; (3) the plaintiff is excluded from performing the job solely because of his or her handicap; and (4) the employer receives federal funds. *Doe v. Washington Univ.*, 780 F. Supp. 628, 632 (E.D. Mo. 1991).

25. See *Guardians Ass'n v. Civil Serv. Comm'n*, 463 U.S. 582, 593-95 (1983) (stating that although Supreme Court has never addressed whether § 504 gives rise to private right of action, Court would most likely find that private right exists due to fact that Court has held that both Title VI and Title IX give rise to private right of action).

26. *Watson*, *supra* note 3, at 767. This relief includes reinstatement, promotion or hiring, and back pay. See *Consolidated Rail Corp. v. Darrone*, 465 U.S. 624, 630-31 (1984) (back pay); *Guardians Ass'n*, 463 U.S. at 607 (finding that injunctive relief does not include awards of constructive seniority).

In an effort to expand the scope of protection for individuals with disabilities well beyond the protection provided in the Rehabilitation Act,<sup>27</sup> Congress enacted the ADA in 1990.<sup>28</sup> Unlike the Rehabilitation Act, the ADA covers entities that do not receive federal funds.<sup>29</sup> The ADA precludes disability discrimination in private employment contexts and in privately-operated public accommodations.<sup>30</sup> In addition, the remedies under the ADA are broader than those available under the Rehabilitation

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27. See S. REP. NO. 116, 101st Cong., 1st Sess. 27 (1989) (noting that ADA applies to many businesses in United States); Laura Pincus, *The Americans with Disabilities Act: Employers' New Responsibilities to HIV-Positive Employees*, 21 HOFSTRA L. REV. 561, 565 (1993) (noting that ADA protects disabled individuals by imposing new, more strict requirements on employers); Jennifer Hertz, Comment, *Physicians with AIDS: A Proposal for Efficient Disclosure*, 59 U. CHI. L. REV. 749, 765 (1992) (recognizing that ADA expands scope of federal protection against disability discrimination based on HIV infection or AIDS); Joel Neugarten, Note, *The Americans with Disabilities Act: Magic Bullet or Band-Aid for Patients and Health Care Workers Infected with the Human Immunodeficiency Virus?*, 57 BROOK. L. REV. 1277, 1281 (1992) (stating that ADA provides "comprehensive rights, protections and legal remedies to HIV-infected individuals seeking health care in both the private and public sectors").

Prior to 1992, the Rehabilitation Act used the term "handicap," even though the ADA currently uses the term "disability." Compare 42 U.S.C. § 12112(a) with 29 U.S.C. § 794(a) (1988). Despite the difference in language, the ADA's definition of "disability" was identical to that of the Rehabilitation Act's definition of "handicap." See 29 U.S.C. § 706(8)(B) (1988) (defining "handicapped individual" as "any person who (i) has a physical or mental impairment which substantially limits one or more of such person's major life activities, (ii) has a record of such impairment, or (iii) is regarded as having such an impairment"); 42 U.S.C. § 12102(2) (defining term "disability" as same). The ADA uses the term "disability" because of "Congress's impression that disabled interest groups prefer that terminology, but no change in concept is intended." HENRY H. FERRITT, JR., AMERICANS WITH DISABILITIES ACT HANDBOOK 25 (1990). Since then, however, Congress amended the Rehabilitation Act's use of the word "handicap." See 29 U.S.C. § 706(8)(B) (1994) (amending 29 U.S.C. § 706(8)(B) (1988)). Congress substituted "disability" for "handicap." *Id.* The statutory definition of disability in the Rehabilitation Act now mirrors the language employed in the ADA. See *id.*; 42 U.S.C. 12102(2).

28. 42 U.S.C. §§ 12101-12213 (1988 & Supp. V 1993). Congress enacted the ADA on July 26, 1990. *Id.* § 12101. The ADA was enacted with the purpose of providing "a clear and comprehensive national mandate for the elimination of discrimination against individuals with disabilities." *Id.* § 12101(b)(1).

29. See 42 U.S.C. § 12111(2) (defining "covered entity" as "employer, employment agency, labor organization, or joint labor-management committee"); *id.* § 12111(5) (defining "employer" as "person engaged in an industry affecting commerce who has 15 or more employees"). Title I of the ADA prohibits employment discrimination by private employers with 15 or more employees. See *id.* (defining "employer" as "person engaged in an industry affecting commerce who has 15 or more employees for each working day in each of 20 or more calendar weeks in the current or preceding calendar year"); see also Pincus, *supra* note 27, at 565 (discussing change in ADA requirements for businesses to qualify under this law). In July 1992, employers with 25 or more employees were covered under the ADA, but in July 1994, its protection expanded to include employers with 15 or more employees. *Id.*

30. 42 U.S.C. § 12101-12213.



Act.<sup>31</sup> For example, the remedies available to a plaintiff filing a Title I ADA claim include reinstatement, promotion and back pay.<sup>32</sup> Furthermore, each prevailing plaintiff can recover up to \$300,000 in compensatory and punitive damages if the defendant employs 500 or more employees.<sup>33</sup>

### B. *Scope of the Rehabilitation Act and ADA*

In the 1980s, when the medical field reported the first cases of AIDS, some controversy emerged over the statutory protections available to individuals with AIDS.<sup>34</sup> Because Congress had not yet enacted the ADA, the debate centered specifically on whether section 504 of the Rehabilitation Act considered persons with contagious diseases to be "disabled" under the Act and thus subject to the Act's protection.<sup>35</sup> The United States Department of Justice attempted to resolve the controversy in 1986 and concluded that an individual's real or perceived ability to transmit a disease such as AIDS did not constitute a disability.<sup>36</sup> In *School Board v. Arline*,<sup>37</sup> however, the United States Supreme Court rejected the Justice Department's position.<sup>38</sup> In *Arline*, the Court held that an individual afflicted

31. Compare 42 U.S.C. § 12117 (stating that remedies set forth in §§ 2000e-4 (Equal Employment Opportunity Commission), 2000e-5 (enforcement provisions), 2000e-6 (Civil Actions by Attorney General), 2000e-8 (Investigations), and 2000e-9 (Conduct of hearings and investigations) apply to ADA); with 29 U.S.C. § 794a(a)(2) (stating that remedies set forth in 2000e-16 (employment by federal government) and 2000e-5(f) (Civil Action) through (k) (attorney's fee) apply to Rehabilitation Act).

32. 42 U.S.C. § 2000e-5(g). The ADA specifies that back pay liability will not accrue from a date more than two years prior to the filing of a charge with the Commission, and that interim earnings shall operate to reduce the back pay allowable. *Id.* § 2000e-5(g)(1).

33. Civil Rights Act of 1991, Pub. L. No. 102-166, § 1977(A)(b)(3)(D), 105 Stat. 1071, 1073 (1991).

34. See Arthur S. Leonard, *Discrimination, in AIDS LAW TODAY: A NEW GUIDE FOR THE PUBLIC* 297, 297-99 (Scott Burris et al. eds., 1993) (noting that in early days of AIDS epidemic, there was no existing body of ready-made precedents to deal with discrimination due to contagious condition; therefore, lawyers, judges and legislators adapted existing disability discrimination law to new problem).

35. See *id.* at 299 (noting that before 1987, it was not clear whether Rehabilitation Act's definition of "handicap" covered people with contagious diseases).

36. James F. Baxley, *Rehabilitating AIDS-Based Employment Discrimination: HIV Infection as a Handicap Under the Vocational Rehabilitation Act of 1973*, 19 SETON HALL L. REV. 23, 25 (1989) (citing Office of Legal Counsel, United States Department of Justice, Memorandum for Ronald E. Robertson, General Counsel, Department of Health & Human Services, Re: Application of Section 504 of Rehabilitation Act to Persons with AIDS Virus (June 23, 1986)).

37. 480 U.S. 273 (1987).

38. *Id.* at 285-86. In *Arline*, an elementary school in Nassau County, Florida fired Gene Arline, a school teacher, after she suffered her third relapse of tuberculosis within two years. *Id.* at 276. She then brought suit in federal court alleging that the school violated § 504 of the Rehabilitation Act of 1973. *Id.* The lower court held that Arline was not a handicapped person under the terms of the statute. *Id.* at 277. The United States Court of Appeals for the Eleventh Circuit re-

with a contagious disease could be "disabled" for purposes of the Rehabilitation Act if the definition of a "handicap" were met.<sup>39</sup>

versed, holding that persons with contagious diseases are within the coverage of § 504. *Id.* The Supreme Court affirmed the Eleventh Circuit and held that because Arline suffered from a contagious disease, she was a "handicapped" person within the meaning of the Rehabilitation Act. *Id.* at 289.

39. *Id.* at 284-85. Congress amended the definition of a "handicapped individual" to include "any person who (i) has a physical or mental impairment which substantially limits one or more of such person's major life activities; (ii) has a record of such impairment, or (iii) is regarded as having such an impairment." 29 U.S.C. § 706(8)(B) (1994). Justice Brennan stated that "society's accumulated myths and fears about disability and diseases are as handicapping as are the physical limitations that flow from actual impairment. Few aspects of a handicap give rise to the same level of public fear and misapprehension as contagiousness." *Arline*, 480 U.S. at 284. Several other cases have since held that the Rehabilitation Act covers individuals infected with HIV. *See, e.g., Doe v. Centinela Hosp. Found.*, No. 89-2668C, 1988 WL 81776, at \*11 (C.D. Cal. June 30, 1988) (holding that Rehabilitation Act covers HIV-infected plaintiff because plaintiff was perceived as having impairment which substantially limited major life activity); *Ray v. School Dist.*, 666 F. Supp. 1524, 1536 (M.D. Fla. 1987) (concluding for purposes of preliminary injunction that carriers of AIDS virus are handicapped within meaning of Rehabilitation Act); *Local 1812, American Fed'n of Gov't Employees v. United States*, 662 F. Supp. 50, 54 (D.D.C. 1987) (noting that asymptomatic HIV infection constituted handicap because it could physically impair immune system thus substantially limiting major life activity as well as be perceived as impairment); *District 27 Community Sch. Bd. v. Board of Educ.*, 502 N.Y.S.2d 325, 336 (Sup. Ct. 1986) (stating that Rehabilitation Act covers asymptomatic HIV carriers because they "ha[ve] a history of, or ha[ve] been misclassified as having [an impairment]") (quotation omitted).

Many scholars agree that HIV is a "handicap" under the Rehabilitation Act. *See, e.g., Robert P. Wasson, Jr., AIDS Discrimination Under Federal, State, and Local Law After Arline*, 15 FLA. ST. U. L. REV. 221, 240 (1987) (stating that individuals with AIDS-related complex (ARC) and those who test seropositive ought to be determined "handicapped" and thereby obtain protection from discrimination under § 504 of Rehabilitation Act of 1973); Terry L. Pabst, Note, *Protection of AIDS Victims from Employment Discrimination Under the Rehabilitation Act*, 1987 U. ILL. L. REV. 355, 368-70 (1987) (arguing that end-stage AIDS victims and AIDS-related complex victims are handicapped individuals under Rehabilitation Act); Stephanie Sherman, Note, *An Individualized Definition of "Handicap" and Its Application to HIV*, 22 U.C. DAVIS L. REV. 653, 677-80 (1989) (suggesting that HIV-infected individuals have physical or mental impairment that substantially limits major life activities and therefore are protected under § 504 of Rehabilitation Act of 1973); Gregory M. Shumaker, Note, *AIDS: Does It Qualify as a "Handicap" Under the Rehabilitation Act of 1973?*, 61 NOTRE DAME L. REV. 572, 586 (1986) (arguing that federal agency guidelines suggest that AIDS qualifies as physical or mental impairment which substantially limits major life activities, and thus Rehabilitation Act protected employees or job applicants with AIDS because they are "handicapped individuals").

The legislative history of the Rehabilitation Act also evidences that HIV is to be included as a "handicap." *See, e.g.,* 134 CONG. REC. H574 (daily ed. Mar. 2, 1988) (statement of Rep. Owens) (indicating that debate on 1987 amendment to Rehabilitation Act clearly demonstrates that members of Congress assumed that both symptomatic and asymptomatic HIV infection were handicaps under Rehabilitation Act of 1973); 134 CONG. REC. H575 (daily ed. Mar. 2, 1988) (statement of Rep. Waxman) (stating that "section 504 and the decisions that have addressed infectious diseases — such as *Arline*, *AFGE v. State*, *Thomas v. Atascadero*, and *Ray v. Desoto* — have made it clear that people with AIDS and HIV infections are

Having found that persons with contagious diseases are protected under the Rehabilitation Act, the Supreme Court in *Arline* further held that, under the Rehabilitation Act, a federally-assisted program could only discriminate against a person on the basis of a communicable disease if that person posed a "significant risk" to the health or safety of others.<sup>40</sup> The Court applied four factors in determining whether a person posed a "significant risk" and was thus not "otherwise qualified" for the position.<sup>41</sup> These four factors are: (1) the nature of the risk (how the disease is transmitted); (2) the duration of the risk (how long the carrier is infectious); (3) the severity of the risk (what the potential harm is to third parties); and (4) the probability that the disease will be transmitted and cause varying degrees of harm.<sup>42</sup> This test for determining "significant risk" (the *Arline* standard) is frequently used by courts in disability discrimination cases.<sup>43</sup>

When Congress enacted the ADA in 1990, it was clear from the legislative history that the Act would protect individuals with AIDS.<sup>44</sup> Even though the ADA's definition of disability included AIDS, the *Arline* standard for "significant risk" still had an influential effect on the application of the ADA.<sup>45</sup> The ADA prohibits employers from discriminating against employees with disabilities, so long as the employees do "not pose a direct

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protected"). *But see* 134 CONG. REC. H579-80 (daily ed. Mar. 2, 1988) (statement of Rep. Dannemeyer) (opposing amendment because it covered asymptomatic individuals).

40. *Arline*, 480 U.S. at 287 & n.16.

41. *Id.* at 287-88.

42. *Id.* at 288. The American Medical Association originally established the four factors that the court approved. *Id.* With regard to implementing the test, the court stated: "[i]n making these findings, courts normally should defer to the reasonable medical judgments of public health officials." *Id.*

43. *See, e.g.*, *Bradley v. University of Tex. M.D. Anderson Cancer Ctr.*, 3 F.3d 922, 924 (5th Cir. 1993) (applying *Arline* standard and specifically stating that fourth *Arline* factor [probability disease will be transmitted] is at issue), *cert. denied*, 114 S. Ct. 1071 (1994); *Martinez v. School Bd.*, 861 F.2d 1502, 1505-06 (11th Cir. 1988) (applying *Arline* to determine that retarded school child with AIDS does not pose significant risk); *Chalk v. United States Dist. Court*, 840 F.2d 701, 707 (9th Cir. 1988) (noting that district court failed to apply *Arline* standard properly); *Doe v. Washington Univ.*, 780 F. Supp. 628, 632 (E.D. Mo. 1991) (noting that probability that disease will be transmitted is at issue).

44. *See* H.R. REP. NO. 485, 101st Cong., 2d Sess., pt.1, at 52 (1990) (stating that "a person infected with the Human Immunodeficiency Virus is covered under the first prong of the definition of the term 'disability' [in ADA] because of a substantial limitation to procreation and intimate sexual relationships"); 28 C.F.R. § 36.104 (1992) (noting that Justice Department rules for implementing ADA include HIV disease, both symptomatic and asymptomatic, as one of several disabilities expressly covered); *see also* *Gates v. Rowland*, 39 F.3d 1439, 1446 (9th Cir. 1994) (noting that ADA defines "disability" in terms identical to Rehabilitation Act).

45. *See* Thomas D. Brierton, *An Examination of the ADA's Direct Threat Defense*, 1994 LAB. L.J. 618, 618 (noting that *Arline* has had great effect on both Rehabilitation Act and ADA).

threat to the health or safety of other individuals in the workplace."<sup>46</sup> The ADA defines "direct threat" as "a significant risk to the health or safety of others that cannot be eliminated by reasonable accommodation."<sup>47</sup> The legislative history of the ADA, as well as the Equal Employment Opportunity Commission (EEOC) guidelines adopted under the ADA, indicate that Congress codified the Supreme Court's four-part test in *Arline* as the standard for the "direct threat" defense under the ADA.<sup>48</sup>

Thus, under the Rehabilitation Act, a *handicapped* person is protected as long as he or she is "*otherwise qualified*" for the position, and under the ADA a *disabled* person is protected as long as he or she does not pose a "*direct threat*" to others.<sup>49</sup> Both "otherwise qualified" and "direct threat" are interpreted to mean that the individual seeking coverage cannot pose a "significant risk" to others, as determined by the *Arline* standard.<sup>50</sup> Thus, the *Arline* analysis can be applied under both the Rehabilitation Act and the ADA to determine the rights of HIV-infected health care workers.<sup>51</sup>

### C. Application of the "Significant Risk" Limitation

When an HIV-infected employee claims discrimination in violation of the Rehabilitation Act and ADA, courts must determine the "significant risk" posed by such employees.<sup>52</sup> First, in respect to the Rehabilitation Act, courts have applied *Arline's* "significant risk" standard and determined that teachers with AIDS are protected.<sup>53</sup> For example, in *Chalk v. United States District Court*,<sup>54</sup> a school district sought to remove a teacher from the classroom and reassign him to an administrative position because

46. 42 U.S.C. §§ 12112(a), 12113(a)-(b) (1988 & Supp. V 1993). For an explanation of the pertinent statutory language of the ADA, see *supra* notes 2, 5. For a discussion of the legislature's intent in enacting the ADA, see *supra* note 27 and accompanying text.

47. 42 U.S.C. § 12111(3).

48. Brierton, *supra* note 45, at 618; see 29 C.F.R. § 1630.2(r) (1994) (explaining that four factors should be considered to determine "direct threat" under ADA: (1) duration of risk; (2) nature and severity of potential harm; (3) likelihood potential harm will occur; and (4) imminence of potential harm).

49. For a discussion of the "otherwise qualified" aspect of the Rehabilitation Act, see *supra* notes 40-43 and accompanying text. For a discussion of the "direct threat" exception under the ADA, see *supra* notes 45-48 and accompanying text.

50. For a discussion of the application of "significant risk" and the *Arline* standard to the Rehabilitation Act, see *supra* notes 40-43 and accompanying text. For a discussion of the application of "significant risk" and the *Arline* standard to the ADA, see *supra* notes 45-48 and accompanying text.

51. See, e.g., *Scoles v. Mercy Health Corp.*, 887 F. Supp. 765, 772 (E.D. Pa. 1994) (employing *Arline* factors in its application of Rehabilitation Act and ADA provisions).

52. For a discussion of the "significant risk" standard under both the ADA and Rehabilitation Act, see *supra* notes 40-48 and accompanying text.

53. See *Chalk v. United States Dist. Court*, 840 F.2d 701, 711 (9th Cir. 1988) (holding that school teacher with AIDS was not "significant risk" to students and therefore was allowed to continue teaching).

54. 840 F.2d 701 (9th Cir. 1988).

he had AIDS.<sup>55</sup> The United States Court of Appeals for the Ninth Circuit reversed the district court's opinion and held that the teacher did not pose a "significant risk" in his prior position and was "otherwise qualified" under the Rehabilitation Act.<sup>56</sup> The court determined that the teacher did not pose a "significant risk" because the scientifically-established methods of transmitting HIV were unlikely to occur in the classroom setting.<sup>57</sup> In holding that there was no evidence of any significant risk to the students or other individuals at the school, the court held that "[t]o allow the court to base its decision on the fear and apprehension of others would frustrate the goals of section 504."<sup>58</sup>

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55. *Id.* at 703. In *Chalk*, the petitioner, Vincent L. Chalk, was a certified teacher of hearing-impaired students in the Orange County School District for six years. *Id.* In February of 1987, after being hospitalized with pneumocystis carinii pneumonia, the hospital diagnosed Chalk as having AIDS. *Id.* After eight weeks of treatment, Chalk's physician found him fit to return to work, but the Orange County Department of Education placed him on administrative leave pending the opinion of an Orange County Health Care Agency doctor. *Id.* Although this physician declared him fit to return to work, Chalk agreed to remain on administrative leave through the end of the school year. *Id.* At the end of the summer, the Department of Education offered Chalk an administrative position with the option of working either at the Department's offices or at home. *Id.* Chalk refused the offer and the Department filed a declaratory relief action in the Orange County Superior Court. *Id.* In return, Chalk filed an action in the United States District Court for the Southern District of California seeking a preliminary and permanent injunction barring the Department from excluding him from the classroom. *Id.* The district court denied Chalk's motion, and Chalk appealed to the United States Court of Appeals for the Ninth Circuit. *Id.* at 704.

56. *Id.* at 704. The Ninth Circuit explained that the district court failed to follow the legal standards set forth in *Arline*. *Id.* at 707. The district court judge addressed the four *Arline* factors but ignored the fact that transmission was unlikely to occur in this situation and the probability of harm was minimal. *Id.* The district court judge was cautious because of the chance that there still might be something unknown to science that might do harm and thus, denied the teacher's motion for preliminary injunction reinstating him to classroom duties. *Id.* The Ninth Circuit responded that "[l]ittle in science can be proved with complete certainty, and section 504 does not require such a test." *Id.* The Ninth Circuit concluded that the district court was wrong in rejecting the consensus of medical opinion and improperly relying on speculation for which there was no credible support in the record. *Id.* at 708.

57. *Id.* at 706-07. The court noted that HIV transmission was known to occur in only three ways: (1) through intimate sexual contact with an HIV-infected person; (2) through invasive exposure to contaminated blood or certain other bodily fluids; or (3) through exposure from mother to infant. *Id.* at 706. The court also explained that medical evidence has shown that HIV may be transmitted only through blood, semen, vaginal secretions and possibly breast milk. *Id.* The Ninth Circuit supported its position that HIV cannot be transmitted through casual contact in the classroom setting with reports from the Surgeon General, the Centers for Disease Control, the American Medical Association and the Institute of Medicine of the National Academy of Sciences. *Id.* at 706-07.

58. *Id.* at 711. The Ninth Circuit recognized that public interest is an important criteria that a court should consider in granting injunctive relief. *Id.* The court, however, noted that the purpose of § 504 of the Rehabilitation Act is to ensure that handicapped persons are not denied jobs or benefits that they are entitled to because of the prejudice or ignorance of others. *Id.*

Similarly, the Rehabilitation Act has also protected students with AIDS.<sup>59</sup> In *Martinez v. School Board*,<sup>60</sup> the United States Court of Appeals for the Eleventh Circuit reversed a district court's holding that a retarded child with AIDS should be removed from the rest of her class because there is a "remote theoretical possibility of transmission" of the HIV virus through tears, saliva and urine.<sup>61</sup> The Eleventh Circuit held that such a remote possibility of transmission did not satisfy the Rehabilitation Act's "significant risk" standard.<sup>62</sup>

In cases where the employment context created a higher risk of substantial harm, the courts have denied protection under the Rehabilitation Act.<sup>63</sup> For example, in *Bradley v. University of Texas M.D. Anderson Cancer Center*,<sup>64</sup> the United States Court of Appeals for the Fifth Circuit held that a surgical technician infected with HIV was not "otherwise qualified" and thus was not within the Rehabilitation Act's protection.<sup>65</sup> The court noted that the surgical technician frequently handled sharp instruments and

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59. See *Martinez v. School Bd.*, 861 F.2d 1502, 1506 (11th Cir. 1988) (holding that retarded child with AIDS could not be removed from classroom because remote possibility of transmission did not satisfy Rehabilitation Act's "significant risk" standard); *Ray v. School Dist.*, 666 F. Supp. 1524, 1535, 1538 (M.D. Fla. 1987) (granting preliminary injunction prohibiting district from excluding three HIV-positive brothers from classroom because weight of medical evidence did not support "future theoretical harm" of transmission of AIDS virus in classroom); *Thomas v. Atascadero Unified Sch. Dist.*, 662 F. Supp. 376, 377 (C.D. Cal. 1987) (granting preliminary injunction prohibiting school district from excluding child with AIDS from classroom, despite child's involvement in biting incident); *District 27 Community Sch. Bd. v. Board of Educ.*, 502 N.Y.S.2d 325, 328 (Sup. Ct. 1986) (upholding New York City Board of Education policy of determining on case-by-case basis whether health and development of children with AIDS permitted them to attend school in unrestricted setting because transmission of AIDS virus in classroom setting was "a mere theoretical possibility" and that exclusion of AIDS victims on that basis would violate § 504 of Rehabilitation Act).

60. 861 F.2d 1502 (11th Cir. 1988).

61. *Id.* at 1503, 1507. Eliana Martinez was seven years old, HIV-positive and suffered from thrush, a disease that can cause blood in the saliva. *Id.* at 1503. She was not toilet trained, and sucked her thumb and forefinger which were frequently covered with saliva. *Id.* The district court found that there was a "remote theoretical possibility of transmission" of the HIV virus through tears, saliva and urine, and therefore permitted her isolation. *Id.* at 1504. The district court recommended that Eliana be taught in a separate room within the classroom, which would consist of a large glass window and sound system to allow her to see and hear the students and teacher in the main classroom. *Id.*

62. *Id.* at 1506-07. The Ninth Circuit remanded the case because the district court failed to make any specific finding with respect to the risk of transmission from blood in the saliva to which other children might be exposed. *Id.*

63. For a discussion of HIV-positive health care worker cases, in which there was a higher risk of substantial harm, see *infra* notes 64-89 and accompanying text.

64. 3 F.3d 922 (5th Cir. 1993), *cert. denied*, 114 S. Ct. 1071 (1994).

65. *Id.* at 924. The University of Texas M.D. Anderson Cancer Center discovered that Brian Bradley, a surgical assistant, was HIV-positive when a July 20, 1991 article in the *Houston Chronicle* revealed the information. *Id.* at 923.

placed his hands inside the body cavity during surgery.<sup>66</sup> The Fifth Circuit then applied the *Arline* standard and concluded that although the risk of transmission from the technician to the patient was small, the duration of the risk was perpetual and the consequence of transmission was fatal.<sup>67</sup> The court determined that these factors made the surgical technician not "otherwise qualified" and thus not within the Rehabilitation Act's protection.<sup>68</sup>

Similarly, the United States District Court for the Eastern District of Missouri held that an HIV-positive dental student was not within the Rehabilitation Act's protection.<sup>69</sup> In *Doe v. Washington University*,<sup>70</sup> a University committee recommended that the student not be allowed to complete his education because of the risk that he could transmit HIV to patients if his hands or fingers were injured while performing one of the many invasive dental procedures required by the dental school's curriculum.<sup>71</sup> The

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66. *Id.* at 924. The court explained that the nature of Bradley's work created some risk because he worked in the sterile area within which surgery is performed and often came very close to open wounds. *Id.* Also, he handled the sharp ends of surgical instruments and has reported suffering five needle puncture wounds while on the job. *Id.*

67. *Id.* The United States Court of Appeals for the Fifth Circuit noted that the first three *Arline* factors were not in dispute — the nature, duration and severity of the risk. The court did state, however, that "[t]he disputed issue is the probability of transmitting the virus." *Id.* The court then determined that although the probability of transmission was small, it was not so low as to nullify the catastrophic consequences of an accident. *Id.* The court stated: "[a] cognizable risk of permanent duration with lethal consequences suffices to make a surgical technician with Bradley's responsibilities not 'otherwise qualified.'" *Id.* For a discussion of the *Arline* factors, see *supra* notes 40-43 and accompanying text.

68. *Bradley*, 3 F.3d at 924.

69. *Doe v. Washington Univ.*, 780 F. Supp. 628, 634-35 (E.D. Mo. 1991).

70. 780 F. Supp. 628 (E.D. Mo. 1991).

71. *Id.* at 630. The plaintiff, "John Doe," was a third-year dental student at Washington University. *Id.* at 629. In March of 1988, the chairman of the Washington University Committee on AIDS learned that the plaintiff was infected with HIV. *Id.* The committee met in April of 1988 to determine how the University should proceed. *Id.* The committee focused on the then-current medical data regarding HIV infection and transmission, the student's strong desire to become a dentist, the large number of invasive procedures required to be performed by this student to complete his graduation requirements, and the frequency of self-injury by dentists. *Id.*

After several more meetings, the committee recommended to the School of Dental Medicine that the student not be permitted to perform invasive dental procedures because of a perceived risk that HIV might be transmitted to patients if the dental student cut or nicked his fingers or hands in the course of performing these procedures. *Id.* at 630. The School of Dental Medicine approved the committee's recommendation and determined that the student would not be able to satisfy the dental school's requirements. *Id.* The school offered the student an indefinite leave of absence, and after several months with no response, the student was dismissed from the dental school. *Id.* The student also did not respond to any of Washington University's offers of assistance in alternative career opportunities. *Id.* In November of 1988, the student filed an action alleging discrimination by the University against the student in violation of § 504 of the Rehabilitation Act. *Id.*

court in *Washington University* determined that although the risk of transmission was low and imprecise, the potential consequence would be a patient's death.<sup>72</sup> Consequently, the court held that the student was not "otherwise qualified" under the Rehabilitation Act and therefore not within its protection.<sup>73</sup>

In addition to cases arising under the Rehabilitation Act, there are several recent employment discrimination cases that interpret "significant risk" under the ADA.<sup>74</sup> In *Doe v. University of Maryland Medical System*

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72. *Id.* at 632. The *Washington University* court believed that the fourth factor, the probability of transmitting the disease, was the real issue in the case. *Id.* According to the court: "[t]his area is at the heart of this country's debate surrounding HIV infected individuals." *Id.* In addressing this factor, the court considered evidence submitted by both parties, including medical journal articles, affidavits, deposition testimony and guidelines from both the U.S. Department of Health and Human Services and the Center for Disease Control. *Id.* at 633. The court determined that based on the evidence presented, trauma to dental workers' hands is common during dental procedures and the use of gloves cannot prevent penetrating injuries to the dental worker's hands caused by needles, sharp instruments or patient bites. *Id.* Further, the court emphasized that clinical training in invasive procedures is critical to the completion of the third and fourth years of dental school. *Id.* The plaintiff still needed to complete a minimum of 1021 clinical procedure hours in order to meet this requirement. *Id.*

The *Washington University* court was convinced that based on the evidence, although the risk of transmission of HIV from an infected dental worker to patient was minimal, there was still *some* risk of transmission. *Id.* The court concluded by noting that the secondary axiom of the medical profession is that if healing is not possible, the goal is not to harm. *Id.* Judge Cahill stated: "[t]o permit even an occasional death to occur because of a failure to scrupulously guard the safety of patients would appear to be morally unacceptable and contrary to the fiduciary responsibilities of the medical profession." *Id.* at 633-34.

73. *Id.* at 634-35. One commentator has criticized the *Washington University* court's holding because the determination of the risk's significance seems flawed. Mary Anne Bobinski, *Risk and Rationality: The Centers for Disease Control and the Regulations of HIV-Infected Health Care Workers*, 36 ST. LOUIS U. L.J. 213, 267 (1992). This commentator argued that the court failed to analyze the nature and risks of the specific procedures to be performed by the dental student. *Id.* In her view, the court did not thoroughly examine the risk reductions created by the use of universal precautions, but instead seemed willing to find that a small but existent risk was significant when coupled with a severe harm. *Id.* The author warns that "[t]his reasoning could eviscerate the protections afforded by the significant risk standard: the risk will be significant if the severity of harm is great, even when the probability of harm is vanishingly small." *Id.*

74. See *Doe v. University of Md. Med. Sys. Corp.*, 50 F.3d 1261, 1266 (4th Cir. 1995) (former neurosurgery resident infected with HIV filed action against university alleging violation of ADA (and Rehabilitation Act) for permanently suspending resident from surgery and then terminating him when he refused alternative residency programs in non-surgical fields); *Mauro v. Borgess Med. Ctr.*, 886 F. Supp. 1349, 1353 (W.D. Mich. 1995) (bringing action by former surgical technician infected with HIV against hospital alleging that his layoff violated the ADA and Rehabilitation Act).

In addition to these cases regarding employment discrimination in the health care context, the ADA has also been used by plaintiffs in non-employment related suits, and in non-health care employment suits. See, e.g., *United States v. Morvant*, 898 F. Supp. 1157, 1165-68 (E.D. La. 1995) (finding dentist liable for violation of ADA by refusing to provide dental care to one patient with AIDS and another



*Corp.*,<sup>75</sup> the United States Court of Appeals for the Fourth Circuit held that an HIV-positive neurosurgical resident was not a “qualified individual with a disability” within the meaning of the ADA.<sup>76</sup> The court noted that despite any extra precautions the plaintiff could take, some measure of risk would always exist and thus the plaintiff was not a qualified individual with a disability under the ADA.<sup>77</sup>

Additionally, in *Mauro v. Borgess Medical Center*,<sup>78</sup> the United States District Court for the Western District of Michigan held that a former surgical technician infected with HIV was not “otherwise qualified” under the ADA because he posed a “‘direct threat’ or ‘significant risk’” to patients in the operating room.<sup>79</sup> The *Mauro* court relied on the *Bradley* decision which held that a surgical technician with identical responsibilities was not “otherwise qualified” under the Rehabilitation Act.<sup>80</sup> Although the

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patient who was HIV-positive); *Doe v. Kohn Nast Graf, P.C.*, 862 F. Supp. 1310, 1316 (E.D. Pa. 1994) (denying in part motion for summary judgment finding potential violation under ADA when attorney infected with HIV filed action against former employer (law firm)).

75. 50 F.3d 1261 (4th Cir. 1995). The plaintiff, a neurosurgical resident at the University of Maryland Medical System Corporation (UMMSC), was stuck with a needle while treating a patient who may have been infected with HIV. *Id.* at 1262. The plaintiff later tested positive for HIV. *Id.* Upon learning that the plaintiff was HIV-positive, UMMSC permanently suspended him from surgical practice and offered him alternative residencies in non-surgical fields. *Id.* at 1262-63. After the plaintiff refused to accept an alternative residency and demanded reinstatement, UMMSC terminated him from its residency program. *Id.* at 1263.

76. *Id.* at 1266. The court found that the plaintiff was not “otherwise qualified” under the ADA or the Rehabilitation Act because he posed a “significant risk” to the health and safety of his patients. *Id.* at 1265-66. The court applied the *Artline* standard for “significant risk” under both the ADA and Rehabilitation Act. *Id.* at 1265.

77. *Id.* at 1266. The court noted that extra precautions such as double-gloving, using only blunt-tipped, solid-bore needles, and making stitches with only one hand were not enough to eliminate the presence of a risk of transmission. *Id.* The court explained that “the risk of percutaneous injury can never be eliminated through reasonable accommodation.” *Id.* at 1266.

The court further commented that the hospital’s decision to terminate the plaintiff was thoroughly deliberated and handled with great sensitivity. *Id.* at 1266 & n.11. Despite the conceded low risk of transmission, the court noted that the hospital made a “considered decision to err on the side of caution in protecting its patients.” *Id.* at 1266. Nothing in the record indicated to the court that the hospital acted with anything other than the best interests of its patients and Dr. Doe at heart. *Id.*

78. 886 F. Supp. 1349 (W.D. Mich. 1995).

79. *Id.* at 1353. In *Mauro*, the plaintiff had been employed as an operating room surgical technician at Borgess Medical Center for two years when officials at the hospital became aware of reason to believe that he was HIV-positive. *Id.* at 1351. When the plaintiff refused to submit to an HIV test and refused to accept an alternative accommodating position at the hospital, he was fired. *Id.*

80. *Id.* at 1353. The *Mauro* court found the *Bradley* case, as well as *Doe v. University of Maryland*, “materially indistinguishable and properly reasoned.” *Id.* The court rejected the plaintiff’s argument that the risk of transmission is so remote as to not justify his termination. *Id.* The court specifically cited the words of the *Bradley* decision to support its argument: “[w]hile the risk is small, it is not so low as

probability of the plaintiff transmitting the disease was small, the *Mauro* court held that when considered along with the other three *Artline* factors, this evidence did not change the fact that transmission was "possible and invariably lethal."<sup>81</sup>

Aside from employment discrimination cases brought under these federal statutes, many state statutes have similar standards and provide additional insight into how courts have treated HIV-infected health care employees.<sup>82</sup> For example, a New Jersey superior court extensively considered the risks that an HIV-positive surgeon posed to his or her patients under the statutorily mandated "substantial harm" standard.<sup>83</sup> In *Estate of Behringer v. Medical Center*,<sup>84</sup> the defendant medical center suspended the surgical privileges of an ear, nose and throat surgeon after the medical center discovered that the surgeon had AIDS.<sup>85</sup> The Estate of Dr. William Behringer asserted a cause of action under the New Jersey Law Against Discrimination, alleging discrimination based on a handicap.<sup>86</sup> As

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to nullify the catastrophic consequences of an accident. A cognizable risk of permanent duration with lethal consequences suffices to make a surgical technician with Bradley's responsibilities not 'otherwise qualified.' " *Id.* (citing *Bradley v. University of Tex. M.D. Anderson Cancer Ctr.*, 3 F.3d 922, 924 (5th Cir. 1993), *cert. denied*, 114 S. Ct. 1071 (1994)).

81. *Id.* at 1353. The court agreed with the medical center's argument that its mission is patient care, and that it is inconsistent with this mission to expose a patient to such a direct risk of transmission when there is no "patient care" reason to do so and the risk can be eliminated. *Id.* The court rejected the plaintiff's argument that the medical center could eliminate the risk without removing him from the operating room. *Id.* The court noted that if the plaintiff were exempted from direct patient contact, which plaintiff claims is only a marginal function of his job, then an additional person would be needed in the operating room to cover such emergency situations. *Id.* at 1353-54.

82. *See, e.g.*, MICH. COMP. LAWS § 37.1101 (1992) (Michigan Handicapper's Civil Rights Act); N.J. STAT. ANN. § 10:5-4.1 (West 1993 & Supp. 1994) (New Jersey Law Against Discrimination); WASH. REV. CODE ANN. § 49.60 (West 1990) (Washington Law Against Discrimination); WIS. STAT. ANN. § 111.31 (West 1988) (Wisconsin Fair Employment Act).

83. *Estate of Behringer v. Medical Ctr.*, 592 A.2d 1251, 1276-83 (N.J. Super. Ct. Law Div. 1991).

84. 592 A.2d 1251 (N.J. Super. Ct. Law Div. 1991).

85. *Id.* at 1257. The Princeton Medical Center diagnosed William H. Behringer as suffering from AIDS on June 17, 1987. *Id.* at 1254. Dr. Behringer was an otolaryngologist and plastic surgeon at the Princeton Medical Center. *Id.* Within hours of his discharge from the hospital, Dr. Behringer received numerous phone calls from well-wishers who were aware of his illness. *Id.* The medical center suspended Dr. Behringer's surgical privileges a few weeks later. *Id.* Due to his death on July 2, 1989, Dr. Behringer never performed any further surgery at the medical center. *Id.*

86. *Id.* at 1274. The New Jersey Law Against Discrimination states:

All of the provisions of the act to which this act is a supplement shall be construed to prohibit any unlawful discrimination against any person because such person is or has been at any time handicapped or any unlawful employment practice against such person, unless the nature and extent of the handicap reasonably precludes the performance of the particular employment.

is required by the statute, the defendants in *Behringer* met their burden of proving a potential risk by showing a "reasonable probability of substantial harm."<sup>87</sup> The court determined that if there was blood contact between the surgeon and a patient, not only was there a risk of transmission, but the patient would have to undergo HIV testing for an extended period of time.<sup>88</sup> Thus, both of these potential hazards satisfied the New Jersey statute's "substantial harm" requirement.<sup>89</sup>

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N.J. STAT. ANN. § 10:5-4.1 (West 1993 & Supp. 1994). The court determined that the medical center was within the scope of the New Jersey Law Against Discrimination (LAD) because it met the definition of "public accommodation" under the statute. *Behringer*, 592 A.2d at 1274. In determining the applicability of the LAD to the plaintiff, the court noted that the policy of the statute is to eradicate unlawful discrimination of all types, and thus the court noted that the statute should be liberally interpreted. *Id.* The court explained that while there was no employer-employee relationship between the surgeon and the medical center, the providing of a fully-equipped, fully-staffed, regulated and controlled operating room to this surgeon whose practice in the medical facility has been passed on and approved by the medical facility was sufficient to bring the surgeon within the scope of the LAD. *Id.* at 1275. The *Behringer* court also held that the plaintiff was "handicapped" within the meaning of the statute because a person with AIDS has a severe handicap within the meaning of the LAD. *Id.*

87. *Behringer*, 592 A.2d at 1276. An employer is not liable under the New Jersey Law Against Discrimination if the employer can prove that the employee posed a "reasonable probability of substantial harm" to others, including co-employees and patients, and if there is a "materially enhanced risk of serious injury." *Id.* (citing *Jansen v. Food Circus Supermarkets*, 541 A.2d 682, 683 (1988)). In applying this standard, the court elaborated further and stated:

[C]ritical to this case, there must be a distinction between the risk of an incident taking place and the risk of injury from such incident. In the present case, both parties agree that the risk of incident, *i.e.*, transmission of the HIV virus from physician to patient, is small, but that the risk of injury from such transmission is high, *i.e.*, death.

*Id.* The court explained that both parties focused on the risk of transmission, but the court believed that the risk of transmission was not the sole risk involved. *Id.* at 1279. The risk of a surgical accident performed by an HIV-infected surgeon may subject a previously-uninfected patient to months or years of continual HIV testing. *Id.*

88. *Id.* at 1279.

89. *Id.* *Behringer* is important because it was the first case to address practice restrictions for HIV-infected surgeons. Arthur J. Becker, Jr., *The Competing Interests in HIV Disclosure for Infected Health Care Workers: The Judicial and Legislative Responses*, 97 DICK. L. REV. 777, 785 (1993). According to Becker:

The decision in *Behringer* sends an important message. Where there is uncertainty about the risks, physicians should err on the side of protection for patients. The court endorsed practice restrictions which attempted to eliminate all risk of transmission. According to the hospital's policy, HIV-infected physicians may not perform procedures that pose any risk of transmission.

*Id.* Moreover, the *Behringer* court established the "zero-tolerance policy": HIV-infected physicians may not perform procedures that pose *any* risk of transmission. David Orentlicher, *HIV-Infected Surgeons: Behringer v. Medical Center*, 266 JAMA 1134, 1135 (1991). Orentlicher criticized this "zero-tolerance" policy because it permits the kinds of irrational or invidious discrimination that the discrimination laws prohibit. *Id.* The *Scoles* court agreed with the reasoning of *Behringer* and applied the same protective rationale to determine "significant risk" under the Reha-

The "significant risk" standard remains the key component in assessing the viability of discrimination claims brought under the Rehabilitation Act and the ADA.<sup>90</sup> Moreover, the court's evaluation of Dr. Scoles' claims under the Rehabilitation Act and the ADA, and specifically, whether he posed a "significant risk" to his patients, meaningfully influences the protection provided to HIV-positive health care workers.<sup>91</sup>

### III. FACTS

Dr. Paul Scoles is an orthopedic surgeon infected with HIV.<sup>92</sup> In July of 1991, Dr. Scoles disclosed his HIV-positive status to the Director of Surgery at the Philadelphia hospital where he worked.<sup>93</sup> Soon after, the hospital's parent company, Mercy Health, asked Dr. Scoles to stop performing surgery at its hospitals and notify former patients of his HIV-positive status.<sup>94</sup> Dr. Scoles refused, but pursuant to a court ruling, a subsidiary of Mercy Health sent letters to 1050 of Dr. Scoles' former patients setting forth this information.<sup>95</sup> Mercy Health also suspended Dr. Scoles' clinical

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bilitation Act and the ADA. *Scoles v. Mercy Health Corp.*, 887 F. Supp. 765, 770-71 (E.D. Pa. 1994).

90. For a discussion of recent discrimination cases that turn on the interpretation the "significant risk" standard, see *supra* notes 52-89 and accompanying text.

91. For a discussion of the *Scoles* decision and its important effects, see *infra* notes 109-77 and accompanying text.

92. *Scoles*, 887 F. Supp. at 767.

93. *Id.* Dr. Scoles disclosed his HIV-positive status to Dr. Leon Clarke, Director of Surgery at Misericordia Hospital. *Id.* Mercy Catholic Medical Center, a subsidiary of Mercy Health Corporation (Mercy Health), operates two hospitals in the Philadelphia area: Fitzgerald Mercy Hospital and Misericordia Hospital. *Id.* Dr. Scoles began working for Mercy Catholic Medical Center on June 1, 1985. Plaintiff's Combined Answering Brief in Opposition to Defendants' Motion for Partial Summary Judgment and Opening Brief in Support of Plaintiff's Second Motion for Partial Summary Judgment at 5, *Scoles v. Mercy Health Corp.*, 887 F. Supp. 765 (E.D. Pa. 1994) (No. 92-6712) [hereinafter Plaintiff's Brief]. Although Dr. Scoles told Dr. Clarke about his HIV status in the strictest confidence, Dr. Clarke immediately told Dr. Toomey, Senior Vice-President for Professional Affairs and Medical Director for Mercy Health and Mercy Catholic Medical Center. *Id.*

94. *Scoles*, 887 F. Supp. at 767. The directors did not review any medical literature or discuss contacting public health officials regarding Dr. Scoles' situation before making their decision to ask Dr. Scoles to stop performing surgery and notify former patients of his HIV-positive status. Plaintiff's Brief, *supra* note 93, at 6.

95. *Scoles*, 887 F. Supp. at 767. Mercy Health sought relief under the Pennsylvania Confidentiality of HIV-Related Information Act, which provides in part: "No court may issue an order to allow access to confidential HIV-related information unless the court finds, upon application, that one of the following conditions exists: . . . (2) The person seeking to disclose the information has a *compelling need* to do so." 35 PA. CONS. STAT. § 7608(a) (1990) (emphasis added). The Pennsylvania Confidentiality of HIV-Related Information Act provided further guidance to the court: "COMPELLING NEED. — In assessing compelling need for subsections (a) and (b), the court shall weigh the need for disclosure against the privacy interest of the individual and the public interests which may be harmed by disclosure." 35 PA. CONS. STAT. § 7608(c) (1990).

The United States District Court for the Eastern District of Pennsylvania did not discuss the Delaware County Court of Common Plea's grant of defendants' petition to notify 1050 former patients of Dr. Scoles of his HIV-positive status. See *Scoles*, 887 F. Supp. at 767 (explaining that Court of Common Pleas granted defendants' request to notify former patients pursuant to Pennsylvania Confidentiality of HIV-Related Information Act, but did not discuss merits of court's determination that there was compelling need to disclose Dr. Scoles' HIV status).

State lawmakers have developed HIV-confidentiality laws because they recognized that AIDS is often associated with traditionally stigmatized groups, such as homosexuals and intravenous drug users. THE CITY OF N.Y. COMM'N ON HUMAN RIGHTS, REPORT ON DISCRIMINATION AGAINST PEOPLE WITH AIDS AND PEOPLE PERCEIVED TO HAVE AIDS 3 (1987). For this reason, many HIV-infected physicians prefer to keep their HIV-status confidential, both to avoid the stigma of AIDS and to maintain the stability of their careers. *Id.* For example, a pediatrician in Texas lost almost all of his patients after a newspaper revealed his HIV-positive status. Peter Applebome, *Doctor in Texas With AIDS Virus Closes His Practice Amid a Furor*, N.Y. TIMES, Oct. 1, 1987, at B8.

Pennsylvania lawmakers originally enacted the Pennsylvania Confidentiality of HIV-Related Information Act in order to promote voluntary blood testing to limit the spread of AIDS. See *In re Milton S. Hershey Medical Ctr. of the Pa. State Univ.*, 595 A.2d 1290, 1294 (Pa. Super. Ct. 1991) (stating that "[i]n the interest of furthering public health, the Act assures that information gained as a result of the HIV testing will remain confidential"). Section 7602 of the Pennsylvania Confidentiality of HIV-Related Information Act provides the legislative intent of the statute, which states: "It is the intent of the General Assembly to promote confidential testing on an informed and voluntary basis in order to encourage those most in need to obtain testing and appropriate counseling." 35 PA. CONS. STAT. § 7602(c) (1990). The Act furthers this goal by assuring that information obtained through HIV testing will remain confidential. See *id.* § 7607 (mandating that individuals who obtain confidential HIV-related information in course of providing health or social services may not disclose such information unless they meet 12 categories of § 7607(a)). Section 7603 of the Act defines "confidential HIV-related information" as:

[a]ny information which is in the possession of a person who provides one or more health or social services or who obtains the information . . . and which concerns whether an individual has been the subject of an HIV-related test, or has HIV, HIV-related illness or AIDS; or any information which identifies or reasonably could identify an individual as having one or more of these conditions, including information pertaining to the individual's contacts.

*Id.* § 7603. Although the Act allows limited dissemination of confidential information, it does provide for general exceptions. See *id.* §§ 7607(a)(1)-(12), 7608(a) (limiting release of confidential HIV-related information to persons listed in these sections). For example, under § 8(a)(2), a court may issue an order allowing access to confidential HIV-related information if the party seeking disclosure has a *compelling need*. *Id.* § 7608(a)(2).

Many states have similar confidentiality statutes protecting HIV-related information and correspondingly allow release of this information after a demonstration of compelling need. See, e.g., ARIZ. REV. STAT. ANN. § 36-665(B) (1990) (stating that no court may issue order for disclosure of confidential communicable disease related information, unless one of five factors is proven, and first factor is demonstration of "compelling need"); CONN. GEN. STAT. § 19a-583(a)(10)(A) (1989) (stating that no person who obtains confidential HIV-related information may disclose it except under 12 conditions, tenth condition specifically stating that court order may authorize such disclosure so long as court order was issued pursuant to demonstration of "compelling need"); DEL. CODE ANN. tit. 16, § 711(5)(a) (1989) (mandating that release of confidential HIV-related information may only

privileges to perform diagnostic or therapeutic invasive procedures at

be made under five circumstances, including release pursuant to court order which was issued because person seeking records demonstrated "compelling need" which cannot be accommodated by any other means); FLA. STAT. ANN. § 381.004(3)(f)(9)(a) (West 1988) (stating that HIV test results may not be disclosed except under 12 circumstances, including issuance of court order upon demonstration of "compelling need"); VT. STAT. ANN. tit. 12, § 1705(a) (1987) (stating that no court shall issue order requiring disclosure of HIV-related testing or counseling information unless court finds that person seeking information demonstrated "compelling need").

To determine whether there is a compelling need to disclose HIV information, the Pennsylvania Confidentiality of HIV-Related Information Act mandates that courts engage in a balancing test — weigh the need for disclosure against the individual's privacy interest. 35 PA. CONS. STAT. § 7608(c) (1990); *see* ARIZ. REV. STAT. ANN. § 36-665 (1990) (ordering that in assessing compelling need, court shall weigh need for disclosure against privacy interest of person and public interest which may be disserved by disclosure that deters future testing or which may lead to discrimination); CONN. GEN. STAT. § 19a-583(a)(10)(A) (1989) (same); DEL. CODE ANN. tit. 16, § 711(5)(a) (1989) (same); FLA. STAT. ANN. § 381.004(3)(f)(9)(a) (West 1988) (same); VT. STAT. ANN. tit. 12, § 1705(a) (1987) (same).

*In re* Milton S. Hershey Medical Center of the Pennsylvania State University, 595 A.2d 1290 (Pa. Super. Ct. 1991), illustrates a significant development regarding application of the compelling need exception. *Id.* In *Hershey*, an attending physician accidentally cut Dr. Doe during an invasive operative procedure on May 19, 1991. *Id.* at 1291. Dr. Doe, a resident physician in a four-year obstetrics and gynecology program, voluntarily submitted to blood testing for the HIV virus the next day. *Id.* at 1291-92. The lab informed Dr. Doe on May 21, 1991 that the test results were positive. *Id.* at 1292. Dr. Doe immediately and voluntarily withdrew from participation in further surgical procedures. *Id.* The results of an additional test, the Western Blot, were returned on May 28, 1991 and confirmed that Dr. Doe was HIV-positive. *Id.* Dr. Doe informed appropriate officials and took a voluntary leave of absence from the program. *Id.* The hospitals relied on the "compelling need" exception to the Pennsylvania Confidentiality of HIV-Related Information Act to obtain court approval to notify Dr. Doe's previous patients of his HIV-positive status. *Id.* at 1293. Hershey Medical Center conducted an investigation and identified 279 patients whom Dr. Doe treated. *Id.* at 1292. Similarly, Harrisburg Hospital identified 168 patients who had been in contact with Dr. Doe. *Id.* Because the hospital records do not reflect every time a physician is cut, the statistics presented included every patient who might have been exposed to Dr. Doe's condition. *Id.* at 1293.

The hospitals wanted to disclose this information because they "felt it their duty to inform the possibly affected individuals of their potential exposure to HIV and to offer them treatment, testing and counseling." *Id.* Also, the hospitals wanted to inform the other treating physicians so that they could contact their patients in the event that Dr. Doe had assisted them in any invasive procedure. *Id.* Lastly, the hospitals advocated a limited disclosure so as to eliminate the mass hysteria that could potentially result from a general disclosure. *Id.* After applying a balancing test, the superior court concluded that although privacy rights are of the utmost importance in Pennsylvania, the "public's right to be informed in this sort of potential health catastrophe is compelling and far outweighs a practicing surgeon's right to keep information regarding his disease confidential." *Id.* at 1302. The *Hershey* court also stated that "[a]fter weighing the competing interests in this case, we find that the scales tip in favor of the public health, regardless of the small potential for transmittal of the fatal virus." *Id.* at 1297; *see* United States v. Westinghouse Elec. Corp., 638 F.2d 570, 578 (3d Cir. 1980) (setting forth factors to consider when balancing competing interests).

Mercy Catholic Medical Center (Center).<sup>96</sup> Mercy Health further requested that Dr. Scoles obtain its approval prior to each proposed invasive procedure he was scheduled to perform.<sup>97</sup> In addition, Mercy Health informed its employees, staff, Board of Directors and two other hospitals of its actions regarding Dr. Scoles, and the Center held a press conference to inform the public of its actions.<sup>98</sup>

In April of 1992, the Center's Medical Board held a hearing at which a committee recommended reinstating Dr. Scoles' privileges.<sup>99</sup> The Center's Board of Directors decided to reinstate Dr. Scoles upon the condition that he inform patients of his HIV-positive status prior to any invasive procedure.<sup>100</sup>

In response to Mercy Health's actions regarding his medical privileges, Dr. Scoles lodged several complaints.<sup>101</sup> Dr. Scoles asserted that Mercy Health's disclosures forced him to terminate his employment with Greater Atlantic Health Service, an entity unrelated to Mercy Health.<sup>102</sup> Consequently, Dr. Scoles was forced to accept a disability policy.<sup>103</sup> Dr. Scoles also complained that the Center stopped referring patients to him, and that Mercy Health removed his name from a list of occupational health program physicians even though his involvement in these programs did not include invasive procedures.<sup>104</sup>

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*Hershey* was significant because it was the first case in Pennsylvania to hold that there is a compelling need for hospitals to notify the former patients of an HIV-infected doctor. Becker, *supra* note 89, at 791. The decision was additionally important because it permitted hospitals to invoke the compelling need exception to AIDS confidentiality laws in order to notify former patients even where the HIV-infected health care worker did not consent to the disclosure. *Id.* In *Scoles*, in response to Mercy Health's disclosure of his HIV status, Dr. Scoles commented that, "[i]t's less a question of why it's wrong as why it's unnecessary' to inform patients. . . . 'The issue here is not [patients'] right to know, but my obligation to teach them that it's a groundless fear.'" Vedantam, *supra* note 11, at B2.

96. *Scoles*, 887 F. Supp. at 767.

97. *Id.*

98. *Id.* Although Mercy Health did not disclose Dr. Scoles' name at the press conference, it provided sufficient information for the press to easily determine his identity. Plaintiff's Brief, *supra* note 93, at 8. Mercy Health also created a telephone "hot line" system and prepared a written transcript for management of possible inquiries resulting from the public announcement. *Id.* at 8-9. Further, Mercy Health hired an outside public relations firm to assist its "in house" media staff. *Id.* at 9.

99. *Scoles*, 887 F. Supp. at 767. The Medical Board voted unanimously to reinstate Dr. Scoles with full privileges and no restrictions. Plaintiff's Brief, *supra* note 93, at 9. The Mercy Board of Directors, however, rejected its own medical board's recommendation and convened an ad hoc joint conference committee. *Id.*

100. *Scoles*, 887 F. Supp. at 767.

101. *Id.* For a discussion of Dr. Scoles' complaints and his legal arguments, see *infra* notes 111-32 and accompanying text.

102. *Id.*

103. *Id.*

104. *Id.* Medical procedures are classified into three types: non-invasive, invasive or exposure-prone. Watson, *supra* note 3, at 752. Non-invasive procedures include open wound and mucous membrane contact, touching and talking proce-

Pursuant to these complaints, Dr. Scoles took legal action against Mercy Health, the Center and other hospital defendants in April of 1994.<sup>105</sup> Dr. Scoles asserted that the defendants' actions violated section 504 of the Rehabilitation Act and section 101 of the ADA.<sup>106</sup> The district court held that the defendants did not violate section 504 of the Rehabilitation Act or section 101 of the ADA because Dr. Scoles was a "significant risk" to his patients and thus was not protected by the acts.<sup>107</sup> In light of the foregoing, the district court determined that Mercy Health properly required Dr. Scoles to inform his patients of his HIV status and obtain their informed consent prior to undergoing any invasive procedure.<sup>108</sup>

#### IV. ANALYSIS

##### A. Application of the "Significant Risk" Concept to Dr. Scoles

In *Scoles*, the district court addressed the question of whether a hospital violated the Rehabilitation Act and the ADA by requiring an orthopedic surgeon to disclose his HIV-positive status to patients and obtain the patients' informed consent before performing invasive surgical proce-

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dures, and minor cutting. *Id.* These procedures involve no real risk of HIV transmission from worker to patient. *Id.* Invasive procedures include most surgeries and pose some risk of transmission to the patient. *Id.* The Centers for Disease Control defines "invasive procedure" as:

surgical entry into tissues, cavities, or organs or repair of major traumatic injuries (1) in an operating or delivery room, emergency department, or outpatient setting, including both physicians' and dentists' offices; (2) cardiac catheterization and angiographic procedures; (3) a vaginal or cesarian delivery or other invasive obstetric procedure during which bleeding may occur; or (4) the manipulation, cutting, or removal of any oral or perioral tissues, including tooth structure, during which bleeding occurs or the potential for bleeding exists.

*Recommendations for Prevention of HIV Transmission in Health-Care Settings*, 36 MORBIDITY & MORTALITY WKLY. REP. 2, 6-7 (1987) [hereinafter *Recommendations for Prevention of HIV Transmission in Health-Care Settings*]. Finally, the last type of medical procedure is exposure-prone procedures that require the health care worker to operate inside the body cavity with little visibility or maneuverability and pose the greatest risk of HIV transmission. Watson, *supra* note 3, at 752.

105. *Scoles*, 887 F. Supp. at 767. In addition to Mercy Health and Mercy Catholic Medical Center, the defendants consisted of: Mercy Health Plan, a subsidiary of Mercy Health Corporation that contracts with health care providers to provide health care to Mercy Health Plan subscribers; Plato A. Marinakos, President and Chief Executive Officer and the former Executive Vice President of Mercy Health; and Thomas F. Toomey, Jr., M.D., Senior Vice President for Professional Affairs and Medical Director for Mercy Health and Mercy Catholic Medical Center. *Id.* at 766.

106. *Id.* at 767. For a discussion of § 504 of the Rehabilitation Act, see *supra* note 1 and accompanying text. For a discussion of § 101 of the ADA, see *supra* note 2 and accompanying text.

107. *Id.* at 772 (finding "direct threat"). For a discussion of the "significant risk" standard, see *supra* notes 40-91 and accompanying text.

108. *Id.*



dures.<sup>109</sup> The court concluded: (1) Dr. Scoles was not “otherwise qualified” under the Rehabilitation Act because performing orthopedic surgery involved the significant risk of transmitting a deadly virus, and (2) the hospital’s informed consent requirement did not violate the ADA because Dr. Scoles posed a “significant risk” to the health and safety of his patients which could not be eliminated by any reasonable accommodation.<sup>110</sup>

### 1. *Dr. Scoles’ Motion for Summary Judgment*

The *Scoles* court first addressed Dr. Scoles’ motion for summary judgment, focusing on the two main aspects of Dr. Scoles’ complaint.<sup>111</sup> First, in determining whether Mercy Health violated section 504 of the Rehabilitation Act,<sup>112</sup> the court applied the Supreme Court’s “significant risk” standard developed in *School Board of Nassau County v. Arline*.<sup>113</sup> *Arline* stated that a federally-assisted program is not liable under the Rehabilitation Act for action taken against a person with a communicable disease if that person poses a “significant risk” to the health or safety of others.<sup>114</sup> In so holding, the Court outlined four factors used to determine whether a person poses a “significant risk.”<sup>115</sup>

The *Scoles* court determined that under the *Arline* standard there was sufficient justification to characterize Dr. Scoles’ condition as a “significant risk.”<sup>116</sup> The court rejected Dr. Scoles’ argument that because (1) there are no documented cases of HIV transmission from a health care worker to a patient, and (2) recent estimates indicate that the probability of such transmission is extremely low, he was not a significant risk.<sup>117</sup> The court noted that the medical facts of HIV transmission which Dr. Scoles

109. *Id.* at 767. For a discussion of the facts of *Scoles*, see *supra* notes 92-108 and accompanying text.

110. *Id.* at 770-72. For a discussion of the *Scoles* court’s reasoning and analysis, see *infra* notes 111-54 and accompanying text.

111. *Id.* at 768. For a discussion of Dr. Scoles’ discrimination claim under the ADA and Rehabilitation Act, see *infra* notes 112-32 and accompanying text.

112. *Id.* Mercy Catholic Medical Center receives federal funds through the Medicare program. Plaintiff’s Brief, *supra* note 93, at 4. Thus, the Rehabilitation Act covered this entity. See 29 U.S.C. § 794(a) (1994) (prohibiting discrimination by any program or activity receiving federal financial assistance). For a discussion of § 504 of the Rehabilitation Act, see *supra* note 1 and accompanying text.

113. 480 U.S. 273 (1987). For a discussion of the *Arline* decision and the “significant risk” standard, see *supra* notes 37-43 and accompanying text.

114. *Arline*, 480 U.S. at 287 & n.16.

115. *Id.* The four factors that a court must weigh are: (1) nature of risk, (2) duration of risk, (3) severity of risk, and (4) probability disease will be transmitted and will cause varying degrees of harm. *Id.*

116. *Scoles*, 887 F. Supp. at 769. Judge Kelly stated: “[u]nder the *Arline* standard discussed by Plaintiff, however, there is some basis to characterize Dr. Scoles’ condition as a “significant risk” even assuming that the probability of Dr. Scoles transmitting the disease during surgery is low.” *Id.*

117. *Id.* Dr. Scoles cited numerous studies and articles indicating that a reliable estimate of the probability of an infected surgeon transmitting the HIV virus to a patient during an invasive procedure is unavailable. *Id.* Dr. Scoles relied on one

presented were not conclusive with regard to the "significant risk" issue.<sup>118</sup> The court explained that under *Arline*, the duration and severity of the risk must also be weighed.<sup>119</sup> The court emphasized that the duration of the risk — how long the carrier is infectious — was high in that, because there is no known cure for the AIDS virus, the risk of transmitting HIV during surgery would be present every time Dr. Scoles operated.<sup>120</sup> Moreover, the severity of the harm was equally as high because AIDS is a fatal disease.<sup>121</sup>

The court also distinguished the cases that Dr. Scoles cited which held that because the risk of HIV transmission was so low, there was no significant risk.<sup>122</sup> The court noted that these cases involved the risk of

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estimate from the Centers for Disease Control in 1991 that indicated that the risk of transmission ranged between 1/41,600 and 1/416,000. *Id.*

AIDS is not easily transmitted — only human blood, semen, vaginal secretions and breast milk have been found to transmit the virus. Larry Gostin, *Hospitals, Health Care Professionals and AIDS: The "Right to Know" the Health Status of Professionals and Patients*, 48 MD. L. REV. 12, 19-20 (1989). Health care workers pose a risk of transmitting HIV to patients when their blood contacts a cut in the patient's skin or the mucous membrane of the patient's mouth or eyes. Watson, *supra* note 3, at 751. HIV transmission may also occur when a needle or sharp instrument contaminated with the worker's blood touches a patient's open wound or punctures the skin. *Id.* More specifically, the Centers for Disease Control have determined that for HIV transmission to take place between a surgeon and patient, three events must occur simultaneously: (1) the infected health care worker must be cut; (2) the sharp object causing the cut must become contaminated with the health care worker's blood and re-contact the patient's open wound; and (3) the worker's HIV infected blood must actually transmit the virus to the patient. CENTERS FOR DISEASE CONTROL, OPEN MEETING ON THE RISKS OF TRANSMISSION OF BLOODBORNE PATHOGENS TO PATIENTS DURING INVASIVE PROCEDURES 49 (1991) (testimony of Dr. David Bell). The probability of all three events occurring during an hour of surgery involving an HIV-infected surgeon is less than one in 83,000. Albert B. Lowenfels & Gary Wormser, *Risk of Transmission of HIV from Surgeon to Patient*, 325 NEW ENG. J. MED. 888, 889 (1991).

118. *Scoles*, 887 F. Supp. at 769. The court noted that Dr. Scoles' main argument is that the risk is not significant because surgeon-to-patient transmission is unlikely and undocumented. *Id.* However, the court held that the facts of HIV transmission as presented by Dr. Scoles do not prove that he is not a "significant risk" to his patients. *Id.*

119. For a discussion of the duration and severity factors of the *Arline* standard, see *supra* note 42 and accompanying text.

120. *Scoles*, 887 F. Supp. at 769.

121. *Id.* The court responded to Dr. Scoles' statement that some HIV-positive people still live for many years after diagnosis, by noting that the current medical knowledge indicates that once AIDS develops, the afflicted individual will ultimately die. *Id.*

122. *Id.* Dr. Scoles cited *Chalk v. United States District Court*, 840 F.2d 701 (9th Cir. 1988), which held that a teacher infected with HIV posed a theoretical risk of transmission that was not a "significant risk." Dr. Scoles also cited *Martinez v. School Board*, 861 F.2d 1502 (11th Cir. 1988), which found that a mentally handicapped child infected with HIV posed a remote, theoretical risk of transmission in school that did not amount to a "significant risk." For a further discussion of *Chalk*, see *supra* notes 54-58 and accompanying text. For a further discussion of *Martinez*, see *supra* notes 60-62 and accompanying text.

transmission in a classroom setting where the contact between teachers and students is casual.<sup>123</sup> The court explained that in Dr. Scoles' case, the contact would be completely different because he would be performing invasive surgical procedures on patients.<sup>124</sup> The court therefore concluded that because the severity of the harm and the duration of risk were so high, and the risk of transmission increases in invasive medical procedures, Dr. Scoles' condition posed a "significant risk" to his patients.<sup>125</sup>

Second, the court refuted Dr. Scoles' claims that Mercy Health violated Title I of the ADA.<sup>126</sup> Under the ADA, Dr. Scoles would be entitled to summary judgment if the court concluded that Dr. Scoles was not a "direct threat to the health or safety of other individuals in the workplace."<sup>127</sup> The ADA defines "direct threat" as a "significant risk to the health or safety of others that cannot be eliminated through reasonable accommodation."<sup>128</sup> The court rejected Dr. Scoles' assertion that he did not pose a "direct threat" to his patients because the probability of surgeon-to-patient transmission of HIV is low, and thus the risk not "significant."<sup>129</sup> The court explained that although employers cannot discriminate on the basis of a slightly-increased risk of harm or a remote risk of harm, the *Arline* standard must still be used to evaluate what is a "significant risk" and thus a "direct threat."<sup>130</sup> The court again specifically considered the duration and severity of the harm and concluded that be-

123. *Scoles*, 887 F. Supp. at 769-70.

124. *Id.* For a discussion of invasive surgical procedures, see *supra* note 104.

125. *Id.*

126. *Id.* at 770. For a discussion of Title I of the ADA, see *supra* note 2 and accompanying text.

127. Section 12113 of the ADA sets forth defenses to charges of discrimination under the Act in stating: "The term '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." 42 U.S.C. § 12113(b) (1988 & Supp. V 1993).

If the court concluded that Dr. Scoles was not a "direct threat," then Mercy Health's defense that he was a "direct threat" would be struck down, and Mercy would be liable for discrimination in violation of the ADA.

128. 42 U.S.C. § 12111(3). The ADA defines "reasonable accommodation" as including: "(A) making existing facilities used by employees readily accessible to and usable by individuals with disabilities; and (B) job restructuring, part-time or modified work schedules . . . acquisition or modification of equipment or devices . . . and other similar accommodations for individuals with disabilities." 42 U.S.C. § 12111(9).

129. *Scoles*, 887 F. Supp. at 770. Dr. Scoles relied on the ADA definitions as well as the interpretive guidelines provided by the EEOC that prohibit employers from discriminating based on only a slightly increased risk of harm. *Id.* (citing 29 C.F.R. § 1630, at 403 app. (1994)).

130. *Id.* The court explained that although Dr. Scoles focused on the probability of harm factor, the same EEOC guidelines adopt the *Arline* standard and require consideration of duration and severity of the harm. *Id.*; see 29 C.F.R. § 1630, at 403 app. (1994) (stating that employer "is not permitted to deny an employment opportunity to an individual with a disability merely because of a slightly increased risk. The risk can only be considered when it poses a significant risk . . ."; then noting that to determine "significant risk," consideration of four

cause the risk will continue as long as Dr. Scoles performs surgery and the potential harm is fatal, Dr. Scoles was a "direct threat" to his patients.<sup>131</sup> The court consequently denied Dr. Scoles' motion for summary judgment.<sup>132</sup>

## 2. *Mercy Health's Motion for Summary Judgment*

In the next part of the opinion the court considered Mercy Health's motion for summary judgment.<sup>133</sup> The court first considered the defendants' claims that the Rehabilitation Act did not protect Dr. Scoles because he was not an "otherwise qualified individual with a disability."<sup>134</sup> The court agreed with the cases cited by the defendants which have denied HIV-positive health care workers protection from disability discrimination.<sup>135</sup> Specifically, the court followed *Estate of Behringer v. Medical Center* in which the New Jersey Supreme Court upheld the suspension of an ear, nose and throat surgeon with AIDS because the surgeon's handicap presented a materially-enhanced risk of substantial harm in the workplace.<sup>136</sup> The court also cited *Bradley v. University of Texas M.D. Anderson Cancer Center* which held that an HIV-positive surgical technician was not "otherwise qualified" under the Rehabilitation Act because, under the *Arline* standard, the duration of the risk was continuous and the severity of the harm was fatal.<sup>137</sup> Moreover, the court mentioned that a dental stu-

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factors is needed: (1) duration of risk; (2) nature and severity of harm; (3) likelihood potential harm will occur; (4) imminence of potential harm).

131. *Scoles*, 887 F. Supp. at 770. Specifically, the court stated: "[s]ince the risk will endure as long as Dr. Scoles performs surgery and the harm is a fatal disease, Plaintiff does not convince the court that he is not a 'direct threat' and entitled to judgment as a matter of law." *Id.*

132. *Id.*

133. *Id.* at 770-72. Judge Kelly focused on the two main aspects of Mercy Health's motion: (1) it did not violate the Rehabilitation Act, and (2) it did not violate the ADA. *Id.*

134. *Id.* at 770. For the text of the Rehabilitation Act, see *supra* note 1.

135. *Id.* 770-71 (citing *Bradley v. University of Tex. M.D. Anderson Cancer Ctr.*, 3 F.3d 922 (5th Cir. 1993) (holding that HIV-positive surgical technician was not "otherwise qualified" for his job and thus not protected by Rehabilitation Act); *Leckelt v. Board of Comm'rs of Hosp. Dist. No. 1*, 909 F.2d 820 (5th Cir. 1990) (holding that licensed practical nurse who was discharged by hospital after refusing to submit HIV test results to hospital was not "otherwise qualified" for his job under Rehabilitation Act); *Doe v. Washington Univ.*, 780 F. Supp. 628 (E.D. Mo. 1991) (holding that HIV-positive dental student was not "otherwise qualified" and thus not protected by Rehabilitation Act); *Estate of Behringer v. Medical Ctr.*, 592 A.2d 1251 (N.J. Super. Ct. 1991) (holding that hospital's suspension of ear, nose and throat surgeon with AIDS did not violate New Jersey anti-discrimination statute because doctor pose a reasonable probability of substantial harm)). For a more thorough discussion of these cases, see *supra* notes 64-73, 83-89 and accompanying text.

136. *Scoles*, 887 F. Supp. at 770. For a discussion of *Behringer*, see *supra* notes 83-89 and accompanying text.

137. *Id.* at 771. For a discussion of *Bradley*, see *supra* notes 64-68 and accompanying text.

dent with AIDS was not "otherwise qualified" under the Rehabilitation Act in *Doe v. Washington University* because although the risk of transmission was low, the consequence would be a patient's death from AIDS.<sup>138</sup> The *Scoles* court agreed with these cases and held that because of the nature of the risks involved, Dr. Scoles was not "otherwise qualified" under the Rehabilitation Act.<sup>139</sup> The court further justified its position explaining that because there will be some risk to Dr. Scoles' patients any time he performs surgery and because the potential harm is fatal, the defendants were justified under the Rehabilitation Act in restricting Dr. Scoles' surgical procedures.<sup>140</sup>

Lastly, the court considered Mercy Health's motion for summary judgment on Dr. Scoles' ADA claims.<sup>141</sup> Although the defendants' argument under the ADA focused on issues unrelated to the risk of transmission, the court applied the same analysis as it did to the defendants' Rehabilitation Act claim.<sup>142</sup>

The court reiterated that the ADA prohibits employers from discriminating on the basis of a disability if the employee does "not pose a direct threat to the health or safety of other individuals in the workplace."<sup>143</sup> Furthermore, the court examined the definition of "direct threat" under the ADA and EEOC guidelines.<sup>144</sup> Specifically, the court explored the portion of the EEOC guidelines that Dr. Scoles relied upon which suggests that a "direct threat" requires a high probability of harm, and not just a remote or speculative risk.<sup>145</sup> Despite this language, the court emphasized that the same EEOC guidelines require an employer to examine *Arline's* "duration" and "severity" of the risk factors when considering an individ-

138. *Id.* For a discussion of *Washington University*, see *supra* notes 69-73 and accompanying text.

139. *Id.*

140. *Id.*

141. *Id.* at 771-72. For the relevant text of the ADA, see *supra* note 2.

142. *Id.* at 771.

143. *Id.*; see also 42 U.S.C. §§ 12112(a), 12113(a)-(b) (1988 & Supp. V 1994) (stating that no covered entity shall discriminate against qualified individual with disability; noting however, that it is defense to charge of discrimination that an application of qualification standards that screen out individual with disability is job-related; explaining that term "qualification standards" includes requirement that individual does not pose "direct threat" to health or safety of others in workplace).

144. *Scoles*, 887 F. Supp. at 771-72. The EEOC Guidelines state that an employer may require that an individual not pose a "direct threat" to himself or others as a condition of employment. 29 C.F.R. § 1630, at 402 app. (1994). To determine "direct threat," the court must decide whether an individual poses a significant risk of substantial harm to others. *Id.* § 1630, at 403 app. The court should then consider four factors: (1) the duration of the risk; (2) the nature and severity of the potential harm; (3) the likelihood that the potential harm will occur; and (4) the imminence of the potential harm. *Id.* § 1630, at 403 app.

145. *Scoles*, 887 F. Supp. at 772; see 29 C.F.R. § 1630, at 403 app. (stating that risk can only be considered when it poses significant risk, i.e., high probability, of substantial harm and that speculative or remote risk is insufficient).

ual with a disability.<sup>146</sup> The court pointed out that although there is great discrepancy regarding the remoteness of the risk of surgeon-to-patient HIV transmission, there is more certainty with regard to the duration and severity of the harm.<sup>147</sup> Once again the court explained that Dr. Scoles posed a permanent risk to his patients each time he performed surgery because there is no known cure for the AIDS virus.<sup>148</sup> The court also explained that the severity of the harm is extremely high — it involves the contraction of a fatal disease.<sup>149</sup> The court stated that “[b]y indicating that employers should consider the *Arline* factors, the ADA guidelines recall the analysis of the Rehabilitation Act cases. It is understandable that the same analysis be applied under both acts, as the Rehabilitation Act and the ADA both protect the rights of the disabled in employment.”<sup>150</sup> Thus, the court’s conclusion that an HIV-positive health care worker performing invasive procedures is not “otherwise qualified” under the Rehabilitation Act, supported the finding that Dr. Scoles presented a “direct threat” under the ADA.<sup>151</sup>

The court concluded that its decision was not based on prejudices or stereotypes of people with AIDS, but rather on documentary evidence and medical literature.<sup>152</sup> The court declared that because there is limited knowledge about the probability of HIV transmission from surgeon to patient and because the disease, at present, is always fatal, the defendants reasonably required Dr. Scoles to inform his patients of his HIV-positive status before performing an invasive procedure.<sup>153</sup> Thus, the court granted defendants’ motion for summary judgment and held that the defendants did not violate the Rehabilitation Act or the ADA.<sup>154</sup>

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146. *Scoles*, 887 F. Supp. at 772. For a discussion of the EEOC guidelines, see *supra* note 144 and accompanying text.

147. *Id.* The court explained that in arguing the probability of surgeon-to-patient HIV transmission, Dr. Scoles quoted a range of roughly 1/40,000 to 1/400,000 while Mercy Health quoted a range of 1/40,000 to 1/500,000. *Id.*

148. *Id.* Although there is presently no known cure for AIDS, there are drugs that prolong and improve the quality of life of an HIV-infected individual. PENNSYLVANIA BAR ASSOCIATION & PENNSYLVANIA MEDICAL SOCIETY, *HIV: A MEDICAL-LEGAL HANDBOOK* 3 (Richard C. Turkington ed., 1995). For example, AZT can reduce the levels of HIV infection, prolong the life of individuals with symptomatic AIDS and reduce maternal transmission of HIV in utero. *Id.* at 4.

149. *Scoles*, 887 F. Supp. at 772.

150. *Id.* For a discussion of the Rehabilitation Act and ADA cases, see *supra* notes 54-81 and accompanying text.

151. *Id.*

152. *Id.* The *Scoles* court carefully considered all the relevant medical data submitted by both parties and determined that “[a]t the very least, there is a great deal of uncertainty in the measure of the risk.” *Id.*; see 29 C.F.R. § 1630, at 403 app. (1994) (explaining that when applying four factors to determine “significant risk,” such consideration must rely only on objective, factual evidence, not on subjective perceptions, irrational fears, patronizing attitudes or stereotypes about particular disability).

153. *Scoles*, 887 F. Supp. at 772.

154. *Id.*

B. *The Scoles Court's Hurdle Over the "Probability of Transmission" Factor*

In *Scoles*, the court determined that Dr. Scoles posed a "significant risk" and "direct threat" to his patients, and thus held that Mercy Health's acts did not violate the Rehabilitation Act or ADA.<sup>155</sup> In so holding, the court followed all of the case law which has determined that HIV-infected health care workers who participate in invasive procedures present "significant risks" to their patients and thus are not covered by the Rehabilitation Act or ADA.<sup>156</sup> The *Scoles* court was also correct in applying the four *Arline* factors to determine whether Dr. Scoles presented a "significant risk" to his patients.<sup>157</sup> The one *Arline* factor which the *Scoles* court admitted was uncertain, however, and which was the disputed issue in other HIV-positive health care worker cases, was the fourth factor: the probability the disease would be transmitted.<sup>158</sup> It is this factor that the *Scoles* court and other courts have had to compensate for in order to determine that HIV-infected health care workers present "significant risks" to their patients.<sup>159</sup> In this regard, if the current trend continues, the probability of transmission factor may exclude all health care workers, regardless of their duties, from the scope of the Rehabilitation Act and ADA.<sup>160</sup>

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155. *Id.* at 768-70. For a complete discussion of the court's holding and rationale, see *supra* notes 111-54 and accompanying text.

156. For a complete discussion of the cases holding that HIV-infected health care workers who participate in invasive procedures present "significant risks" to their patients, see *supra* notes 63-91 and accompanying text.

157. For a discussion of the four *Arline* factors used to determine "significant risk," see *supra* note 42 and accompanying text.

158. See *Scoles* 887 F. Supp. at 769 (noting that probability of transmission from surgeon to patient during invasive procedure is uncertain, mainly due to state of current medical knowledge); see also *Doe v. University of Md. Medical Sys. Corp.*, 50 F.3d 1261, 1265-66 (4th Cir. 1995) (noting that Dr. Doe did not dispute that first three *Arline* factors weigh in favor of finding that he poses significant risk, rather that risk that he will transmit HIV to one of his patients is so small that it cannot be considered "significant risk"); *Bradley v. University of Tex. M.D. Anderson Cancer Ctr.*, 3 F.3d 922, 924 (5th Cir. 1993) (noting that parties do not dispute first three factors, but that disputed issue is probability of transmitting virus), *cert. denied*, 114 S. Ct. 1071 (1994); *Mauro v. Borgess Medical Ctr.*, 886 F. Supp. 1349, 1353 (W.D. Mich. 1995) (noting that plaintiff's contention is that probability of transmission is so small as to overwhelm first three factors and create question of fact for jury); *Doe v. Washington Univ.*, 780 F. Supp. 628, 632 (E.D. Mo. 1991) (stating that "[t]he Court believes that it is the fourth factor, the probability the disease will be transmitted, that is really at issue").

159. See, e.g., *Bradley*, 3 F.3d at 924 (focusing on duration and severity factors because risk was "small"); *Mauro*, 886 F. Supp. at 1353 (explaining that even though probability is small, when viewed in conjunction with other three factors, it is not dispositive).

160. See *Watson*, *supra* note 3, at 802-06 (noting problems that arise when courts fail to be fastidious in gathering and quantifying medical data and the futility of attempting to determine whether some risk amounts to a "significant risk" without using a comparable risk analysis); *id.* (using *Leckelt v. Hospital Dist. No. 1*, 909 F.2d 820 (5th Cir. 1990), involving HIV-positive nurse who refused to submit to HIV testing and was subsequently fired, as model for problems in determining "significant risk").

In *Scoles*, the court acknowledged Dr. Scoles' argument that surgeon-to-patient transmission of the HIV virus is unlikely and undocumented, but noted that there is still "some" basis to characterize Dr. Scoles' condition as a "significant risk" due to *Arline's* duration and severity factors.<sup>161</sup> In essence, because *Arline* directs a court to weigh all four of the factors together, the court held that the uncertainty with regard to the probability of Dr. Scoles transmitting HIV to his patients was outweighed by the fact that the risk of him transmitting the disease would be present each time he performed surgery and if the disease developed in one of his patients, it would always cause death.<sup>162</sup> Thus, the court compensated for the uncertainty of the probability factor by applying more weight to the duration and severity factors.<sup>163</sup>

Courts having decided similar cases that involve HIV-infected surgical technicians have dealt with the situation in an identical fashion.<sup>164</sup> For example, in *Bradley v. University of Texas M.D. Anderson Cancer Center*, the court explained that while the risk that the surgical technician would transmit HIV was small, it was not so low as to nullify the "catastrophic" consequences of an accident.<sup>165</sup> The court explained that because a surgical technician infected with HIV presented a "cognizable" risk of permanent duration, with lethal consequences, he was not "otherwise qualified" under the Rehabilitation Act.<sup>166</sup> Similarly, in *Mauro v. Borgess Medical Center*, the court did not dispute the evidence that the probability of transmission from an HIV-infected surgical technician to a patient was very small but noted that when "viewed in conjunction with the other three relevant considerations [*Arline* factors], it amounts to a mere scintilla of

161. *Scoles*, 887 F. Supp. at 769.

162. *Id.* at 769, 770, 771, 772; see also *School Bd. v. Arline*, 480 U.S. 273, 288 (1987) (noting that inquiry for "significant risk" should include a consideration of (1) nature of risk, (2) duration of risk, (3) severity of risk, and (4) probability disease will be transmitted and cause varying degrees of harm).

163. See *Scoles* 887 F. Supp. at 769 (arguing that under the Rehabilitation Act, even if probability of Dr. Scoles transmitting HIV during surgery is low, there is still some basis to characterize him as "significant risk" due to duration and severity factors); see also *id.* at 770 (arguing that under ADA, duration and severity of harm factors are sufficient to characterize Dr. Scoles as "direct threat" and "significant risk"); *id.* at 772 (noting that current knowledge about HIV with regard to duration and severity factors is more certain and these two factors sufficiently characterize Dr. Scoles as not "otherwise qualified" under Rehabilitation Act and as posing "direct threat" under ADA).

164. For a discussion of cases involving HIV-infected surgical technicians which have approached the probability of transmission factor similar to *Scoles*, see *infra* notes 165-67 and accompanying text.

165. 3 F.3d 922, 924 (5th Cir. 1993). The *Bradley* court noted that the parties did not dispute the first three *Arline* factors, but the disputed issue was the probability of transmitting the virus. *Id.* For a complete discussion of *Bradley*, see *supra* notes 64-68 and accompanying text.

166. *Id.*



evidence that does not alter the facts that transmission is possible and invariably lethal."<sup>167</sup>

Although the *Scoles* court properly applied the *Arline* analysis to Dr. Scoles' situation, in other health care worker situations, where the worker's duties involve less invasive procedures, courts should be careful not to blindly diminish the significance of the probability factor in determining significant risk.<sup>168</sup> For example, an anesthesiologist may be involved during surgery in only "touch and talk" procedures to administer anesthesia.<sup>169</sup> Clearly, these procedures create a very small probability of transmission because they do not involve actually performing the invasive procedure.<sup>170</sup> In this type of situation, the probability of transmitting HIV would be even less than in Dr. Scoles' situation.<sup>171</sup>

In fact, the contact between HIV-positive health care workers who do not perform invasive surgical procedures and patients more closely resembles the contact between teachers and students in the classroom setting.<sup>172</sup> In cases involving teachers and students with AIDS, such as *Chalk v. United States District Court* and *Martinez v. School Board*, the courts held that the remote, theoretical risk of transmission in the classroom setting did not amount to a "significant risk."<sup>173</sup> In order to prevent discrimination, situa-

167. 886 F. Supp. 1349, 1353 (W.D. Mich. 1995). The *Mauro* court specifically noted that probability of transmission is only one of four factors used to determine "significant risk" under *Arline*. *Id.* The court held that the threat to patient safety posed by the HIV-infected surgical technician's presence in the operating room was still direct and significant because there existed a real possibility of transmission, the consequence of which was invariably death. *Id.* For a further discussion of the *Mauro* decision, see *supra* notes 78-81 and accompanying text.

168. See *Watson*, *supra* note 3, at 755 (noting that for HIV transmission to take place, three events must occur: (1) infected health care worker must be cut; (2) sharp object causing cut must become contaminated with health care worker's blood and recontact patient's open wound; and (3) worker's HIV infected blood must actually transmit the virus to patient; and noting that probability of all three events occurring during hour of surgery is less than one in 83,000).

169. *Id.* at 796. In addition, a nurse's duties may be exposure-prone or may only involve touch and talk procedures, depending on whether he or she merely passes instruments to surgeons or assists them inside the patient. *Id.*

170. For discussion of the necessary events for HIV transmission to occur, see *supra* note 168.

171. See *Scoles*, 887 F. Supp. at 772 (noting that Dr. Scoles quoted probability of transmission between surgeon and patient at 1/40,000 to 1/400,000, and Mercy Health quoted probability of surgeon-to-patient HIV transmission at 1/40,000 to 1/150,000).

172. See U.S. PUBLIC HEALTH SERVICE, SURGEON GENERAL'S REPORT ON ACQUIRED IMMUNE DEFICIENCY SYNDROME 23-24 (1986) (explaining that transmission in classroom setting would necessitate exposure of open cuts to blood or other bodily fluids of infected person, which is highly unlikely occurrence; and even then, routine safety procedures for handling blood or other body fluids would be effective for preventing transmission in classroom setting; concluding that casual social contact between children and persons infected with HIV is not dangerous).

173. See *Chalk v. United States Dist. Ct.*, 840 F.2d 701, 712 (9th Cir. 1988) (holding that teacher infected with HIV be reinstated to classroom duties because he did not pose "significant risk" to others in school); *Martinez v. School Bd.*, 861

tions involving HIV-infected health care workers performing non-invasive surgical procedures should be analogized to cases like *Chalk* and *Martinez*, and not to cases like *Scoles*, where the health care worker's duties involved performing invasive surgical procedures. The courts should be wary not to use the *Arline* factors to discriminate against *all* health care providers.

Moreover, one commentator has noted the problem in applying the *Arline* analysis in such a blanket fashion to health care workers and has proposed that the *Arline* four-part factual inquiry be applied through a comparable risk analysis.<sup>174</sup> Under a comparable risk approach to apply-

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F.2d 1502, 1506 (11th Cir. 1988) (holding that student infected with HIV did not pose "significant risk" to classmates because remote, theoretical risk of transmission is not sufficient to meet "significant risk" requirement). For a more detailed discussion of *Chalk*, see *supra* notes 54-58 and accompanying text. For a more detailed discussion of *Martinez*, see *supra* notes 59-62 and accompanying text.

174. See Watson, *supra* note 3, at 791 (suggesting that significant risks should be identified only in context and in comparison to other risks posed by workplace or situation because if risks of comparable magnitude are tolerated in particular setting, then risk posed by individual with contagious disease cannot be considered significant). Professor Watson pointed out that raw figures and percentages are not useful in determining the "significant risk" of HIV-infected health care workers because a 1.5% risk might sound appreciable and significant to one person, while to another person it might sound remote and insignificant. *Id.* Watson noted that if raw figures are used under the "significant risk" standard, then "whether the Act protects the individual with a disabling contagious disease turns entirely on the predilections, and possibly the prejudices and stereotypes, of the fact-finder, precisely what the Rehabilitation Act and the ADA prohibit." *Id.*

Professor Watson supported his comparative risk theory by pointing out other courts that have used a comparative risk analysis. *Id.* For example, three Supreme Court Justices utilized a comparative risk analysis in *International Union, UAW v. Johnson Controls*, 499 U.S. 187 (1991). Watson, *supra* note 3, at 792. *Johnson Controls* involved a Title VII challenge to Johnson Controls' policy which barred all women, except those who were medically diagnosed as infertile, from jobs which involved actual or potential lead exposure exceeding Occupational Safety and Health Administration (OSHA) standards. *Johnson Controls*, 499 U.S. at 202. The issue in the case was whether Johnson Controls' fetal protection policy qualified as a bona fide occupational qualification (BFOQ) reasonably necessary to protect the safety of third parties. *Id.* at 200. A unanimous Supreme Court held that the fetal protection policy did not qualify as a BFOQ. *Id.* at 202. Justices White, Kennedy and Rehnquist each concurred in the opinion and reached their conclusion through a comparative risk analysis. *Id.* at 211-24. Justice White, writing for the three, evaluated the likelihood of fetal exposure and the extent of the harm if exposure did occur. *Id.* He then applied a comparative risk analysis to determine if the risk was substantial. *Id.* That is, he explained that if Johnson Controls' fetal protection policy mandated a risk-avoidance level substantially higher than other risks tolerated by the employer, then the policy would not be justified as a safety BFOQ. *Id.*

In addition, the Third Circuit used a comparative risk analysis to assess "significant risk" under the Rehabilitation Act in *Strathie v. Department of Transportation*, 716 F.2d 227 (3d Cir. 1983). Watson, *supra* note 3, at 793. In *Strathie*, a hearing-impaired applicant for school bus driver challenged a state licensing requirement that excluded all hearing aid wearers from that job because they posed "potential safety risks." *Strathie*, 716 F.2d at 232. The Third Circuit determined the significance of the risk posed by this hearing aid-wearer by comparing it with the risks posed by bus drivers who wore eyeglasses and found the risks to be similar. *Id.*

ing *Arline*, the court would conduct an individualized determination of the health care worker's job duties, job performance and infection control record.<sup>175</sup> The court would then quantify these factors and compare them to other patient risks which are normally tolerated in the health care setting.<sup>176</sup> The HIV-infected health care worker would only pose a significant risk if the court determined that the risk this person posed was greater than risks normally tolerated in the health care setting.<sup>177</sup> This

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Because the Department of Transportation did not exclude individuals who wore eyeglasses from bus driver positions, the court determined that the risks posed by drivers with hearing aids was not appreciable (significant). *Id.*

175. Watson, *supra* note 3, at 795. Watson notes that HIV-infected health care workers may be involved in three different levels of patient procedures which pose three different levels of risk. *Id.* The first level is non-invasive procedures that include touching and talking, open wound and mucous membrane contact and minor cutting, and involve no real risk of HIV transmission. *Id.* The second is invasive procedures which include most surgeries and involve some, although possibly negligible, risks. *Id.* Finally, the third type is exposure-prone procedures which require the worker to operate inside a body cavity where vision is obstructed or maneuverability is limited and present the greatest risk of HIV transmission to patients. *Id.*

Professor Watson advocates that courts should next evaluate the individual worker's job performance because a worker who cuts herself frequently while performing invasive procedures or who fails to follow universal barrier precautions or infection control procedures poses a greater risk to patients than careful workers. *Id.* at 796. This step prevents relying upon generalized guidelines about the degree of risk posed by various types of procedures that fails to account for individual worker's job performance. *Id.* Watson notes that courts cannot simply rely on studies of puncture wounds or recontact injuries that merely provide only average risk rates. *Id.* She states: "[w]orkers who are less skilled or simply sloppy clearly pose a greater risk to patients than the average practitioner; similarly, the exceptionally skilled or exceptionally careful surgeon poses less risk." *Id.*

176. *Id.* at 797. Watson notes that in quantifying the risk an HIV-infected health care worker poses, courts should remember that it is not the goal of the disability discrimination statutes to try to remove all potential risks. *Id.* The point of the comparative risk analysis is that even if a worker infected with HIV presents some risk, the risk is "significant" only if comparable risks are not tolerated. *Id.*

177. *Id.* Watson recognizes that obtaining medical treatment always involves risks — no hospital or health care provider tries to eliminate every potential risk. *Id.* at 798. Some risks that are inherent in the delivery of medical care arise from many different causes: (1) some workers are not as skilled as others; (2) some workers create heightened risks because of their mental or physical states; (3) some medical treatment carries a risk of harmful side effects; and (4) all workers are human and do make mistakes. *Id.*

The fact that a worker presents a significant risk of transmitting HIV to a patient does not end the inquiry, according to Watson. *Id.* at 797. The final step requires courts to determine whether a *reasonable accommodation* can reduce the risk to a level that makes it comparable with other risks. *Id.* Watson believes that reasonable accommodation in the context of health care workers infected with HIV may "demand nothing more than a double-gloving requirement or a proscriptio[n] on performing only those procedures that create the most risk." *Id.* If a worker is determined to pose a significant risk because of the worker's past lapses in infection control or barrier precautions, Watson notes that reasonable accommodation may only require that this worker be given an opportunity to comply fully with universal barrier precautions and other requirements while under supervision. *Id.*

approach would assist courts in applying the *Arline* analysis without using it improperly as a vehicle for discrimination against all health care workers.

#### V. IMPACT

The *Scoles* decision is an important case in the Third Circuit because it demonstrates that the federal courts in Pennsylvania are following the well-established approach to determining "significant risk" under the Rehabilitation Act and ADA.<sup>178</sup> In addition, this case illustrates the effect of this analysis when applied to HIV-infected health care workers.<sup>179</sup> If blindly followed, however, without an examination into the health care provider's duties, *Scoles* may act as a green light for discrimination within the health care profession.

Although Dr. Scoles posed a "significant risk" to his patients because he performed invasive surgery, other HIV-infected health care workers who perform less invasive procedures should not be removed from their

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Watson analogizes the risks posed by an HIV-infected health care worker to the risks posed by a worker with hepatitis. *Id.* at 799. Hepatitis, like HIV, is transmitted by blood. *CDC Guidelines for Prevention of Transmission of Human Immunodeficiency Virus and Hepatitis B Virus to Health-Care and Public-Safety Workers*, 38 MORBIDITY & MORTALITY WKLY. REP. 5-6 (1989). However, the HIV virus has an infection rate of less than .3% after a worker cut or needlestick injury, and the hepatitis virus has an infection rate of 6% to 30% after the same type of injury. *Id.* at 5. Although it is easier to contract hepatitis than HIV, hepatitis is not as fatal as HIV — only 1.9% to 2.2% of those infected with hepatitis die from the disease. *Id.* at 5-7. Also, 10% to 30% of all health care workers have been or are infected with hepatitis whereas less than 1% of all health care workers are infected with HIV. *Id.* at 5-6. There have been over 300 reported cases of transmission of hepatitis from a health care worker to a patient; three of these patients died immediately from acute hepatitis, while researchers estimate that another three to six will die from chronic hepatitis. *Recommendations for Preventing Transmission of Human Immunodeficiency Virus and Hepatitis B Virus to Patients During Exposure-Prone Invasive Procedures*, 40 MORBIDITY & MORTALITY WKLY. REP. at 2-3 (1991). Conversely, there are no documented cases of AIDS transmission from a health care worker to a patient. Watson, *supra* note 3, at 800. Unlike HIV, however, there has not been a demand for banning all health care workers who are active hepatitis carriers. Deborah M. Barnes, *Health Workers and AIDS: Questions Persist*, 241 Sci. 161, 328 n.102 (1988). In several situations, hepatitis-infected health care workers continued to perform invasive procedures on the condition that they double-glove and refrain from performing certain exposure-prone procedures. *Recommendations for Prevention of HIV Transmission in Health-Care Settings*, *supra* note 104, at 68. Watson suggests that the calculation of acceptable levels of risk must be consistent. Watson, *supra* note 3, at 801. She argues that if the disability acts exclude health care workers who are HIV positive from protection but fail to exclude those who carry hepatitis, then they allow our fear and irrational prejudice about AIDS to dictate our responses rather than actuality and significance of the risk posed by the disease. *Id.* Professor Watson notes that a comparative risk approach is beneficial because it "replaces prejudice with a factually-based assessment which allows courts to be consistent in determining when risk becomes significant." *Id.*

178. For a discussion of the approach to determining "significant risk" under the Rehabilitation Act and ADA, see *supra* notes 40-91 and accompanying text.

179. For a discussion of *Scoles* and its "significant risk" analysis, see *supra* notes 109-77 and accompanying text.

practice simply because they create “some” risk. The goal of the Rehabilitation Act and ADA is to protect HIV-infected health care workers unless they pose a *significant* threat to the health and safety of their patients.<sup>180</sup> The significant risk standard itself illustrates that some risk is tolerable in the health care setting, but the difficult legal issue for health care providers lies in determining when “some” risk amounts to a “significant” risk.

*Patricia M. Bailey*

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180. For a discussion of the goals of the Rehabilitation Act and ADA, see *supra* notes 23, 27 and accompanying text.