[Journal of Contemporary Health Law & Policy (1985-2015)](https://scholarship.law.edu/jchlp)

Volume 16 | Issue 1 Article 6

1999

HIV-Infected Surgical Personnel Under the ADA: Do They Pose a Direct Threat or Are Reasonable Accommodations Possible?

Ryan J. Rohlfsen

Follow this and additional works at: https://scholarship.law.edu/jchlp

Recommended Citation

Ryan J. Rohlfsen, *HIV-Infected Surgical Personnel Under the ADA: Do They Pose a Direct Threat or Are Reasonable Accommodations Possible?*, 16 J. Contemp. Health L. & Pol'y (2000).

Available at: https://scholarship.law.edu/jchlp/vol16/iss1/6

This Article is brought to you for free and open access by CUA Law Scholarship Repository. It has been accepted for inclusion in Journal of Contemporary Health Law & Policy (1985-2015) by an authorized editor of CUA Law Scholarship Repository. For more information, please contact edinger@law.edu.

HIV-Infected Surgical Personnel Under the ADA: Do They Pose a Direct Threat or Are Reasonable Accommodations Possible?

Erratum
127

This article is available in Journal of Contemporary Health Law & Policy (1985-2015): https://scholarship.law.edu/jchlp/vol16/iss1/6

HIV-INFECTED SURGICAL PERSONNEL UNDER THE ADA: DO THEY POSE A DIRECT THREAT OR ARE REASONABLE ACCOMMODATIONS POSSIBLE?

*Ryan J. Rohlfsen**

INTRODUCTION

The Americans with Disabilities Act of 1990[1] (ADA) has been heralded as a watershed in the fight for equal treatment of disabled people.[2] Among other things, the ADA and its predecessor companion statute, the Rehabilitation Act of 1973[3] (Rehabilitation Act), prohibits employers from discriminating against an employee based upon a real or perceived disability of that employee.[4] Within the ambit of "disabilities" protected by the ADA and the Rehabilitation Act, courts and relevant administrative agencies recognize the Acquired Immune Deficiency Syndrome (AIDS) and its cause, the Human Immunodeficiency Virus (HIV).[5] Thus, the ADA has significant implications for HIV-positive workers in many fields. Key among these fields is the health care industry. The specter of tainted blood and infected workers transmitting the virus to patients looms large on the health care horizon.[6] Because of the deadly nature of HIV, many people are justifiably

---

* Attorney, Shughart, Thomson & Kilroy, P.C.; J.D., 1999, Drake University Law School; B.A., 1996, Drake University. The author would like to thank James Albert and Keith Miller, Professors of Law, for their inspiration and guidance in developing this article.

1. 42 U.S.C. §§ 12101-12213 (1994).

2. *See* 136 Cong. Rec. S9689 (daily ed. July 13, 1990) (statement of Senator Harkin).

3. 29 U.S.C. §§ 701-797b (1994).

4. *See* Patricia M. Bailey, Note, *"Significant Risk" Concept Justifies Practice Restrictions of an HIV-Infected Surgeon, Scoles v. Mercy Health Corp.*, 40 VILL. L. REV. 687, 687-88 (1995).

5. *See* Bragdon v. Abbott, 118 S. Ct. 2196, 2213 (1998).

6. *See* R. Bradley Prewitt, Comment, *The "Direct Threat" Approach to the HIV-Positive Health Care Employee Under the ADA*, 62 MISS. L.J. 719, 722-23 (1992) (discussing the danger of HIV in the health care industry).

concerned about HIV infection in the event they must accept health care. A key issue challenging courts today is: what steps can the health care employer take to alleviate or lessen the risks that an HIV-infected employee poses to a patient without violating that employee's rights under federal disability law.[7]

Many cases and articles have been written covering the risks of HIV-positive health care workers (HCWs) in various employment positions.[8] This Article specifically focuses on the legal risks involved with HIV-positive HCWs who perform invasive surgical procedures. Of course, given the inherently invasive nature of surgical work, surgical HCWs who are HIV-positive pose a higher risk of infecting patients than other HCWs.[9] This analysis involves balancing three interests: the rights of the HIV-positive HCW, the considerations of liability and safety for the employer health care provider, and the rights and safety of the patients. This Article addresses how the ADA and the Rehabilitation Act, in theory, reconcile these competing interests and how the courts are interpreting the statutes to balance them.[10]

Part II of this Article discusses the applicable statutory provisions of the ADA and Rehabilitation Act to paint the background for interpretative case law.[11] Part III examines how courts are analyzing the statutory provisions in light of the issues specifically raised by HCWs in the operating room.[12] This Part of the analysis includes a brief examination of guidelines promulgated by public health authorities.[13] Finally, this Article concludes by noting the discrepancies in the analysis used by various courts when faced with a situation involving an HIV-positive surgical HCW and how these discrepancies may be in conflict with the Supreme Court's guidance.[14]

---

7. *See infra* Part III (discussing the statutory provisions and interpretative case law relating to the disability protection of HIV-positive individuals).

8. *See, e.g.*, Prewitt, *supra* note 6, at 722-23.

9. *See, e.g.*, Mary Anne Bobinski, *Risk and Rationality: The Centers for Disease Control and Regulation of HIV-Infected Health Care Workers*, 36 ST. LOUIS U. L.J. 213, 226-29 (1991) (discussing guidelines for HIV-positive HCWs in performing invasive procedures).

10. *See infra* Parts II-III.

11. *See infra* Part II.

12. *See infra* Part III.

13. *See infra* Part III.B.

14. *See infra* Part IV.

I. HIV, HCWs AND DISABILITY DISCRIMINATION

The ADA has had a major impact on hospitals and other health care institutions and organizations.[15] Similarly, AIDS, a disability under the ADA and the Rehabilitation Act, has had a major impact on health care providers. In 1992, the Centers for Disease Control (CDC) reported that 8,467 HCWs were diagnosed with AIDS.[16] Of these, sixty-one were surgeons, 872 were other physicians, 3,383 were nurses and aides, and 1,098 were technicians.[17] One can only speculate that in 1999, given the trends over the last several years in the spread of HIV, these numbers will continue to rise.[18] Therefore, the ADA and the Rehabilitation Act offer perhaps the only effective federal remedy to address this situation.[19]

The ADA was enacted as a wide-ranging remedial statute designed to eliminate the ills of discrimination against the forty-three million Americans Congress identified as disabled.[20] Title I of the ADA specifically relates to employment situations involving disabled persons.[21] Under Title I, no employer may "discriminate against a qualified individual with a disability because of the disability of such individual in regard" to virtually all aspects of the employer/employee relationship, including hiring.[22] The general rule, while facially clear in scope and

15. *See* Katherine Benesch, *AIDS and the ADA in the Health Care Workplace*, 23 BRIEF 22, 22 (1994). It should be noted that the ADA's coverage must be construed at least as broadly as that of the Rehabilitation Act. *See* 42 U.S.C. § 12201(a) (1994).

16. *See* Benesch, *supra* note 15, at 24.

17. *See id.*

18. Indeed, given the fact that the 1992 CDC report looked only at those HCWs with "AIDS," one can safely assume that these figures do not include HIV-positive individuals that had not yet manifested the signs required to be classified as having AIDS. Thus, the numbers of HCWs who could potentially pose a risk to patients and fellow HCWs is likely much higher than those provided above.

19. The focus of this part of this Article is the ADA. Because the ADA covers private entities, unlike the Rehabilitation Act, it arguably has a broader reach. However, the analysis regarding the issues addressed in this Article is identical under either statute largely due to the fact that the ADA simply incorporates much of the Rehabilitation Act's language and analysis. *See Bragdon*, 118 S. Ct. at 2202 (1998).

20. *See* 42 U.S.C. § 12101 (1994).

21. *See id.* §§ 12111-12117.

22. *Id.* § 12112(a).

application, is subject to a maze of definitions and exceptions. Of particular importance to the scope of this Article are the meaning and application of the terms "discriminate" and "qualified individual with a disability."[23]

A person is considered disabled under the ADA if any one of three conditions are met.[24] First, the individual is disabled if he or she suffers from a "physical or mental impairment that substantially limits one or more of the major life activities of such individual."[25] Second, an individual is disabled if there is "a record of such an impairment."[26] Finally, an individual is considered disabled under the ADA if an employer regards him or her as having an impairment, even if she actually does not suffer from one.[27]

A "qualified individual with a disability" is a disabled person who, "with or without reasonable accommodation, can perform the essential functions of the employment position that [the disabled person] holds or desires."[28] Thus, if a person is so disabled that an employer cannot reasonably accommodate the disability, then that person is not "qualified" for protection under Title I of the ADA. Similarly, if the individual possesses a disability that poses a direct threat to others, that individual is likewise not "qualified."[29] A "direct threat" is defined by the ADA as "a significant risk to the health or safety of others that cannot be eliminated by reasonable accommodation."[30]

An employer discriminates against a qualified disabled employee when the employer fails to make "reasonable accommodations" for any known impairments of the employee.[31] The employer can be re-

---

23. *Id.* § 12111.
24. *See* 42 U.S.C. § 12102(2)
25. *Id.* § 12102(2)(A).
26. *Id.* § 12102(2)(B).
27. *See id.* § 12102(2)(C).
28. 42 U.S.C. §12111(8).
29. *Id.* §12111 (3).
30. *Id.* "Direct threat" is the term used by the ADA. "Significant risk" is used by the Rehabilitation Act, and by the ADA in its definition of "direct threat." Both terms mean the same and are analyzed the same. *Compare School Bd. of Nassau County v. Arline*, 480 U.S. 273, 288 (1986) *with* 28 C.F.R. § 36.208 (1998) (utilizing the same analysis for both the Rehabilitation Act and the ADA regarding direct threat and significant risk).
31. 42 U.S.C. § 12112(b)(5)(A). "Reasonable accommodation" is defined by the ADA to include such things as: making employment facilities accessible and usable for disabled individuals; special training; job restructuring;

lieved of the burden of making the accommodation (i.e., the accommodation becomes unreasonable) if the employer demonstrates that the "accommodation would impose an *undue hardship* on the operation of the business. . . ."[32]

II. ARE HIV-POSITIVE SURGICAL HEALTH CARE WORKERS ENTITLED TO STATUTORY PROTECTION AGAINST DISCRIMINATION BY THEIR EMPLOYERS?

The legislative history pre-dating passage of the ADA clearly demonstrates Congress' intent to protect individuals classified as HIV-positive.[33] In turn, the Rehabilitation Act also extended protection to cover HIV-positive individuals.[34] Furthermore, the Supreme Court recently recognized that an individual with asymptomatic HIV is considered "disabled" within the meaning of the ADA.[35] However, an

---

modifying the work schedule; reassignment; acquisition of special equipment; and "other similar accommodations." *Id.* § 12111(9).

32. *Id.* § 12112(b)(5)(A) (emphasis added). "Undue hardship" is defined by the ADA as "an action requiring significant difficulty or expense, when considered in light of" several factors set forth in the statute. *Id.* § 12111(10). Those factors include:

> (i) the nature and cost of the accommodation needed under [the ADA];
> (ii) the overall financial resources of the facility or facilities involved in the provision of the reasonable accommodation; the number of persons employed at such facility; the effect on expenses and resources, or the impact otherwise of such accommodation upon the operation of the facility;
> (iii) the overall financial resources of the [employer]; the overall size of the business . . . with respect to the number of its employees; the number, type, and location of its facilities; and
> (iv) the type of operation or operations of the [employer], including the composition, structure, and functions of the workforce . . . the geographic separateness, administrative, or fiscal relationship of the facility or facilities in question. . . .

Id.

33. *See* H.R. Rep. No. 101-485(II), at 52 (1990), reprinted in 1990 U.S.C.C.A.N. 303, 334 ("[A] person infected with [HIV] is covered under the first prong of the definition of the term 'disability' because of a substantial limitation on procreation and intimate sexual relationships."); 28 C.F.R. § 36.104 (1998) (listing HIV as a physical or mental impairment under the statute).

34. *See* Bailey, *supra* note 4, at 688-89.

35. *Bragdon,* 118 S. Ct. at 2208-09. The *Bragdon* court addressed whether an individual with asymptomatic HIV had an impairment that substantially limited a major life activity. *Id.*; *see also* 42 U.S.C. § 12102(2)(A)

HIV-positive individual whose condition meets the statutory definition of disability[36] is not automatically entitled to statutory protection. As noted above,[37] if an individual is so disabled that he or she cannot work, even with reasonable accommodation, the individual is not qualified under the ADA.[38] Additionally, if the individual, as an employee, poses a direct threat or significant risk to the safety of the working environment, then the individual does not qualify for protection under the ADA.[39] Finally, if an individual could work with an accommodation from his employer, but that accommodation places an undue hardship upon the employer, then the individual is likewise not qualified for statutory protection.[40]

A. HIV and the Direct Threat/Significant Risk Analysis

The ADA defines a "direct threat" as "a significant risk to the health and safety of others that cannot be eliminated by reasonable accommodation."[41] Congress designed this definition to codify the Supreme Court's four-factor test set forth in *School Board of Nassau County v. Arline,*[42] a 1986 case decided under the Rehabilitation Act.[43] Under both the ADA and the Rehabilitation Act, the analysis of whether there is a direct threat or significant risk is identical: an indi-

---

(1994) (defining "disabled" under the ADA). Other courts have recognized that an individual who has HIV also meets the statutory definition of being disabled. *See Anderson v. Gus Mayer Boston Store of Delaware*, 924 F. Supp. 763, 777 (E.D. Tex. 1996); *see also* 42 U.S.C. § 12102 (2) (B) (stating that an individual is disabled if the individual has a record of a disability). An individual who does not have HIV, but is regarded has having it by his employer, could also fall within the ADA's definition of disability. *See* 42 U.S.C. § 12102(2)(C) (stating that an individual who is "regarded as" disabled is entitled to protection if the other relevant elements of the ADA are met).

36. The definition of disability is the same for the ADA and the Rehabilitation Act. *See Bragdon*, 118 S. Ct. at 2202.

37. *See supra* Part II (discussing the elements of statutory disability protection).

38. *See* 42 U.S.C. § 12111(8) (1994).

39. *See id.*; *see also supra* notes 28-29 and accompanying text (discussing the definition of a direct threat/significant risk).

40. *See* 42 U.S.C. § 12111(10).

41. 42 U.S.C. § 12111(3).

42. 480 U.S. 273 (1986).

43. *See* Bragdon, 118 S. Ct. at 2210 (noting that the ADA's direct threat provision codifies Arline) (citing 28 C.F.R. pt. 26, App. B., 626 (1997)).

vidual whose disability poses a direct threat or significant risk of harm to others is not qualified for protection under either statute.[44]

A court's decision of whether a direct threat or significant risk exists requires balancing the *Arline* factors.[45] In *Arline*, the Supreme Court held that an individual afflicted with a contagious disease could be "disabled" under the Rehabilitation Act if the required *prima facie* elements of the Act were met.[46] The *Arline* Court established that whether a disabled individual poses a direct threat or significant risk depends upon weighing four factors based on the current state of medical knowledge:

> (1) the nature of the risk (how the disease is transmitted);
> (2) the duration of the risk (how long is the carrier infectious);
> (3) the severity of the risk (what is the potential harm to third parties); and
> (4) the probab[ility] that the disease will be transmitted and will cause varying degrees of harm.[47]

In assessing these factors, the Court noted that significant deference should be given to the "reasonable medical judgment of public health officials," such as the guidance given by the CDC.[48] Further, the Court held that even if a weighing of the four factors concludes that an individual poses a significant risk to others, it does not mean reasonable accommodation on the part of the employer is impossible.[49] The factors involved in determining if reasonable accommodation is possible are different from those considered in analyzing whether there is a direct threat.[50]

1. Case Law Interpreting Arline and Direct Threat/Significant Risk

Courts faced with a claim of employer discrimination based upon an

44. *See* Bailey, *supra* note 4, at 688-90.
45. *See id.* at 698-705.
46. *See Arline*, 480 U.S. at 289.
47. *Id.* at 288.
48. *Id.*
49. *See id.* Likewise, the ADA states that an employee is not a direct threat and not prohibited by the statutes, if the employer can reasonably accommodate the disability to substantially alleviate the threat to others that the disability imposes. 42 U.S.C. § 12111(3).
50. 42 U.S.C. §§ 12113(3), (9).

employee's HIV status have not uniformly applied the *Arline* analysis. In situations not involving HIV-positive HCWs, courts have almost uniformly given equal weight to all four of the *Arline* factors, including risk of transmission.[51] In such cases, the courts almost always find no direct threat or significant risk, thus concluding that the employee is entitled to protection under the ADA or Rehabilitation Act.[52] A different analysis has also developed in cases involving HIV-positive HCWs, particularly those whose job descriptions include performing or assisting with some sort of invasive procedure.[53] In such situations, courts tend to give uneven weight to the *Arline* factors by de-emphasizing the fourth prong, which evaluates the risk of transmission, in favor of finding that the worker poses a direct threat or significant risk and thus, is not qualified for statutory protection.[54]

2. Courts Equally Balancing All Four of the Arline Factors

In *Chalk v. United States District Court,*[55] the Ninth Circuit closely followed the Supreme Court's analysis established in *Arline*. In *Chalk*, a school administrator reassigned a school teacher, diagnosed with AIDS,[56] to an administrative position and barred him from teaching in the classroom.[57] The teacher subsequently filed a complaint, alleging that such an action violated the Rehabilitation Act while also requesting an injunction against the school administrators.[58] The district court denied the plaintiff's request for an injunction on the grounds that he constituted a significant risk to the school children because he had AIDS.[59]

In reversing the district court's denial of the injunction, the Ninth Circuit court utilized the *Arline* four-factor approach to determine whether the plaintiff presented a significant risk.[60] The court accorded equal weight to all four factors in concluding that no significant risk

51. *See infra* Part III.A.1.a.
52. *See infra* Part III.A.1.a.
53. *See infra* Part III.A.1.b.
54. *See infra* Part III.A.1.b.
55. 840 F.2d 701 (9th Cir. 1988).
56. *See id.* at 703.
57. *See id.*
58. *See id.*
59. *See id.* at 705.
60. *See* 840 F.2d at 705.

existed.[61] In so concluding, the court carefully examined the fourth prong of the *Arline* test and noted the overwhelming weight of credible medical evidence demonstrating the minimal risk of transmission through casual contact between HIV-positive individuals and non-infected individuals.[62]

Other courts have accepted the *Chalk* analysis, requiring that the risk of transmission be significant to justify disparate treatment of HIV-positive individuals.[63]

The Eleventh Circuit in *Onishea v. Hopper*[64] recently declared that all four factors of the *Arline* test should be given due consideration.[65] The court stated that the *Arline* test required "a significant risk of HIV transmission before sanctioning"[66] any sort of discriminatory behavior against an HIV-positive individual.[67] Even though the threat of HIV transmission poses a risk to a non-infected individual in virtually any setting, the court held that the risk must be significant before any discrimination would be allowed.[68] The court concluded that both *Arline* and congressional intent required the acceptance of some risks under the disability discrimination statutes to prohibit employers from "unduly indulging [in] their fears."

61. *See id.* at 705-09.

62. *See id.* at 706-08.

63. In *Doe v. Dolton Elementary School District No. 148*, 694 F. Supp. 440, 445-46 (N.D. Ill. 1988), the district court held that an HIV-positive student, who was threatened with removal from the classroom, was entitled to an injunction where medical evidence showed no significant risk of HIV transmission in school. In *New York State Association for Retarded Children, Inc. v. Carey*, 612 F.2d 644 (2d Cir. 1979), the Second Circuit, in a pre-*Arline* decision, applied a "significant transmission risk" standard, virtually identical to the fourth *Arline* prong. *Id.* at 650. The court found that hepatitis B-infected students posed less than a significant risk to other students, and thus were entitled to protection under the Rehabilitation Act. *Id.* This decision has direct application to cases involving HIV, as hepatitis B has identical transmission pathways as HIV. *See Onishea v. Hopper*, 126 F.3d 1323, 1332 (11th Cir. 1997).

64. *Onishea*, 126 F.3d at 1323.

65. *See id.* at 1332.

66. *Id.*

67. *See id.*

68. *Id.*

3. *Courts De-Emphasizing the Probability of Transmission Factor of Arline*

While some courts emphasize that all four of the *Arline* factors must be given equal weight, other courts conclude that probability of transmission, based on medical testimony, need not be significant to support a finding of disparate treatment.[69] This re-balancing of the *Arline* factors is especially evident in cases involving HIV-positive surgical HCWs. Even though there has never been a documented case of HIV being transmitted to a patient by an HIV-positive surgical HCW, courts have concluded the other *Arline* factors, such as the severity and nature of the risk, outweigh the probability of transmission.[70]

A seminal case involving HIV-positive surgical HCWs and the determination of disability under the ADA and the Rehabilitation Act is *Doe v. University of Maryland Medical System Corporation.*[71] In this case, the Fourth Circuit addressed the issue of whether an HIV-infected neurosurgeon posed a significant risk or direct threat to his patients, and thus, whether or not the doctor qualified for statutory protection.[72] Ironically, the surgeon-plaintiff became infected with HIV after being stuck with a needle while treating an HIV-positive patient.[73]

The *Doe* court directly utilized the *Arline* analysis to resolve whether the plaintiff posed a significant risk, thereby removing the plaintiff from statutory protection.[74] However, the court concluded that the *Arline* factors "discount[] the severity of anticipated harms by the statistical probability that they will occur."[75] After a detailed evaluation of the authoritative CDC guidelines regarding HIV-positive surgical HCWs, the court concluded that the doctor posed a significant risk to his patients.[76] The court reached this conclusion even after finding that, according to the CDC, not all procedures employed by neurosurgeons are "exposure-prone," and that the statistical probability of sur-

69. *See infra* notes 72-105 and accompanying text.
70. *See infra* notes 72-105 and accompanying text.
71. 50 F.3d 1261 (4th Cir. 1995).
72. *See id.* at 1262.
73. *See id.*
74. *See id.* at 1265.
75. *Id.* (quoting the district court's unpublished decision).
76. *See* 50 F.3d at 1263-66.

geon-patient exposure is virtually non-existent.[77] Thus, the court rejected the express language of *Arline* and chose to re-define the test by giving less weight to the probability of transmission. The court concluded that if transmission from surgeon to patient was "possible," the HIV-positive surgeon posed a significant risk to the health and safety of his patients that could not be reasonably accommodated.[78]

In *Bradley v. University of Texas M.D. Anderson Cancer Center*,[79] the Fifth Circuit determined that an HIV-positive surgical technician posed a significant risk to patients and thus, was disqualified from statutory disability protection.[80] In reaching this decision, the *Bradley* court stressed the "catastrophic consequences" of the transmission of HIV from a surgical technician to a patient and minimized the low probability of transmission.[81] Thus, the court tipped the balance of the *Arline* test to weigh against the significance of the fourth prong. The court concluded that it would be impossible for the hospital to eliminate the risk of transmission associated with the surgical technician's job through reasonable accommodation.[82] The court held that an accommodation to eliminate the risk of transmission would be tantamount to an elimination of the "essential functions" of the job, and therefore, not reasonable.[83]

Another controversial case arose in *Scoles v. Mercy Health Corporation*.[84] In *Scoles*, an HIV-positive orthopedic surgeon sued his hospital-employer for violation of the ADA and the Rehabilitation Act. He claimed that the hospital prohibited him from performing surgery without first obtaining informed consent from his patients, including disclosure of his HIV status.[85]

The issue for the court was whether the surgeon posed a direct

---

77. *See id.*

78. *See id.* at 1266.

79. 3 F.3d 922 (5th Cir. 1993).

80. *See id.* at 924-25.

81. *See id.* at 924.

82. *See id.* at 925. A surgical technician's job includes handing the handles of instruments to surgeons while holding the sharp end. *See id.* at 924. This task usually takes place within inches of open wounds, and sometimes requires placing a hand inside the body cavity. *See id.*

83. *See id.* at 925.

84. 887 F. Supp. 765 (E.D. Penn. 1994). The case was settled prior to a decision by the appellate court.

85. *See id.* at 766-68.

threat or significant risk to patients, falling outside of the requirements for statutory protection under both statutes.[86] In its analysis, the court placed heavy emphasis on the severity of the risk involved with an HIV-positive surgeon while severely discounting the surgeon's arguments that the risk of transmission was very low.[87] The court essentially decided that because no one was sure of the extent of the risk of transmission, it would not place much weight on that factor. The court concluded, as a matter of law, that an HIV-positive HCW, who performs invasive surgical procedures, is not qualified for protection under either the ADA or the Rehabilitation Act.[88]

Finally, the most recent case, and perhaps the most poignant example of a re-weighing of the *Arline* factors, is *Estate of Mauro v. Borgess Medical Center*.[89] In *Mauro*, the defendant-hospital fired the plaintiff from his position as a surgical technician after the hospital learned he was HIV-positive.[90] The plaintiff alleged that in so doing, the hospital violated the ADA and the Rehabilitation Act by discriminating against him because of his disability.[91] The hospital argued that the plaintiff could not be reasonably accommodated in his job due to the direct threat/significant risk posed to patients by the plaintiff, and therefore, the decision to fire him did not violate the protection of either Act.[92]

In its analysis, the court noted that the first three factors of the *Arline* test all addressed the risk of HIV transmission should the surgical technician bleed while inside a body cavity.[93] The court then analyzed, in great detail, the evidence regarding the probability of transmission between the plaintiff and a patient.[94] The court considered the plaintiff's job description and how the job was generally carried out in practice.[95] The evidence established that without accommodation for his HIV status, the plaintiff's position would create the possibility that

86. *See id.* at 767-68.
87. *See id.* at 771-72.
88. *See id.* at 772.
89. 137 F.3d 398 (6th Cir. 1998).
90. *See id.* at 400-01.
91. *See id.*
92. *See id.* at 401.
93. *See id.* at 403.
94. *See* 137 F.3d at 403-06.
95. *See id.*

he could bleed into a patient during surgery.[96] Even though no accommodation was suggested, and the credible medical evidence downplayed the risk of transmission and highlighted the possibility of accommodation, the court concluded that the plaintiff was a direct threat/significant risk to patients.[97] With this ruling, the court effectively held that HIV-positive surgical HCWs are "not otherwise qualified as a matter of law."[98]

The dissent in this case fundamentally questioned the majority's use of the *Arline* test, emphasizing that the transmissibility factor was not given due consideration.[99] The court noted that while it was "not ontologically impossible for [the plaintiff] to transmit" the deadly disease, "the chance that he [would] do so to any given patient" was very small.[100] The dissent carefully reviewed the medical evidence available regarding the transmission of HIV by surgical personnel, and concluded that under *Arline*, a court must consider transmissibility in determining whether an individual poses a significant risk/direct threat.[101] Because the medical evidence established that the probability of transmission was so low, the dissent concluded that *Arline* essentially prohibited the majority's finding that HIV-positive surgical HCWs were a significant risk ordirect threat as a matter of law.[102] The dissent argued the issues of significant risk and reasonable accommodation were jury questions, the solution preferred by the *Arline* court's insistence upon an individualized "case-by-case" inquiry into these questions.[103]

---

96. *See id.*

97. *See id.* at 406-07.

98. *Id.* at 413 (Boggs, C.J., dissenting) (stating holding of the majority).

99. *See* 137 F.3d at 407-08.

100.*Id.* at 408 ("Whether we call the risk 'extremely small,' 'vanishingly small,' 'negligible,' or whatever, assessing the risk remains a judgment that must be made by considering both the actual probability of harm and the degree of the consequences, just as the Supreme Court [in *Arline*] instructed us.").

101. *See id.* at 409-16.

102. *See id.* at 413 (concluding that the majority "misapplied the standard found in *Arline*, and ignored relevant principles of risk observed by statisticians and by lay people").

103. *See id.* at 411; *see also Rizzo v. Children's World Learning Centers*, 84 F.3d 758, 764 (5th Cir. 1996) ("Whether one is a direct threat [or poses a significant risk] is a complicated, fact intensive determination, not a question of law.").

Other courts are also in accord with the general analysis expounded by the *Doe, Bradley, Scoles,* and *Mauro* courts.[104] These courts all de-emphasize the fourth factor of the Arline test relating to the risk of transmission of HIV in the surgical environment and instead focus on the nature of the disease itself.

4. *Re-Balancing the Arline Test? The Supreme Court's Decision in Bragdon v. Abbott*

In *Bragdon v. Abbott,*[105] the Supreme Court addressed the question of whether an HIV-positive dental patient, who requested that a dentist perform an invasive dental procedure, posed a direct threat to the health and safety of the dentist and was not qualified for protection under the ADA.[106] The Court began its analysis by noting that the ADA's definition of direct threat codifies the language and considerations employed by the four *Arline* factors.[107] The Court held that for an individual to pose a direct threat to others, and thus not be qualified under the ADA, that individual must present a *significant* risk.[108] The Court intimated that the determination of whether the risk was significant necessitated a careful weighing of all the *Arline* factors.[109] Indeed, after briefly noting the risk with an invasive procedure involving an HIV-positive patient, the court focused on the fourth prong of the *Arline* test and evaluated whether the risk of transmissibility was enough to conclude that the plaintiff-patient constituted a significant risk/direct threat.[110]

The defendant-dentist presented several studies evaluating the risk of transmissibility of HIV in invasive dental procedures.[111] These

104. *See, e.g., Doe v. Washington Univ.*, 780 F. Supp. 628, 632-34 (E.D. Mo. 1991) (concluding that an HIV-positive dental student was not otherwise qualified to perform invasive procedures because of the significant risk to patients); *cf. Estate of Behringer v. Medical Ctr.*, 592 A.2d 1251, 1276-77 (N.J. Super. Ct. Law Div. 1991) (finding no violation of state statute proscribing discrimination against the disabled because an HIV-positive surgeon-plaintiff posed a "reasonable probability of substantial harm" to others).

105. 118 S. Ct. 2196 (1998).

106. *See id.* at 2209-10.

107. *See id.* at 2210.

108. *See id.*

109. *See id.*

110. *See* 118 S.Ct. at 2210-12.

111. *See id.* at 2212.

studies showed that HIV could be transmitted by invasive dental procedures,[112] yet, the Court, rejected these studies as being inconclusive and unpersuasive.[113] Absent a showing of transmissibility implicating a significant risk to the defendant, the Court refused to classify the HIV-positive patient as being a direct threat or significant risk to the dentist in the performance of invasive dental procedures.[114]

The *Bragdon* Court rejected arguments that solely because of the severity of the disease, an HIV-positive individual is automatically a direct threat/significant risk when involved in an invasive medical procedure. The Court placed a balanced emphasis on the risk of transmission prong of the *Arline* test. In so doing, the Court concluded that even though the severity of the risk to the dentist in performing invasive procedures was high, when balanced with the virtually nonexistent evidence of transmissibility, the risk was not "significant" under the *Arline* test. Arguably, this case emphasizes the Court's desire to re-focus the analysis of direct threat or significant risk on the factors originally delineated by *Arline*. Such an analysis will require that, when deciding a case involving an invasive medical procedure and an HIV-positive patient *or* HCW, the Court will place proper emphasis on the risk of transmission of HIV and not merely focus on the severity of the risk. Indeed, the ADA and the Rehabilitation Act are about compensating and allowing for the taking of reasonable risks.[115] Such risks are inherently necessary to provide an effective remedy against discrimination of disabled Americans.

B. CDC Guidance in Determining the Risks and Accommodations Possible With HIV-Positive Surgical HCWs

According to the Supreme Court, not only must courts apply all four factors of the *Arline* test to determine whether a risk posed by an

112. *See id.*

113. *See id.*

114. *See id.*

115. *See, e.g.*, 118 S.Ct. at 2210 (noting that risk-taking is a part of the ADA and necessary to provide an effective remedy against discrimination); Estate of Mauro, 137 F.3d at 407 (6th Cir. 1996) (Boggs, C.J., dissenting) ("The ADA thus requires employers to employ people they would rather not employ, and by whom they believe, rightly or wrongly, their patients would prefer not to be ministered to.").

individual is significant, but that the evaluation of risk must be based on objectively sound medical evidence.[116] Even a good-faith belief that a conclusion regarding the risk of an HIV-positive employee is sound is not enough.[117] Rather, employers must make determinations of the risk posed by the employee based upon a standard of objective reasonableness of the medical evidence and data.[118] The Supreme Court also made clear that the reasonableness of an employer's determination regarding the risk posed by an employee will be judged against the standards and views set forth by "public health authorities, such as the CDC."[119]

As of 1995, no documented case exists of an HIV-positive surgeon transmitting the virus to a patient.[120] Indeed, the CDC estimates that the risk that a single patient might contract the virus from an HIV-positive surgeon ranges from .0024 percent (1 in 42,000) to .00024 percent (1 in 417,000).[121] However, the CDC estimates that the cumulative risk of transmission by an HIV-positive surgeon during the course of his career ranges from .8 percent to 8.1 percent.[122]

In light of the low risk of transmissibility between an HIV-positive surgical HCW and a patient, the CDC recommendeds that HIV-positive surgical HCWs be allowed to perform most surgical procedures.[123] The CDC concludes that strict adherence to "universal pre-

116. *See Bragdon*, 118 S. Ct. at 2210.

117. *See id.*

118. *See id.*

119. *Id.* (citing School Bd. of Nassau County v. Arline, 480 U.S. 273, 288 (1987)). The Supreme Court went on to note that the views of public health authorities are not conclusive and can be refuted by "citing a credible scientific basis for deviating from the accepted norm." *Id.* (citation omitted).

120. *See University of Md. Med. Sys. Corp.*, 50 F.3d 1261, 1263 n.5 (citing Centers for Disease Control, U.S. Dept. of Health & Human Servs., Recommendations for Preventing Transmission of Human Immunodeficiency Virus and Hepatitis B Virus to Patients During Exposure-Prone Invasive Procedures, 40 MORBIDITY & MORTALITY WEEKLY REPORT 1, 3-4 (July 12, 1991) [hereinafter CDC Recommendations].

121. *See id.* at 1263 (citing CENTERS FOR DISEASE CONTROL, U.S. DEPT. OF HEALTH & HUMAN SERVS., OPEN MEETING ON THE RISKS OF TRANSMISSION OF BLOOD-BORNE PATHOGENS TO PATIENTS DURING INVASIVE PROCEDURES (Feb. 21-22, 1991)).

122. *See id.*

123. *See* CDC Recommendations, *supra* note 120, at 5.

cautions" should be sufficient for effective infection control.[124] If universal precautions are followed, the CDC reasons that "[c]urrently available data provide no basis for recommendations to restrict the practice of HCWs infected with HIV . . . who perform invasive procedures."[125]

The CDC recommendations did not stop with simply stating a general rule that HIV-positive surgical HCWs can continue working if universal precautions were followed. Rather, the CDC distinguishes between invasive procedures (including most surgical procedures) and a more limited class of what the CDC terms "exposure-prone" procedures.[126] Exposure-prone procedures are those that create a greater risk of injuring the surgical HCW through a skin pierce.[127] While not specifying which medical procedures would qualify as exposure-prone, the CDC does provide a statement of general guidance:

> Characteristics of exposure-prone procedures include digital palpitation of a needle tip in a body cavity or the simultaneous presence of the HCWs fingers and a needle or other sharp instrument or object in a poorly visualized or highly confined anatomic site. Performance of exposure-prone procedures presents a recognized risk of percutaneous injury to the HCW, and if such an injury occurs the HCWs blood is likely to contact the patient's body cavity, subcutaneous tissues, and/or mucous membranes.[128]

The CDC leaves to health care employers a substantial portion of the decision making as to whether procedures performed at their facility are "exposure-prone" and under what circumstances, if any, can HIV-positive surgical HCWs perform such procedures.[129] It is clear, however, from the language of the CDC's recommendations, that simply because a procedure is invasive, it is not necessarily exposure-prone.[130] Indeed, the CDC seems to almost suggest that an invasive procedure is presumed not to be exposure-prone unless it meets the

---

124. *See id.* Universal precautions include hand-washing, wearing protective gloves and masks, and the exercise of care in using sharp instruments such as needles and scalpels. *See id.*

125. *Id.*

126. *See id.*

127. *See id.*

128. CDC RECOMMENDATIONS, *supra* note 120, at 4.

129. *See id.* at 5.

130. *See id.* at 3-5.

definition.[131]

C. Direct Threat/Significant Risk and Reasonable Accommodation

In the analysis of direct threat or significant risk involving an HIV-positive surgical HCW, if the risk of transmission can be reasonably accommodated, no direct threat exists.[132] Thus, under the CDC's guidelines regarding HIV-positive surgical HCWs, universal precautions should be a sufficient reasonable accommodation in virtually all circumstances.[133] However, even with the precautionary language of the CDC, courts addressing the issue of whether a reasonable accommodation can be made for an HIV-positive surgical HCW have concluded in the negative.[134] Such a conclusion is arguably contradictory to the Supreme Court's admonition that courts defer to the guidance of health care authorities, such as the CDC, and focuses on the severity of the risk of HIV while disregarding the actual risk of transmission. Courts addressing the issue of direct threat or significant risk of an HIV-positive surgical HCW largely ignore the general invasive and exposure-prone distinction suggested by the CDC.[135] Even those courts that discuss the distinction universally defer to the hospital-defendant's ultimate determination regarding the significance of the risk and whether reasonable accommodations can be made.[136] In almost all of these cases, the reasonable accommodation offered by the hospitals was for the HIV-positive surgical HCW to discontinue working in the invasive surgical environment.[137] Rather, the hospitals typically either fired the HIV-positive surgical HCW, or offered that

131. *See id.*

132. *See* 42 U.S.C. § 12111(3) (1994). Indeed, this statutory language of the ADA, meant to incorporate the *Arline* factors, expressly provides for the balance of all the factors, including transmission. *See id.*; *see also* 28 C.F.R. § 36.208 (1998).

133. *See supra* Part II.B.

134. It should be noted that the Supreme Court in *Bragdon* concluded that the CDC recommendations involving the use of universal precautions with invasive dental surgery do not "assess the level of risk" involved. *See Bragdon,* 118 S.Ct. at 2211 (1998). Rather, these recommendations, in the Court's view, set out "the best way to combat the risk of HIV transmission." *Id.*

135. *See, e.g., Scoles,* 887 F. Supp. at 768-69.

136. *See supra* notes 80–99 and accompanying text.

137. *See supra* note 137 and accompanying text.

person an administrative position.[138] While some courts allowed an HIV-positive surgical HCW to work on a patient with informed consent,[139] most did not address this issue.[140] No attempt was made by any of these courts to ascertain whether, as a reasonable accommodation, the surgical HCW could perform the large class of invasive procedures identified by the CDC as not posing a significant risk to the patient.[141] The failure by these courts to assess the significance of the risk based upon the CDC's recommendations to find reasonable accommodations is congruent with their failure to give proper consideration to all four *Arline* factors, including risk of transmission.[142]

III. CONCLUSION

Health care facilities that employ HIV-positive surgical HCWs face an unenviable dilemma. If they retain the HIV-positive HCW, they face the potential for major legal, social, and moral liability to a patient who may become infected by the employee. On the other hand, if the health care facility simply discharges the employee or fails to offer reasonable accommodation, the facility faces potential liability from the employee who brings an action under the ADA and/or the Rehabilitation Act. While the courts addressing this issue tend to categorically defer to the employer's decision to dismiss the HIV-positive surgical HCW

and/or the employer's failure to offer the HCW accommodation, the Supreme Court appears to have compassed the analysis back to its original heading. Under this analysis, courts should carefully consider not only the severity of HIV when determining if an HIV-positive surgical HCW is a direct threat or significant risk, but also should consider the actual risk of transmission based upon those factors outlined by the CDC. In the final analysis, however, the HIV-positive surgical

138. *See*, e.g., *supra* note 137 and accompanying text.

139. *See*, e.g., *Scoles*, 887 F. Supp. at 765.

140. *See*, e.g., *supra* note 137 and accompanying text. Of course, the plaintiff in *Scoles* argued that even informed consent was not reasonable, as it eliminated his patient list. *Scoles*, 887 F. Supp. at 767.

141. *See supra* note 137 and accompanying text. As the courts did not address alternative avenues of reasonable accommodation, they did not reach the reasonable accommodation/undue hardship balancing noted previously. *See supra* notes 30-33 (noting factors for determining whether undue hardship exists).

142. *See supra* Part II.A.

HCW faces a difficult battle as health care facilities and courts must remember the Hippocratic maxim to "first, do no harm" in their attempt to protect both the patient and the HIV-positive surgical HCW.