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"SUBSTANTIALLY LIMITED:" THE REPRODUCTIVE RIGHTS OF WOMEN LIVING WITH HIV/AIDS

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Women living with HIV/AIDS are frequently marginalized because of gender, health status, and, often, socioeconomic class. This Article explores the tension between the law and reproductive rights of women living with HIV/AIDS by analyzing both legal precedents and the evolving public health understanding of HIV/AIDS and reproduction. Of pivotal importance is the 1998 United States Supreme Court's decision in *Bragdon v. Abbott*,[1] which, while providing protection for people with HIV/AIDS under the Americans with Disabilities Act of 1990 (ADA), inadvertently served to perpetuate a damaging stigma against women with HIV/AIDS who choose to reproduce.

This Article explores the societal and legal consequences of *Bragdon* and examines the way in which the law is out of step with medical advancements regarding HIV/AIDS treatment and mother-to-child transmission. The Article also considers obstacles women with HIV/AIDS face in medical contexts and their impact on the choice to reproduce, while proposing measures to ameliorate these problems. Finally, the Article considers the potential implications of the ADA Amendments Act of 2008 (ADAAA) and how it may influence courts' future interpretations of *Bragdon*. It also discusses why Congress, when passing the ADAAA, should have explicitly

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1. 524 U.S. 624 (1998).

addressed *Bragdon* to combat the stigma surrounding HIV/AIDS and reproduction.

I. INTRODUCTION

In 2009, a woman was six months pregnant in New York City.[2] She went to her normally scheduled prenatal appointment and was tested for HIV.[3] She discovered that she not only had HIV but full-blown AIDS, having only six CD4 cells.[4] Panicked, her obstetrician initially did not feel comfortable treating her in this condition.[5] The woman then attempted to see an HIV/AIDS physician, and, after sitting in the waiting room for hours, she was informed that the doctor would not treat her because she was pregnant.[6] Ultimately, with the help of a community-based organization, an infectious disease specialist collaborated with the woman's obstetrician and, together, they administered the proper prenatal and postnatal protocol to prevent perinatal, or mother-to-child, transmission.[7] After a course of antiretroviral (ARV) therapy and a caesarean section procedure, the woman delivered a healthy, HIV-negative child.[8] While this woman eventually received appropriate medical treatment, the obstacles she overcame stem from a stigma surrounding HIV/AIDS and reproduction.

Eleven years earlier, in 1998, the Supreme Court decided *Bragdon v. Abbott*,[9] taking seemingly progressive steps to prevent this very type of discrimination from occurring—discrimination against people living with HIV/AIDS by denying them appropriate medical treatment.[10] In *Bragdon*, Sidney Abbott, a woman living with HIV, brought an action against her dentist, Randon Bragdon, under the ADA,[11] because Bragdon refused to treat her in his office.[12] After the

2. Telephone Interview with Michelle Lopez, Treatment Educator, Cmty. Healthcare Network of New York City (Dec. 2, 2009) [hereinafter Lopez Interview].
3. *Id.*
4. *Id.* CD4 cells, also known as T cells, are part of the immune system that defends against infection. When a person's CD4 cell count drops below 200, that person's HIV has developed into AIDS. *See* Dep't of Health and Human Servs.: Ctrs. for Disease Control and Prevention, *Living with HIV/AIDS*, http://www.cdc.gov/hiv/resources/brochures/livingwithhiv.htm (last visited Mar. 9, 2010).
5. *See* Lopez Interview, *supra* note 2.
6. *See id.*
7. *See id.*
8. *Id.*
9. 524 U.S. 624 (1998).
10. *See generally id.* at 637, 641–46 (using a number of different sources to confirm that HIV is a handicap that warrants statutory coverage).
11. 42 U.S.C. §§ 12101-12213 (1990).

lower courts granted summary judgment in favor of Abbott,[13] Bragdon appealed, and the Supreme Court granted certiorari to hear the case.[14] The case posed two questions: (1) was Abbott's HIV-positive status considered a disability under the ADA?;[15] and, if so, (2) could Bragdon have refused treatment if her HIV posed a "'direct threat to the health or safety of others[?]'"[16] The Court, in an opinion delivered by Justice Kennedy, held that Abbott's HIV-positive status, although asymptomatic at the time, was considered a disability under the ADA because it was "a physical . . . impairment that substantially limit[ed] one or more of [her] major life activities."[17]

The *Bragdon* Court easily found that HIV was considered a physical impairment under the regulations issued by the Department of Health and Human Services.[18] However, in order to rise to the level of a disability under the ADA, the impairment had to substantially limit a major life activity.[19] After a lengthy analysis, the Court subscribed to Abbott's argument that her HIV-positive status substantially limited her ability to reproduce,[20] and that reproduction

12. *Bragdon*, 524 U.S. at 629. Bragdon informed Abbott "of his policy against filling cavities of HIV-infected patients." *Id.*

13. The United States District Court for the District of Maine granted summary judgment in favor of plaintiff, Abbott. Abbott v. Bragdon, 912 F.Supp. 580, 584 (D. Me. 1995), *aff'd*, 107 F.3d 934 (1st Cir. 1997). The United States Court of Appeals for the First Circuit affirmed the district court's ruling. Abbott v. Bragdon, 107 F.3d 934, 937, 949 (1st Cir. 1997), *vacated*, 524 U.S. 624 (1998).

14. *Bragdon*, 524 U.S. at 628.

15. *Id.* at 630–631.

16. *Id.* at 648 (quoting 42 U.S.C. § 12182(b)(3) (1990)).

17. *Id.* at 630. The 1990 ADA provides other provisions under which a person may be considered to have a disability. In addition to having a physical impairment, one could have a mental impairment that substantially limits a major life activity. 42 U.S.C. § 12102(2)(A) (2005). A person could have a record of a physical or mental impairment that substantially limits a major life activity. *Id.* § 12102(2)(B). Moreover, if a person does not have a physical or mental impairment that substantially limits a major life activity, but that person is regarded as having such an impairment, the individual is considered to have a disability under the ADA. *Id.* § 12102(2)(C).

18. *See Bragdon*, 524 U.S. at 637. The Department of Health and Human Services' definition of "physical impairment" is the same as that in the regulations set forth by the Department of Health, Education, and Welfare (HEW), issued in 1977, interpreting the Rehabilitation Act of 1973, which has largely been incorporated into the ADA. *Id.* at 632.

19. *See id.* at 637. "The statute is not operative, and the definition not satisfied, unless the impairment affects a major life activity." *Id.*

20. *See id.* at 641. Abbott testified that she chose not to have a child specifically because she had HIV. *Id.*

was a "major life activity" for purposes of the ADA.[21] In his opinion, Justice Kennedy qualified the Court's holding by noting that, while the Court could have decided whether or not HIV substantially limited other major life activities, its proverbial hands were tied to decide the case on reproduction grounds specifically.[22] Justice Kennedy explained:

> Given the pervasive, and invariably fatal, course of the disease, its effect on major life activities of many sorts might have been relevant to our inquiry. [Abbott] and a number of *amici* make arguments about HIV's profound impact on almost every phase of the infected person's life. In light of these submissions, it may seem legalistic to circumscribe our discussion to the activity of reproduction. We have little doubt that had different parties brought the suit they would have maintained that an HIV infection imposes substantial limitations on other major life activities.
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> From the outset, however, the case has been treated as one in which reproduction was the major life activity limited by the impairment. It is our practice to decide cases on the grounds raised and considered in the Court of Appeals and included in the question on which we granted certiorari.[23]

The Court proceeded to deem reproduction a major life activity;[24] the crux of the case rested upon whether Abbott's physical impairment substantially limited reproduction.[25] By aligning itself with the statutory framework provided in the 1990 ADA,[26] the Supreme Court held that the ADA protected Abbott because her HIV-positive status substantially limited her ability to reproduce.[27] While *Bragdon* resulted in a fortuitous outcome, the reasoning behind it contributed to divergent lower court findings.[28] Moreover, *Bragdon*

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21. *Id.* at 641.
22. *Id.* at 637–38.
23. *Id.* (citations omitted).
24. *Id.* at 639.
25. *Id.* at 639–40.
26. *See id.* at 629–32.
27. *See id.* at 624–25.
28. *See infra* Part II. *Compare* Blanks v. Sw. Bell Commc'ns, 310 F.3d 398 (5th Cir. 2002) (finding that an HIV-positive male employee was not physically disabled under the ADA), *with* Teachout v. New York City Dep't of Educ., No. 04 Civ. 945 (S.D.N.Y. Feb. 22, 2006), 2006 WL 452022 (finding that a reasonable trier of fact could conclude that HIV substantially limited a male employee's ability to reproduce).

inadvertently supported the notion that women with HIV/AIDS should not reproduce.[29]

This Article discusses how the *Bragdon* reproduction standard not only gave rise to legal inconsistencies but also allowed for further stigmatization of women with HIV/AIDS who choose to reproduce. This stigma has little basis in public health and perpetuates both gender and socioeconomic discrimination. Part II of this Article discusses how *Bragdon*'s reproduction standard influenced other courts to view ADA protection of people living with HIV/AIDS primarily in the context of reproduction, leading to divergent results.[30] Part III demonstrates how, regardless of lower courts' interpretations, the reproduction standard did not fully reflect public health reality in 1998 when *Bragdon* was decided.[31] Part IV addresses how *Bragdon*'s framework has become more and more outdated in the context of current public health data.[32] Part V steeps the discussion of law and public health in reality, addressing the reasons why women with HIV/AIDS choose—or choose not—to reproduce and the social determinants of health that play a role in their medical care, or lack thereof.[33] It proceeds to propose collaborative efforts that could be made between HIV/AIDS physicians and obstetricians to provide optimal health care. Part VI discusses potential legal solutions, and potential problems, posed by the ADAAA, in protecting women with HIV/AIDS who reproduce.[34] Finally, Part VII reaffirms the notion that women with HIV/AIDS should not be "substantially limited" from making their own reproductive choices.[35]

Public health scholars such as Lawrence Gostin and James Hodge have articulated the need for feminist legal theory to address the reality many women living with HIV/AIDS face:

> Feminist theories, despite all of their degrees and differences, agree that "*the evaluation of medical practices must give* primary *attention to the impact of such practices on women*—not just on individual women but on women as a group, including especially disadvantaged women such as

29. *See Bragdon*, 524 U.S. at 639.
30. *See infra* Part II.
31. *See infra* Part III.
32. *See infra* Part IV.
33. *See infra* Part V.
34. *See infra* Part VI.
35. *See infra* Part VII.

> poor women and women of color." . . . [W]omen have been viewed as "vectors" of disease who infect unsuspecting men or children. The rise of heterosexual and vertical transmission of HIV was attributed in part to women. And like other high-risk groups, HIV-positive women became silent victims of the disease . . . .[36]

This Article expounds upon this assertion by addressing how women with HIV/AIDS are marginalized. It seeks to remedy this marginalization by proposing legal and jurisprudential changes that support the notion that all women have the right to choose whether or not to reproduce.

II. COURTS' INCONSISTENT INTERPRETATIONS OF *BRAGDON*'S REPRODUCTION STANDARD

By stating that having HIV/AIDS substantially limits a woman's ability to reproduce, the *Bragdon* Court created a standard that undercut its own goal—it invoked the ADA to protect a woman living with HIV from being discriminated against in a medical setting, but it simultaneously established a framework under which medical professionals could discriminate against women with HIV/AIDS in the context of reproduction.[37] When authoring the *Bragdon* opinion, Justice Kennedy went out of his way to mention that *Bragdon* could have been decided on grounds other than reproduction, and that if another plaintiff had brought the case, he or she could have argued that HIV/AIDS substantially limited a different major life activity.[38] His view was correct; reliance on the *Bragdon* reproduction standard does not sufficiently protect everyone living with HIV/AIDS. Despite Justice Kennedy's intentions, however, lower courts have largely adhered to the reproduction standard when determining whether HIV/AIDS is a disability under the ADA.[39]

United States v. Happy Time Day Care Center,[40] a district court case decided while *Bragdon* was in flux,[41] demonstrated the difficulty

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36. Lawrence O. Gostin & James G. Hodge, Jr., *Piercing the Veil of Secrecy in HIV/AIDS and Other Sexually Transmitted Diseases: Theories of Privacy and Disclosure in Partner Notification*, 5 DUKE J. GENDER L. & POL'Y 9, 70–71 (quoting Karen Lebacqz, *Feminism and Bioethics: An Overview*, SECOND OPINION, Oct. 1991, at 11, 12).

37. *See* Bragdon v. Abbott, 524 U.S. 624, 641, 655 (1998).

38. *Id.* at 637–38.

39. *See, e.g.*, Cruz Carillo v. AMR Eagle, Inc., 148 F. Supp. 2d 142, 144 (D. P.R. 2001).

40. 6 F. Supp. 2d 1073 (W.D. Wis. 1998).

of using the reproduction standard for HIV/AIDS-related ADA cases.[42] In *Happy Time Day Care*, a case alleging discrimination against a five-year-old boy living with HIV, the court held that using the reproduction standard then-posed by *Bragdon*[43] would be problematic.[44] It determined that "[t]he correct and more logical application is to start by identifying those activities that are important in the life of [the boy]. Procreation does not make this list."[45] Basing its analysis on major life activities important to a small child, the court ultimately determined that a genuine issue of material fact existed as to whether the boy was disabled under the ADA because his HIV substantially limited his ability to care for himself.[46] Consequently, it denied the defendants' motion for summary judgment.[47] While the *Happy Time Day Care* court rationally related the facts of the matter to the goals of the ADA, the court may have decided differently if the case had occurred a few months later. After *Bragdon*, the court might have felt compelled to apply the reproduction standard to this situation, and, consequently, it might have found that the boy was not protected under the ADA.

Shortly after *Bragdon* was decided, one commentator recognized how the case could produce problematic results in lower courts: "[B]y basing its decision on the 'major life activity' of reproduction, the Court creates a new category of individuals whom it will consider disabled—a category that does not adequately protect those with HIV . . . ."[48] This commentator's observation portends the inconsistent and sometimes peculiar applications of the reproduction standard established in *Bragdon*.

Some lower courts applied the reproduction standard broadly, expanding the boundaries of the ADA beyond HIV/AIDS, to protect anyone who encountered problems reproducing.[49] In HIV/AIDS-

41. The Supreme Court heard oral arguments for *Bragdon* on March 30, 1998, and decided it on June 25, 1998. *Happy Time Day Care* was decided on April 13, 1998.
42. *See Happy Time Day Care*, 6 F. Supp. 2d at 1078–80.
43. Abbott v. Bragdon, 107 F.3d 934 (1st Cir. 1997), *cert. granted*, 524 U.S. 624 (1998).
44. *Happy Time Day Care*, 6 F. Supp. 2d at 1078–80.
45. *Id.* at 1080.
46. *Id.* at 1081.
47. *Id.* at 1084.
48. Christiana M. Ajalat, Note, *Is HIV Really a "Disability"?: The Scope of the Americans with Disabilities Act after* Bragdon v. Abbott, *118 S. Ct. 2196 (1998)*, 22 HARV. J.L. & PUB. POL'Y 751, 760 (1999).
49. *See, e.g.*, LaPorta v. Wal-Mart Stores, Inc., 163 F. Supp. 2d 758 (W.D. Mich. 2001) (holding that a genuine issue of material fact existed as to whether a female employee's infertility was a disability under the ADA and whether the woman's

related cases, some courts found that Abbott's *choice* not to procreate was the deciding factor in determining whether her HIV substantially limited her major life activity of reproduction.[50] Therefore, courts did not always find that people with HIV/AIDS were protected against discrimination under the ADA.[51] For instance, in *Blanks v. Southwest Bell Communications, Inc.*,[52] the United States Court of Appeals for the Fifth Circuit affirmed a district court decision that a male plaintiff living with HIV was not considered disabled under the ADA because he and his wife had previously decided not to have children, and his wife had undergone a procedure to prevent her from becoming pregnant.[53] Similarly, in *Gutwaks v. American Airlines, Inc.*,[54] a district court ruled that a homosexual man living with HIV was not disabled because, since he had no intention of having children, his HIV did not limit a major life activity.[55] In both *Blanks* and *Gutwaks*, if the plaintiffs had merely expressed a desire to have children before being diagnosed with HIV, they would have been deemed disabled under the ADA.[56] However, because these plaintiffs did not choose, or at least express a desire, to reproduce, they somehow became less worthy of protection and more vulnerable to discrimination.

Other courts have applied the reproduction standard differently. In *Teachout v. New York City Department of Education*,[57] a district court held that a plaintiff's HIV infection was a disability under the

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employer was obligated to provide reasonable accommodations for her to receive infertility treatment).

50. *E.g.*, Worster v. Carlson Wagon Lit Travel, Inc., 353 F. Supp. 2d 257, 265–66 (D. Conn. 2005).

51. Gutwaks v. Am. Airline, Inc., No. 3:98-CV-2120-BF, 1999 WL 1611328, at *4 (N.D. Tex. Sept. 2, 1999); Cruz Carillo v. AMR Eagle, Inc., 148 F. Supp. 2d 142, 144–46 (D. P.R. 2001); Blanks v. Sw. Bell Commc'ns, Inc., 310 F.3d 398, 401 (5th Cir. 2002).

52. 310 F.3d 398.

53. *Id.* at 401. The court stated that in *Sutton v. United Airlines, Inc.*, 527 U.S. 471 (1999), the Court considered the "hemic and lymphatic" systems "major life activities." *Blanks*, 310 F.3d at 401. However, the *Sutton* Court actually stated that "[u]nder the regulations, a '*physical impairment*' includes '. . . anatomical loss affecting one or more of the following body systems: . . . hemic and lymphatic.'" 527 U.S. at 479–480 (emphasis added). If the court had actually determined that the proper functioning of the hemic and lymphatic systems were major life activities, it may have found that the plaintiff's HIV substantially limited these systems and therefore limited a major life activity.

54. 1999 WL 1611328.

55. *Id.* at *4.

56. *See Blanks*, 310 F.3d at 401; *Gutwaks*, 1999 WL 1611328 at *4–5.

57. No. 04 Civ. 945, 2006 WL 452022 (S.D.N.Y. Feb. 22, 2006).

ADA because it substantially limited his ability to reproduce.[58] The plaintiff in *Teachout* did not even mention the issue of reproduction during his deposition.[59] Nevertheless, the court applied the reproduction standard to his situation, stating that "the Supreme Court has acknowledged the abundance of medical evidence showing that the HIV infection substantially limits the ability to reproduce as a general matter, and [plaintiff] is not required to reinvent that wheel in response to [defendant's] motion for summary judgment."[60] Although the court acknowledged that the *Bragdon* Court had declined to consider whether HIV was a disability *per se*, it ultimately decided that the *Bragdon* Court made it clear that the plaintiff should be protected under the ADA because his HIV affected his physical ability to reproduce.[61]

The *Teachout* court dispelled the notion that personal choice was the determining factor, stating that "[i]t is not necessary for a plaintiff to want to have children, or for a plaintiff to plan to have children, to show that his *ability* to have children has been substantially limited by infection with HIV."[62] However, the court subsequently distinguished personal choice from physical ability:

> If, however, a plaintiff were to claim that his HIV infection substantially limited his ability to reproduce, but the evidence in the record showed that he was physically incapable of reproduction for reasons unrelated to his HIV-positive status, such as a voluntary irreversible sterilization, then in that case, the plaintiff would not have a disability under the ADA.[63]

While the court departed from the *Blanks* personal choice standard, its interpretation of *Bragdon* was nevertheless problematic because it excluded some people living with HIV/AIDS solely because they had been physically unable to reproduce before having HIV.[64]

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58. *Id.* at *8.
59. *Id.* at *7.
60. *Id.*
61. *See id.* at *7–8. The court also stated that plaintiff's "failure to mention reproduction at his deposition is not evidence that he carries some previously unknown strain of the disease, one that does not affect the ability to reproduce." *Id.* at *7.
62. *Id.* at *7.
63. *Id.*
64. *See* discussion *infra* Part IV (explaining the problematic nature of the *Bragdon* standard).

The aforementioned cases address discrimination allegations in employment settings and some places of public accommodation,[65] but courts have also applied the *Bragdon* standard in cases involving HIV/AIDS-based discrimination in other places of public accommodation, such as doctors' offices and hospitals.[66] Most notably, the *Bragdon* standard was applied in *Lesley v. Hee Man Chie*,[67] where a woman living with HIV brought a discrimination claim against her obstetrician for transferring her to a different hospital for prenatal care, labor, and delivery.[68] Here, the First Circuit[69] did not grapple with whether the plaintiff was disabled, because the parties did not dispute this issue.[70] In fact, the court cited *Bragdon* to conclude that "Lesley's HIV-positive status is a disability for purposes of the [Rehabilitation] Act."[71] The *Lesley* court's reliance on *Bragdon* presented a peculiar dichotomy. It maintained

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65. The setting in *Happy Time Day Care* is considered a public accommodation. *See* 42 U.S.C. § 12181(7)(K) (2006) (defining day cares as public accommodations). Also, most employers are covered entities under the ADA. *See* 42 U.S.C. § 12111(5) (2006). While this Article primarily discusses HIV/AIDS-related ADA discrimination in medical settings, the discussed cases are relevant because this Article focuses on the definition of disability under the ADA, which is the same in both employment settings and other places of public accommodation.

66. *See* 42 U.S.C. § 12181(7)(F) (providing that public accommodations include a "professional office of a health care provider, hospital, or other service establishment").

67. 250 F.3d 47, 56–57 (1st Cir. 2001).

68. The plaintiff sued under the 1990 ADA, section 504 of the 1973 Rehabilitation Act, and the Massachusetts Public Accommodations Statute, but she ultimately stipulated to dismissal of the ADA claim. *Id.* at 51. This case was decided under the Rehabilitation Act because the hospital was a place that received federal funding. Disability Rights Section, U.S. Department of Justice, A Guide to Disability Rights Laws (Sept. 2005), *available at* http://www.ada.gov/cguide.htm. The court therefore examined the definition of disability under the Rehabilitation Act. 29 U.S.C. § 701, *et seq.* (1973). The *Lesley* court's use of the Rehabilitation Act as the ground upon which to bring a disability claim does not diffuse the applicability of this case when examining the ADA's definition of disability. Indeed, "[t]he ADA's definition of disability is drawn almost verbatim from the definition of 'handicapped individual' included in the Rehabilitation Act of 1973 . . . . Congress' repetition of a well-established term carries the implication that Congress intended the term to be construed in accordance with pre-existing regulatory interpretations." Bragdon v. Abbott, 524 U.S. 624, 631 (1998). *See also id.* at 645 (stating that "repetition of the same language [from the Rehabilitation Act] in a new statute [the 1990 ADA] indicates, as a general matter, the intent to incorporate its administrative and judicial interpretations as well.").

69. This court also decided *Abbott v. Bragdon*, 107 F.3d 934 (1st Cir. 1997), *cert. granted*, 524 U.S. 624.

70. *Lesley*, 250 F.3d at 53.

71. *Id.* (citing *Bragdon*, 524 U.S. at 631).

that the plaintiff's HIV substantially limited her ability to reproduce.[72] However, the plaintiff's complaint centered on her obstetrician's refusal to treat her like every other pregnant patient, implying that her HIV status should *not* have affected her ability to reproduce.[73] Put another way, the plaintiff defined herself as substantially limited in reproducing, yet she wanted her obstetrician not to view her as such when she was pregnant.[74] Thus, *Lesley* epitomizes the incongruity of the reproduction standard, specifically in situations when a woman with HIV/AIDS is attempting to reproduce.[75]

One commentator expounds upon this paradox when discussing potential legal issues surrounding assisted reproductive technologies (ARTs) for women with HIV/AIDS or other physical impairments that hinder reproduction:[76]

> Under a narrow reading of *Bragdon*, a court might find that a medical condition "substantially limits" reproduction for a particular individual only if the condition's reproductive risks lead that person to refrain from having children. If proof of the specific plaintiff's unwillingness to reproduce is necessary to establish a reproductive disability under *Bragdon*, persons seeking to have children through ARTs

72. *See id.* at 58.

73. *See id.* at 53.

74. The court ultimately decided that the doctor had not discriminated against the patient because he transferred the patient to a hospital that was better versed in HIV-related prenatal care in 1994, when the plaintiff was pregnant. *See id.* at 56. It distinguished the case from *Bragdon* because the doctor did not try to argue that the patient's HIV posed a direct threat to him or to others. *See id.* at 57. Rather, the court decided the doctor's decision to transfer the patient was in the best interest of the patient, and no discriminatory pretext existed in the case. *See id.* at 57–58.

75. *See* Ajalat, *supra* note 48, at 764–65 (stating that under the *Bragdon* standard, an HIV-infected mother has a decisional disability and not a physical disability).

76. The term "assisted reproductive technologies" is also referred to as ARTs. *Assisted Reproductive Technology: Home*, Ctrs. for Disease Control and Prevention, http://www.cdc.gov/ART/ (last visited Mar. 9, 2010); *see also* Carl H. Coleman, *Conceiving Harm: Disability Discrimination in Assisted Reproductive Technologies*, 50 UCLA L. REV. 17, 19 (2002). The most common methods of ARTs have included assisted insemination, assisted ovulation, and in vitro fertilization. *Id.* at 22–23 (citing N.Y. STATE TASK FORCE ON LIFE & THE LAW, ASSISTED REPRODUCTIVE TECHNOLOGIES: ANALYSIS AND RECOMMENDATIONS FOR PUBLIC POLICY 43–60 (1998)).

> could not claim they are disabled because they have medical conditions associated with reproductive risks.[77]

This scenario is quite circular. If a woman with HIV/AIDS would like to reproduce, and a medical provider refuses to assist her, she may have no recourse because she is specifically claiming that her HIV status does not substantially limit her ability to reproduce.[78] Since her argument would not fall under the *Bragdon* reproduction framework, a court might not find that she has a disability, and she might not be protected under the ADA. This situation is clearly a problematic one, one that undermines the precise purpose of the ADA.

III. THE REPRODUCTION STANDARD FROM A 1998 PUBLIC HEALTH STANDPOINT

The *Bragdon* Court stated that "an HIV-infected woman's ability to reproduce is substantially limited in two independent ways: If she tries to conceive a child, (1) she imposes on her male partner a statistically significant risk of becoming infected; and (2) she risks infecting her child during gestation and childbirth, *i.e.*, perinatal transmission."[79] Reliance on these risks as the sole reasons why a person with HIV/AIDS is disabled under the ADA is both misleading and stigmatizing.[80] The *Bragdon* Court emphasized the importance of looking to public health authorities to determine whether Bragdon's refusal to treat Abbott in his dentist office was a reasonable choice.[81] To follow the *Bragdon* Court's rationale, this Article will examine HIV/AIDS and reproduction in the context of public health.

A. Partner Transmission Data: 1998

When discussing the risk of female-to-male partner transmission, the *Bragdon* Court cited "[c]umulative results of 13 studies collected in a 1994 textbook on AIDS" to conclude "that 20% of male partners of women with HIV became HIV-positive themselves."[82] The Court

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77. Coleman, *supra* note 76, at 35.
78. *Id.*
79. Bragdon v. Abbott, 524 U.S. 624, 625 (1998).
80. *See* discussion *infra* Part IV.
81. *Bragdon*, 524 U.S. at 650 ("In assessing the reasonableness of petitioner's actions, the views of public health authorities, such as the U.S. Public Health Service, CDC, and the National Institutes of Health, are of special weight and authority." (citing Sch. Bd. of Nassau City v. Arline, 480 U.S. 273, 288 (1987))).
82. *Id.* at 639.

emphasized the transmission risk women posed to men, when in reality, according to public health data published in 1998, the very year *Bragdon* was decided, "[t]he rate of transmission of HIV from male to female [was] two to three [times] higher than that from female to male."[83] Both biological[84] and socio-cultural gender differences contributed—and still contribute—to this reality.[85] In the United States:

> From a biological perspective, women have an elevated risk . . . of contracting disease within the context of a heterosexual relationship. . . . This increased biological risk also can be seen epidemiologically. Women currently comprise one of the fastest growing groups of people with HIV/AIDS, with increased infection rates seen most heavily among minority women.[86]

From a socio-cultural standpoint:

> [W]omen are essentially at more risk because of the conditions in cultures and communities that remove their control over their own bodies. Women are often blamed incorrectly as the source of HIV infection . . . . Conversely, many more women are monogamous, but are at high risk due to the sexual behavior of their male partner.[87]

Even based on 1994 public health data, it is not at all clear that the *Bragdon* Court's assumption that the risk of female-to-male transmission during heterosexual intercourse substantially limits a person's ability to reproduce.[88] Well before 1998, ARTs were

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83. JAMES MCINTYRE, HIV IN PREGNANCY: A REVIEW 6, *available at* http://data.unaids.org/Publications/IRC-pub01/jc151-hiv-in-pregnancy_en.pdf (written in conjunction with a working group on HIV and pregnancy, composed of staff of the World Health Organization's Reproductive Health Programme and the Joint United Nations Programme on HIV/AIDS (UNAIDS)). While this review provides an analysis of women and HIV/AIDS in an international context, it demonstrates the reality in the United States as well.

84. Biologically, in women, the "Langerhans' cells of the cervix may provide a portal of entry for HIV and it has been suggested that some HIV serotypes may have higher affinity for these, and therefore to be more efficient in heterosexual transmission." *Id.*

85. *Id.*

86. Gostin & Hodge, *supra* note 36, at 68 (footnotes omitted).

87. MCINTYRE, *supra* note 83, at 7.

88. For a discussion of the Court's rationale, see *Bragdon v. Abbott*, 524 U.S. 624, 639–40 (1998).

considered viable options for women to reproduce without engaging in sexual intercourse.[89] Consequently, a person with HIV/AIDS could reproduce without posing any transmission risk to his or her sexual partner.[90] Since ARTs were a proven method of alternative reproduction prior to 1998, the Court's statement that "a woman infected with HIV who tries to conceive a child imposes on the man a significant risk of becoming infected"[91] does not necessarily hold true. By focusing on this risky scenario alone, the Court opens up the possibility for lower courts to perpetuate the idea that a woman with HIV/AIDS is always placing her partner at risk by attempting to reproduce.

B. Perinatal Transmission Data: 1998

The *Bragdon* Court's focus on the risks of perinatal transmission once again suggests a viewpoint that women with HIV/AIDS should not reproduce.[92] Citing public health data from 1992 and 1994, the Court stated that the risk of perinatal transmission was approximately 25%.[93] While the Court acknowledged that ARV therapy lowered the risk to about 8%,[94] it did not discuss whether the 25% figure or the 8% figure was the relevant statistic. Rather, according to the Court, "[i]t cannot be said as a matter of law that an 8% risk of transmitting a dread and fatal disease to one's child does not represent a substantial limitation on reproduction."[95] Therefore, the Court implied that, even when a woman with HIV/AIDS takes every possible precaution, having HIV/AIDS would still substantially limit her ability to reproduce.

A 1998 report of public health data confirmed that, if a woman living with HIV/AIDS took no medicine or preventive measures, the probability that she would have transmitted HIV to her child was indeed approximately 25%.[96] However, in the early to mid-1990s,

89. *See Assisted Reproductive Technology: Home*, Ctrs. for Disease Control and Prevention, http://www.cdc.gov/ART/ (last visited Mar. 9, 2010).

90. *See* CTR. FOR HIV LAW & POL'Y, HIV AND PREGNANCY: A GUIDE TO MEDICAL AND LEGAL CONSIDERATIONS FOR WOMEN AND THEIR ADVOCATES 16–17 (2009), *available at* http://www.hivlawandpolicy.org/resources/view/474 (addressing ways in which serodiscordant couples can conceive without transmission).

91. *Bragdon*, 524 U.S. at 639.

92. *See id.* at 640–41.

93. *Id.* at 640.

94. *Id.* Petitioner, Bragdon mentions the 8% perinatal transmission rate when antiretroviral therapy is used. *Id.*

95. *Id.* at 641.

96. MCINTYRE, *supra* note 83, at 9–10.

ARV therapy was beginning to decrease this risk significantly.[97] During this time, public health authorities also began pinpointing factors that contributed to perinatal transmission[98] and steps a woman could take before, during, and after pregnancy to prevent it.[99]

C. Bragdon *and Public Health*

By conclusively deciding that having HIV/AIDS substantially limited a woman's ability to reproduce, regardless of preventive measures, the *Bragdon* Court sidestepped the public health reality present in 1998.[100] It did not mention the importance of prenatal care and prevention, and it consequently set a precedent in the United States that the risks of reproducing would largely outweigh the benefits. By focusing on the substantial limitation HIV/AIDS placed on reproduction,[101] the *Bragdon* Court made a seemingly absolute statement, and lower courts have yet to reconcile it with medical advancements surrounding HIV/AIDS and reproduction.

Moreover, the Court's implicit suggestion that women with HIV/AIDS should not reproduce has contributed to an atmosphere in which women who would like to reproduce have been dissuaded from following the proper care protocol, due to fear of stigma or judgment.[102] This discouragement undercuts the advice of public health authorities in the 1990s.[103] For example, in 1995, the Centers for Disease Control and Prevention (CDC) recommended that "HIV-infected women should receive information about all reproductive options. Reproductive counseling should be nondirective. Health-

97. "The estimated annual incidence of perinatal infections declined by 27% in the United States between 1992 and 1995 after the widespread implementation of antiretroviral therapy in pregnancy." *Id.* at 10 (citation omitted).

98. *See id.* at 10–15.

99. In fact, in 1998, public health authorities had already suspected that "successful use of antiretroviral therapy . . . has [led] to suggestions that it may eventually be possible to reduce perinatal transmission rates to less than 2%." *Id.* at 15–16 (citing Bryson Y. Perinatal HIV-1 Transmission: Recent Advances and Therapeutic Interventions. *AIDS*, 1996, 10 ((Supp. 3):S33-S42)). In addition to a consistent routine of ARV therapy, other preventive measures identified in 1998 included a woman delivering through a caesarean-section procedure and avoiding breast feeding. *Id.* at 16.

100. *See Bragdon*, 524 U.S. at 660–63 (Rehnquist, C.J., concurring in part and dissenting in part) (emphasizing that the majority opinion was contrary to the sound studies of public health authorities).

101. *Id.* at 641.

102. *See infra* Part IV.

103. *Bragdon*, 524 U.S. at 662–64 (Rehnquist, C.J., concurring in part and dissenting in part).

care providers should be aware of the complex issues that HIV-infected women must consider when making decisions about their reproductive options and should be supportive of any decision."[104] Meanwhile, the *Bragdon* Court believed that "[c]onception and child birth are not impossible for an HIV victim but, without doubt, are dangerous to the public health."[105] While it left open the possibility that women living with HIV/AIDS could safely reproduce, its conclusion implied that a woman with HIV who chooses to reproduce is making a detrimental decision, regardless of personal circumstances.[106]

IV. RELIANCE ON THE *BRAGDON* STANDARD REMAINS PROBLEMATIC TODAY

The *Bragdon* Court's obvious disapproval of the choice to reproduce was perhaps more understandable given the public perception of HIV/AIDS in 1998. However, while treatments to prevent HIV/AIDS transmission have improved, the *Bragdon* Court's framework remains static. For well over the past decade, advancements in HIV/AIDS treatment have reduced the risk of partner and perinatal transmission.[107] Specifically, as predicted in the late-1990s, the use of ARVs, combined with caesarian-section delivery, has decreased the risk of perinatal transmission to below 2%.[108] In addition, HIV/AIDS is no longer considered an absolute death sentence.[109] The use of ARVs has proven to extend the lives of those living with HIV, in this case enabling mothers to live longer lives and to care for their children.[110]

The legal world's lack of progress regarding its view of HIV/AIDS and reproduction is problematic because it fails to incorporate the

104. Ctrs. for Disease Control & Prevention, *U.S. Public Health Service Recommendations for Human Immunodeficiency Virus Counseling and Voluntary Testing for Pregnant Women*, 44 MORBIDITY & MORTALITY WKLY. REP., July 7, 1995, at 10, *available at* www.cdc.gov/mmWR/PDF/rr/rr4407.pdf.

105. *Bragdon*, 524 U.S. at 641.

106. *See id.* (noting that "[t]he decision to reproduce carries economic and legal consequences").

107. CTR. FOR HIV LAW & POL'Y, *supra* note 90, at 4 (discussing the substantial decline in perinatal HIV transmission between 1994 and 2005 as a result of ARVs).

108. *Id.* (citing Ctrs. for Disease Control & Prevention, *Achievements in Public Health: Reduction in Perinatal Transmission of HIV Infection—United States, 1985–2005*, 55 MORBIDITY & MORTALITY WKLY. REP 592 (2006)). Absent any intervention, the risk of perinatal transmission remains at 25%. *Id.*

109. Robert L. Burgdorf, Jr., *Restoring the ADA and Beyond: Disability in the 21st Century*, 13 TEX. J. C.L. & C.R. 241, 319 (2008).

110. CTR. FOR HIV LAW & POL'Y, *supra* note 90, at 4.

scientific evidence behind HIV/AIDS transmission,[111] and it does not combat discrimination against women with HIV/AIDS.[112] As expressed in this Article, women living with HIV/AIDS have not only been discouraged from reproducing,[113] but they also have struggled to access comprehensive medical treatment when pregnant.[114] This lack of medical care severely *increases* the chances that a child will be born with HIV.[115]

If a woman with HIV/AIDS wants to reproduce and a doctor refuses to treat her properly, it would be difficult for the woman, in light of the *Bragdon* reproduction standard, to feel as though she has an ally in the legal world. While the *Bragdon* Court stated that a woman with HIV/AIDS who reproduces creates a danger to the public health,[116] the public health is compromised even more if the woman does not receive the proper medical treatment because she is frightened to disclose her HIV status to her doctor.[117] For example, the woman might decide not to mention her HIV status to her obstetrician and consequently not receive the appropriate prenatal care. Unfortunately, this scenario is steeped in reality. According to a Community Liaison at Children's National Medical Center, in Washington, D.C., if HIV/AIDS doctors discourage women from reproducing, some women will stop receiving HIV/AIDS treatment and will seek prenatal care without ever mentioning their HIV status to their obstetricians.[118]

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111. *See infra* Part V.

112. *See Stop Violence Against Women: HIV/AIDS, Women, and Human Rights*, http://www.amnestyusa.org/women/hivaids.html (last visited Mar. 9, 2010) (explaining that women infected with HIV are often "socially ostracized" and that "[d]iscrimination is integrally linked to women's experiences with HIV/AIDS").

113. *See* Bragdon v. Abbott, 524 U.S. 624, 641 (1998) (cautioning that conception for an HIV victim is "dangerous to the public health").

114. *See* HIV & AIDS Stigma and Discrimination, http://www.avert.org/aidsstigma.htm (last visited Mar. 9, 2010). "In healthcare settings people with HIV can experience stigma and discrimination such as being refused medicines or access to facilities . . . ." *Id.*

115. CTR. FOR HIV LAW & POL'Y, *supra* note 90, at 4. If perinatal transmission is "sharply reduced" by prenatal care, then conversely, with no medical intervention, perinatal transmission is more likely. *See id.*

116. *Bragdon*, 524 U.S. at 641.

117. *See* CTR. FOR HIV LAW & POL'Y, *supra* note 90, at 4; Gregory M. Herek et al., *HIV-Related Stigma and Knowledge in the United States: Prevalence and Trends, 1991–1999*, AM. J. PUB. HEALTH, Mar. 2002, at 371, 376.

118. Telephone Interview with Ebony Johnson, Cmty. Liaison, Family Connections, Children's Nat'l Med. Ctr., D.C. (Nov. 20, 2009).

Situations such as this one have occurred and continue to occur because of the stigma surrounding women living with HIV/AIDS who would like to procreate.[119] The legal world has done little to combat this stigma, both when *Bragdon* was decided, as well as today.[120] By evading this reality, courts have established a framework that is more damaging to the public health than it would have been if the issue had been comprehensively addressed.

V. TRANSLATING REALITY INTO LAW

A. Women with HIV/AIDS and the Choice to Reproduce

A legal structure that fully protects women with HIV/AIDS must recognize that the choice to reproduce is a complicated one, but that many women will either choose to reproduce or will have the choice forced upon them.[121] Some women with HIV/AIDS want to reproduce, seeing the decision to have children as central to their womanhood.[122] At times, however, cultural and economic factors do not always place women in full control of this decision.[123] Stigmatizing women with HIV/AIDS who give birth serves only to marginalize them and further endanger the public health.

According to a 2009 study, 59% of women living with HIV[124] wanted to have a child, and the main reason for this desire was "'to experience motherhood.'"[125] Likewise, in other studies, women living with HIV/AIDS have cited both social and personal reasons for wanting to procreate.[126] Culturally,

> most Western societies encourage reproduction and emphasize motherhood as a valued role for women. . . . Pregnancy elevates a woman's status in some communities and is often an opportunity for women to feel good about themselves. Babies represent love, acceptance, and a legacy

119. *See* Herek et al., *supra* note 117, at 371.

120. *See id.*

121. *See* Karolynn Siegel & Eric W. Schrimshaw, *Reasons and Justifications for Considering Pregnancy Among Women Living with HIV/AIDS*, 25 PSYCHOL. WOMEN Q. 112, 115–16 (2001).

122. *Id.* at 117.

123. *See* Gostin & Hodge, *supra* note 36, at 68–69.

124. The women in the study were all of reproductive age (ages fifteen to forty-four). Sarah Finocchario-Kessler et al., *Understanding High Fertility Desires and Intentions Among a Sample of Urban Women Living with HIV in the United States*, AIDS BEHAV., Nov. 12, 2009, http://www.ncbi.nlm.nih.gov/pubmed/19908135.

125. *Id.* Contrarily, having HIV was cited as the main reason *not* to have a child. *Id.*

126. Siegel & Schrimshaw, *supra* note 121, at 116.

> for the future, even for a woman without a sense of future for herself.[127]

Put simply, for many women, motherhood epitomizes femininity.[128] Therefore, many women, with or without HIV/AIDS, choose the path of reproduction at some point in their lives.

However, the decision to reproduce is not always that of the woman, and access to timely and appropriate medical care is not a given.[129] At times, a woman may have no true choice regarding whether or not she becomes pregnant or carries her child to term. Public health experts recognize that "[m]any women . . . lack control over their own exposure [to HIV and other sexually transmitted infections] because of their inability to make critical life choices due to poverty, domestic violence, and discrimination."[130] Likewise, some women "lack the power in their relationships to require male partners to refrain from sex or to use condoms."[131] This lack of power and control can lead not only to sexually transmitted infections but also to unintended pregnancy. Regardless of the situation, ample evidence indicates that women with HIV/AIDS will continue to become pregnant, whether planned or unplanned.[132] Given this reality, the question of how medical and legal settings should adjust remains to be answered.

B. Social Determinants of Health: The Physician-Patient Power Play

Society views HIV/AIDS as a taboo disease. Because primary transmission methods include sexual intercourse and injection drug use, some people feel that HIV/AIDS is caused by scandalous and blame-worthy behavior.[133] The disease remains in the shadows of

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127. Deborah Ingram & Sally A. Hutchinson, *Double Binds and the Reproductive and Mothering Experiences of HIV-Positive Women*, 10 QUAL. HEALTH RES. 117, 118 (2000).

128. *See id.*

129. *See infra* Part V.B.

130. Gostin & Hodge, *supra* note 36, at 69; *see also* Jane Stoever, *Stories Absent from the Courtroom: Responding to Domestic Violence in the Context of HIV and AIDS*, N.Y.L. SCH. CLINICAL RES. INST., Research Paper Series No. 09/10 #2 (discussing the correlation between HIV/AIDS and domestic violence).

131. Gostin & Hodge, *supra* note 36, at 69.

132. Ctrs. for Disease Control & Prevention, HIV/AIDS, Pregnancy & Childbirth, http://www.cdc.gov/hiv/topics/perinatal/index.htm (last visited Mar. 9, 2010).

133. *See generally* Herek et al., *supra* note 117, at 371 (discussing negative feelings toward people with AIDS (PWAs), such as the "belief that they deserve their illness");

society, distinguished from other serious diseases, such as cancer, diabetes, and heart disease.[134] Moreover, HIV/AIDS has been particularly prevalent in minority populations, including homosexual men, injection drug users, and women of color.[135] This marginalization of people with HIV/AIDS seeps into the medical world, often affecting medical services.[136] For women, especially women of color, social determinants of health play a large role in both access to and choice of health care.[137]

According to the World Health Organization (WHO):

> The social determinants of health are the conditions in which people are born, grow, live, work and age, including the health system. These circumstances are shaped by the distribution of money, power and resources at global, national and local levels . . . [and] are mostly responsible for health inequities—the unfair and avoidable differences in health status seen within and between countries.[138]

Social determinants of health are evident in the United States, where, according to a state-by-state study,

> [w]omen of color fared worse than White women across a broad range of measures . . . and in some states these disparities were quite stark. Some of the largest disparities were in the rates of new AIDS cases, late or no prenatal

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Motoko Y. Lee et al., *Victim-Blaming Tendency Toward People with AIDS Among College Students*, J. SOC. PSYCHOL., June 1999, at 300 (citing surveys in which people blamed the victims of AIDS for contracting the virus through behavior).

134. *See* Herek et al., *supra* note 117, at 371.

135. Ctrs. for Disease Control & Prevention, *Cases of HIV Infection and AIDS in the U.S. and Dependent Areas,* 2007, HIV/AIDS SURVEILLANCE REP., 2009, at 14, 26, http://www.cdc.gov/hiv/topics/surveillance/basic.htm (last visited Apr. 11, 2010).

136. *See* Press Release, U.S. Dep't of Health & Human Servs., Texas Orthopaedic Surgeon to Provide Individuals Living with HIV/AIDS Equal Access to Services (Oct. 16, 2009), http://www.hhs.gov/news/press/2009pres/10/20091016a.html (last visited Apr. 11, 2010).

137. "Health disparities in HIV/AIDS, viral hepatitis, STDs and TB are inextricably linked to a complex blend of social and economic determinants that influence which populations are most severely affected by these diseases." Memorandum from U.S. Dep't of Health & Human Servs., Ctrs. for Disease Control & Prevention, Human Immunodeficiency Virus (HIV) Prevention Projects for Cmty.-Based Orgs. 9–10, http://www.cdc.gov/hiv/topics/funding/PS10-1003/pdf/PS10-1003_FOA.pdf (last visited Mar. 9, 2010).

138. World Health Org., Social Determinants of Health, http://www.who.int/social_determinants/en/ (last visited Mar. 9, 2010).

> care, no insurance coverage, and lack of a high school diploma.[139]

Hence, many women of color find themselves in precarious health care situations, sometimes in the crossroads of HIV/AIDS and reproduction. While appropriate medical care is the conceivable solution, navigating the health care system often proves difficult.

A power dynamic exists between many patients and their physicians; patients often defer to their physicians' opinions regarding medical issues because of their physicians' education and expertise.[140] This relationship, while usually beneficial, can become detrimental in certain circumstances. Social determinants of health intensify this physician-patient power play:

> In order to benefit from the medical advances that can reduce perinatal transmission and extend health and life, women need accurate, complete, and understandable information that trustworthy professionals provide honestly and respectfully. Women at greatest risk—including poor women, substance users, sex workers, and survivors of domestic violence—often have, at best, very fragile connections to health care. Many have experienced disrespectful treatment from doctors, service providers, and bureaucrats and rely on their peers for information about HIV, other health issues, and medicine.[141]

Women with HIV/AIDS often feel uncomfortable communicating their needs to medical providers because of previous experiences both inside and outside of doctors' offices.[142] Couple this situation with pregnancy, and a woman with HIV/AIDS who is discouraged from having a baby is severely disadvantaged in receiving adequate care.

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139. KAISER FAMILY FOUND., PUTTING WOMEN'S HEALTH CARE DISPARITIES ON THE MAP: EXAMINING RACIAL AND ETHNIC DISPARITIES AT THE STATE LEVEL 2 (2009), http://www.kff.org/minorityhealth/upload/7886.pdf (last visited Apr. 11, 2010).

140. *See* Timothy E. Quill & Howard Brody, *Physician Recommendations and Patient Autonomy: Finding a Balance Between Physician Power and Patient Choice*, 125 ANNALS INTERNAL MED. 763, 765–66 (1996).

141. CTR. FOR HIV LAW & POL'Y, *supra* note 90, at 4.

142. *See id.*

Some women living with HIV/AIDS reported being misinformed by their doctors about the risks involved in procreating.[143] For example, one woman recalled,

> I only had really one week to decide what to do. I found out I was HIV positive when I was 13 weeks pregnant. And in 1990, of course, they [doctors] said there was a 75% or 80% chance of transmission. That's baloney.
>
> She went on to say that she decided to have an abortion, a decision that she now regrets.[144]

Other women have been in medical settings that have attempted to shame them into choosing not to reproduce.[145] According to a study concluded in 2000:

> One mother whose baby tested negative spoke angrily about the lack of sensitivity demonstrated at a local public health office where HIV-positive women sought prenatal care: "Don't ever have on your wall the poster with the little baby that says she has her daddy's eyes and her mother's AIDS. Every time I go into [the local public health unit] and it is hanging up, I want to rip it off the wall. Don't you think we have enough guilt that they need to walk in and see that?"[146]

As comments such as these indicate, the lack of helpful and accurate information for women living with HIV/AIDS, combined with the stigma surrounding HIV/AIDS and reproduction, creates a paradoxical and uncomfortable situation for women living with HIV/AIDS.[147]

In addition to stigma, some medical professionals have little experience treating HIV/AIDS and therefore are unaware of which protocol to follow when addressing HIV/AIDS and reproduction.[148]

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143. *See* Richard L. Sowell & Terry R. Misener, *Decisions to Have a Baby by HIV-Infected Women*, 19 W. J. OF NURSING RES. 56, 63 (1997).

144. *Id.* at 62 (alteration in original).

145. *See* Ingram & Hutchinson, *supra* note 127, at 122.

146. *Id.* (alteration in original).

147. *See supra* notes 143–45 and accompanying text.

148. The American Congress of Obstetricians and Gynecologists has provided recommendations to obstetricians and gynecologists, but there is no uniform protocol. *See* The American Congress of Obstetricians and Gynecologists, Routine Screening Welcome, http://www.acog.org/departments/dept_notice.cfm?recno=39&bulletin=4617 (last visited Mar. 9, 2010) [hereinafter Routine Screening Welcome]; The American Congress of Obstetricians and Gynecologists, Perinatal Welcome,

Since no specific framework is required, an obstetrician could treat a pregnant patient without following the medically accepted protocol for testing a mother for HIV at various stages in her pregnancy.[149] In addition, if a pregnant woman is known to have HIV/AIDS, some medical professionals are not equipped with enough information to treat her.[150] While the American Congress of Obstetricians and Gynecologists (ACOG) has recently provided recommendations to obstetricians and gynecologists (OB/GYNs) regarding routine HIV testing[151] and perinatal transmission prevention,[152] no mandatory protocol exists.[153] This lack of a standard could prove harmful to a patient whose doctor does not follow these recommendations.

In order to improve reproductive services for women living with HIV/AIDS, the ACOG, the American Medical Association (AMA), and medical schools should emphasize collaboration between the OB/GYN and HIV/AIDS specialties. Specifically, OB/GYNs, while now merely encouraged to provide opt-out HIV testing,[154] should be required to do so. This testing should be combined with physician-patient pre- and post-test counseling and a full discussion of what testing entails.[155] Likewise, HIV/AIDS specialists should have opt-out pregnancy counseling for all women of reproductive age. The opt-out nature of these practices would prevent women from feeling forced to succumb to mandatory protocols, but it would also, over time, solidify the idea that testing and counseling are not

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http://www.acog.org/departments/dept_notice.cfm?recno=39&bulletin=3527 (last visited Mar. 9, 2010) [hereinafter Perinatal Welcome].

149. Telephone Interview with Maryellen Grysewicz, RN, C, ACRN, Children's Hospital of Philadelphia and former public health HIV/AIDS nurse (Dec. 8, 2009) (discussing how a mother gave birth to a child with HIV because she contracted HIV while pregnant and was not tested regularly throughout her pregnancy).

150. *Id.*

151. Routine Screening Welcome, *supra* note 148.

152. Perinatal Welcome, *supra* note 148.

153. *See* Routine Screening Welcome, *supra* note 148; Perinatal Welcome, *supra* note 148.

154. Press Release, The American Congress of Obstetricians and Gynecologists, Routine HIV Screening Recommended for All Women, Regardless of Individual Risk Factors (Aug. 1, 2008), http://www.acog.org/from_home/publications/press_releases/nr08-01-08-1.cfm (last visited Mar. 9, 2010) [hereinafter Routine HIV Screening Recommended for All Women].

155. The most sensitive type of HIV test is called the ELISA test. It detects HIV antibodies in the blood and is 99.5% sensitive. A positive ELISA test should be confirmed by a second test called the Western Blot. In addition, newer rapid testing technologies are beginning to emerge. These tests can be done with a saliva sample, and preliminary results could form in as little as twenty minutes. *See* CTR. FOR HIV LAW & POL'Y, *supra* note 90, at 11–12.

extraordinary measures that only apply to marginalized communities.[156]

The coordination between HIV/AIDS and OB/GYN education would also increase awareness that a distinct crossover field exists in medicine today. It would decrease the stigma surrounding HIV/AIDS and reproduction because it would be treated as a more commonplace issue in the medical world. Ultimately, a doctor has a duty to treat his or her patient, including a patient with an ADA-recognized disability, unless the patient presents a direct threat to others.[157] While a medical provider certainly should use his or her discretion based on medical expertise, purported "discretion" based on personal opinions or moral judgments should be viewed as discrimination. Professional medical associations and medical schools should emphasize this distinction to prevent further discrimination against HIV/AIDS and reproduction.

VI. NEW LEGAL FRAMEWORK: THE ADA AMENDMENTS ACT OF 2008

A. Legislative Intent to Include HIV/AIDS

Congress realized that the Supreme Court was narrowing the ADA in a way that undermined its legislative intent, and it therefore decided to broaden the Act by passing the ADAAA.[158] Similar to the provisions of the ADA, to have a disability under the ADAAA, a person must have: (1) an impairment that (2) substantially limits (3) one or more major life activities.[159] When discussing the purposes of the ADAAA, Congress cited a litany of Supreme Court cases that interpreted the ADA much more narrowly than Congress had intended.[160] It referred to cases such as *Sutton v. United Air Lines, Inc.*[161] and *Toyota Motor Manufacturing, Kentucky, Inc. v. Williams*,[162] stating that their holdings "have narrowed the broad

156. *See id.* at 4–5; Routine HIV Screening Recommended for All Women, *supra* note 154.

157. 42 U.S.C. § 12182(b)(3) (2007); Bragdon v. Abbott, 524 U.S. 624, 648-49 (1998) (discussing the ADA's "direct threat" provision).

158. ADA Amendments Act of 2008, Pub. L. No. 110-325, 122 Stat. 3553 (2008) (codified as amended at 42 U.S.C. §§ 12101-12213 (2009)).

159. ADAAA § 3(1); 42 U.S.C. § 12102(2).

160. ADAAA § 2(a)(4)-(7).

161. 527 U.S. 471 (1999).

162. 534 U.S. 184 (2002). The *Toyota* Court narrowed the definition of "substantially limited" to mean "prevents or severely restricts." *Id.* at 198. *Toyota* was decided by the same Supreme Court Justices as *Bragdon*, implying that when the *Bragdon* Court

scope of protection intended to be afforded by the ADA, thus eliminating protection for many individuals whom Congress intended to protect."[163] However, Congress did not expressly mention *Bragdon* at all. This exclusion by no means indicates that Congress meant to exclude HIV/AIDS from being considered a disability under the ADA. In fact, as Congresswoman Tammy Baldwin stated:

> Although the ADA clearly intended to protect people living with HIV[,] . . . all too often whether or not they could proceed with their discrimination claim has turned on the court's view of evidence as to their child-bearing ability and intentions: highly personal, intimate matters that are completely unrelated to the discrimination they experienced.[164]

Also, the House Education and Labor Committee stated that the ADAAA will likely "affect cases such as *U.S. v. Happy Time Day Care Center* in which the courts . . . recogniz[ed], among other things, that 'there is something inherently illogical about inquiring whether' a five-year-old's ability to procreate is substantially limited by his HIV infection."[165] Hence, a new disability framework emerged.

B. New Definition of Disability

Prior to the passage of the ADAAA, a commentator proposed that, "[r]ather than having the Court over-extend the ADA in such a fashion as to disable it and open it up to many novel claims, it would be far better for Congress to pass legislation which clearly prohibits discrimination against those with HIV infection."[166] The ADAAA did just that, introducing promising provisions that, if interpreted

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held that HIV substantially limited the plaintiff's ability to reproduce, it meant that HIV "prevents or severely restricts" a person's ability to reproduce. *See id.*; *see also Bragdon*, 524 U.S. at 647. Therefore, *Toyota*'s narrowing of the term "substantially limited" further emphasized the *Bragdon* Court's belief that a woman with HIV/AIDS should not reproduce.

163. ADAAA § 2(a)(4).

164. 154 CONG. REC. H8297 (daily ed. Sept. 17, 2008) (statement of Rep. Baldwin).

165. H.R. REP. NO. 110-730, pt. 1, at 13–14 (2008) (Comm. on Educ. & Labor) (citing United States v. Happy Time Day Care Ctr., 6 F. Supp. 2d 1073, 1080 (W.D. Wis. 1998)).

166. Ajalat, *supra* note 48, at 768.

appropriately by the courts, could protect people living with HIV/AIDS without relying on the reproduction standard.[167]

Specifically, the ADAAA's provisions categorize HIV/AIDS as a disability, even when asymptomatic, because it is "episodic or in remission . . . [and] would substantially limit a major life activity when active."[168] While "reproductive functions" are considered "major life activities" under the ADAAA,[169] "major bodily function[s] . . . of the immune system" are considered "major life activities" as well.[170] The very nature of HIV/AIDS involves suppressing a person's immune system.[171] Therefore, HIV/AIDS, even in the asymptomatic HIV phase, is clearly considered a disability under the ADAAA solely because it substantially limits functions of the immune system.[172] By laying out these provisions, Congress gives courts a less specific, less stigmatizing, and more inclusive reason why people with HIV/AIDS should be protected under the ADA.

C. *EEOC Regulations: HIV/AIDS Essentially a Disability* Per Se

While the ADAAA makes it relatively clear that HIV/AIDS meets the definition of a disability, the question remains whether courts will more consistently determine that HIV/AIDS is a disability *per se*. Currently, defining HIV/AIDS as a disability *per se* would broadly protect all people living with HIV/AIDS from discrimination, regardless of whether or not they are able—or have chosen—to reproduce.[173] As an alternative to statutory or judicial

167. *See Happy Time Day Care*, 6 F. Supp. 2d at 1080 (indicating that there is something "inherently illogical" about inquiring whether a five-year-old's ability to procreate is substantially limited by his HIV infection).

168. ADAAA § 3(4)(D).

169. ADAAA § 3(2)(B). "[R]eproductive functions" are considered "major bodily functions," which are included in the list of "major life activities" in the ADAAA. *Id.*

170. *Id.* "[F]unctions of the immune system" are considered "major bodily functions," which are included in the list of "major life activities" in the ADAAA. *Id.*

171. *See* Dep't of Health and Human Servs.: Ctrs. for Disease Control and Prevention, *Basic Information: HIV*, *available at* http://www.cdc.gov/hiv/topics/basic/index.htm #hiv ("HIV finds and destroys a type of white blood cell (T cells or CD4 cells) that the immune system must have to fight disease.").

172. *See* EMILY A. BENFER, AM. CONSTITUTION SOC'Y FOR LAW & POL'Y, THE ADA AMENDMENTS ACT: AN OVERVIEW OF RECENT CHANGES TO THE AMERICANS WITH DISABILITIES ACT 7 (2009), *available at* http://www.acslaw.org/files/Benfer%20ADA AA_0.pdf.

173. 154 CONG. REC. H8298 (daily ed. Sept. 17, 2008) (statement of Rep. Baldwin) ("Under the ADA Amendments Act, [people who are HIV/AIDS positive] will all be assured legal protection [from] discrimination based on their HIV status, irrespective of their child-bearing intentions . . . .").

modifications,[174] regulatory change seems to be the most feasible way to accomplish this goal.[175] In the ADAAA, Congress expressly granted the Equal Employment Opportunity Commission (EEOC), the Attorney General (under the Department of Justice), and the Secretary of Transportation legally binding regulatory authority to amend their regulations implementing the ADAAA.[176] Accordingly, on September 23, 2009, the EEOC issued proposed regulations.[177] In these new regulations, the EEOC specifically states that "major life activities" include:

> The operation of major bodily functions, including functions of the immune system, special sense organs, and skin; normal cell growth; and digestive, genitourinary,

174. Changing the statutory language of the ADA (and now the ADAAA), to include HIV as a disability *per se* would be problematic for both practical and ideological reasons. First, making such a blanket statement would hamper legislative and judicial efficiency. Considering it takes years to push most bills through Congress, the lag between introducing a new ADAAA standard and implementing it would not benefit many people living with HIV today. *See* Burgdorf, *supra* note 109, at 253, 268 (discussing gaps in enforcement of the ADA and pending legislation). From a judicial angle, it could take years for the Supreme Court to grant certiorari to a case in which it could classify HIV as a disability *per se*, taking even longer for lower courts to follow suit. *See, e.g.*, Bragdon v. Abbott, 524 U.S. 624, 628–29 (indicating an approximate four year gap between a dentist's refusal to treat an HIV patient and the Court's ruling on how the ADA applied to the situation). Moreover, in light of rapid medical advancements surrounding HIV/AIDS treatment, the issue might be moot by the time Congress and the courts make changes. *See* CTR. FOR HIV LAW & POL'Y, *supra* note 90, at 9 (discussing "improvements in HIV care").

175. *See* Burgdorf, *supra* note 109, at 261–62 (referencing epilepsy regulations endorsed by the Equal Employment Opportunity Commission (EEOC) as illustrative of how a regulatory framework better realizes the intentions of Congress than the judicial system, which has carved out exceptions to the definition of epilepsy as a *per se* disability).

176. ADA Amendments Act of 2008, Pub. L. No. 110-325, § 506, 122 Stat. 3553 (2008). The Act states that:

> "The authority to issue regulations granted to the Equal Employment Opportunity Commission, the Attorney General, and the Secretary of Transportation under this Act includes the authority to issue regulations implementing the definitions of disability in section 3 (including rules of construction) and the definitions in section 4, consistent with the ADA Amendments Act of 2008."

Id.

177. Equal Employment Opportunity Commission, 74 Fed. Reg. 48,431 (Sept. 23, 2009) (to be codified at 29 C.F.R. pt. 1630) (requesting that written comments on these regulations be received by Nov. 23, 2009).

> bowel, bladder, neurological, brain, respiratory, circulatory, cardiovascular, endocrine, hemic, lymphatic, musculoskeletal, and reproductive functions. *For example*, kidney disease affects bladder function; cancer affects normal cell growth; diabetes affects functions of the endocrine system (e.g., production of insulin); epilepsy affects neurological functions or functions of the brain; and *Human Immunodeficiency Virus (HIV) and AIDS affect functions of the immune system and reproductive functions.* Likewise, sickle cell disease affects functions of the hemic system, lymphedema affects lymphatic functions, and rheumatoid arthritis affects musculoskeletal functions.[178]

While the EEOC is responsible for Title I of the ADA, as amended,[179] the Department of Justice has yet to issue new regulations to implement the ADAAA under other titles, including Title III, Public Accommodations.[180] Because discrimination in places of public accommodation, including medical settings, is

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178. Equal Employment Opportunity Commission, 74 Fed. Reg. at 48,440 (emphasis added).

179. Title I "prohibits employment discrimination on the basis of disability." 29 C.F.R. app. § 1630 (2009).

180. The Department of Justice is responsible for issuing regulations for Title III, Public Accommodations. *See* Dep't of Justice, ADA Title III Technical Assistance Manual Covering Public Accommodations and Commercial Facilities, http://ada.gov/taman3.html (last visited Mar. 9, 2010). However,

> [o]n January 21, 2009, the Department of Justice notified the Office of Management and Budget (OMB) that the Department has withdrawn its draft final rules to amend the Department's regulations implementing title II and title III from the OMB review process. This action was taken in response to a memorandum from the President's Chief of Staff directing the Executive Branch agencies to defer publication of any new regulations until the rules are reviewed and approved by officials appointed by President Obama. No final action will be taken by the Department with respect to these rules until the incoming officials have had the opportunity to review the rulemaking record. Incoming officials will have the full range of rule-making options available to them under the Administrative Procedure Act.
>
> Withdrawal of the draft final rules does not affect existing ADA regulations. Title II and title III entities must continue to follow the Department's existing ADA regulations, including the ADA Standards for Accessible Design.

Dep't of Justice, Proposed ADA Regulations Withdrawn from OMB Review, http://www.ada.gov/ADAregswithdraw09.htm (last visited Mar. 9, 2010).

problematic, the Department of Justice's definition of disability should be identical to the EEOC's definition,[181] including HIV/AIDS in a list of disabilities. Otherwise, courts might continue to interpret the definition of disability narrowly, deciding that *per se* HIV/AIDS disability protection should be limited to employment cases and not extending this protection to places of public accommodation.

D. ADAAA Expands "Regarded As" Standard

If, for some reason, a person is not considered actually disabled under the ADA, the ADAAA proposes another manner in which he or she qualifies for ADA protection.[182] The 1990 ADA provided an option for courts to decide that a person living with HIV has a disability if he or she is "*regarded as* having . . . an impairment [that substantially limits one or more major life activities]."[183] The 2008 ADAAA expands that notion by adding,

> [a]n individual meets the requirement of "being regarded as having such an impairment" if the individual establishes that he or she has been subjected to an action prohibited under this Act because of an actual or perceived physical or mental impairment whether or not the impairment limits or is perceived to limit a major life activity.[184]

Initially, the ADAAA's "regarded as" provision seems to be the solution for how people living with HIV/AIDS can be protected from discrimination without relying on the reproduction standard.[185] In a sense, it could send a message that people living with HIV/AIDS are not necessarily physically disabled, but that they should still be protected against discrimination from people who view them as less capable.[186] As the *Happy Time Day Care* court stated, "Congress

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181. The EEOC currently defines "[d]isability" as: "(1) A physical or mental impairment that substantially limits one or more of the major life activities of such individual; (2) A record of such impairment; or (3) Being regarded as having such an impairment." 29 C.F.R. § 1630.2(g) (2009).

182. *See* 42 U.S.C. § 12102(3) (2009).

183. *Id.* § 12102(2) (1990) (emphasis added).

184. *Id.* § 12102(3)(A) (amending 42 U.S.C. § 12102(2) (1990)).

185. *See id.* § 12102(1)(C), (3)(A); *see also* discussion *supra* Part III.

186. *See* Mary Johnson, Letter to the Editor, *Poverty is Scourge Behind Global AIDS Epidemic*, N.Y. TIMES, July 11, 1998, at A10 (New York Edition), *available at* http://www.nytimes.com/1998/07/11/opinion/l-poverty-is-scourge-behind-global-aids-epidemic-830585.html?scp=5&sq=bragdon%20v.%20abbott&st=cse. The Letter states:

acknowledged that society's accumulated myths and fears about disability and disease are as handicapping as are the physical limitations that flow from actual impairment."[187] The "regarded as" prong could be beneficial for many discrimination cases, but whether it would adequately protect everyone living with HIV/AIDS, namely women who want to reproduce, is a question future court cases will likely determine.

Whereas the "regarded as" prong under the 1990 ADA allowed for reasonable accommodations to be provided to someone who is thought to have a physical or mental disability, the ADAAA makes it clear that individuals who are "regarded as" disabled are no longer entitled to any reasonable accommodation.[188] Professor Chai Feldblum and collaborators at the Georgetown University Law

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> Those of us who pushed for passage of the Americans with Disabilities Act were comforted that the law would cover those who were, to quote the law, "regarded as having a disability" and facing discrimination as a result. The point wasn't what kind of disability they had; it was that they were considered disabled and being treated shabbily as a result.
>
> Then came Bragdon v. Abbott, all the way to the Supreme Court. To the nonlawyers among us, it seemed the part of the law that applied in this case was that "regarded" bit: Dr. Randon Bragdon, a dentist, regarded Sidney Abbott of Bangor, Me., who has H.I.V., as disabled; that's why he wouldn't treat her.
>
> But no; everyone's off discussing whether having reproductive problems makes one "disabled." The point shouldn't be what the disability is—or even if Ms. Abbott was disabled: the point should be that she was regarded as disabled and denied a service as a result. How did things move away from this clear point?

Id.

187. United States v. Happy Time Day Care Ctr., 6 F. Supp. 2d 1073, 1083 (quoting School Bd. Of Nassau County v. Arline, 480 U.S. 273, 284 (1987) (discussing the intent of the "regarded as" test under the Rehabilitation Act)).

188. The ADAAA states:

> A covered entity under subchapter I of this chapter, a public entity under subchapter II of this chapter, and any person who owns, leases (or leases to), or operates a place of public accommodation under subchapter III of this chapter, need not provide a reasonable accommodation or a reasonable modification to policies, practices, or procedures to an individual who meets the definition of disability in section 12102(1) of this title solely under [the "regarded as" prong].

Pub. L. No. 110-325, § 6(a)(1), 122 Stat. 3553 (2008) (codified as amended at 42 U.S.C. § 12201(h) (2009)).

Center Federal Legislation and Administrative Clinic discuss the reasoning behind this decision:

> [W]hen one reviews the facts of the cases in which reasonable accommodations have been found to be required under the ["regarded as"] prong, it seems clear that the plaintiffs in those cases should have been covered under the *first* prong of the definition of disability. Hopefully, that will be the case now under the [ADAAA] . . . .[189]

This expectation seems like a plausible outcome, but the concept has yet to be tested in the courts.

While removing the reasonable accommodation requirement to the expanded "regarded as" prong is theoretically logical, the omission might give courts an opportunity to deny reasonable accommodations to some people with perceived impairments who might need them. For example, in the HIV/AIDS and reproduction context, a court might decide that a pregnant woman with asymptomatic HIV is not actually disabled but "regarded as" impaired. It might also find that an ART, such as in vitro fertilization, is considered a reasonable accommodation to help the woman conceive without placing her partner at risk of transmission. It therefore might decide that the woman is not entitled to the reasonable accommodation of an ART because she is merely "regarded as" impaired. While ARTs are medical procedures that should not be considered reasonable accommodations, a court attempting to narrow the broadened scope of the ADAAA might choose to interpret the statute in such a manner. This scenario, while hopefully never a reality, reveals the potential problems the "regarded as" standard could present in the HIV/AIDS and reproduction context.

E. Progress, but No Mention of Bragdon

Congress made it clear that the intention of the ADA and the ADAAA was and is to protect people living with HIV/AIDS from discrimination.[190] It also revealed the logical dissonance the

189. Chai Feldblum, Kevin Barry & Emily A. Benfer, *The ADA Amendments Act of 2008*, 13 TEX. J. C.L. & C.R. 187, 237–38 (2007).

190. *See* 154 CONG. REC. H8296 (daily ed. Sept. 17, 2008) (Background on Legislation); *see also* 154 CONG. REC. H8297–98 (daily ed. Sept. 17, 2008) (statement of Rep. Baldwin) ("Under the ADA Amendments Act, [people who are HIV/AIDS positive] will all be assured legal protection [from] discrimination based on their HIV status, irrespective of their child-bearing intentions . . . .").

reasoning behind *Bragdon* poses for cases such as *Happy Time Day Care*, where the person being discriminated against was a five-year-old boy who was nowhere near reproductive age.[191] However, although Congress hinted at the problematic reproduction-based HIV/AIDS disability standard, it did not explicitly address the *Bragdon* standard's potential for stigma. Therefore, Congress implicitly condoned the reproduction standard as one possible criterion by which to decide HIV/AIDS cases.[192] In doing so, Congress did not attempt to counteract the stigmatizing nature of *Bragdon*.

While time will tell whether or not Congress needed to be more explicit to refocus HIV/AIDS-related ADA jurisprudence, an unambiguous reference to *Bragdon* could have sent a message that went beyond the simple irrationality of the reproduction standard and directly attacked the discriminatory view of HIV/AIDS and reproduction. Although the ADAAA is a progressive step that presents a potential solution, Congress could have quashed some stereotypes by simply mentioning that the *Bragdon* standard is narrow and outdated. Instead, *Bragdon*'s legal authority lingers, and the stigma surrounding women with HIV/AIDS and reproduction remains.

VII. CONCLUSION: WHERE THE LAW SHOULD MEET REALITY

Women with HIV/AIDS often live difficult and marginalized lives, despite many medical advances. The law could, and should, serve as a powerful tool to protect their rights and to fight damaging stereotypes. Unfortunately, while medical and public health authorities have modified their recommendations surrounding HIV/AIDS and reproduction to reflect advances in treatment and understanding, the legal world has been slow to follow suit. As discussed, post-*Bragdon* case law has relied on the *Bragdon* Court's rationale that having HIV/AIDS substantially limits a woman's ability to reproduce.[193] Lower courts' reliance on the reproduction standard not only has resulted in inconsistent results for HIV/AIDS-based ADA cases, but it also has perpetuated the belief that women with HIV/AIDS should not reproduce.[194]

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191. *See* Bragdon v. Abbott, 524 U.S. 624, 624–26 (1998); *Happy Time Day Care*, 6 F. Supp. 2d at 1074–75.

192. *See supra* text accompanying notes 168–69.

193. *See supra* Part II.

194. *See supra* Parts II, IV–V.

When passing the ADAAA, Congress attempted to rectify courts' narrow applications of the ADA. Congress unequivocally intended to make the ADAAA as broad as possible, expanding provisions under which HIV/AIDS could be considered a disability, unrelated to reproduction.[195] Also, by granting regulatory authority to the EEOC, the Attorney General, and the Department of Transportation, Congress enabled regulatory bodies to create binding provisions that include HIV/AIDS in a list of diseases considered disabilities *per se*.[196] In addition, by expanding the "regarded as" prong, Congress provided another mechanism by which people with HIV/AIDS could argue that they are protected under the ADA.[197]

Despite this progress, however, Congress neglected to mention *Bragdon* explicitly.[198] Therefore, it did not do all it could have done to overcome the stereotypes surrounding HIV/AIDS and reproduction. Under the new provisions of the ADAAA, a woman with HIV/AIDS may have more effective recourse against reproduction-related discrimination because the standard under which she is "disabled" no longer undercuts the services she wants to receive.[199] However, by not mentioning the *Bragdon* reproduction standard's potential for stigma, Congress did not address the stereotype that HIV/AIDS substantially limits a woman's ability to reproduce. While this notion is sometimes true, it is not a full reflection of reality. By failing to confront the *Bragdon* standard directly, Congress left open the possibility that courts will not revisit the reproduction standard.

While the general perception of HIV/AIDS has improved, women still encounter discrimination in medical and social settings.[200] The

195. ADA Amendments Act of 2008, Pub. L. No. 110-325 § 3(2)(B), 3(4)(D), 122 Stat. 3553 (2008) (codified as amended at 42 U.S.C. § 12101 (2009)); *see supra* Part VI.B. (discussing Congress's intent to include HIV/AIDS within the definition of disability beyond the reproduction standard).

196. ADAAA § 506 (Rule of Construction Regarding Regulatory Authority); *see supra* Part VI.C.

197. *See supra* Part VI.D.; 42 U.S.C. §§ 12102(3)(1)(C), 12102(4)(A) (2008) ("[A]n individual meets the requirement of 'being regarded as having such an impairment' if the individual establishes that he or she has been subjected to an action prohibited under this Act because of an actual or perceived physical or mental impairment whether or not the impairment limits or is perceived to limit a major life activity.").

198. *See generally* 42 U.S.C. §§ 12101-12213.

199. *See id.* § 12188 (2008) (stating that a person who claims discrimination in a place of public accommodation [under Title III of the ADA] may seek remedies under 42 U.S.C. § 2000a-3 [Civil Actions for Preventive Relief]).

200. *See supra* Part V.

stigma surrounding HIV/AIDS and reproduction has contributed to potential public health dangers.[201] Fearing judgment, women with HIV/AIDS still feel discouraged from taking precautions to prevent partner and perinatal transmission.[202] They therefore might forego seeking proper medical care, increasing the chance of transmitting HIV.

Looking forward, courts may well interpret the ADAAA broadly, as Congress intended. If they do so, the law surrounding HIV/AIDS and discrimination will become a more constructive force for changing the perception of women with HIV/AIDS who choose to reproduce. Despite their physical impairment, these women should be able to exist in a reality where they are not "substantially limited" in making reproductive choices free from stigma. Legal changes will hopefully lead to a wider acceptance of women's reproductive choices, allowing them to emerge from marginalized communities and to live empowered lives.

201. *See supra* Part IV.
202. *See supra* Parts III, V.