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THE DUTY TO TREAT ASYMPTOMATIC HIV-POSITIVE PATIENTS OR FACE DISABILITY DISCRIMINATION UNDER *ABBOTT V. BRAGDON*: THE SCYLLA AND CHARYBDIS FACING TODAY'S DENTAL AND HEALTH CARE PROVIDERS

I. INTRODUCTION

Imagine yourself in the following scenario. You are an experienced dentist with a small private practice, and you routinely accept new patients and referrals. One of your long-time patients is scheduled for a routine tooth cleaning and dental examination. You make every effort to keep updated documentation on your patients, and in that pursuit, you request that the patient complete a basic written health questionnaire. In the section relating to medications and relevant medical history, the patient reveals that she is taking medications for Acquired Immunodeficiency Syndrome ("AIDS"),[1] and that she has tested positive for Human Immunodeficiency Virus ("HIV-positive").

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1. *See generally* Bragdon v. Abbott, 118 S. Ct. 2196 (1998). Justice Kennedy delivered the opinion of the Court, during which he devoted a fair amount of introductory material to a thorough discussion of the physiological description of the progression of the AIDS virus:

> The disease follows a predictable and, as of today, an unalterable course. Once a person is infected with HIV, the virus invades different cells in the blood and in body tissues. Certain white blood cells, known as helper T-lymphocytes or CD4 cells, are particularly vulnerable to HIV. The virus attaches to the CD4 receptor site of the target cell and fuses its membrane to the cell's membrane. HIV is a retrovirus, which means it uses an enzyme to convert its own genetic material into a form indistinguishable from the genetic material of the target cell. The virus' genetic material migrates to the cell's nucleus and becomes integrated with the cell's chromosomes. Once integrated, the virus can use the cell's own genetic machinery to replicate itself. Additional copies of the virus are released into the body and infect other cells in turn.
>
> The virus eventually kills the infected host cell. CD4 cells play a critical role in coordinating the body's immune response system, and the decline in their number causes corresponding deterioration of the body's ability to fight infections from many sources.

Id. at 2203 (citations omitted).

After reviewing the registration and health questionnaire forms, you proceed with the appointment. Once the cleaning is complete, you notice upon closer examination that she has a cavity forming on a back tooth at her gum line that is in need of a filling. You discuss this need for further treatment with her, but explain that your small office is not equipped with the devices, equipment, and protective gear to adequately treat patients with such infectious diseases. You agree to perform the procedure at a local hospital, if she agrees to pay the additional fees for usage of the hospital setting. She refuses. You are unclear whether she objects to the additional fees, the relocation to the hospital setting, or your infectious disease treatment policies.

Shortly after that initial visit, you learn that she has filed a disability discrimination suit against you under the Americans with Disabilities Act ("ADA")[2] for failure to fill her cavity in your office. You are called to defend your risk assessments, medical judgment, patient treatment, and decision-making process. You face a major litigation battle that must explore the concepts of such integral, yet amorphous and somewhat ambiguous concepts as "disability"[3] and "direct threat."[4] You thought your doctor-patient relationship was defined by contractual principles, good faith, fair dealing, free enterprise, and minimally-regulated commerce.[5] Now, you are confronted with a brick

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2. 42 U.S.C. §§ 12,101-12,213 (1994).

3. *See id.* § 12,102(2)(A)-(C); *see also* discussion *infra* Part II.

4. *See* 42 U.S.C. § 12,111(3); *see also* discussion *infra* Part II.

5. *See generally* 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 (1992). Cohen explains that "an HCP [health care provider] has no duty to treat anyone with whom it does not have a pre-existing contractual relationship." *Id.* at 235. She later declares that "[c]ontract theory governs the relationship between the physician and patient . . . . Until both parties manifest either an express or implied intent to create a contractual relationship, the physician has no duty to treat the patient." *Id.*

The American Bar Association commented on the constitutional defenses Dr. Bragdon tried to make regarding his commercial, due process, and economic rights:

> The ADA was not unconstitutional as applied to Bragdon. Title III of the ADA appropriately regulates private dental practices, an economic activity, and is rationally related to a legitimate goal, and thus does not violate the Commerce Clause. The ADA also does not violate Bragdon's due process right to freedom from unjustified intrusions on his personal freedom because it does not require him to treat in his office anyone who poses a direct threat, nor does it violate his limited right to freedom of

wall intimating that you have a duty to treat all patients across the board, regardless of your personal and professional risk assessments concerning contagions, contamination, and safety. What do you do?

Dr. Randon Bragdon, a dentist in Maine, confronted a nearly identical situation in late 1995, when his former patient sued him for refusing to perform treatment on her cavity in his dental office because of her HIV-positive condition.[6] Bragdon faced having to defend his recommendation to his patient, Ms. Abbott, that he treat her in a hospital setting, against her allegations of illegal discriminatory behavior under the ADA.[7] Bragdon encountered insurmountable statutory, regulatory, precedential, legislative, judicial, and public policy obstacles as he defended his case from the United States District Court for the District of Maine[8] to the First Circuit Court of Appeals,[9] and ultimately to the United States Supreme Court;[10] yet, he would not prevail.[11]

Consequently, the current federal judicial climate remains hospitable to the allegedly aggrieved HIV-positive patients who sue health care and dental providers for what the patients characterize as unlawfully terminated, delayed, unsatisfactory, or incomplete treatment.[12] More than ever before, the provider faces a duty to treat patients universally, regardless of disability, with the narrow exception of those cases in which the risk of harm to the provider, his staff, or other patients is so signifi-

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contract.

American Bar Association, *Case Law Development*, 20 MENTAL & PHYSICAL DISABILITY L. REP. 196, 196 (1996).

6. *See* Abbott v. Bragdon, 163 F.3d 87, 88 (1st Cir. 1998).

7. *See* Bragdon v. Abbott, 118 S. Ct. 2196, 2201 (1998).

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

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

10. *See* Bragdon v. Abbott, 118 S. Ct. 2196 (1998).

11. *See* Abbott v. Bragdon, 163 F.3d 87 (1st Cir. 1998). On remand from the United States Supreme Court, the court held, "we again find that Dr. Bragdon did not submit evidence to the district court demonstrating a genuine issue of material fact on the direct threat issue. Absent such a showing, the district court appropriately entered summary judgment in favor of Ms. Abbott." *Id.* at 90.

12. *See, e.g.*, Doe v. Montgomery Hosp., No. 95-3168, 1996 WL 745524 (E.D. Pa. Dec. 23, 1996); Sharrow v. Bailey, 910 F. Supp. 187 (M.D. Pa. 1995); United States v. Morvant, 898 F. Supp. 1157 (E.D. La. 1995); Woolfolk v. Duncan, 872 F. Supp. 1381 (E.D. Pa. 1995); Howe v. Hull, 873 F. Supp. 72 (N.D. Ohio 1994).

cant and extreme, that alternative treatment arrangements are warranted. The pool of remedies afforded to these claimants includes compensatory and punitive damages,[13] injunctive relief and equitable remedies,[14] forced training and education of providers and their staff,[15] and required posting of a nondiscriminatory policy of treatment,[16] regardless of disability, including HIV and AIDS.[17]

The AIDS epidemic has undeniably shaken the American workplace, and particularly, the health care industry, since its first diagnosis in the United States nearly twenty years ago.[18]

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13. *See generally* Alix R. Rubin, *HIV Positive, Employment Negative? HIV Discrimination Among Health Care Workers in the United States and France*, 17 COMP. LAB. L.J. 398 (1996). Rubin compares the provisions and remedies of the Rehabilitation Act to the ADA:

> While the standards of discrimination appear to be almost identical under the Rehabilitation Act and the ADA, the ADA is more expansive than the Rehabilitation Act, and available remedies differ. Under the Rehabilitation Act, possible remedies include damages and the elimination of all federal financial assistance to the medical center; remedies under the ADA, on the other hand, include injunctive relief . . . and back pay (damages).

Id. at 424-25 (footnotes omitted).

14. *See id.*

15. *See, e.g., Morvant*, 898 F. Supp. at 1168 (ordering that defendants who refused to provide treatment to persons with HIV or AIDS "undergo training concerning HIV and the practice of dentistry").

16. *See, e.g., Howe*, 873 F. Supp. at 79-80. The court ordered that:

> [D]efendants are to prominently post signs in their waiting rooms stating that "[t]his health care provider is prohibited by law from discriminating on the basis of HIV or AIDS. If you believe that this health care provider has discriminated on the basis of AIDS or HIV, you may wish to consult with an attorney."

Id.

17. *See, e.g., Morvant*, 898 F. Supp. at 1168. In *Morvant*, the United States District Court for the Eastern District of Louisiana ordered that:

> (1) Defendants be enjoined from refusing to provide treatment to persons with HIV or AIDS, on the basis of their HIV positive status;
> (2) Defendants be enjoined from having a blanket policy of "referring" out all people with HIV or AIDS . . .
> (3) Defendants be required to adopt and post a policy of non-discrimination on the basis of disability, including HIV and AIDS;
> (4) Defendants and their staff be required to undergo training concerning HIV and the practice of dentistry.

Id.

18. *See* R. Bradley Prewitt, Comment, *The "Direct Threat" Approach to the HIV-Positive Health Care Employee Under the ADA*, 62 MISS. L.J. 719, 719-23 (1993). Prewitt characterizes the status of the AIDS epidemic as of 1993, with regard to employment issues, as follows:

As the medical community's increased awareness and knowledge of the spread of the infection throughout the world has increased, the clinical definitions used to describe the virus have expanded.[19] The repercussions of AIDS, however, are just now reaching the forefront of the legal community. Patients, legislators, attorneys, and health care practitioners struggle to make sense of the ambiguity surrounding the current legal protection mechanisms for the disabled that concern HIV-positive patients throughout the various stages of AIDS,[20] from asymptomatic[21] to highly symptomatic.[22]

> The employment of HIV-positive individuals with AIDS has generated growing concern over occupational exposure and transmission. However, from a social policy perspective, fears of workplace transmission typically have had little basis in fact; there have been no documented cases of HIV infection through casual contact in the workplace.
>
> In the health care industry, however, the threat of contact with contaminated blood, fluids, and body tissues—all primary modes of virus transfer—makes the fear of infection a legitimate concern. This concern is due to not merely the presence of HIV-positive employees, but also the performance of invasive procedures by such employees.

Id. at 721-22 (footnotes omitted); *see also* 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, 1277 (1992) (stating that AIDS "has rapidly assumed epidemic proportions in many urban areas, has confronted the medical profession with difficult ethical and legal dilemmas . . . . The magnitude of the AIDS epidemic is reflected in an array of alarming statistics and projections"); Rubin, *supra* note 13, at 398 (stating that "the first cases of acquired immune deficiency syndrome (AIDS) were reported on June 5, 1981").

19. *See* Rubin, *supra* note 13, at 398.

20. *See generally* Bragdon v. Abbott, 118 S. Ct. 2196 (1998). The Court documented the stages of the HIV infection in a clinical manner:

> The initial stage of HIV infection is known as acute or primary HIV infection. In a typical case, this stage lasts three months. The virus concentrates in the blood. The assault on the immune system is immediate. The victim suffers from a sudden and serious decline in the number of white blood cells. There is no latency period. Mononucleosis-like symptoms often emerge between six days and six weeks after infection, at times accompanied by fever, headache, enlargement of the lymph nodes (lymphadenopathy), muscle pain (myalgia), rash, lethargy, gastrointestinal disorders, and neurological disorders. Usually these symptoms abate within 14 to 21 days. HIV antibodies appear in the bloodstream within 3 weeks; circulating HIV can be detected within 10 weeks.

Id. at 2203-04 (citations omitted).

21. See *id.* at 2204. The Court utilized the continuum of medical classifications and nomenclature to depict the various stages of the virus, from contraction to incubation, to manifestation of some symptoms, to full-blown AIDS:

> After the symptoms associated with the initial stage subside, the disease enters what is referred to sometimes as its asymptomatic phase. The

At the most basic levels of legal analysis and interpretation, we cannot escape the inevitable confrontation we must face with public health epidemics such as the AIDS virus. The cooperation of lawyers, advocates, medical professionals, researchers, and politicians is crucial in this ongoing pursuit to treat the physiological aspects of the virus, and to safeguard the legal rights of the individuals involved.

Part II of this article examines the relevant statutory authority at issue in *Abbott v. Bragdon*,[23] and how that body of statutory law first evolved from the Rehabilitation Act of 1973[24] to the Americans with Disabilities Act of 1990.[25] The next section surveys the current posture of the United States federal courts on the application of the ADA to the potential plaintiff class of HIV-positive patients.

Part III highlights the First, Fourth, and Ninth Circuits and their leadership in the judicial exploration into this unfamiliar legal territory. The First Circuit's treatment of the landmark

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> term is a misnomer, in some respects, for clinical features persist throughout, including lymphadenopathy, dermatological disorders, oral lesions, and bacterial infections. Although it varies with each individual, in most instances this stage lasts from 7 to 11 years. The virus now tends to concentrate in the lymph nodes, though low levels of the virus continue to appear in the blood. It was once thought the virus became inactive during this period, but it is now known that the relative lack of symptoms is attributable to the virus' migration from the circulatory system into the lymph nodes.

Id. (citations omitted).

22. *See id.* The court described the benchmarks of the continuum of AIDS stages, as the virus progresses on its terminal course:

> A person is regarded as having AIDS when his or her CD4 count drops below 200 cells/mm3 of blood or when CD4 cells comprise less than 14% of his or her total lymphocytes. During this stage, the clinical conditions most often associated with HIV, such as pneumocystis carinii pneumonia, Kaposi's sarcoma, and non-Hodgkins lymphoma, tend to appear. In addition, the general systemic disorders present during all stages of the disease, such as fever, weight loss, fatigue, lesions, nausea, and diarrhea, tend to worsen. In most cases, once the patient's CD4 count drops below 10 cells/mm3 [sic], death soon follows.

Id. (citations omitted).

23. 912 F. Supp. 580 (D. Me. 1995), *affd*, 107 F.3d 934 (1st Cir. 1997), *cert. granted in part*, 118 S. Ct. 554 (1997), *vacated and remanded*, 118 S. Ct. 2196 (1998), *affd on remand*, 163 F.3d 87 (1st Cir. 1998), *and cert. denied* 67 U.S.L.W. 3614 (U.S. May 24, 1999).

24. 29 U.S.C. §§ 701-797b (1994).

25. 42 U.S.C. §§ 12,101-12,213 (1994).

Abbott case has made noteworthy strides in establishing a legal standard for discrimination by the medical community in its treatment of HIV patients. This note traces the progression of *Abbott* from its origins in Maine courts through the United States Supreme Court in late 1998. Part IV discusses the Court's majority opinion authored by Justice Kennedy, and the Court's pro-plaintiff rationale and decision-making process against the ADA's statutory backdrop.

Finally, Part V discusses the preliminary impacts and predicted future implications of the *Abbott* decision on both the medical community and legal marketplace. The note concludes with a summary of this landmark case, its statutory foundations, public policy ramifications, and greater societal impacts.

II. RELEVANT STATUTORY AUTHORITY: THE AMERICANS WITH DISABILITIES ACT AND THE REHABILITATION ACT

As the legislation in the area of disability discrimination broadens in scope and purpose beyond conventional categories and stereotypes, the litigation and uncertainty surrounding whom it benefits, excludes, regulates, and impacts increases exponentially.[26] This newness and unfamiliarity with the unique nature and scope of AIDS within the context of the law, rather than within medicine, is partially to blame for the confusion and ambiguity that plague modern case law.

The succinct, plain language of statutes like the Americans with Disabilities Act and the Rehabilitation Act lead interested parties down one path of explicit interpretation, while the legislative history surrounding related regulatory definitions and

26. *See, e.g.,* School Bd. v. Arline, 480 U.S. 273 (1987); Doe v. Dekalb County Sch. Dist., 145 F.3d 1441 (11th Cir. 1998); Runnebaum v. NationsBank, 123 F.3d 156 (4th Cir. 1997); Doe v. University of Md. Med. Sys. Corp., 50 F.3d 1261 (4th Cir. 1995); United States v. Happy Time Day Care Ctr., 6 F. Supp. 2d 1073 (W.D. Wis. 1998); Hamlyn v. Rock Island County Metro. Mass Transit Dist., 986 F. Supp. 1126 (C.D. Ill. 1997); Cloutier v. Prudential Ins. Co. of Am., 964 F. Supp. 299 (N.D. Cal. 1997); Doe v. Montgomery Hosp., No. 95-3168, 1996 WL 745524 (E.D. Pa. Dec. 23, 1996); Anderson v. Gus Mayer Boston Store, 924 F. Supp. 763 (E.D. Tex. 1996); Sharrow v. Bailey, 910 F. Supp. 187 (M.D. Pa. 1995); Hoepfl v. Barlow, 906 F. Supp. 317 (E.D. Va. 1995); United States v. Morvant, 898 F. Supp. 1157 (E.D. La. 1995); Howe v. Hull, 873 F. Supp. 72 (N.D. Ohio 1994); Doe v. Kohn, Nast & Graf, P.C., 862 F. Supp. 1310 (E.D. Pa. 1994).

congressional floor debates[27] diverge down multiple paths of implicit meaning and intent. The general rule prohibiting discrimination on the basis of an individual's disability is rather concise, but compact with dense definitions and phrases that have become the subject matter of much litigation. In the following central provision, "[n]o individual shall be discriminated against on the basis of disability in the full and equal enjoyment of the goods, services, facilities, privileges, advantages, or accommodations of any place of public accommodation by any person,"[28] numerous clauses fall prey to ambiguity and disputing interpretations.

For instance, "disability"[29] and "public accommodation"[30] continue to baffle statute readers, as well as those charged with interpretation. Some commentators choose to read the statute narrowly and grant only limited protection to a limited subset of the population.[31] On the other hand, the majority of congressional intent and judicial preferences today seem to opt for a broader reading that will grant antidiscriminatory protection to as broad a group of plaintiff applicants as is plausible and reasonable in circumstances involving the proscribed activity.[32] Therefore, the judiciary, legislature, medical community, and

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27. *See, e.g.*, Memorandum from Douglas W. Kmiec, Acting Assistant Attorney General, Office of Legal Counsel, to Arthur B. Culvahouse, Jr., Counsel to the President (Sept. 27, 1988), *reprinted in Americans with Disabilities Act of 1989: Hearings on S. 933 Before the Subcomm. on the Handicapped of the Senate Comm. on Labor and Human Resources*, 101st Cong. 338-68 (1989).

28. 42 U.S.C. § 12,182(a).

29. *See id.* § 12,102(2)(A)-(C).

30. *See id.* § 12,181(7).

31. *See* Michael D. Carlis & Scott A. McCabe, Comment, *Are There No Per Se Disabilities Under the Americans with Disabilities Act? The Fate of Asymptomatic HIV Disease*, 57 MD. L. REV. 558, 581 (1998). The authors comment on the lingering uncertainty in disability discrimination case law by remarking that, "[d]espite this general consensus among federal courts, the reasoning contained in most of the case law is limited. No case provides a thorough analysis of whether asymptomatic HIV disease is a disability under the Act." *Id.*

32. Authors Carlis and McCabe remark on the emerging consensus of the federal judiciary:

> In the last decade, many federal courts have considered whether asymptomatic HIV disease is a disability (or handicap) under either the Rehabilitation Act of 1973, as amended, or the ADA. These courts, with the exception of the Fourth Circuit, have unanimously recognized that asymptomatic HIV disease is covered as a disability.

Id. at 580-581 (footnote omitted).

even the American public, still struggle to make sense of the discrepancies and contradictions in the current law regarding the status of AIDS as a disability.

The legislative history continues to baffle many observers because the framework of support for an explicit inclusion of HIV within the ADA seemed capable of withstanding the political battles and controversies necessary to bring about the enlargement of the class of disabled citizens. For instance, Representative Dannemeyer conceded that, "with the adoption of this act [ADA] we are instantaneously going to bring within the definition of disabled person across this land every HIV carrier in America."[33] Representative Waxman similarly championed a broad inclusion of HIV patients within the ADA's protective arms: "all such individuals [from asymptomatic HIV infection, to symptomatic HIV infection] are covered under the first prong of the definition of disability in the ADA."[34] Lastly, Senator Armstrong emphasized the conclusive posture of the legislative community behind the incorporation of AIDS into the ADA's provisions when he remarked, "the legislative history of this bill makes clear that infection with the AIDS virus—even in the absence of any disabling symptoms—is a covered disability."[35]

Yet, Bragdon's attorneys explain that the committee reports and congressional records seemingly contradict the ADA's conspicuous silence on the inclusion of AIDS as a result of "the negotiated political price" that is integral to the political agenda and related processes.[36] Perhaps, the debaters conceded, AIDS would not qualify as a "per se disability" under the ADA,[37] but that patients could still maneuver themselves into the position of receiving statutory protection by establishing the requisite levels of "impairment"[38] constituting a disabled condition under the statute.[39] Other legislators may have earnestly believed

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33. Brief for the Petitioner at 23 n.17, Bragdon v. Abbott, 118 S. Ct. 2196 (1998) (No. 97-156).

34. *Id.*

35. *Id.*

36. *See id.* at 25-26.

37. *See id.* at 24; *see also* 42 U.S.C. § 12,102(2) (1994). "Disability" is defined using three general conditions that can satisfy the status, rather than by listing specific conditions that automatically and categorically apply on a "per se" level. *See id.* § 12,102(2)(A)-(C).

38. *See* 42 U.S.C. § 12,102(2)(A)-(C).

39. *See* Brief for the Petitioner at 27 n.20, Bragdon v. Abbott, 118 S. Ct. 2196

that the virus was implicitly incorporated into the statute under the general penumbra of closely-related conditions, infections, or terminal diseases. Regardless of the rationale and intentions, uncertainty still lingers because of the glaring absence of plain language in the ADA's text.

At the heart of these disputes are the definitions of "disability,"[40] "impairment,"[41] "major life activity,"[42] "public accommodation,"[43] "reasonable accommodation,"[44] "undue hardship,"[45] and "direct threat"[46] under the ADA and its supplemental regulatory and statutory provisions. The crux of most litigation centers around whether an asymptomatic HIV patient qualifies as a member of the potential plaintiff class, who can sue for alleged discrimination that violates the protective guarantees of the ADA.[47] Most courts, legislators, and agencies agree that the ADA should not be construed so narrowly as to permit private business owners to refuse to serve customers or to grant access to patrons in places of "public accommodation," based solely on an individual's HIV-positive status.[48] Yet, not all of

(1998) (No. 97-156) ("A finding of disability under the ADA will always require an individualized inquiry into whether a plaintiff satisfies any of the three prongs of the definition.").

40. *See* 42 U.S.C. § 12,102(2)(A)-(C).

41. *See id.*

42. *See id.*

43. *See id.* § 12,181(7)(A)-(L). The "professional office of a health care provider, hospital, or other service establishment" is explicitly listed in section 12181(7)(F) as a private entity that is considered a public accommodation if its operations affect commerce. *Id.*

44. *See id.* § 12,111(9).

45. *See id.* § 12,111(10).

46. *See id.* § 12,111(3).

47. *See* Carlis & McCabe, *supra* note 31, at 580. ("[M]any federal courts have considered whether asymptomatic HIV disease is a disability . . . under . . . the ADA.").

48. *See* Susan Moriarity Miltko, *The Need for Professional Discretion: Health Professionals Under the Americans with Disabilities Act*, 89 NW. U. L. REV. 1731 (1995). Miltko writes of the ADA's incorporation of, meaning behind, and underlying policies for the "public accommodation" provisions:

> The ADA is also more extensive than previous civil rights statutes in its definition of public accommodations. The Act defines places of public accommodation as private entities that affect commerce and fall into one of the twelve categories listed in the statute. While the status of a physician's office as a place of public accommodation has been contested under previous civil rights legislation, the ADA explicitly includes hospitals and the professional offices of health care providers within its defini-

the nation's courts are able to agree universally on classifying the HIV disease as a per se disability;[49] therefore, each new case is examined individually, with regards to the symptoms of the HIV disease, the activity level of the plaintiff, and the relative degree of the plaintiff's impairment.

The deciding factor continues to focus on the degree of symptoms the HIV-positive plaintiff manifests at the time of the alleged discrimination on the basis of the patient's impaired health.[50] Understandably, the broad range of differing opinions

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tion.

> In general, the protections of the ADA are patterned after the protections afforded individuals with disabilities under the Rehabilitation Act. However, the ADA extends the protections found in the Rehabilitation Act in two significant ways. First, the ADA applies to all employers and places of public accommodation, not just those controlled or supported by the federal government. Accordingly, all professional offices of health care providers and hospitals are subject to the provisions of the ADA. Second, the ADA's public accommodation provisions drop the "solely by reason of her or his handicap" language found in Section 504 of the Rehabilitation Act. Instead, the ADA prohibits any discrimination "on the basis of disability." Thus, someone claiming discrimination under the ADA need not prove that the sole basis of exclusion was the individual's disability, as was necessary under the Rehabilitation Act. Rather, discrimination that is even partially based on a person's disability is deemed illegal under the ADA. Through its unprecedented specificity, scope, and affirmative requirements, the ADA provides extensive new rights to millions of disabled Americans.

Id. at 1743-44. (footnotes omitted).

49. *See generally* Brief for the Petitioner at 26-27, Bragdon v. Abbott, 118 S. Ct. 2196 (1998) (No. 97-156). The Petitioner's Brief discussed the impracticality of elevating HIV to the status of a per se disability under the ADA:

> What is clear concerning the decision whether HIV is a per se disability is that a move from reliance on the statute to reliance on legislative history is a move from what is arguably plain and in accord with common sense . . . to what is less plain and logically unsupportable (that all asymptomatic persons with HIV are substantially limited in a major life activity). The Court should therefore decline the invitation to elevate parts of the legislative history which treat HIV as a disability per se to the status of the statute.

Id.

50. In *Abbott*, Justice Kennedy discussed Bragdon's perceptions of how much a patient's symptomatic condition impacts the treating provider's, or even the greater public's, awareness of a potential disability, such as having AIDS:

> [Bragdon] claims that Congress intended the ADA only to cover those aspects of a person's life which have a public, economic, or daily character. The argument founders on the statutory language. Nothing in the definition suggests that activities without a public, economic, or daily dimension may somehow be regarded as so unimportant or insignificant

on even the most fundamental basics of the parties' health conditions complicates litigation and provides numerous discovery and evidentiary hurdles.[51] Until recently, the affected parties were left to turn to conflicting case law to attempt to dis-

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> as to fall outside the meaning of the word "major." The breadth of the term confounds the attempt to limit its construction in this manner.

118 S. Ct. 2196, 2205 (1998) (citations omitted).

51. *Compare* Brief for the Respondent at 5, 13, *Abbott* (No. 97-156), *with* Brief for the Petitioner at 3, *Abbott* (No. 97-156). Abbott maintains in the Respondent's Brief:

> There is no dispute here that HIV is a physical impairment. The statutory term "physical impairment" refers to a physiological condition which worsens or diminishes one's physiological state. Upon infection, HIV creates abnormalities and deficiencies in the blood and immune systems and renders bodily fluids infectious and diminished in quality.

Brief for the Respondent at 5, *Abbott* (No. 97-156).

Later in the Respondent's Brief, clinical and medical aspects of HIV are presented:

> Based on undisputed medical evidence in the record, HIV fits easily within the plain meaning of "physical impairment." HIV infection is an incurable disease which, even before the onset of outward signs of illness, diminishes bodily functions in two ways. First, HIV creates abnormalities and deficiencies in the blood and immune systems. When HIV enters the body, it multiplies and has an immediate and destructive effect on the blood (hemic) and lymphatic systems, which are critical to the body's defense against infection. Thus, even before the onset of overt symptoms, HIV infection causes a progressive destruction of the body's blood, lymphatic and immune systems, diminishing the body's capacity to fight infections. Second, the bodily fluids of an HIV-positive person, including blood, semen, and breast milk, are infectious. In the most basic sense, then, the bodily fluids of a person with HIV are abnormal, damaged, and diminished in quality.

Id. at 13 (citations and footnotes omitted).

Justice Kennedy concedes that HIV has immediate impairing characteristics:

> The initial stage of HIV infection is known as acute or primary infection. In a typical case, this stage lasts three months. The virus concentrates in the blood. The assault on the immune system is immediate. The victim suffers from a sudden and serious decline in the number of white blood cells. There is no latency period.

Abbott, 118 S. Ct. at 2203.

Bragdon, however, in the Petitioner's Brief, presents a contrasting view of asymptomatic AIDS patients and their physical conditions:

> Approximately five percent of individuals infected with HIV have "remained clinically healthy and immunologically normal for more than a decade." In fact, the "median interval between infection and the development of AIDS has been 10 years." During this period, many asymptomatic individuals with HIV remain clinically health and immunologically normal. As the word itself connotes, asymptomatic HIV infection does not substantially limit a person's ability to care for one's self, perform manual tasks, walk, see, hear, speak, breathe, learn, or work.

Brief for the Petitioner at 3, *Abbott* (No. 97-156) (citations omitted).

cern the current direction of a judicial response and interpretation to a myriad of complex fact patterns.

III. CURRENT POSTURE OF FEDERAL COURTS ON APPLICABILITY OF THE ADA TO HIV-POSITIVE PATIENTS

A. *Key Judicial Players Set the Stage for Landmark Adjudication: The First, Fourth, and Ninth Circuits Step Forward and Respond*

While the Fourth Circuit continues to adopt a position different[52] from the majority of the other circuits, such as the First and Ninth Circuits,[53] on the scope of the ADA's protections extending to asymptomatic HIV-positive patients, the case law is starting to align into a discernible pro-plaintiff progression. Most federal jurisprudence supports the broadening interpretation of the ADA and its protections, regardless of where the plaintiff's HIV status lies on the symptomatic continuum.[54] The legislative history underlying the ADA rises to the forefront of judicial consideration as federal judges repeatedly remind parties of the antidiscriminatory purposes of the statute, namely to prohibit the foreclosure of "full and equal enjoyment of the goods, services, facilities, privileges, advantages, or accommodations of any place of public accommodation" merely on the basis of a disability.[55]

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52. *See, e.g.,* Runnebaum v. NationsBank, 123 F.3d 156 (4th Cir. 1997); Ennis v. National Ass'n of Bus. & Educ. Radio, 53 F.3d 55 (4th Cir. 1995); Doe v. University of Md. Med. Sys. Corp., 50 F.3d 1261 (4th Cir. 1995).

53. *See generally* Carlis & McCabe, *supra* note 31, at 560 (explaining the emerging consensus between the First and Ninth Circuits).

54. *See id.* at 559. The authors assert that "[t]he Fourth Circuit is the first federal jurisdiction to interpret the [ADA's] protective scope so narrowly" as to hold "that individuals with asymptomatic HIV disease are not disabled under the principal definition of 'disability' in the [ADA]." *Id.* at 558-59. According to these writers, the "Fourth Circuit stands alone in its refusal to apply the Act's protection to individuals with asymptomatic HIV disease." *Id* at 589.

55. 42 U.S.C. § 12,182(a) (1994). The statute provides:

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

Id.

The majority of courts[56] hold that even asymptomatic HIV is still considered a "disability" under the ADA, mainly because these courts acknowledge the AIDS virus' "inescapable effect on an individual's hemic or lymphatic systems."[57] Many consider the physiological occurrences within the blood stream, immune system, and cells of the body to constitute the requisite level of "physical . . . impairment"[58] to satisfy the statutory definition of "disability."[59] The societal stigma and external physical effects of the virus' progression are unnecessary elements in satisfying this statutory hurdle. Nor are these manifestations or aspects of the disease required to arrive at the conclusion that internal havoc continues to wage within the patient's cells, no matter how seemingly inconspicuous.[60] Additionally, the infections, fever, skin conditions, weakness, pneumonia, dementia, and diarrhea that later accompany the various stages of the AIDS virus also manifest physical conditions that would further constitute impairment.[61]

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56. *See* Carlis & McCabe, *supra* note 31, *passim*. For example, the First Circuit, the Ninth Circuit, a California federal district court, a Pennsylvania federal district court, and a Texas federal district court have all held that asymptomatic HIV is considered a disability. *See id.* at 580-89.

57. Carlis & McCabe, *supra* note 31, at 589.

58. 42 U.S.C. § 12,102(2)(A)-(C). The statute's first prong of the disability definition focuses on the most concrete and tangible manifestations of impairing symptoms: "[A] physical or mental impairment that substantially limits one or more of the major life activities of such individual." *Id.* § 12,102(2)(A).

59. *See* Carlis & McCabe, *supra* note 31, at 589.

60. *See* Bragdon v. Abbott, 118 S. Ct. 2196, 2204 (1998). The Court explained:

> It was once thought the virus became inactive during this period, but it is now known that the relative lack of symptoms is attributable to the virus' migration from the circulatory system into the lymph nodes. . . .
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> . . . .
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> In light of the immediacy with which the virus begins to damage the infected person's white blood cells and the severity of the disease, we hold it is an impairment from the moment of infection. As noted earlier, infection with HIV causes immediate abnormalities in a person's blood, and the infected person's white cell count continues to drop throughout the course of the disease, even when the attack is concentrated in the lymph nodes.

Id.

61. *See id.* at 2203-04 (detailing the stages of the AIDS virus from the "acute or primary infection," to the "asymptomatic phase," to later symptomatic phases, to its final phases, concluding in death).

Should this internal, microbiological physical destruction of the immune system not satisfy the statutory hurdles, however, the third component of the "disability" definition, incorporating social stigma and lay opinion, will probably fill the gap. One commentator remarked, "an enormous social stigma is attached to the diagnosis of AIDS that encompasses both fear of contagion and prejudice directed toward the victims' lifestyles."[62] Some commentators take a further leap in logic by declaring that public stigma is similarly manifested in the community of health care providers.[63] The National Commission on AIDS, a presidential and congressional advisory board, observed as early as 1990, that only 2,000 of the 600,000 practicing physicians in the United States were willing to remain on the referral list for the Physicians Association for AIDS Care.[64]

The second component of the definition for "disability" may apply in situations in which a person carries the dormant HIV virus in his body for long periods of time.[65] This component takes into account the often lengthy incubation periods for diseases like AIDS.[66] Once the disease overtly manifests itself, the progression is slow enough to allow for a lengthy medical history or period of hospitalization.[67] This progression and deterioration process could be classified under the last type of disability classification due to the "record of such an impairment."[68]

Notwithstanding the Fourth Circuit's denial of a per se disability status for asymptomatic HIV-positive patients, the progression of *Abbott v. Bragdon* through the First Circuit has

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62. Neugarten, *supra* note 18, at 1278-79.

63. *See, e.g.,* Cohen, *supra* note 5, at 234; Rubin, *supra* note 13, at 398; Neugarten, *supra* note 18, at 1341; Prewitt, *supra* note 18, at 722-23.

64. *See* Neugarten, *supra* note 18, at 1279.

65. *See* Bragdon v. Abbott, 118 S. Ct. 2196, 2204 (1998).

66. *See id.* ("Although it varies with each individual, in most instances this stage lasts from 7 to 11 years.").

67. *See* Brief for the Respondent, at 6, *Abbott* (No. 97-156). The respondent noted:

> By setting an unexpected and premature end-point on life, a fatal disease, such as HIV, limits a wide array of major life activities (including those activities which require thinking about the future) and inevitably changes the experience of life itself. Individuals with HIV are also substantially limited because they require life-long and complex medical care.

Id.

68. 42 U.S.C. § 12,102(2)(B) (1994).

accomplished a great deal in terms of settling the status of the applicable case law. Even though Maine is not one of the areas in the United States with the highest density of reported AIDS cases,[69] the jurisdiction proactively tackled the issue of an HIV patient's disability status under antidiscrimination statutes such as the ADA and its federal predecessor, the Rehabilitation Act. Perhaps jurisdictions facing the complexities of the AIDS epidemic on larger scales due to an increased population base, such as New York, California, and Washington, D.C., will mirror Maine's response to this pressing public health issue.

B. *The First Circuit Steps to the Plate with* Abbott v. Bragdon

1. Overview and Background Information

As of December 29, 1998, the uncertainty surrounding the ADA's application to AIDS finally began to dissipate. For, on the eve of a new year, the United States Court of Appeals for the First Circuit, on remand from the United States Supreme Court, again affirmed its previous decision in favor of an HIV-positive dental patient alleging discriminatory treatment by her former dentist.[70] Bragdon had unsuccessfully argued that the court of appeals should embrace an individualized, more subjective medical assessment of the risks surrounding treatment of HIV-positive patients. He had pressed both the court of appeals and the Supreme Court to apply the treating doctor's assessment rather than that of a distanced trier of fact using a reasonable prudent person standard borrowed from tort law or the opinion of a removed public health official.[71] The Supreme

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69. *See generally* Rubin, *supra* note 13, *passim* (contrasting the reported cases in the United States with those of France, particularly the urban locations in the respective countries, like New York, San Francisco, Washington, D.C., and Paris).

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

71. *See* Abbott v. Bragdon, 107 F.3d 934, 944 (1st Cir. 1997).

> The second threshold determination involves the degree of deference due the medical judgments of public health authorities. The government joins Ms. Abbott in arguing for a rule which, if embraced, would cede great deference to those authorities. They posit that, in the absence of dissent among public health authorities, a service provider should be bound to accept the expressed collective judgment of those authorities unless he can demonstrate that this judgment is medically unreasonable. In contrast, Dr. Bragdon asseverates that, at least in the case of a service pro-

Court and First Circuit Court of Appeals rejected Bragdon's proposal. Both courts affirmed their former approaches allowing an objective, third-party evaluation of the appropriateness of a health care practitioner's discrete decision making in a given scenario.[72]

As a result of this decision, the Maine courts have a solid preference for allowing public health officials to make these assessments instead of the medical professional who actually faced the particular treatment decision. The bench is unwilling to allow the person who faces the particular conflicting interests, medical risks, and safety assessments to make the legal determinations surrounding treatment of disabled patients, for fear that such a decision introduces subjectivity, personal prejudice, and social stigma into the medical treatment relationship. The judicial preference for objective risk assessment of patient, staff, and provider safety becomes even more evident with this landmark case.

2. Factual Summary

Abbott v. Bragdon commenced in a Maine district court[73] when the patient, Sidney Abbott, filed suit against her long-time dentist, Dr. Randon Bragdon, for allegedly refusing to treat her gum line cavity in his Bangor, Maine office after learning of her HIV-positive condition. Abbott volunteered the

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> vider who is himself a skilled professional (such as a doctor or dentist), a court should defer to the provider's judgment, as long as it appears to have been reasonable in light of then-current medical knowledge.

Id.

72. *See id.* at 945.

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

Id.

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

information regarding her long-term asymptomatic HIV-positive condition during the process of completing and discussing health forms and registration materials at Bragdon's office.[74] It is significant to note that Abbott was not a gratuitous "walk-in" patient as her visit was prescheduled through an appointment for her routine dental treatment.[75] Her cavity was also not unusual in and of itself, but Bragdon felt her HIV condition complicated the treatment because of the likelihood of blood, saliva, or aerosol mists of these bodily fluids making contact with the dentist and his dental staff.[76]

Once his examination revealed the need for a cavity filling, Bragdon discussed his infectious disease treatment policy with Abbott.[77] Bragdon suggested that he would prefer to treat her in a hospital setting, where he would be better equipped to deal with the precautions, equipment, and protectionary measures necessitated by her infectious condition.[78] He presented this option to Abbott and explained that he would still be willing to do the procedure and would not need to refer her to a specialist but that he would expect her to assume the financial responsibilities associated with any additional charges the hospital would impose.[79]

Abbott declined this option and sued Bragdon for discrimination under Title III of the ADA, as well as the Maine Human Rights Act ("MHRA").[80] The court combined its analysis of the two statutes because it noted that the state human rights statute merely served to complement the ADA.[81] The majority of the litigation surrounding this landmark case centered around the relative applicability of the statutory interpretations and underlying congressional intent regarding the asymptomatic HIV status of patients like Abbott.

74. *See id.* at 584.
75. *See id.*
76. *See Abbott*, 107 F.3d at 943.
77. *See Abbott*, 912 F. Supp. at 584.
78. *See id.*
79. *See Abbott*, 107 F.3d at 937-38.
80. *See Abbott*, 912 F. Supp. at 583-84.
81. *See id.* at 591-92.

3. Procedural History

The district court granted summary judgment for Abbott.[82] The court held that Abbott had a "disability" as a matter of law because her HIV condition, even though asymptomatic, is a "physical impairment"[83] under the ADA.[84] The court held that her condition also substantially limited one of her major life activities, namely, procreation, because of her shortened life expectancy and the risk of transmitting the virus to her potential unborn child and/or the child's father.[85] Either of these two limitations, qualified Abbott as a member of the potential class of disabled plaintiffs under the ADA.

The court did not focus on whether Abbott manifested a desire to procreate, whether she even considered marriage and having a family, whether she was heterosexual, whether she was fertile, or any other practical consideration surrounding procreation decisions. In that respect, maybe the procreation argument was too attenuated or creative in the court's opinion, and in some ways merited a sua sponte consideration of potential alternative rationales. Yet, these alternative considerations never received the judicial spotlight because the district court found Abbott sufficiently established her prima facie case when she proved that her asymptomatic HIV status had substantially limited her major life activity of reproduction. The court ultimately concluded that she was "disabled as a matter of law under the ADA" because of her limited reproductive condition.[86]

The court concentrated its analysis on whether the average reasonable person would consider the health effects of AIDS an impairment to one's ability to reproduce. To many observers of this case's development, the lymphatic and cell impairment dwarfs the lifestyle arguments concerning one's ability to conceive, carry, give birth to, and raise a child. These commenta-

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82. *See id.* at 595.

83. 42 U.S.C. § 12,102(2)(A) (1994). The first prong of the disability definition concerns either a physical or mental impairment that substantially limits a patient's major life activities. *See id.*

84. *See Abbott*, 912 F. Supp. at 586-87.

85. *See id.*

86. *Id.* at 587.

tors consider that type of disability broader and more generally applicable to a larger section of the potential plaintiff class.[87] For instance, by making reproduction impairment the focal point, one could argue that the floodgates are open, and consequently, any infertile individual could come forward to join the amorphous, overly-broad, and ever-expanding plaintiff class. Again, the court adopted a pro-plaintiff stance in allowing a plaintiff such as Sidney Abbott to effortlessly clear the hurdle of establishing herself as "disabled" under the ADA.

The trial court denied Bragdon's claim that the ADA was unconstitutional and disagreed with his claim that the ADA unjustly inhibited his freedom to contract.[88] His arguments for the freedom to practice dental medicine on a local level, uninhibited by the federal government's regulatory interference under the Commerce Clause,[89] as well as his protests over his curbed due process rights were both flatly denied.[90] Because Bragdon operated a private facility, and his dental services presumably had an impact on the local economy, his conduct was regulated under the applicable public statutes. Bragdon, therefore, could not use private enterprise, due process concerns of personal security and privacy, or his contractual arrangement particular to Abbott to escape his potential liability exposure under the ADA.[91] Rather than arguing for a blanket statutory loophole exception to its application on his patient's behalf, Bragdon should have focused on the nuances in interpretation and application of the ADA and its companion statutes.

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87. *See, e.g.,* Carlis & McCabe, *supra* note 31, at 581. ("The cases generally conclude that HIV always impairs individuals' hemic systems . . . .").

88. *See Abbott*, 912 F. Supp. at 594-95. The court stated:

> Defendant asserts that the ADA also violates his fundamental right to freedom of contract, also deriving from the Fifth and Fourteenth Amendments to the Constitution, by forcing him to accept patients against his will. . . . The Supreme Court, however, has dramatically curtailed the due process right to freedom of contract which Defendant seeks to invoke against the ADA. . . . [T]he Court determines that due process freedom of contract fails to provide grounds for declaring the ADA unconstitutional.

Id.

89. *See id.* at 592-94.

90. *See id.* at 594-95.

91. *See id.* at 592-95.

The district court found that the ADA was constitutional as applied to Bragdon's practice because Title III of the ADA properly and explicitly regulates private practices such as Bragdon's dental office.[92] Because his practice is an economic activity in the Bangor, Maine, marketplace, as well as a place of "public accommodation," the state and federal regulations impacting his practice must merely satisfy the "rational basis" scrutiny test[93] for constitutionality. Namely, the ADA's regulation of Bragdon's practice must be rationally related to some legitimate federal policy goal, such as the protection against discrimination for disabled patients.[94] The district court, applying the rational basis test, held that the ADA survived Bragdon's constitutional challenge.[95]

Likewise, Bragdon's due process claims of inhibited contractual and economic freedoms failed. The trial court found that the ADA did not violate his due process right "to freedom from unjustified intrusions on his personal freedom because it does not require him to treat in his office anyone who poses a direct threat, nor does it violate his limited right to freedom of contract."[96] In the circuit court's opinion, Bragdon's claims simply did not rise to the level of a valid due process constitutional challenge. Instead, the court focused on what it considered Bragdon's only potentially viable defense—the "direct threat" argument.[97] Bragdon would have been wiser had he strategically

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92. *See id.* at 592-94. At the appellate level, Judge Selya wrote, "on the facts of record, the defendant's refusal to render routine dental care to an HIV-positive patient offends a duly enacted federal statute and thus cannot be tolerated by a court of law." Abbott v. Bragdon, 107 F.3d 934, 949 (1st Cir. 1997).

93. *See Abbott*, 912 F. Supp. at 594. The court explained that rational basis scrutiny will apply to federal statutes, such as the ADA that regulate private enterprise, like Bragdon's dental practice:

> Having determined that title III of the ADA appropriately regulates Defendant's dental practice, the Court must also determine whether title III survives rational basis scrutiny, meaning that title III must be rationally related to a legitimate constitutional end, and that the means chosen by Congress must be reasonably tailored to reach that end.

Id. (citations omitted).

94. *See id.*

95. *See id.* ("Defendant does not contest title III on rational basis grounds, and the Court concurs in the judgment of the Morvant Court that title III meets this minimal scrutiny.").

96. American Bar Association, *supra* note 5, at 196.

97. *See Abbott*, 107 F.3d at 943. ("The term 'direct threat' is defined by the [ADA]; in this context it contemplates the existence of 'a significant risk to the health

concentrated his case around the overwhelming clinical details surrounding the risks of spreading AIDS, the meticulous practical burdens of treating AIDS patients (or conversely, treating patients as a provider with AIDS), and the mind-boggling ramifications one faces upon contracting the terminal virus.

The circuit court held, however, that this "direct threat" defense is only appropriate when the plaintiff's treatment requires an invasive procedure that would pose a significant risk to the health and safety of others.[98] Unfortunately for Bragdon, a simple, noninvasive, and routine cavity procedure did not rise to the degree of presenting the requisite "significant risk" the ADA demands. District Judge Brody wrote the opinion for the lower court, in which he explained the narrow application of this "direct threat" exception relative to the general duty of a health care provider to treat all patients, regardless of disability: "The ADA does not require a covered entity to extend its public accommodations to any individual who poses a direct threat to the health or safety of others."[99]

Judge Brody echoed the statutory definition of "direct threat" under the ADA to emphasize that a risk only satisfies this definition when policy, procedure, practice, and service modifications fail to eliminate that harm to public health and safety.[100] A practitioner is expected to perform all adaptations and revisions to his treatment and services as practical, without incurring undue hardship up to the point at which no amount of behavioral or practice modification is able to mitigate the extreme level of risk. For example, the Centers for Disease Control ("CDC")[101] and public health officials do not consider it onerous to require a practitioner to wear protective masks,

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or safety of others that cannot be eliminated by a modification of policies, practices, or procedures or by the provision of auxiliary aids or services.'").

98. *See id.*

99. *Abbott*, 912 F. Supp. at 587.

100. *See id.*

101. *See id.* at 588 n.7 (explaining the function of the CDC and its role in providing guidelines for health care of HIV patients). *See generally* Brief for the Petitioner, Bragdon v. Abbott, 118 S. Ct. 2196 (1998) (No. 97-156). The CDC establishes and revises the clinical definitions for AIDS, and also recommends the precautionary measures that doctors and dentists are to utilize in their offices when treating HIV patients. These guidelines serve to eliminate infectious disease risks that out-patient and in-office treatment may otherwise pose to medical providers or professionals, staff, and other patients.

wash his hands more frequently, use strong sterilizing agents on utensils, wear double gloves if necessary, and purchase as many disposable instruments as possible.[102] These procedures have documented results in decreasing the risks of spreading contagious diseases like AIDS and are proven most effective in this risk containment in comparison to their overall costs in terms of time, money, and effort.[103]

On appeal, the Court of Appeals for the First Circuit affirmed the trial court's decision in favor of Abbott.[104] It is most significant to note, however, that the court of appeals only granted certiorari on one limited issue. It pinpointed the question of whether the assessment of risks involved in treating an HIV-positive patient can be made from the standpoint of the health care practitioner involved in the treatment of the plaintiff-patient or whether public health officials, objective third-party medical experts, or some sort of expert panel must make the risk determination involved in the treatment decision.[105]

When the court of appeals affirmed the lower court's decision, Bragdon appealed again,[106] alleging that the plaintiff's experts were erroneously permitted to utilize medical information and knowledge that were not available at the time he made his initial assessment of the treatment risks. Bragdon asserted that this utilization of more recent evidentiary information unfairly advantaged the plaintiff's claim.[107]

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102. *See Abbott*, 912 F. Supp. at 588 n.7.

103. *See id.*

104. *See Abbott*, 107 F.3d at 949 (affirming the district court's holding that granted Abbott's motion for summary judgment).

105. *See id.* at 944-45 (describing the appropriate balance between giving deference to the authority of public health officials and making independent assessments as a skilled professional when there is no consensus, evidence of unreasonableness, or dissent among qualified officials).

106. *See id.* at 949, *cert. granted in part*, 118 S. Ct. 554 (1997).

107. *See* Bragdon v. Abbott, 118 S. Ct. 2196, 2211-13 (1998).

IV. THE UNITED STATES SUPREME COURT CHAMPIONS *ABBOTT'S* CAUSE OF PATIENTS' RIGHTS TO MEDICAL AND DENTAL TREATMENT

A. *The United States Supreme Court's Majority Opinion*[108]

The Supreme Court affirmed the lower court's holding that Abbott's HIV infection qualified as an ADA disability and vacated and remanded the Court of Appeals for the First Circuit's grant of summary judgment in favor of Abbott.[109] The Court remanded the case so that Bragdon would be given an opportunity to combat the information and expert testimony Abbott raised against him.[110] Bragdon claimed the significant risk of infection warranted a transferral of the patient to an alternative location for treatment, where he alleged that the equipment, gear, and precautionary measures could more easily, readily, and efficiently be utilized in the treatment of a patient with infectious diseases, such as Abbott.[111]

It is important to note that the Supreme Court vacated and remanded only part of the lower court's decision, thereby sending the case back to the First Circuit Court of Appeals for limited evidentiary review, rather than reversing the entire decision in Bragdon's favor.[112] Understandably, the Supreme Court and the nation's lower courts tread lightly through such murky waters of public health epidemics and their potential applica-

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108. *See id.* at 2200. Justice Kennedy delivered the opinion for the majority of the Court, in which Justices Stevens, Souter, Ginsburg, and Breyer joined. Justice Stevens filed a concurring opinion, in which Justice Breyer joined. Justice Ginsburg filed a concurring opinion. Chief Justice Rehnquist filed an opinion concurring in the judgment in part and dissenting in part. Justices Scalia and Thomas joined Chief Justice Rehnquist's opinion. Justice O'Connor joined Part II of Chief Justice Rehnquist's opinion and filed her own opinion concurring in the judgment in part and dissenting in part. (Kennedy's opinion is a majority because he was joined by the minimal number of justices, four, to constitute a simple majority.) *See id.*

109. *See id.* at 2213.

110. *See id.* (concluding that the "proper course is to give the Court of Appeals the opportunity to determine whether our analysis of some of the studies cited by the parties would change its conclusion that petitioner presented neither objective evidence nor a triable issue of fact on the question of risk").

111. *See* Brief for the Petitioner at 7, 8, 43, Bragdon v. Abbott, 118 S. Ct. 2196 (1998) (No. 97-156).

112. *See Abbott*, 118 S. Ct. at 2213.

tion to federal statutory protection mechanisms. This does not appear to be either an area of radical policymaking or radical adjudication. The court of appeals consequently ordered supplemental briefing on the limited issue remaining: "whether performance of the cavity-filling procedure posed a 'direct threat' to others and thereby came within an exception to the ADA's broad prohibition against discrimination."[113] After the parties submitted their new briefs on this issue, the court entertained more oral argument before ultimately reaffirming the district court's summary judgment order.[114] Therefore, the First Circuit was able to solidify its position of a broad reading of the protections afforded to "disabled" parties under the ADA. The court failed to place significant emphasis on the statistical battles and medical expert testimonials the parties prioritized. Rather, they focused on the rights of HIV patients to obtain medical and dental treatment. Justice Kennedy believed that a remand would allow the court of appeals to more fully explore the plethora of clinical evidence, statistics, and guidelines.[115] The social stigma and political controversy surrounding this litigation undeniably weighed heavily in each litigant's presentation of viable resolutions, as well as the Court's ultimate consideration of those alternatives.

B. *Step-By-Step Analysis Through Statutory Provisions and the Supreme Court's Decision Making in the Majority's Opinion*

1. The First Tier in the Majority's ADA Interpretation

Justice Kennedy, writing for the majority, neatly outlined the statutory analysis for an HIV-positive patient's discrimination claim against her treating health care provider under the ADA. First, the Court focused its review on the definition of "disability"[116] under section 12,102(2) of the ADA.[117] The Court held that Abbott's HIV infection qualified as a "disability" under the definition of "physical or mental impairment," which is de-

113. Abbott v. Bragdon, 163 F.3d. 87, 88 (1st Cir. 1998).
114. *See id.* at 90.
115. *See Abbott*, 118 S. Ct. at 2200.
116. *See* 42 U.S.C. § 12,102(2)(A)-(C) (1994).
117. *See Abbott*, 118 S. Ct. at 2201-07.

scribed as a condition that "substantially limits one or more of the major life activities"[118] of the petitioning individual.[119]

2. The Second Tier in the Majority's ADA Interpretation

The second tier of the Court's statutory interpretation centered around three steps. First, the Court examined whether Abbott's HIV status was a "physical impairment."[120] Skeptics[121] remark that the very nature of an asymptomatic stage of any disease, even if terminal, dictates that this first requirement cannot be met.[122] It is almost as if the proponents of this specious argument believe that asymptomatic status and physical manifestations or evidence of impairment to casual observers of the outside world are irreconcilable. Second, Justice Kennedy directed his focus to the identification of the "major life activity" that Abbott relied upon to argue she qualified as a member of an ADA plaintiff class.[123] Abbott used "reproduction and child bearing" as the requisite "major life activities" that she alleged were impaired by her HIV condition.[124] Abbott argued that all aspects of having children—from conception to parenting—were hampered in some way by her condition. Yet, her age, fertility, sexual orientation, and health were never factored into this reproduction analysis.[125] The Court re-

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118. 42 U.S.C. § 12,102(2)(A).

119. *See Abbott*, 118 S. Ct. at 2207.

120. *See id.* at 2202.

121. *See* Brief for the Petitioner at 3, *Abbott* (No. 97-156) (stating that "[a]s the word itself connotes, asymptomatic HIV infection does not substantially limit a person's ability to care for one's self, perform manual tasks, walk, see, hear, speak, breathe, learn, or work"); Carlis & McCabe, *supra* note 31, at 596-97 (describing the Fourth Circuit judges' unwillingness to deem asymptomatic HIV patients as disabled under the ADA: "Judge Williams explained . . . that asymptomatic HIV disease is not a disability . . . . The judges dismissed outright any argument that asymptomatic HIV disease constitutes a per se disability and suggested that an individual . . . with asymptomatic HIV disease could not 'credibly' argue that he was disabled under the . . . individualized-inquiry rule").

122. *See* Brief for the Petitioner at 3, *Abbott*, (No. 97-156) (explaining that an asymptomatic HIV patient is unable to clear the first prong of the ADA's disability definition because he cannot prove substantial impairment to a major life activity when he suffers no overt physical manifestations of the disease and no substantial lifestyle or routine curtailment).

123. *See Abbott*, 118 S. Ct. at 2204-05.

124. *See Abbott*, 118 S. Ct. at 2202, 2204-05.

125. *See* Abbott v. Bragdon, 107 F.3d 934, 941-42 (1st Cir. 1997).

sponded to the litigants' positions by marrying the two considerations of impairment and major activities and asking whether the impairment substantially limited Abbott's reproduction and procreation life activities.[126]

3. The United States Supreme Court's Study of Administrative and Regulatory Authority

The Court conceded that the available case law was not dispositive on many of these specific statutory issues; therefore, the Court looked to "interpretations of parallel definitions in previous statutes and the views of various administrative agencies which have faced [these] . . . interpretative question[s]."[127] For instance, one of the first statutes the Court referred to in this analysis was the Rehabilitation Act: "The ADA's definition of disability is drawn almost verbatim from the definition of 'handicapped individual' included in the Rehabilitation Act of 1973, [section] 706(8)(B)."[128] The Court was convinced of Congress's intent to explicitly and heavily borrow language from earlier statutes and then to incorporate that text into the ADA. The relevant "borrowed" excerpt of the ADA reads, "[e]xcept as otherwise provided in this chapter, nothing in this chapter shall be construed to apply a lesser standard than the standards applied under title V of the Rehabilitation Act of 1973."[129]

The first step in the subsection (A) analysis was to determine whether Abbott's HIV status constituted a "physical impairment." In order to perform this analysis, the Court deferred to the regulatory authority of the Department of Health, Education and Welfare ("HEW"), and its first regulations in 1977 interpreting the Rehabilitation Act of 1973.[130] The HEW regulations defined the phrase "physical or mental impairment" to encompass the following two components:

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126. *See Abbott*, 118 S. Ct. at 2204-05.

127. *Id.* at 2202.

128. *Id.*

129. *Id.* (citing 42 U.S.C. § 12,201(a) (1994)). Justice Kennedy further explained that the similarity of language between the two statutes required the Court "to construe the ADA to grant at least as much protection as provided by the regulations implementing the Rehabilitation Act." *Id.*

130. *See id.*

> (A) [A]ny physiological disorder or condition, cosmetic disfigurement, or anatomical loss affecting one or more of the following body systems: neurological; musculoskeletal; special sense organs; respiratory, including speech organs; cardiovascular; reproductive; digestive; genito-urinary; hemic and lymphatic; skin; and endocrine; or (B) any mental or psychological disorder, such as mental retardation, organic brain syndrome, emotional or mental illness, and specific learning disabilities.[131]

The dispute really focused not on the previous definitions, but rather on the list of examples that accompanied the regulations. When HEW first issued the regulations, it decided not to include an explicit and comprehensive listing of specific disorders that would qualify as "physical or mental impairment[s]," opting instead to give just a framework of examples. The HEW clearly feared that a specific list would prove too narrow, as medicine and technology continue to make rapid advances in this field of public health and epidemiological research.[132]

Despite these intentions, the comments included with the regulations contained the following list of the representative population of disorders, conditions, and diseases that would meet the definition of "physical impairment": orthopedic diseases; visual, speech, and hearing impairments; cerebral palsy; epilepsy; muscular dystrophy; multiple sclerosis; cancer; heart disease; diabetes; mental retardation; emotional illnesses; and substance problems, such as drug and alcohol addiction.[133] Notice that AIDS and HIV are conspicuously absent from this listing. Today, the Justice Department bears the responsibility for these regulations, even though the HEW definitions remain in force.[134] These regulations, along with the representative condition and disease listing, remain intact.[135]

Not surprisingly, the Court's analysis continues to progress to deeper levels, given that neither HIV infection nor AIDS is explicitly mentioned in the listing incorporated in these regula-

131. 45 C.F.R. § 84.3(j)(2)(i) (1998).

132. *See Abbott*, 118 S. Ct. at 2202 (citing 42 Fed. Reg. 22,685 (1977), *reprinted in* 45 C.F.R. pt. 84, app. A, at 334 (1997)).

133. *See id.*

134. *See id.* at 2203.

135. *See id.* (citing 28 C.F.R. § 41.31(b)(1) (1997)).

tions. Justice Kennedy, however, wrote that the "HIV infection does fall well within the general definition set forth by the regulations."[136] To Kennedy, the fact that the virus begins to wreak havoc immediately on the patient's white blood cells, as well as the overall severe consequences of the disease, which almost certainly ends in death, lends support to the holding that HIV is "an impairment from the moment of infection."[137] Kennedy emphasized the immediate, drastic, and detrimental effects of the virus on the infected person's physiological health, such as the hemic and lymphatic systems.[138] In an effort to foreclose any doubt of HIV's satisfaction of the statutory criteria, Kennedy wrote, in summary, "[the] HIV infection satisfies the statutory and regulatory definition of a physical impairment during every stage of the disease."[139]

4. The Third Tier in the Majority's ADA Interpretation

The third tier complicated the analysis further by incorporating "major life activity" into the impairment discussion; for, it is not until the impairment impacts such an activity that the "disability" definition is satisfied.[140] The Court focused on reproduction as the only subset of "major life activity" because Abbott identified procreation as the area of her allegedly perceived impairment. Perhaps an alternate "major life activity" would have merited the Court's attention and persuaded the justices to decide differently, had the litigants presented other such arguments.

The Court then examined the issue of whether reproduction qualified as "a major life activity" when it granted certiorari.[141] Justice Kennedy quickly dismissed any notions of interpretative complexity or ambiguity with his succinct conclusion that "[r]eproduction falls well within the phrase 'major life activity,'" as "[r]eproduction and the sexual dynamics surround-

136. *Id.*
137. *Id.* at 2204.
138. *See id.*
139. *Id.*
140. *See id.* at 2205.
141. *See id.* at 2205-06.

ing it are central to the life process itself."[142] The "Rehabilitation Act regulations support the inclusion of reproduction as a major life activity, since reproduction could not be regarded as any less important than working and learning."[143] Kennedy was also quick to point to signaling terms like "such as," before the regulation's listing to disclaim any notion of coverage exhaustion.[144]

5. The Fourth Tier of the Majority's ADA Interpretation

The fourth tier of the ADA's "disability" definition analysis involved whether Abbott's particular "physical impairment" was a substantial limitation on the particular "major life activity" she identified—reproduction.[145] The Court held that Abbott's infection restricted her ability to have children in two ways. First, Justice Kennedy mentioned the significant risks that an HIV-positive woman takes, carries, and potentially imposes on her male partner when she tries to conceive. He highlighted a statistic that predicted a "[twenty-five percent] risk of female-to-male transmission" according to the cumulative results of more than a dozen national studies.[146] Second, Justice Kennedy discussed the possibility of perinatal transmission of HIV, which is the risk that a woman faces of infecting her newborn child with the disease during either the gestation period or childbirth process. Kennedy cited statistical support in published studies that confirmed the accuracy of a twenty-five percent risk of transmission of the virus from mother to child during the birth process.[147]

Throughout the substantial limitation discussion, Justice Kennedy was careful to point out that the ADA addresses limi-

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142. *Id.* at 2205.

143. *Id.* (citing 45 C.F.R. § 84.3(j)(2)(ii) (1997)). "[F]unctions such as caring for one's self, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning, and working" are included in the representative listing. *Id.*

144. *See id.*

145. *See id.* at 2204-09.

146. *Id.* at 2206 (citation omitted).

147. *See id.* (citation omitted). Kennedy mentions that most studies fall "within the 25% to 30% range," out of a total of 13 studies that placed the risk between 14% at a minimum, and 40% at a maximum. *Id.* (citation omitted).

tations, but "not utter inabilities."[148] The Court's holding and rationale focused on the overall public health dangers as well as the economic and legal consequences that an HIV-positive woman must face if she decides to become a mother, rather than emphasizing the slight possibility that conception and childbirth are still possible for HIV patients through the use of antiretroviral therapy.[149] Foremost, Kennedy was quick to distinguish that the "disability" definition "does not turn on personal choice."[150] Rather, a plaintiff meets the significant limitation statutory hurdle upon proving that formidable difficulties exist but not by proving that the difficulties are insurmountable.[151]

Justice Kennedy also discussed the deference the Court must give to the truth of Abbott's testimony in the context of reviewing the appropriateness of granting summary judgment, remarking that "testimony from the respondent that her HIV infection controlled her decision not to have a child is unchallenged."[152] Kennedy clarified the developing precedent from the lower district court and court of appeals, concluding that, "no triable issue of fact impedes a ruling on the question of statutory coverage" of the ADA to Abbott's circumstances.[153] The Supreme Court ultimately held that Abbott's HIV infection fell within the statutory parameters of a "physical impairment" because it "substantially limit[ed] a major life activity, as the ADA defines it."[154]

The Court then turned to the discussion of the inclusion of asymptomatic HIV patients within the penumbra of these ADA statutory "major life activity" protections. Kennedy highlighted numerous regulatory agency decisions, opinions, and orders, as well as applicable case law from lower courts to support the

148. *Id.*

149. *See id.* Justice Kennedy discussed Bragdon's assertion that therapies such as antiretroviral therapy or drugs can lower the risk of transmission of AIDS from mother to child through the birth process. He cited statistics that equate the risk to as low as eight percent and implied that this relatively low figure cannot qualify as a substantial limitation to an HIV patient's reproductive lifestyle choices. *See id.*

150. *Id.*

151. *See id.*

152. *Id.*

153. *Id.* at 2207.

154. *Id.*

notion that asymptomatic HIV patients are covered under the ADA.[155] For example, the Office of Legal Counsel of the Department of Justice ("OLC")[156] issued a "comprehensive and significant" opinion in 1988 that concluded that the Rehabilitation Act protected "symptomatic and asymptomatic HIV-infected individuals against discrimination," years before the ADA was even signed into law by President Bush in 1990.[157] The OLC determined that HIV, even in its asymptomatic phases was a "physical impairment" under the Rehabilitation Act because it was a physiological disorder of the hemic and lymphatic systems.[158] The OLC further proclaimed that HIV positivity substantially impacts the reproductive activity of even asymptomatic patients: "HIV-infected individuals cannot, whether they are male or female, engage in the act of procreation with the normal expectation of bringing forth a healthy child."[159] Kennedy also referenced Surgeon General C. Everett Koop's letter that characterized HIV patients as "clearly impaired," even during asymptomatic phases of the disease.[160]

Similarly, agencies have continued to adhere to the conclusion that asymptomatic phases of the virus are also incorporated into the definitions within the ADA. The Comptroller General's Task Force on AIDS in the Workplace, the Presidential Commission on the Human Immunodeficiency Virus Epidemic, and the Department of Health and Human Services have all considered asymptomatic phases deserving of the same statutory protections as the final, most visible stages of the virus.[161]

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155. *See id.* at 2207-12.

156. *See id.* at 2207 (supplying the background information on the Office of Legal Counsel of the Department of Justice ("OLC"), namely that the OLC makes official determinations and publishes its opinions in the form of regulatory guidelines). The OLC views asymptomatic AIDS patients as disabled citizens, deserving of ADA statutory protection because at that stage, hemic and lymphatic systems are physically impaired, pregnancy is endangered, and sexual relations are threatened or limited due to contagion risks. *See id.*

157. *Id.* at 2207-08.

158. *See id.* at 2207.

159. *Id.* (citation omitted).

160. *See id.*

161. *See id.* (citing 5 C.F.R. § 1636.103 (1997); 7 C.F.R. § 15e.103 (1998); 22 C.F.R. § 1701.103 (1997); 24 C.F.R. § 9.103 (1997); 34 C.F.R. § 1200.103 (1997); 45 C.F.R. §§ 2301.103, 2490.103 (1997)).

C. *Majority Opinion Critique: Case-Specific Details that Chief Justice Rehnquist and Justices Scalia and Thomas Believe Undermine* Abbott's *Prima Facie Case*

Chief Justice Rehnquist believes that Justice Kennedy only tackled "half of the relevant question" when he considered whether Abbott's reproductive activity constituted a "major life activity" under the ADA.[162] Rehnquist was far more concerned with curtailing Abbott's arguments for a more liberal reading of the ADA and method of statutory interpretation, than he was with analyzing the risk assessments and "direct threat" arguments that Bragdon made. Chief Justice Rehnquist characterized Kennedy's analysis as a "truncat[ion of] the question" because he did not find "a shred of record evidence indicating that, prior to becoming infected with HIV, [Abbott's] major life activities included reproduction."[163] In his opinion, the Court too readily conceded that the petitioner satisfied her burden of proving each element of her prima facie case. The Chief Justice was unwilling to bend in his steadfast position that a sweeping, global incorporation of asymptomatic HIV-positive patients contravened the statute's underlying purpose.

Furthermore, Chief Justice Rehnquist argued, in the alternative, that reproduction was not a "major life activity" in the first place.[164] The Chief Justice stood firmly behind his reading of the trial record that the only indication the Court was provided of Abbott's HIV status affecting her reproductive decisions was the evidence that, "after learning of her HIV status, [Abbott], whatever her previous inclination, conclusively decided that she would not have children."[165] To Rehnquist, the respondent presented "absolutely no evidence that, absent

162. *Id.* at 2214 (Rehnquist, C.J., concurring in the judgment in part and dissenting in part) (arguing that the majority shortcut the requisite analysis with its truncated test for determining ADA statutory application and protection).

163. *Id.* at 2214-15 (Rehnquist, C.J., concurring in the judgment in part and dissenting in part).

164. *See id.* at 2215 (Rehnquist, C.J., concurring in the judgment in part and dissenting in part) (disagreeing with the classification of reproduction as an activity and disapproving of the Court's casual dismissal of Abbott's lacking evidentiary presentation on her particular lifestyle choices and timetables for reproduction).

165. *Id.* (Rehnquist, C.J., concurring in the judgment in part and dissenting in part).

the HIV, [she] . . . would have had or was even considering having children."[166] He was not willing to entertain alternative speculation or future predictions of Abbott's lifestyle and parenting decisions.

The Chief Justice deemed Abbott's argument that a "major life activity" determination should not involve the particular circumstances of each litigant's case as "inartful" and plagued with careless diction.[167] That analysis, to Rehnquist, was misclassified, as he considered reproduction to be a "process," rather than an "activity."[168] Finally, Chief Justice Rehnquist proffered that, even if he conceded reproduction was a "major life activity," he still failed to see the validity of Abbott's argument that her HIV condition "substantially limited" her ability to reproduce.[169] Rehnquist literally and narrowly interpreted the definitional sections of the ADA, and construed the verb tense and plain wording of the statute as absolutely critical to the Court's analysis. He, therefore, dismissed Abbott's arguments of future impaired delivery and parenting abilities, and pointed out that she did not establish any present hurdles to her reproductive capabilities.[170]

V. PRELIMINARY IMPACTS OF AND REACTIONS TO THE *ABBOTT* DECISION

A. *Strong Precedential Value of the Case*

Despite the underlying disparities and disagreements on the various levels of our nation's benches, the precedential value of this landmark case remains strong, as a growing consensus

166. *Id.* (Rehnquist, C.J., concurring in the judgment in part and dissenting in part).

167. *See id.* at 2215 n.2 (Rehnquist, C.J., concurring in the judgment in part and dissenting in part) (focusing on the semantics of the majority's classification of reproduction and major life activities for HIV patients).

168. *See id.* (Rehnquist, C.J., concurring in the judgment in part and dissenting in part).

169. *See id.* at 2216 (Rehnquist, C.J., concurring in the judgment in part and dissenting in part) (arguing that Abbott failed to prove that she would be unable to engage in sexual intercourse, become pregnant, carry the child to term, deliver the child, and then care for the child in a normal, competent capacity).

170. *See id.* (Rehnquist, C.J., concurring in the judgment in part and dissenting in part).

continues to build behind incorporating asymptomatic AIDS patients under the ADA. Justice Kennedy wrote that "[e]very court which addressed the issue before the ADA was enacted in July 1990 . . . concluded that asymptomatic HIV infection satisfied the Rehabilitation Act's definition of handicap."[171] He later enumerated a long list of cases in support of this proposition, from jurisdictions including Florida, California, and New York.[172] Perhaps the fact that AIDS had been around for nearly two decades,[173] combined with the available conflicting and ambiguous body of case law, was sufficient to convince the Court to step forward and offer overdue statutory interpretation and adjudication.

Clearly, the Supreme Court recognized the landmark precedential value that Abbott's case would have on this generation, as well as on those of the future, in terms of redefining social, moral, political, and even economic policy, if necessary, to provide proper accommodations for disabled citizens. The repeated remands of the case to lower courts to exhaust evidentiary procedures and to grant numerous opportunities to hear subsequent oral argument, evidence the thoroughness with which the nation's courts approached this issue. No justice or judge was prepared to expeditiously dismiss the case's treatment without first fully utilizing the judicial and administrative resources at hand.

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171. *Id.* at 2208 (concurring with the regulatory and agency authority at hand that asymptomatic HIV patients qualify as handicapped under the Rehabilitation Act, and then later, as disabled under the ADA).

172. *See id.* (citing Doe v. Garret, 903 F.2d 1455, 1457 (11th Cir. 1990), *cert. denied*, 499 U.S. 904 (1991); Ray v. School Dist., 666 F. Supp. 1524, 1536 (M.D. Fla. 1987); Thomas v. Atascadero Unified Sch. Dist., 662 F. Supp. 376, 381 (C.D. Cal. 1986); District 27 Community Sch. Bd. v. Board of Ed., 502 N.Y.S.2d 325, 335-37 (Sup. Ct. 1986)).

173. *See* Rubin, *supra* note 13, at 398. Rubin states:

> Since the first cases of acquired immune deficiency syndrome (AIDS) were reported on June 5, 1981, the human immunodeficiency virus (HIV), which is believed to cause AIDS, has had a profound impact both on the lives of those infected with the disease and on the lives of those who are not.

Id. (citation omitted).

B. *Anticipated Medical Community Reactions*

As a result of decisions like *Abbott v. Bragdon*, doctors and dentists alike will argue that they feel pressured to treat patients with contagious, infectious diseases, even at significant risk to themselves, their staffs, and other patients.[174] These providers will argue they would rather battle the dangerous microbiological hurdles and physiological threats, rather than risk exposure to the liability of a discrimination lawsuit because they allegedly treated a patient differently on the basis of the patient's disabled condition.[175] Therefore, as the liability base increases for doctors and dentists, there will probably be an increased push to study and research precautionary and safety measures, as well as to lower the costs of implementing those procedures associated with regulatory compliance.

Otherwise, many health care providers may face discrimination litigation if they do not adapt their facilities, services, and staff training policies and procedures to accommodate the increased demands and complexities of treating patients with infectious diseases. Ignorance and outdated technology, facilities, and training will no longer serve as adequate excuses for a doctor who chooses not to treat HIV-positive patients. Bragdon's costly litigation experience poignantly forewarns practitioners who choose to use a pretextual defense for failing to treat infectious patients. The federal courts are equating this case's factual scenario to an exercise of discrimination, rather than to a business, contractual, or professional judgment in a medical treatment context.

The doctor's freedom to contract and even his due process rights are potentially inhibited by legal mandates that he must treat HIV-positive patients just like all other patients, unless he can prove to the trier of fact that there was a significant

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174. *See* Brief for Petitioner, at 43-45, Bragdon v. Abbott, 118 S. Ct. 2196 (1998) (No. 97-156).

175. For cases involving doctors and health care providers potentially facing large liability exposure for alleged delays, pretextual referrals to specialists or other facilities, or refusals to treat HIV-positive patients, see Abbott v. Bragdon, 163 F.3d 87 (1st Cir. 1998); Doe v. Montgomery Hosp., No. 95-3168, 1996 WL 745524 (E.D. Pa. 1996); Sharrow v. Bailey, 910 F. Supp. 187 (M.D. Pa. 1995); Woolfolk v. Duncan, 872 F. Supp. 1381 (E.D. Pa. 1995); Howe v. Hull, 873 F. Supp. 72 (N.D. Ohio 1994).

risk that warranted a referral to a specialist.[176] In the alternative, only in the most severe cases would a complete refusal to treat patients with such compromised immune systems possibly suffice as an acceptable proof offering in this risk assessment.[177] Doctors face the uncertainties of malpractice insurance premium increases, personal liability, and related liability concerns that may arise out of agency, respondeat superior, or vicarious liability principles because of the decisions they make during the scope of their employment or private practice. Almost certainly, the "face" of medicine is changing from a contractual arrangement to more of a broadened level of professional service, in which the provider may indeed confront something similar to the common law duty to treat.

C. *Predicted Legal Response*

As the public's initial panic dissipates and media attention wanes with the increased prevalence of AIDS, legislators are apt to react rationally to policymaking in this difficult arena of a global public health pandemic. Perhaps, the legislative response will even rise to the level of proactivity. Conspicuous judicial cue cards might encourage broadened political and legislative interpretations of these initial statutory protections. If, however, the ambiguity in the ADA and its definitions continues to prove problematic,[178] it is likely the legislative response will answer the call for more explicit enumeration, explanation, and detail. Whether that response comes in the form of a listing or recognition of current regulatory authority remains to be seen. It would not be surprising though, to see some sort of amendment to the Americans with Disabilities Act of 1990 emerge. In particular, one potential amendment could explicitly include asymptomatic HIV-positive patients within the

176. *See generally* 42 U.S.C. § 12,113(a)-(b) (1994) (explaining that providers can use the protection of the health and safety of others as a valid defense in appropriate circumstances, when required to confront a disability discrimination allegation).

177. *See* Abbott v. Bragdon, 912 F. Supp. 580, 588-89 nn.10-11 (D. Me. 1995). ("In this case, however, neither the duration nor severity [of the transmission risk] outweigh the evidence as to how the disease is transmitted and the slight probability of transmission.").

178. See *supra* Part II of this note for a discussion of the ADA's most litigated provisions and the disparity in interpretations of these key provisions.

scope of the ADA's potential plaintiff class. Just as the insurance industry, medical professionals, health care facilities, and medical institutions struggle to learn how to adapt to meet the changing needs of these specialized patients, legislators and government officials will be forced to accommodate the complex needs of these disabled individuals, if they are to follow the direction provided them by the Rehabilitation Act of 1973 and subsequent legislation.

Litigation and common law will most likely enlarge the class of the potential plaintiffs to comply with the underlying policy goal of the protection of opportunities for disabled persons. The federal judiciary, with the exception of the Fourth Circuit,[179] stands poised to continue to apply the ADA's protective provisions to asymptomatic HIV patients.[180] Aside from the Fourth Circuit anomaly, many federal courts[181] regard HIV disease as a disability under the ADA or as a handicap under the Rehabilitation Act.[182] However, even the Fourth Circuit has not foreclosed the potential for asymptomatic patients to join the plaintiff class. The circuit's

> disagreement is rooted in its opinion that under the ADA, there are no per se disabilities . . . [and that] each individual condition must undergo an independent, case-by-case analysis of whether the condition is physically impairing and whether the impairment substantially limits one or more of the individual's major life activities.[183]

Although the class may not be firmly established and the requisite criteria for membership not so clearly defined, the potential to join the plaintiff pool is still a viable option for patients like Sidney Abbott.

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179. *See* Runnebaum v. NationsBank, 123 F.3d 156 (4th Cir. 1998). In this action the Fourth Circuit affirmed the district court's grant of summary judgment on the ground that the appellant-employee's asymptomatic human immunodeficiency virus (HIV) infection was not a disability contemplated by the ADA. *See id.* at 161.

180. *See* Carlis & McCabe, *supra* note 31, at 588-89.

181. *See, e.g.,* United States v. Morvant, 898 F. Supp. 1157, 1161-62 (E.D. La. 1995); Howe v. Hull, 873 F. Supp 72, 78 (N.D. Ohio 1994).

182. *See* Carlis & McCabe, *supra* note 31, at 589.

183. *Id.*

If we want to keep these specialized patients healthy, working, providing for their families, and contributing to our economies and societies for as long as humanly possible, we need to be willing to make some sort of legal provisions in the interim to help them meet these goals at their own levels of competency and feasibility. By recognizing that a greater portion of our society may now fit the definition of "disabled," we are making the requisite concessions to level the playing field so that citizens can have the same access to health, employment, recreation, and other forms of activities and services. The balancing of a person's access to these "major life activities" against the clinical and perceptual risks of treating infectious patients will certainly involve the cooperation of our legislators, medical providers, health care professionals, and the greater public.

VI. CONCLUSION

The ADA is not an easy statute to interpret, let alone to apply to complex practical situations. Sidney Abbott sought routine dental treatment in the form of a noninvasive procedure and received what she considered to be the discriminatory "runaround" in addition to a pretextual excuse for denying her dental treatment. Abbott disagreed with Dr. Bragdon that the particular risk assessment concerning the contagiousness and dangerous nature of her asymptomatic condition could be fairly and accurately determined from his spontaneous, biased, and entangled perspective. Rather, from her perspective as a patient, Abbott perceived a referral to either another facility or provider for a simple cavity-filling procedure as flatly unacceptable. Consequently, Abbott litigated to push for an objective determination of the threat of contagion,[184] so that she and other patients like her could continue to live their lives in as normal and undisturbed a manner as possible, given their terminal conditions with AIDS.

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184. *See* Bragdon v. Abbott, 118 S. Ct. 2196, 2210 (1998) ("The existence . . . of a significant risk must be determined from the standpoint of the person who refuses the treatment or accommodation, and the risk assessment must be based on medical or other objective evidence.").

Abbott fought to define a potential plaintiff class of HIV-positive patients deserving full statutory protection under the broad guarantees of the ADA. Abbott battled the discrimination and stigma of individuals like Bragdon, and struggled to assign legal liability to those ignoring the protections due her under the long arms of applicable federal statutes. Because of her efforts, our legislators and judges will probably mirror the commitments of medical researchers and patient advocates, who press daily for a fast-paced approach to treating, and ultimately, curing, this overwhelming health pandemic.

Lisa Taylor Hudson