

HEALTH CARE ADMINISTRATION LAW: THE ADA AND ACCESS TO HEALTH CARE

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I. INTRODUCTION

As patients with disabilities have sought access to care under the Americans with Disabilities Act (“ADA”), the courts have slowly begun to flesh out this law in its application to health care providers. In the courts’ interpretations of the ADA, they have relied heavily on both the legislative history and the pre-ADA case law dealing with the disabled patients’ access to care. In particular, the courts have looked to the Rehabilitation Act of 1973. This reliance is well-founded, as the ADA is built upon and flows from this earlier law. This paper chronologically examines the Rehabilitation Act cases and then the ADA cases dealing with patient access to health care. A comparative analysis of the cases under both laws is then made to clarify the present position and perhaps show the future direction of the courts in interpreting the ADA.

While the ADA protects against all disability-based discrimination, this article will focus mainly on the case law dealing with the disabilities Acquired Immune Deficiency Syndrome (“AIDS”) and Human Immunodeficiency Virus (“HIV”), significant interpretations of the

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ADA having been made in these cases. A few pivotal cases dealing with other kinds of disabilities will also be analyzed.

II. The Duty To Treat

A. PHYSICIANS' COMMON LAW DUTY TO TREAT

Before the Rehabilitation Act of 1973 and the Americans with Disabilities Act of 1990, the only legal duty of a physician to accept a patient for treatment arose out of the common law. Under the common law rule, the physician-patient relationship was based on contract and, therefore, the physician and the patient were both free to choose or reject each other.¹ There were, however, two well-recognized exceptions to this common law rule. Under the *emergency treatment rule* it was accepted that because the patient in need of emergency medical treatment did not have the option of choosing or rejecting the physician, in all fairness, neither did the physician have the option of choosing nor rejecting the patient. A duty was imposed upon the physician to treat the emergency room patient who entered under emergency circumstances. This duty only extended through the true emergency situation, and ended once the patient was in stable condition, and could be transferred.²

The second exception to the common-law rule was that the physician could not abandon the patient once the physician-patient relationship was established. A physician was bound to continue to treat the patient until the relationship ended, for example, when the patient no longer required treatment, or by mutual agreement, or by

¹ Ann Bitton Gavzy & James V. Hetzel, *To Treat or Not to Treat: Healthcare Providers' Duties*, 126 N. J. Law. 52, 56 (1989) (citing George, J. Annas, *Legal Risks and Responsibilities of Physicians in the Aids Epidemic*, Hastings Ctr. Rept., Apr.-May 1988 (Special Supp.), at 26-30). See generally Nancy A. Moore, *Aids Discrimination Under the Rehabilitation Act: When A Physician Refuses to Treat, Who is Liable?*, 42 DePaul L. Rev. 505, 513-14 (1992) (citing Bernard Lo, *Obligations to Care for Persons with Human Immunodeficiency Virus*, 4 Issues L. & Med. 367 (1988)); Jill Cohen, *Access to Medical Care for HIV-Infected Individuals Under the Americans with Disabilities Act: A Duty to Treat*, 18 Am. J.L. & Med. 233, 236 (1992).

² Cohen, *id.* at 236. See also Lynn Deitzer, *The Physician's Duty to Treat Persons With AIDS*, 27 New Eng. L. Rev. 565, 571 (1992) (citing Troyen A. Brennan, *Ensuring Adequate Health Care for the Sick: The Challenge of the Acquired Immunodeficiency Syndrome as an Occupational Disease*, 1988 Duke L.J. 29, 35, 38).

the act of the patient, or by the act of the physician after the physician had given adequate notice to the patient.³

The only other circumstance under which a physician might have been required to treat a patient was the one in which the physician was an employee of a hospital or a managed care company such as a Health Maintenance Organization (“HMO”) or Preferred Physician Organization (“PPO”) and his employer directed him to treat certain patients. A refusal to treat in such a circumstance resulted in a breach of contract with the employer, unless the employee-physician could defend his refusal to treat.⁴

B. ETHICAL DUTY TO TREAT

The various medical and dental professional associations continue to put forth their official stands on the health care provider’s ethical duty to treat patients. In 1987 the American Medical Association (“AMA”) stated that a physician may not ethically refuse to treat a patient whose condition is within the physician’s current realm of competence solely because the patient is seropositive for the AIDS virus.⁵ In 1991 the same statement was issued.⁶ In 1986 the American College of Physicians and Infectious Disease Society of America stated that the denial of care to sick and dying patients for any reason is unethical.⁷ The American Dental Association in 1991 issued an advisory opinion which stated that a dentist has the general obligation to provide care to those in need, and that a decision not to provide treatment to an individual because the individual has AIDS or is HIV seropositive is unethical.⁸ The American College of Surgeons in 1991 concluded that surgeons, too, have the same ethical obligations to render care to HIV-infected patients as they have to

³ Gavzy, *supra* note 1, at 56 nn.9-12; Moore, *supra* note 1, at 514. *See also* Deitzer, *supra* note 2, at 571 & nn.62-63.

⁴ Gavzy, *supra* note 1, at 56 nn.14-15.

⁵ Moore, *supra* note 1, at 511-12 n.55 (citing Council on Ethical and Jud. Aff., Am. Medical Ass’n, *Ethical Issues Involved in the Growing AIDS Crisis*, 259 JAMA 1360, 1361(1988)).

⁶ Council on Ethics and Jud. Aff., Am. Medical Ass’n, Code of Medical Ethics 145 (1994).

⁷ Gavzy, *supra* note 1, at 57 n.22 (citing *Joint Position Paper of the Am. C. of Physicians and The Infectious Disease Soc’y of Am.*, Health and Public Pol’y Committee, Am. C. of Physicians and The Infectious Disease Soc’y of Am. (1986)).

⁸ Moore, *supra* note 1, at 511 & n.54 (citing Am. Dental Ass’n Council on Ethics, bylaws and Jud. Aff., ADA Principles of Ethics and Code of Professional Conduct 2(1991)).

care for other patients.⁹ The American College of Emergency Physicians (“ACEP”) in 1988 issued a following statement which confirmed its belief that appropriate emergency care should be provided to all patients who seek emergency care, regardless of HIV status or risk factor.¹⁰ Later, in 1993, the ACEP statement was amended to include that appropriate emergency care should be provided to all patients who seek emergency care, regardless of risk factors for or known infection with HIV or other blood borne infections.¹¹ These professional associations, however, have no power to impose sanctions. Additionally, with the enactment of the laws that impose a legal duty to treat, these ethical pronouncements have become less relevant to the disabled patient’s pursuit of access to care. Nevertheless, courts have sometimes used these associations’ positions in reaching their decisions.¹²

II. Federal Requirements

A. The Rehabilitation ACT of 1973

1. Generally

Efforts by Congress to prohibit discrimination against persons with disabilities began with laws designed to help returning World War I veterans with disabilities to find jobs.¹³ Over the next few decades, the anti-discriminatory legislation continued to focus on vocational rehabilitation, culminating with The Rehabilitation Act of 1973.¹⁴ The Rehabilitation Act appears to be a broad prohibition against discrimination: “[N]o otherwise qualified individual with handicaps in the United States . . . shall, solely by reason of her or his handicap, be

⁹ *Id.* (citing Am. C. of Surgeons, *Statement on the Surgeon and HIV Infections*, Am. C. Surgeons Bull., Dec. 1991, at 28-31).

¹⁰ *Id.* (from Am. C. of Emergency Physicians, *AIDS—Statement of Principles and Interim Recommendations for Emergency Department Personnel and Prehospital Care Providers*, 17 *Annals of Emergency Med.* 1249 (1988)).

¹¹ *HIV and Bloodborne Infections in Emergency Medicine*, Am. C. Emergency Physicians Policy Statement (Feb. 1993) (on file with author).

¹² *United States v. Morvant*, D.D.S., No. 93-CA3251, 1995 WL 131093, at *5 (E.D. La. Mar. 22, 1995).

¹³ Deitzer, *supra* note 2, at 572-73 (discussing the Smith Fess Act and its amendments).

¹⁴ 29 U.S.C. § 503 (1973) (current version codified at 29 U.S.C.A. § 793 (1985 & Supp. 1995)).

excluded in the participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving federal financial assistance.”¹⁵ It was, however, still limited to vocational rehabilitation because of its definition of a “handicapped person.”¹⁶ Section 504 of The Rehabilitation Act of 1973 defined the term *handicapped individual* as “any individual who (A) has a physical or mental disability which for such individual constitutes or results in a substantial handicap to employment and (B) can reasonably be expected to benefit in terms of employability from vocational rehabilitation services.”¹⁷

The 1974 amendment to the Rehabilitation Act greatly changed the act’s focus by amending the definition of a handicapped individual. The amended version was patterned after the language in Title VI of the Civil Rights Act of 1964 and was meant to include equal access to any programs and activities, not just employment.¹⁸ The new definition of handicapped individual included those who were *perceived* as having a handicap as well as those who actually had a handicap, and it also omitted any reference to employment or vocational rehabilitation. The regulations defined a person with a handicap as one who “(i) has a physical or mental impairment which substantially limits one or more major life activities, (ii) has a record of such an impairment, or (iii) is regarded as having such an impairment.”¹⁹ An impairment was defined as “any physiological disorder or condition . . . affecting one or more . . . body systems . . . [including] . . . hemic and lymphatic.”²⁰

¹⁵ Section 504 of The Rehabilitation Act of 1973 (current version codified at 29 U.S.C.A. § 794 (1985 & Supp. 1995)).

¹⁶ Moore, *supra* note 1, at 516 (citing legislative history and case law that the original version was limited to vocational rehabilitation).

¹⁷ Rehabilitation Act of 1973, Pub. L. No. 93-112, § 7, 87 Stat. 359 (1973) (current version codified at 29 U.S.C.A. § 706(8)(B) (1985 & Supp. 1995)). For a discussion of the original definition see Deitzer, *supra* note 2, at 572-73.

¹⁸ Deitzer, *supra* note 2, at 574. “The definition was derived from the Title VI of the Civil Rights Act recognizing the handicapped as a minority whose civil rights had been violated, rather than ‘objects of charity or a potential workforce.’” *Id.* at n.93 (quoting N.L. Albert, *A Right to Treatment for AIDS Patients*, 92 Dick. L. Rev. 743, 762 (1988)). See also Moore, *supra* note 1, at 514 & nn.77, 79 (citing legislative history to the effect that the amended version of Section 504 was fashioned after Title VI of the Civil Rights Act of 1964).

¹⁹ 29 U.S.C. § 706(7)(B) (1974) (current version codified at 29 U.S.C.A. § 706(8)(B) (1985 & Supp. 1995)). For a discussion of the change in the definition see Moore, *supra* note 1, at 516—17 & nn.86—88.

²⁰ 34 C.F.R. § 104.3(j)(2)(i) (1995). See also Joel Neugarten, *The Americans with Disabilities Act: Magic Bullet or Band-Aid for Patients and Health Care Workers Infected With the Human Immunodeficiency Virus?*, 57 Brook. L. Rev. 1277, 1309 (1992); Moore, *supra* note 1, at 515—16 & n.83.

The 1974 amendment did not change the limitation that only *otherwise qualified* individuals with handicaps were protected by the act.²¹ Otherwise qualified individuals were those who could meet the essential requirements of a program or position with or without *reasonable accommodation* by the covered entity.²² Accommodation was reasonable up to the point where the nature of the program was altered by the accommodation or the accommodation created an undue burden on the covered entity.²³

The amended version also did not change the limitation that the law was only applicable to entities receiving federal funding.²⁴ Initially, physicians in private practice were not liable under this law unless they were receiving federal funding and the procedure to be performed on the particular patient was specifically covered by the federal funding.²⁵ Hospitals were the more probable defendants as they were more than likely receiving federal funding through Medicare, or under the Hospital Survey and Construction Act of 1944.²⁶ A hospital could be liable for the acts of a physician under *respondeat superior* if the physician was an employee of the hospital, or under the theory of ostensible agency if the hospital had done any act which led the patient to believe that the physician was the agent of the hospital.²⁷ A later amendment extended the liability of those who received federal funding to say that if a health care provider received federal funds for any activity or program, the health care provider was covered, regardless of whether the specific procedure done on a particular patient plaintiff was funded.²⁸

14. Early Case Law Under the Rehabilitation Act

Early courts interpreting the amended Rehabilitation Act struggled with the issues of right of action, damages, and whether the definition of handicapped included individuals with contagious diseases,

²¹ 29 U.S.C. § 504 (1974) (current version codified at 29 U.S.C.A. § 794 (1985 & Supp. 1995)).

²² See 34 C.F.R. § 104.3(kXI) (1995).

²³ See 34 C.F.R. § 104.12(a) (1995) (setting out the factors to be considered in determining undue hardship).

²⁴ *Id.* at 1309 & n.145.

²⁵ *Glanz v. Vemick*, 756 F. Supp. 632, 637 (D. Mass. 1991).

²⁶ 42 U.S.C. § 291 (1944) (Hill-Burton Act) (current version codified at 42 U.S.C.A. § 291 (1991 & Supp. 1995)).

²⁷ *Glam*, 756 F. Supp. at 636-37.

²⁸ Sydney D. Watson, *Eliminating Fear Through Comparative Risk: Docs, AIDS, and the Antidiscrimination Ideal*, 40 Buff. L. Rev. 739, 765-66 n.119 (1992) (discussing the Civil Rights Restoration Act of 1987).

both symptomatic AIDS and asymptomatic HIV. The courts also defined the burden of proof which involved an examination of the meaning of the term otherwise qualified. In 1981 in *Pushkin v. University of Colorado*²⁹ the Tenth Circuit held that plaintiffs had a private right of action under the Rehabilitation Act. The 8th Circuit in *Miener v. Missouri*³⁰ further held that damages could be awarded under Section 504. In 1981, the *Pushkin* court also set out the burden of proof standard which a plaintiff must meet. The plaintiff in *Pushkin*, who suffered from multiple sclerosis, was denied admission into a psychiatric residency program. The court rejected the rational basis test of equal protection, and refused to require that plaintiff prove discriminatory intent under the disparate treatment test of *McDonnell Douglas v. Green*³¹ as modified in *Texas Department of Community Affairs v. Burdine*,³² The court stated that a disparate impact test would be a better test to use where a facially neutral practice has a discriminatory impact on persons within a protected class.³³ The court, however, found that none of these tests were applicable because the statute itself set forth the test to be used; that is, that the individual was qualified and, though qualified, he was rejected solely because of his handicap.³⁴ In effect, the *Pushkin* court modified the traditional burden-shifting test established in *McDonnell Douglas* as modified in *Burdine*. Under this new model for ADA cases:

- 1) The plaintiff must establish a prima facie case by showing that he was an otherwise qualified disabled person apart from his handicap, and was rejected under circumstances

²⁹ 658 F.2d 1372 (10th Cir. 1981).

³⁰ 673 F.2d 969 (8th Cir. 1982), *cert. denied*, 459 U.S. 909 (1982).

³¹ 411 U.S. 792 (1993) (setting forth the basic allocation of burdens and order of presentation of proof in a Title VII case alleging discriminatory treatment).

³² 450 U.S. 248 (1981). The court explained the nature of proof. "The burden that shifts to defendant, therefore, is to rebut the presumption of discrimination by producing evidence that the plaintiff was rejected, or someone else was preferred, for a legitimate, nondiscriminatory reason. The defendant need not persuade the court that it was actually motivated by the proffered reasons." *Id.* at 255.

³³ *Pushkin*, 658 F.2d at 1385 (citing *Griggs v. Duke Power Co.*, 401 U.S. 424 (1971) which held that a facially neutral practice may have a discriminatory impact on persons within a protected class).

³⁴ *Id.* at 1385-87 (citing *Southeastern Community College v. Davis*, 442 U.S. 397 (1979) wherein the Supreme Court stated that if the individual's handicap would preclude him from doing the job in question, then the individual would not be otherwise qualified, so if the individual could perform the job in question, then he could not be rejected solely on the basis of his handicap).

which gave rise to the inference that his rejection was based solely on this handicap;

2) Once the plaintiff establishes his prima facie case, defendant has the burden of going forward and proving that the plaintiff was not an otherwise qualified disabled person, that is, one who is able to meet all of the program's requirements in spite of his handicap, or that his rejection from the program was for reasons other than his handicap;

3) The plaintiff then has the burden of going forward with rebuttal evidence showing that the defendants' reasons for rejecting the plaintiff are based on misconceptions or unfounded factual conclusions, and that reasons articulated for the rejection other than the handicap encompass unjustified consideration of the handicap itself.³⁵

The court then found that Pushkin successfully rebutted the defendants' claim that Pushkin could not meet the program's requirements. Pushkin showed that he was *otherwise qualified*.

In 1984 in *United States v. University Hospital*,³⁶ the Second Circuit found Baby Jane Doe, who suffered from numerous birth defects, to be *handicapped* within the Rehabilitation Act. The parents of Baby Jane Doe had refused to give permission to the hospital to operate on the baby, but rather chose a more conservative course of treatment. The hospital was sued by the Department of Health and Human Services ("HHS") for refusing to release the baby's medical records to them so that HHS could conduct an investigation into an alleged violation of the Rehabilitation Act.

As to the burden of proof, the *University Hospital* court did not follow *Pushkin* in allowing a rebuttal by plaintiff when the handicap was related to the alleged discriminatory decision. On the *otherwise qualified* issue, the court cited *Southeastern Community College v. Davis*³⁷ and *Doe v. New York University*³⁸ as the leading cases in establishing the burden of proof. The court then held that these cases could be distinguished, however, because they concerned relatively static situations involving education, transportation, and employ

³⁵ *Id.* at 1387.

³⁶ 729 F.2d 144 (2d Cir. 1984).

³⁷ 666 F.2d 761 (2d Cir. 1981) (holding that an otherwise qualified person is one who can meet all of a program's requirements *in spite of* his handicap, not *except as to limitations* imposed by the handicap).

³⁸ 442 U.S. 397 (1981) (holding that the burden of the defendant is to rebut the inference that the handicap was improperly taken into account by going forward with evidence that the handicap is relevant to qualifications for the position sought).

ment where it felt the decision of the provider could be challenged as a pretext for discrimination. The court went on to hold that “the [otherwise qualified] phrase cannot be applied in the relatively fluid context of medical treatment decisions.”³⁹ Section 504 “prohibits discrimination against a handicapped individual only where the individual’s handicap is unrelated to, and thus improper to consideration of, the services in question.”⁴⁰ “[T]he ‘otherwise qualified’ criterion of Section 504 cannot be meaningfully applied to a medical treatment decision.”⁴¹ The court found that to try to judge medical decisionmaking would require lengthy litigation involving conflicting expert testimony which this court did not think was intended by the statute. The court, therefore, held that the Rehabilitation Act did not reach medical treatment decisions regarding defective newborn infants, and, therefore, HHS did not have the authority to investigate or compel the production of medical records.⁴²

Subsequently, the question of whether or not individuals with contagious diseases were handicapped arose in situations not involving health care. In 1986 in *Community School Board v. Board of Education of New York*,⁴³ a New York court found that HIV-positive, but asymptomatic, schoolchildren were handicapped under Section 504 because they had impairment of the hematologic and lymphatic systems. The court also found that the plaintiff could not be excluded because of a mere theoretical possibility of transmission of the disease. In 1987 in *Ray v. School District of Desoto County*,⁴⁴ a federal district court found that HIV-infected schoolchildren were handicapped under Section 504.

A similar case reached the Supreme Court in 1987. In *School Board of Nassau County v. Arline*⁴⁵ the Court dealt with the issue of whether or not the *contagious state* was a handicap. A teacher with tuberculosis was permanently dismissed after a relapse of the disease, and the school board admitted that the sole reason for her dismissal was her diagnosis of tuberculosis. The Supreme Court affirmed the court of appeals holding that Congress had patterned the amended Section 504 after Title VI of the Civil Rights Act of 1964, and intended to prevent discrimination against not only those who were actually handicapped, but also those who are merely per

³⁹ *Id.* at 156-57 (citing legislative history to show Congress did not intend this Act to reach into the medical realm).

⁴⁰ *University Hospital*, 729 F.2d at 156.

⁴¹ *Id.*

⁴² *Id.* at 145.

⁴³ 502 N.Y.S.2d 325 (Sup. Ct. 1986).

⁴⁴ 666 F. Supp. 1524 (M.D. Fla. 1987).

⁴⁵ 480 U.S. 273 (1987).

ceived as having a handicap, regardless of their physical condition. Nevertheless, the *Arline* court did not answer the question of whether or not a person who is simply contagious, such as an asymptomatic HIV-positive person who does not suffer from physical or mental impairments, would qualify as *handicapped* under the Act. It held, rather, that it was the *underlying contagious disease* of tuberculosis in this particular case that qualified this individual for protection against discrimination.⁴⁷ The *Arline* court cited regulations by HHS, which included in the definition of physical impairment “any physiological disorder or condition . . . affecting one or more of the following body systems . . . respiratory . . . reproductive . . . hemic . . . and lymphatic . . .”⁴⁸

The Supreme Court, however, did make significant rulings in *Arline*. It found that the contagious state may be considered in determining whether the individual is otherwise qualified, that is, whether or not the individual could meet the essential requirements of the program or position with or without reasonable accommodation.⁴⁹ In making the otherwise qualified determination, the contagious state did not justify the *per se* exclusion of all those with contagious diseases from the protection of the Act, “for the impact of such an exclusion would be to foster the very irrational fear that the Act sought to prevent.”⁵⁰ *Arline* said that each case must be individually evaluated to determine whether or not a person has been denied a benefit or a service as a result of discrimination or because the contagious state caused a significant risk which could not be eliminated by reasonable accommodation.⁵¹

The Court went on to set out the test to be used in order to determine the significance of the risk and whether it could be eliminated by reasonable accommodations by adopting the standards submitted by the AMA in their *amicus curiae* brief. It found that each inquiry should include findings of facts, based on reasonable medical judgment given the state of medical knowledge, about (1) the nature of the risk (how the disease is transmitted), (2) the duration of the risk (how long the carrier is infectious), (3) the severity of the risk (what the potential harm is to third parties) and (4) the probabilities the disease will be transmitted and will cause varying degrees of harm.⁵²

46. *Id.* at 277-279.

47. *Id.* at 281-82 & n.7.

48. *Id.* at 281 (quoting 45 C.F.R. § 84.3(j)(2)(i) (1985)).

49. *Id.* at 285,288.

50. *Id.* at 285.

51. *Id.* at 286-88.

52. *Id.* at 288. *See also* Watson, *supra* note 28, at 785.

In making such determinations, the Court found that lower courts “should defer to the reasonable medical judgments of public health officials.”⁵³ In a footnote, the court said that “this case does not present nor do we address, the question whether courts should defer to the reasonable medical judgment of private physicians on which an employer has relied.”⁵⁴ The *Arline* case was remanded to see if the plaintiff was otherwise qualified.⁵⁵ Subsequently, the lower court found that this teacher’s contagious state was not a significant risk, and the teacher should not be excluded from teaching.⁵⁶

While the *Arline* Court had not actually found that the state of contagion was included in the definition of handicapped, in the next several years courts across the country held that individuals with AIDS, as well as symptomatic and asymptomatic HIV-infected individuals, were within the definition of handicapped under Section 504. Also, while *Arline* did not specifically mention *Pushkin’s* shifting burden analysis, the cases that followed *Arline* allowed the plaintiff to rebut the decision of a physician not to treat within the context of the otherwise qualified test.

In 1988 in *Chalk v. United States*⁵⁷ the Ninth Circuit Court affirmed the district court’s finding that a teacher with AIDS was handicapped under Section 504 of the Rehabilitation Act, and applied *Arline’s* otherwise qualified test.⁵⁸ The teacher was otherwise qualified, unless found to be a significant risk to health and safety of other employees and reasonable accommodation would not eliminate the risk. Relying on current medical opinion of public health officials that casual contact with this condition in the classroom setting did not present a significant risk,⁵⁹ the court concluded that the teacher was otherwise qualified.

That same year in *Doe v. Centinela Hospital*⁶⁰ a United States district court in California held that a plaintiff must prove four elements: “(1) he falls within the Rehabilitation Act’s definition of an ‘individual with handicaps’; (2) he is ‘otherwise qualified’ for the benefit or program from which exclusion has occurred; (3) his handicap constitutes the sole reason for his exclusion; and (4) Section 504 applies to the program that excluded him”.⁶¹ The court found that an

⁵³ *Id.* at 288.

⁵⁴ *Id.* at 289 n.18.

⁵⁵ *Id.*

⁵⁶ *Arline v. School Board of Nassau County*, 692 F. Supp. 1286 (M.D. Fla. 1988).

⁵⁷ 840 F.2d 701 (9th Cir. 1988).

⁵⁸ *Id.* at 707-708.

⁵⁹ *Id.* at 707-709.

⁶⁰ 57 U.S.L.W. 2034 (C.D. Cal. June 30, 1988).

⁶¹ *Id.* at *4.

asymptomatic HIV-positive patient denied entry into a drug rehabilitation program was perceived to have a handicap, and therefore protected by the Rehabilitation Act.⁶² However, the court limited its findings to the facts of this case, and did not reach the broader question of whether or not all asymptomatic HIV-positive patients were covered by the Act. The court then applied the *Arline* otherwise qualified test in order to determine the *significant risk*.⁶³

In a 1990 employment discrimination case, *Leckelt v. Board of Commissioners of Hospital District No. 1*,⁶⁴ the Fifth Circuit Court adopted the *Pushkin* burden-shifting of proof, and took for granted, without reasons, that an asymptomatic HIV-positive employee had an impairment under the protection of the Act.⁶⁵ In this case, while the plaintiff nurse was found to be handicapped because of his HIV-positive infection, he was not otherwise qualified to keep his position, not because of his handicap, but because he had not followed hospital rules and regulations.⁶⁶ The medical opinion of the defendant was not at issue as to whether the plaintiff was otherwise qualified.

Ruling on a motion for summary judgment in another significant case, a United States district court in Massachusetts in *Glanz v. Vernick*⁶⁷ held that an HIV-positive patient was handicapped within the meaning of Section 504 of the Rehabilitation Act.⁶⁸ In making the decision of whether or not there were genuine issues of fact surrounding the inquiry as to whether the patient was otherwise qualified, however, the *Glanz* court found a problem with the *Arline* test. In this case, after a physician had recommended that a patient have ear surgery, the physician found out the patient was HIV-positive and refused to perform the surgery. In applying the *Arline* otherwise qualified test, the court noted that the significance of the risk in medical cases was to be determined by "reasonable medical judgment of public health officials."⁶⁹ The problem was that the *reasonable medical judgment* was to be made by the very medical people who were being accused of discrimination. The implication was that the court would not be able to tell if their judgment of the risk was biased. Complete reliance on medical opinion would allow doctors to refuse medical treatment to HIV-infected persons under the guise of a sound

62. *Id.* at *5-6.

63. Cohen, *supra* note 1, at 238-39.

64. 909 F.2d 820 (5th Cir. 1990).

65. *Id.* at 825.

66. *Id.* at 830.

67. 756 F. Supp. 632 (D. Mass. 1990).

68. *Id.* at 635.

69. *Id.* at 638.

medical decision.⁷⁰ The court did not distinguish the medical judgment of the treating health care provider from the medical judgment of public health officials.

The *Glanz* court reestablished the rationale used in the interpretation of the Civil Rights Act of 1964 and established in *Pushkin*⁷¹ that is, that the plaintiff must initially present a *prima facie* case that he was otherwise qualified to receive the medical procedure before the burden would shift to the defendant to prove that he was not qualified. The burden would then shift back to the plaintiff who would have the right to show that the medical reason for the refusal to treat was a pretext for discrimination or that the defendants based their decision on an “unjustified consideration of the handicap itself.”⁷² Under this analysis, the *Arline* individual assessment was done with the use of *current medical knowledge* to determine whether there was a *significant risk*. The plaintiff would then have a chance to show that this defendant’s medical determination was a pretext for discrimination. Upon examination of the facts, the court denied the summary judgment and held that there were genuine issues of fact as to the “otherwise qualified” determination. *Glanz* also found that the physician had discriminated, but could not be held individually liable under the Rehabilitation Act because he did not receive federal funding for this particular patient.⁷³ *Glanz* found, however, that the *hospital*, which received federal funding, was liable under the doctrine of *respondeat superior*, though the doctor was not liable individually.⁷⁴

In cases following *Glanz*, some courts did not agree that the plaintiff should have the opportunity to dispute the medical reasons given by the health care provider. In *Doe v. Kahala Dental Group*⁷⁵ the plaintiff alleged that the defendant dental group violated Hawaii’s anti-discrimination statute by refusing to perform dental work because plaintiff declined to reveal his HIV status. The court accepted the dentist’s argument that procedures would expose the dentist to significant risk, and did not follow *Glanz* to inquire further whether the medical opinion was a pretext for discrimination.”

⁷⁰ *Id.* at 638-639.

⁷¹ *Id.* at 638.

⁷² *Id.* at 638-639 (citing *Pushkin*, 658 F.2d at 1387).

⁷³ *Id.* at 636-37.

⁷⁴ *Id.*

⁷⁵ 808 P.2d 1276 (D. Haw. 1991).

⁷⁶ *Id.* at 1277—78. See also Neugarten, *supra* note 20, at 1322 (1992) (asserting that this approach discounted Center for Disease Control guidelines for universal precautions).

In 1993, a district court in Pennsylvania again refused to allow inquiry into medical decision-making process. In *Toney v. United States Healthcare, Incorporated*⁷⁷ the plaintiff did not claim a denial of access to health care, but rather, discrimination in the manner in which he was handled and the effect of such treatment protocol. The court held that under the Rehabilitation Act, plaintiff must prove that although he was handicapped, he was otherwise qualified for medical treatment, and that he was denied solely by reason of his handicap, and that the program received federal funding.⁷⁸ The court, however, did not follow *Glanz* as to the burden of proof where the plaintiff would have the opportunity to prove the defendant's reason for his actions was a pretext. The *Toney* court followed the Second Circuit's decision in *University Hospital* instead, which concluded that the otherwise qualified wording of the Rehabilitation Act "cannot be applied in the relatively fluid context of medical treatment decisions without distorting its plain meaning." Accordingly, "where the handicapping condition is related to the condition(s) to be treated, it will rarely, if ever be possible to say with certainty that a particular decision was discriminatory. . . [T]here is no evidence of Congressional intent to involve federal personnel in medical treatment decisions."⁷⁹ The *Toney* court concluded that "a determination by a physician of when her regular patient's condition warrants an additional office visit is a medical treatment decision not subject to judicial review."⁸⁰ The court distinguished *Glanz* on the grounds that in *Glanz* the plaintiff was suffering from a condition unrelated to his HIV status, an ear infection, while *Toney's* handicapping condition, HIV infection, was exactly the same condition for which he sought medical attention.⁸¹

Following *University Hospital* and *Johnson v. Thompson*⁸² the *Toney* court also found that the Rehabilitation Act required a finding that the disability was the sole basis for the discrimination and that because the doctor saw other patients with the same disability, the plaintiff failed in this regard and was not entitled to judgment as a matter of law.

⁷⁷ 838 F. Supp. 201 (E.D. Pa. 1993).

⁷⁸ *Id.* at 202-203.

⁷⁹ *Id.* at 203 (quoting *University Hospital*, 729 F.2d at 156-57,160).

⁸⁰ *Id.* at 204.

⁸¹ *Id.* at 203.

⁸² 971 F.2d 1487, 1493-94 (10th Cir. 1992), cert. denied, 507 U.S. 910 (1993) (following *University Hospital* in holding that the term otherwise qualified cannot be applied in the context of medical treatment decisions without distorting its plain meaning).

⁸³ *Thney*, 838 F. Supp. at 204.

B. CENTER FOR DISEASE CONTROL GUIDELINES

Before an examination of the cases under the ADA, it is important to note the actions of the Center for Disease Control⁸⁴ ("CDC") over the period of time during which these cases were being decided. In 1983 the CDC published a document entitled *Guideline for Isolation Precautions in Hospitals*.⁸⁵ In this document the CDC recommended that blood and body fluid precautions be taken when a patient was known or suspected to be infected with blood borne pathogens. In 1987 the CDC issued *Recommendations for Prevention of HIV Transmission in Health-Care Settings*.⁸⁶ The difference in the recommendations made in the two documents was that in the 1987 recommendation, the CDC recommended that blood and body fluid precautions be consistently used for all patients regardless of their blood borne infection status. Because the blood and certain body fluids of all patients were to be considered potentially infectious for HIV and other blood borne pathogens, the precautions became known as *universal precautions*.

In 1991 the CDC issued recommendations for the prevention of transmission of HIV and Hepatitis B Virus to patients during *exposure-prone procedures*.⁸⁷ These recommendations stated that health care workers who performed non-invasive procedures and adhered to universal precautions and followed guidelines for disinfection and sterilization of instruments and other reusable devices posed no risk of transmission of HIV to patients. The CDC defined two kinds of invasive procedures: non-exposure prone and exposure prone. Those workers who performed non-exposure prone procedures did not pose a significant risk if they adhered to universal precautions, practiced recommended techniques and followed recommended sterilization and disinfectant procedures. Those who performed exposure-prone procedures were to know their HIV status, and those who were HIV-

84. Center for Disease Control, U.S. Department of Health and Human Services, *Update: Universal Precautions for Prevention of Transmission of Human Immunodeficiency Virus, Hepatitis B Virus, and Other Bloodborne Pathogens in Health-Care Settings*, 37 *Morbidity and Mortality Wkly. Rept.* 377-382, 387-388 (1988) (on file with author).

85. *Id.* (citing J.S. Garner, Simons, B.P., *Guidelines for Isolation Precautions in Hospitals*, 4 *Infect. Control* 245-325 (1983)).

86. *Id.* (citing Center for Disease Control, U.S. Department of Health and Human Services, *Recommendations for Prevention of HIV Transmission in Healthcare Settings*, 36 *Morbidity and Mortality Wkly. Rept. fSupp. No. 2S* 1987)).

87. Center for Disease Control, U.S. Department of Health and Human Services, *Recommendations for Preventing Transmission of Human Immunodeficiency Virus and Hepatitis B Virus to Patients During Exposure-Prone Invasive Procedures*, 40 *Morbidity and Mortality Wkly. Rept.* 1-9 (1991) (on file with author).

positive were to refrain from exposure-prone procedures “unless they have sought counsel from an expert review panel and been advised under what circumstances, if any, they could continue to perform exposure-prone procedures.”⁸⁸ Also, these workers were to notify potential patients of their HIV-positive status before performing any permitted exposure-prone procedure.

The CDC Recommendations issued in 1991 restricting health care workers who performed exposure-prone procedures were met with great opposition by the health care workers and AIDS activists. The Recommendations were thought to be without scientific evidence, and both under-inclusive in some regards and over-inclusive in others. The CDC dropped a proposal to designate exposure-prone procedures, but did not withdraw its 1991 recommendations.⁸⁹ Later in 1991, however, when five patients died in Florida after contracting AIDS from an infected dentist, Congress passed legislation requiring states to enact into law the 1987 CDC guidelines or their equivalent.⁹⁰ The Occupational Safety and Health Administration (“OSHA”) has also endorsed *universal precautions*⁹¹ which require health care employers to “institute engineering and work practice controls, provide medical surveillance and training in infection control practices, and provide adequate protective clothing and equipment.”⁹²

These CDC Guidelines have been used by the courts in their interpretation of the reasonable accommodations requirement which may be necessary to eliminate the significant risk of the contagious individuals under the Rehabilitation Act and ADA.⁹³ The fact that these precautions are required in the treatment of all patients figured greatly in later decisions regarding the reasonableness of accommodations which must be made for HIV and AIDS patients.

88. Neugarten, *supra* note 20, at 1304-1305.

89. Watson, *supra* note 28, at 763.

90. Neugarten, *supra* note 20, at 1306; Watson, *supra* note 28, at 763. See, e.g., La. Rev. Stat. Ann. § 37:1746-47 (West 1988 & Supp. 1996). See also Jane H. Barney, *Health Care Workers' Duty to Under Go Routine Testing for HIV/AIDS and to Disclose I\>sitii'? Results to Patients*, 52 La. L. Rev. 933 (1992).

91. Neugarten, *supra* note 20, at 1336.

92. See 29 U.S.C.A. § 6511aMb> (1991 & Supp. 1995).

93. Neugarten, *supra* note 20, at 1326-1328.

IV. The Americans with Disabilities Act

A. AN Overview

In 1990 Congress passed the Americans with Disabilities Act” under its authority to regulate interstate commerce and to enforce the Fourteenth Amendment with regard to discrimination against individuals with disabilities.”⁹⁶ It is clear from the legislative history of the ADA and the language of the statute itself that Congress intended to codify the case law under the Rehabilitation Act of 1973,“ as amended, and to broaden both the covered entities and the protections afforded by this law beyond the Rehabilitation Act and its case progeny.⁹⁷ The purpose of the ADA is “to provide a clear and comprehensive national mandate for the elimination of discrimination against individuals with disabilities.”⁹⁸ The definition of disability tracks the amended Rehabilitation Act definition, defining a disability as either 1) a physical or mental impairment that substantially limits one or more of the major life activities of such an individual; 2) a record of such an impairment; or 3) being regarded as having such an impairment.⁹⁹

Asymptomatic and symptomatic HIV-infected individuals and individuals with AIDS are both included under either the first prong of the definition of individuals with disabilities, on the grounds that the disease substantially limits the major life activities of procreation and intimate sexual relations,“ or under the third prong because of

94. 42 U.S.C.A. §§ 12101-12213(1995).

95. 42U.S.C.A. § 12101(bX4) (1995).

96. Rosemary E. Mahoney & M.D. Gibofsky, *The Americans with Disabilities Act of 1990*, 13 J. Legal Med. 51, 57, 67, 111 (1992) (citing case law and legislative history showing the ADA was built upon the Rehabilitation Act and its cases). See also 28 C.F.R. §§ 36.104, 208 (1991). For reference to the relationship between the Rehabilitation Act of 1973 and the Americans with Disabilities Act see *Section By- Section Analysis and Response to Comments* in 56 Fed. Reg. 35546—548 (1995).

97. Cohen, *supra* note 1, at 242; Mahoney, *supra* note 96, at 62 (1992) (citing H R. Rep. No. 485(11), 101st Cong., 2d Sess. 24, reprinted in 1990 US. Code Cong. & Admin. News 303,329).

98. 42 U.S.C.A § 12101(bXI) (1995).

99. 42 U.S.C.A § 12102(2) (1995); 28 C.F.R. § 36.104(1991).

100. 28 C.F.R. § 36.104UMi) (1991). See Cohen, *supra* note 1, at 244. According to legislative history, HIV-infected individuals are included under first prong because of a substantial limitation to procreation and intimate sexual relationships. *Id.* at 244 n.84.

the perception of contagiousness.¹⁰¹ Homosexuals, bisexuals,¹¹² and drug users, except for persons who have been rehabilitated,¹¹¹ are specifically excluded from the definition as disabled; however, they may fall under the protection of the ADA if they fit under the third prong, "being regarded as having a physical or mental impairment that substantially limits a major life activity."¹⁰⁴ This third prong might also include the sexual partners of these groups,¹⁰⁵ as does the specific ADA provision protecting those who associate with the disabled.¹⁰⁶

Whereas the Rehabilitation Act prohibits discrimination only by entities which receive federal funding, Title III of the ADA extends the prohibition against discrimination to any individual or private entity who owns, leases, or operates a place of public accommodation.¹⁰⁷ Public accommodations include the professional offices of health care providers and hospitals.¹⁰⁸

Under the ADA, private entities who own, lease, or operate a place of public accommodation are prohibited from discriminating against individuals on the basis of disability in the full and equal enjoyment of the goods, services, facilities, privileges, advantages, or accommodations of any place of public accommodation.¹⁰⁹ Discrimination generally can include denying participation in or benefit previously listed, affording separate or unequal access or offering the above in a non-integrated setting, and utilizing administrative standards or criteria or methods of administration which deny or separate or exclude.¹¹⁰

The ADA sets forth a few specific activities which will be considered discriminatory. For example, private entities may not set up eligibility criteria that screen out or tend to screen out individuals with a disability unless such criteria are necessary for the provision of the goods, services, facilities, privileges, advantages, or accommodations being offered.¹¹¹ The health care provider is prohibited from screen

¹⁰¹ 28 C.F.R. § 36.104(l)(iii) (1991).

¹⁰² 28 C.F.R. § 36.104(l)(iv) (1991).

¹⁰³ 28 C.F.R. § 36.209(1991).

¹⁰⁴ Neugarten, *supra* note 20, at 1319 n.201 (citing H.R. Rep. No. 485, 101st Cong., 2d Sess., pt. 3, at 75, reported in 1990 U.S.C.C.A.N. 303, 498 (1992))- 28 C FR § 36.209(a)(2)(iii) (1991).

¹⁰⁵ Neugarten, *supra* note 20, at 1319 n.205.

¹⁰⁶ 28 C.F.R. § 36.205 (1991).

¹⁰⁷ 42 U.S.C.A. § 12182(a) (1995); 28 C.F.R. § 36.104(1991).

¹⁰⁸ 42 U.S.C.A. § 12181(7)(F) (1995).

¹⁰⁹ 42 U.S.C.A. § 12181(7) (1995); 28 C.F.R. § 36.104 (1991).

¹¹⁰ 42 U.S.C.A. § 12182(b)(1)(A) (1995); 28 C.F.R. § 36.201(1991)

¹¹¹ 42 U.S.C.A. § 12182(b)(2)(A)(i) (1995); 28 C.F.R. § 36.301(1991)

ing patients, such as requiring that a prospective patient undergo HIV testing as a means of screening for infected individuals.¹¹² These entities may impose legitimate safety requirements that are necessary for safe operations.¹¹³

Further, entities must make reasonable modifications in policies, practices, or procedures, when such modifications are necessary unless such modifications would fundamentally alter the nature of the goods, services, facilities, privileges, advantages, or accommodations being offered.¹¹⁴ In the context of medical services, physicians are allowed to *refer patients* “if the patient is seeking treatment outside the doctor’s specialization or if the doctor would make a similar referral for an individual without that disability.”¹¹⁵

Entities must also provide auxiliary aids and services unless such aids and services would fundamentally alter the nature of the goods or services or result in an undue burden; examples of auxiliary aids and services include such things as qualified interpreters, readers and notetakers, Brailled materials and assistive listening devices or systems. If providing auxiliary aids or services would result in fundamental alteration or undue expense, then alternatives must be provided that would ensure that, to the maximum extent possible, individuals with disabilities are treated equally.¹¹⁶ Finally, entities must remove architectural barriers, and communication barriers that are structural in nature in existing facilities where such removal is readily achievable or else provide readily achievable, alternative methods of access.¹¹⁷

The ADA does set an important limitation. While the ADA does not state that an individual be otherwise qualified, it does state that this law does not require that individuals who pose a direct threat to the health or safety of others be permitted to participate in or receive the benefit of that private entity’s goods, services, facilities or public accommodations.¹¹⁸ The ADA adopted the otherwise qualified test articulated in *Arline* to define a *direct threat*. “The term ‘direct threat’ means a significant risk to the health or safety of others that

112. *Id.*

113 28 C.F.R. § 36.301(b) (1991).

114 42 U.S.C.A. § 12182(b)(2)(A)(ii) (1995); 28 C.F.R. § 36.302(1991).

115 28 C.F.R. § 36.302(b) (1991). *See also* Mahoney, *supra* note 96, at 62 nn.89-92 (citing H.R. Rep. No. 485(11), 101st Cong., 2d Sess. 24 (1990)).

116 42 U.S.C.A. § 12182(b)(2)(A)(iii) (1995); 28 C.F.R. § 36.303 (1991).

117 42 U.S.C.A. § 12182(b)(2)(A)(iv) & (v) (1995); 28 C.F.R. § 36.304 (1991).

118. 42 U.S.C.A. § 12182(b)(3) (1995).

cannot be eliminated by modification of policies, practices, or procedures or by the provision of auxiliary aids or services.”¹¹⁹

B. Cases Under the ADA

Many of the first cases after the passage of the ADA were brought under both the Rehabilitation Act and the ADA. The ADA cases continued to build upon the foundation set by cases under the Rehabilitation Act. As the ADA cases are examined chronologically in this section, it becomes clear that the courts are grappling with same basic definitions of handicapped persons, now *individuals with disabilities*, and continuing to clarify the burden of proof. The courts are also dealing with new issues, such as defining who is a private entity operating a place of public accommodation, and how state actions for damages should be treated under the ADA.

*In the Matter of Baby K*¹²⁰ the defendant was a hospital rather than a physician. The case is noteworthy, however, in that the court followed the *Glanz* rationale rather than that of *University Hospital*. The court held that an anencephalic infant who lacked cerebral function was a handicapped and disabled person under the Rehabilitation Act and that the hospital's refusal to provide ventilator treatment to the infant when the infant had trouble breathing, over her mother's objections, would violate the Rehabilitation Act. The court rejected the hospital's reliance on *United States v. University Hospital*¹²¹ asserting instead that “the hospital's contention that ventilator treatment should be withheld because Baby K's recurring breathing troubles are intrinsically related to her handicap were groundless and no such distinction would be permissible within the context of racial discrimination.”¹²² On the ADA claim, however, the court found simply that “[I]n contrast to the Rehabilitation Act, the ADA does not require that a handicapped individual be ‘otherwise qualified’ to receive the benefits of participation.”¹²³ The facts of this case did not require the court to speak to the issue that medical opinion could, or could not, in different cases, find a patient was a direct threat because of a significant risk and, therefore, *not otherwise qualified*.

119. *Id.*; 28 C.F.R. § 36.208 (1991). See also Neugarten, *supra* note 20, at 1310 n.157 (asserting that the ADA has adopted a standard identical to that set forth in *Arline*)

¹²⁰ 852 F. Supp. 1022 (E.D. Va. 1993).

¹²¹ 729 F.2d 144 (2d Cir. 1984).

¹²² *Baby K*, 832 F. Supp at 1028.

¹²³ *Id.* at 1028-29.

In *United States v. Morvant*¹²⁴ the federal government brought action under the ADA on behalf of the deceased patient, Pena, and other aggrieved HIV-positive persons, alleging discrimination under the ADA. Pena, who had been a patient of Dr. Morvant's for ten years, alleged that Morvant refused treatment after Morvant became aware that the plaintiff was HIV-positive. Another plaintiff claimed that he made an appointment but was refused treatment when he arrived for the appointment. Morvant moved for dismissal on the grounds of no cause of action because he could not be individually liable because he practiced dentistry as a professional corporation. He also argued that the government could not sue in the name of deceased or unknown plaintiffs.

The court found that the definition public accommodation in the ADA included the professional office of a health care provider, and that Morvant's professional dental corporation operated a place of public accommodation. The court went on to find that Dr. Morvant, as the owner, president, and sole director of his professional dental corporation owned and operated his dental practice, and, therefore, was an operator under the ADA.¹²⁵

On the question of whether or not the government could sue for damages in tort on behalf of an aggrieved person who has died, previous courts had found that federal law¹²⁶ directs the court to apply the law of the forum state. In applying Louisiana law previous courts had found that discrimination under the ADA was an "offense or quasi-offense" within the meaning of Louisiana law¹²⁷ and the survivorship statute applied. The Louisiana statute provides for a one year statute of limitations in favor of deceased survivors; therefore, the court found the federal government could seek damages on behalf of Pena's survivors.¹²⁸ Additionally, the *Morvant* court held that the government may seek damages for initially unidentified persons aggrieved when there has been a *discriminatory pattern or practice* because, when the initial suit is filed, the government may not know who the aggrieved are.¹²⁹

¹²⁴ 843 F. Supp 1092 (E.D. La. 1994).

¹²⁵ *Id.* at 1094-95 (citing EEOC v. AIC Security, No. 92-C7330, 1993 WL 427454, at *9 (N.D. 111. Oct. 21, 1993)). In *AIC Security* the court had found a sole shareholder of a corporation was the person responsible for making the discriminatory decision on behalf of the employer corporation and concluded that the remedial purposes of the ADA would be subverted if those persons most responsible for discriminatory acts and policies were shielded from personal liability by a corporate entity.

¹²⁶ 42 U.S.C.A. § 1988 (1994).

¹²⁷ LA. Civ. Code Ann. art. 2315.1 (West 1979 & Supp. 1996).

¹²⁸ *Morvant*, 843 F. Supp. at 1095.

¹²⁹ *Id.* at 1095-96 (citing *Teamsters v. U.S.*, 431 U.S. 324,360 (1977)).

In *Mayberry v. Von Valtier*¹³⁰ the burden of proof was further refined. Mayberry, a sixty-seven year-old deaf woman, was a patient of Dr. Von Valtier. The doctor and patient communicated by passing notes or by using a signor, either a professional interpreter or one of Mayberry's children. There was evidence in Valtier's office notes that an interpreter was needed for effective communication. Mrs. Mayberry requested an interpreter for her physical examination in 1992 and Dr. Von Valtier's office consented to pay for one pursuant to her responsibility under the ADA. Dr. Von Valtier was billed for the interpreter. She paid and sent the interpreter a letter saying she could not use the interpreter any longer, nor could she treat Mayberry any longer. She wrote that she would lose money on her office visits when she paid for the interpreter. Plaintiff sought an injunction to order Dr. Von Valtier to treat her and to pay for an interpreter, to post a policy providing for interpreters, and to notify her patients of their right to auxiliary aids and services.¹³¹ The court followed the *Pushkin/Glanz* modified-burden-shifting analysis and ruled that intent was not a necessary element in the burden of proof.¹³² The plaintiff would have to prove first that she had a disability, that the defendant was a public accommodation within the meaning of the ADA, and that the plaintiff was denied medical treatment because of her disability under circumstances that indicated that the referral was based solely¹³³ on her handicap. At that point the burden would shift to the defendant to show there was not a denial or that the denial was lawful. The burden would then shift back to the plaintiff to show that the defendant's reason for denial was just a pretext.¹³⁴

The court found under the *Pushkin/Glanz* modified-burden-shifting analysis that the plaintiff was disabled, the defendant was a private entity owning, leasing, or operating a place of public accommodation, and the plaintiff was discriminated against solely on the basis of her disability. This was evidenced by Dr. Von Valtier's own words in the letter to the interpreter, and in her notes that, while an interpreter was needed, she would not pay for an interpreter, nor could she see Mrs. Mayberry again. In defense, the physician claimed she was not required to supply auxiliary aids if such steps would funda

¹³⁰ 843 F. Supp. 1160 (E.D. Mich. 1994) (denying defendant's motion for summary judgment).

¹³¹ *Id.* at 1162-63.

¹³² *Id.* at 1166.

¹³³ The notion of "solely" was challenged in another case. *See infra* text accompanying notes 137-162.

¹³⁴ *Id.*

mentally alter the nature of the services being offered, or would result in an undue burden, and that alternatives were allowed.¹³⁵ Von Valtier claimed that notes were an adequate, alternative means of communication between her and Mayberry. The plaintiff then produced evidence convincing the court that there was question as to whether or not effective communication could be supported by the use of notes instead of an interpreter. Additionally, the defendant admitted that she could pay for the interpreter fees which showed that she would not have been unduly burdened.¹³⁶ The court denied the doctor's motion for summary judgment.

In *Howe v. Hull*¹³⁷ the plaintiff, representative of the estate of Charon, brought suit alleging that defendants refused to provide Charon with medical treatment because he was infected with HIV. The defendants moved for summary judgment on several issues. The HIV-positive plaintiff, Charon, had a severe reaction to a drug and had gone to a hospital emergency room for treatment. The emergency room physician, Dr. Reardon, determined that he should be admitted to the hospital and, following hospital procedure, called the on-call physician, Dr. Hull, to admit Charon because Charon was from out of town and had no local physician. Dr. Reardon told Dr. Hull that the plaintiff was HIV-positive and suffering from a drug reaction, and that he might have a severe skin disease. During this communication Dr. Hull told Dr. Reardon that "if you get an AIDS patient in the hospital, you will never get him out."¹³⁸ Hull directed that the plaintiff be transferred to the AIDS program at another hospital.

On the issue of whether or not a private physician could be liable under the ADA as an operator of a public accommodation, the court, following *Morvant*, held that the intent of the ADA was not to "relieve from personal liability those committing discriminatory acts."¹³⁹ The Court reasoned that ADA remedies are much broader than the remedies under Title VII. Dr. Hull was the Vice chief of staff, the Medical Director of Special Services, and, as the on-call physician, had authority to make the decision to admit a patient to the hospital. The court held Dr. Hull could be individually liable, as his decision was discretionary and not the implementation of institutional policy or the instructions of superiors.¹⁴⁰

¹³⁵ *Id.* at 1167 (citing 42 U.S.C.A. § 12182(b)(2)(A)(iii) (1995)).

¹³⁶ *Id.* at 1166-67.

¹³⁷ 874 F. Supp. 779 (N.D. Ohio 1994).

¹³⁸ *Id.* at 783.

¹³⁹ *Id.* at 787-88.

¹⁴⁰ *Id.* at 788.

The defendants Hull and the hospital claimed that the discrimination was not based *solely* on the plaintiff's disability. There was some evidence that the emergency room physician, Dr. Reardon, had told Hull that the plaintiff might be suffering from a very serious skin disease, although this information was not given to the physician at the hospital to which plaintiff was to be transferred. On the Rehabilitation Act claim, the court found that the denial of treatment could have been done solely on the basis of his disability because Charon was otherwise qualified; the hospital could have treated his severe allergic drug reaction.¹⁴¹ On the ADA claim the court modified the *Pushkin/Glanz* modified-burden-shifting analysis used in *Mayberry* and held that the *solely on the basis of* standard that appears in the Rehabilitation Act was purposefully omitted by Congress in the ADA, and that this is evidenced by the fact that the regulations implementing the ADA have never indicated otherwise. Therefore, the discrimination under the ADA did not have to be based solely on the disability. Under this standard, the court found that Charon was transferred to avoid treatment of an HIV-infected individual, and this did not have to be the sole reason for transfer.¹⁴²

The plaintiff in this case also claimed intentional or negligent infliction of emotional distress under state law. The plaintiff argued that the emotional distress arose out of the defendant's refusal to treat for a discriminatory reason, not out of the words he used with Dr. Reardon regarding not admitting an AIDS patient. While confining its findings to the facts in this case, the court held that under Ohio law, Dr. Hull's refusal to admit Charon because he was HIV-positive was not an intentional, but a reckless infliction of emotional distress because Hull knew the probability was high that Charon would eventually find out that he was transferred to another hospital because he was HIV-positive. The court found that the negligent infliction of emotional distress was not possible because in Ohio, negligent infliction requires a contemporaneous physical injury which was not present in this case.¹⁴³

Subsequently, in the trial on the merits in *Howe v. Hull*¹⁴⁴ the court found that Hull was an individual subject to personal liability under the ADA because he operated a hospital within the meaning of the ADA where he denied admission to a patient infected with HIV for treatment of a drug reaction and his decision was personal and not

141. *Id.*

142. *Hd.* at 788-89.

143. *Id.* at 789-91.

144. 873 F. Supp. 72 (N.D. Ohio 1994).

the implementation of the hospital's policy.¹⁴⁵ The court set out a specific test for individual liability. The defendant must be in a position of authority, and acting within the ambit of this authority, he or she must have both the power and discretion to perform potentially discriminatory acts. Finally, the discriminatory acts must be the result of the exercise of the individual's own discretion, as opposed to the implementation of institutional policy or the mandates of superiors.¹⁴⁶ The hospital was found liable because it delegated authority to him.¹⁴⁷

The *Hull* court followed *Mayberry* in defining the criteria a plaintiff must meet in order to establish a *prima facie* case of discrimination: a) the plaintiff must have a disability; b) the defendant must have discriminated against the plaintiff; c) the discrimination must have been on the basis of the disability.¹⁴⁸ The court found AIDS and HIV infection are both disabilities within the meaning of the ADA.¹⁴⁹ It also found that discrimination in public accommodations can take the form of denial, segregation, screening or eligibility requirements or provision of unequal medical benefits. The court also found that under the ADA *on the basis of disability* means it was necessary that the disability was a *motivating factor* rather than the *sole* factor in the decision to discriminate.¹⁵⁰

On the doctor's defense of referral, the court held that referral is not discrimination on the basis of the disability when the physician would refer a similar patient without the disability.¹⁵¹ "The test, whether the referring provider would similarly refer an individual without a disability, implies a contemporaneous analysis of the referring provider's *subjective belief at the time of the referral*."¹⁵² The court stated in a footnote that "clearly, where the disability and the medical condition for which treatment is sought are unrelated, the health care provider may not properly consider the disability in referring the patient elsewhere. The more complicated question, however,

145. *Id.* at 77. See also *Morvant*, 843 F. Supp. at 1092 (allowing individual liability for operator of a dental office); *EEOC v. AIC Security*, No. 92—C7330, 1993 WL 427454, at *9 (N.D. 111. Oct. 21, 1993) (finding individual liability for a supervisor); *Carparts Distribution Center, Inc. v. Automotive Wholesaler's Ass'n of New England*, 37 F.3d 12, 15-19 (1st Cir. 1994) (interpreting Title I of the ADA broadly in holding that an insurer may be liable as an employer).

¹⁴⁶ *Hull*, 873 F. Supp. at 78.

¹⁴⁷ *Id.*

¹⁴⁸ *Id.*

¹⁴⁹ *Id.* (citing *T.E.P. v. Leavitt*, 840 F. Supp. 110, 111 (D. Utah 1993)). See also 28 C.F.R. § 36.104(1)(B)(ii) (1991).

¹⁵⁰ *Hull*, 873 F. Supp. at 78.

¹⁵¹ *Id.*

¹⁵² *Id.* at 79 (emphasis added).

concerns a medical condition that is complicated by the disability.”¹⁵³ However, the court said it specifically did not have to decide in this case whether a health care provider may properly consider an individual’s disability when the disability complicates the medical condition for which the individual is seeking treatment.¹⁵⁴

The court then found Charon was entitled to damages because he met the necessary criteria; he had HIV. Dr. Hull’s refusal to admit Charon constituted discrimination because it was a denial of the opportunity to receive medical treatment,¹⁵⁵ and the fact that the plaintiff was HIV-infected was the motivating factor behind this denial. The defendant offered as his defense for refusal to treat Charon the referral because of the rare skin disease. The court, however, found that Charon showed that reason to be a pretext because he did not have the skin disease, but only a drug reaction which could have been treated at that hospital.¹⁵⁶ The defendants were required to post signs in their waiting rooms stating that “[t]his health care provider is prohibited by law from discriminating on the basis of HIV or AIDS. If you believe that this health care provider has discriminated on the basis of AIDS or HIV, you may wish to consult with an attorney.”¹⁵⁷

In the trial on the merits in *United States v. Morvant*¹⁵⁸ the Department of Justice moved for summary judgment against Dr. Morvant on the issue of liability under the ADA. Dr. Morvant cross motioned on the issue of liability, and contended that if he were liable for his referrals then the ADA was unconstitutional. Dunne, like Pena, was a longstanding patient of Dr. Morvant. Dr. Morvant told Pena and Dunne that Morvant could not keep his staff if he required them to treat AIDS patients. Dr. Morvant referred Pena to a dentist who Morvant said specialized in the treatment of AIDS/HIV patients. Morvant contended that he believed Pena required more specialized care and that he did not know the things he should know to treat an AIDS patient. Another patient, Hodgkinson, made an appointment, but upon revealing his positive HIV status to the hygienist, and before Morvant examined his mouth, the hygienist informed the patient that the defendants were not equipped to treat him and referred him to another dentist.¹⁵⁹

¹⁵³ *Id.* at 79 n.2.

¹⁵⁴ *Id.*

¹⁵⁵ *Id.* at 79 (citing 42 U.S.C.A. § 12182(b)(1)(A)(i) (1995)).

¹⁵⁶ *Id.*

¹⁵⁷ *Id.* at 79-80.

¹⁵⁸ No. 93-CA3251, 1995 WL 131093 (E.D. La. Mar. 22, 1995).

¹⁵⁹ *Id.* at *1.

The court cited *Mayberry* for the principle that the ADA incorporates the standards of the Rehabilitation Act of 1973, and its regulations, except where the ADA has specifically adopted other standards.¹⁶⁰ The court relied on *Mayberry (Pushkin/Glanz)* for its finding that a modified *McDonnell Douglas/Burdine* shifting analysis should apply in ADA cases. The plaintiff must prove that 1) he is disabled; 2) the defendant institution is a place of public accommodation; and 3) the plaintiffs were denied full and equal medical treatment because of their disability. At this point the defendant may prove that there was not a denial or that the denial was lawful; the burden then would shift back to the plaintiffs to show that the defendant's reasoning is merely a pretext for unlawful discrimination.¹⁶¹

The court found that the first three criteria were met by the plaintiffs. They were individuals with a disability, Dr. Morvant, individually, was an operator of a public accommodation, and they were denied treatment and referred to another dentist under circumstances which might indicate the denial and referral were discriminatory. The court then considered the burden to have shifted to defendant and focused on the defendant's assertion that his denial of treatment was lawful. Morvant claimed that he referred the plaintiffs because he believed "that HIV-positive and AIDS individuals required specialized treatment and infection control for the benefit of themselves, for the benefit of other patients, and for the benefit of Dr. Morvant's staff."¹⁶² Morvant raised two defenses: 1) lawful referral and 2) "direct threat" because of a "significant risk" of infection to the safety of themselves and Morvant and his staff.¹⁶³

On the doctor's first defense, referral, the court laid out the requirements of referral as set out in the Code of Federal Regulations: "(1) the treatment being sought is outside the referring provider's area of specialization; and (2) in the normal course of operations the referring provider would make a similar referral for an individual without a disability who seeks or requires the same treatment or services."¹⁶⁴ The government argued that because the plaintiffs had gone to Morvant simply to have their teeth cleaned, that the service they needed was within his specialization, and in the normal course of operations he would not have referred these patients. Morvant countered with the argument that the disability itself created specialized complications requiring the referral and special infection control pro

¹⁶⁰ *Id.* at *2 (citing 42 U.S.C.A. § 12201(a) (1995)).

¹⁶¹ *Id.* at *3.

¹⁶² *Id.* at *4.

¹⁶³ *Id.* at *4-5.

¹⁶⁴ *Id.* at *5 (referencing 28 C.F.R. § 36.302(b)(2) (1991)).

cedures. The government's experts testified that there is no specialty recognized by the American Dental Association in the treatment of persons with AIDS or who are HIV-positive. The experts also testified that such a referral is in contravention of the American Dental Association's ethical policies. They also testified that to make an appropriate referral, an individual assessment must be done; the patient has to be examined, the medical history must be inquired into, and the personal physician contacted. This individual assessment was not done by Morvant.¹⁶⁵

Further, the experts testified that in 1986 the CDC had issued *Recommended Infection Control Practices for Dentistry*, updating these recommendations in 1987 and 1993. Because these precautions were to be consistently used for all patients, they were known as *universal precautions*. No further precautions are necessary in providing routine dental care to persons with HIV and AIDS. Therefore, referral because of the need for special infection control precautions of persons with HIV or AIDS was not appropriate.¹⁶⁶ The court found that Morvant's evidence simply could not overcome the testimony of these experts.¹⁶⁷

On the *direct threat* issue, the government cited the Department of Justice Regulations which codify the standard set out in the *Arline* case for identifying an otherwise qualified individual:

- a) A public accommodation does not have to permit an individual to participate in or benefit from foods, services, facilities, privileges, advantages and accommodations of that public accommodation when the individual poses a direct threat to the health or safety of others, b) Direct threat means a significant risk to the health or safety of others that cannot be eliminated by modification of policies, practices or procedures or by the provision of auxiliary aids or services, c) In determining whether an individual poses a direct threat to the health or safety of others, a public accommodation must make an individual assessment, based on reasonable judgment that relies on current medical knowledge or on the best available objective evidence to ascertain: the nature, duration and severity of the risk; the probability that the potential injury

¹⁶⁵ *Id.* at *5-6.

¹⁶⁶ *Id.* at *6-7. See also Neugarten, *supra* note 20, at 1315 (1992) (noting that there are no accommodations necessary to eliminate the risk of an AIDS patient or an HIV-positive patient because the health care workers are required to exercise universal precautions when engaging in invasive procedures regardless of whether or not the patient is HIV-positive).

¹⁶⁷ *Id.* at *7.

will actually occur, and whether reasonable modifications of policies, practice, or procedures will mitigate the risk.¹⁶⁸

Dr. Morvant did no *individual assessment* of the plaintiffs. Further, while the nature, duration, and severity of this disease were unquestioned, “the universal precautions as prescribed by the CDC are universally accepted as ‘reasonable modifications’ of practices that will significantly mitigate the risk.”¹⁶⁹ Dr. Morvant knew of these universal precautions. Therefore, the risk could have been reasonably accommodated without undue burden or alteration of the nature of the services. On Morvant’s claim that the ADA’s prohibition on referrals is unconstitutional, the court found that there was “reasonable connection between the regulatory means selected and the asserted ends.”¹⁷⁰ Therefore, the regulation was constitutional.

Subsequently, in *Woolfolk v. Duncan*¹⁷¹ a managed health care program enrollee, Woolfolk, brought action against a primary care physician, Dr. Duncan, along with the hospital, and the health care program for discrimination under the Rehabilitation Act, the ADA, and for the infliction of mental distress and negligent hiring under state law. After Woolfolk informed Dr. Duncan of his HIV status, Dr. Duncan told Woolfolk that he did not treat HIV patients, but referred them to infectious disease physicians. Under Woolfolk’s particular health care program it was necessary that Dr. Duncan authorize any care by any other health care provider, such as specialists, and it was also necessary that Dr. Duncan authorize emergency room admissions. On one occasion, Dr. Duncan refused to authorize the admission of Woolfolk into the emergency room. When the hospital admitted Woolfolk without the authorization of Dr. Duncan, Woolfolk was diagnosed with pneumonia, staph aureus bacteremias, upper G.I. bleeding and AIDS. The physician here did not claim the defenses of referral or direct threat, but made a medical treatment decision that the patient did not need emergency care or referral.

Under the Rehabilitation Act, the court held that denial of medical benefits included referrals to specialty and hospital care.¹⁷² The court used the *Mayberry (Pushkin/Glanz)* burden-shifting analysis, finding that the plaintiff was disabled because he was HIV-positive, but whether he was otherwise qualified and whether he was denied med

¹⁶⁸ *Id.* at *8-9 (citing 28 C.F.R. § 26.208(c) (1991)).

¹⁶⁹ *Id.* at *9.

¹⁷⁰ *Id.* at *11.

¹⁷¹ 872 F. Supp. 1381 (E.D. Pa. 1995).

¹⁷² *Id.* at 1388 & n.7.

ical benefits solely because of his disability were issues of fact.¹⁷³ Therefore, the court denied summary judgment for Dr. Duncan.

In determining that the otherwise qualified issue was still a question of fact, though it required the court to judge a physician's medical treatment plan, the *Woolfolk* court found itself at odds with the court in *University Hospital*¹⁷⁴ which had been followed in *Toney*. In *University Hospital* and *Toney* the courts found that where the handicapping condition was closely connected to the condition to be treated, it would be impossible to determine with certainty whether or not a medical decision was discriminatory.¹⁷⁵ The *Woolfolk* court found that it was possible for a jury to decide that the treatment plan discriminated based solely on the patient's disability.¹⁷⁶

Under the ADA claim, summary judgment was denied for Dr. Duncan who claimed *Woolfolk* had no evidence that Duncan treats all HIV-positive patients differently than non-HIV patients. The *Woolfolk* court found that nothing in the ADA requires a finding that the defendant was engaged in a "pattern or practice of discrimination."¹⁷⁷

On the state law claim, a physician's refusal to treat a seriously ill patient could be sufficiently outrageous to be intentional or reckless infliction of emotional distress, and so summary judgment was denied. The court also found that there were genuine issues of fact as to whether or not Dr. Duncan was an employee or an independent contractor of the managed health care company, and, therefore, whether it could be vicariously liable under the claims. There were also genuine issues of fact as to whether there was negligent hiring by the managed health care company.¹⁷⁸

V. Comparative Analysis of the Rehabilitation Act Cases and the ADA Cases

Under the Rehabilitation Act, on the issue of burden of proof, the courts have used two different standards. The *Pushkin* court, followed by *Glanz*, adopted and modified the modified-burden-shifting

¹⁷³ *Id.* at 1387.

¹⁷⁴ *Id.* at 1388-89.

¹⁷⁵ *Id.*

¹⁷⁶ *Id.* at 1389-90.

¹⁷⁷ *Id.* at 1390-91. In *Toney*, this rationale had been effective to prove plaintiff was discriminated against solely because of his disability under the Rehabilitation Act

¹⁷⁸ *Id.* at 1391-92.

analysis which had been used in discrimination cases under the Civil Rights Act. The plaintiff first presents a *prima facie* case of discrimination, and then the defendant is given an opportunity to show the discrimination did not happen, or was lawful, at which point the burden shifts back to the plaintiff to show the defense is a pretext. In HIV/AIDS cases this defense and rebuttal have consisted of expert testimony using the *Arline* rationale to prove whether or not plaintiff was otherwise qualified; an individual assessment was to be done to identify the significance of the risk according to the current state of medical knowledge, and if the risk was significant or could not be eliminated by reasonable accommodation, the plaintiff could try to show that there was no significant risk or that it could be eliminated by reasonable accommodation.

On the other hand, another line of cases, *University Hospital*, followed by *Toney* and *Kahala Dental Group* seems to stop short of the last element. In these cases the court stopped with the medical opinion of the physician, refusing to allow the next step by the plaintiff, that of proving the medical opinion is a pretext. The court would not place its judgment above medical opinion in determining whether the denial of treatment was valid or a pretext.

Under the ADA, on the issue of burden of proof, in *Mayberry v. Von Valtier*,¹⁷⁹ a district court in Michigan used the modified-burden-shifting analysis established in *Pushkin* and followed by *Glanz*. Under *Mayberry* the court refused to find that *prima facie* case included the element of intent on the part of the defendant. "The plaintiff must prove that she has a disability, the defendant's office is a place of public accommodation, and that she was denied full and equal medical treatment because of her disability."¹⁸⁰ Plaintiff must also prove the denial was under circumstances which lead to the inference that such denial was based solely on her handicap. Once the plaintiff establishes a *prima facie* case, the burden shifts to defendant to prove either that plaintiff was not denied medical treatment, or that such denial was not unlawful. The burden then shifts to plaintiff to rebut defendant's reasons as a pretext for discrimination. In the cases that followed *Mayberry*, the courts clarified these elements in the burden-shifting analysis. Of the three elements in plaintiff's *prima facie* case, the courts no longer had to deal with the first element because the legislative history and federal regulations have made it clear that contagious diseases including symptomatic and asymptomatic HIV-positive individuals are covered under the protection of the ADA.¹⁸¹

¹⁷⁹ 843 F. Supp. 1160 (E.D. Mich. 1994).

¹⁸⁰ *Id.* at 1166.

¹⁸¹ 28 C.F.R. § 36.104(l)(iii) (1991). See Cohen, *supra* note 1, at 244.

As to the second element, in defining a private entity who owns, leases or operates a place of public accommodation, the court in *Morvant* held that, though Morvant's professional dental corporation owned and operated his dental office, Morvant individually, as the owner, president, and sole director of his professional dental corporation, owned and operated his dental practice, and, therefore, was individually liable as an operator under the ADA. The court refused to allow discrimination by the individual to be shielded by the corporate veil. The court in *Howe v. Hull*¹⁸² followed *Morvant* in finding a private physician who was the on-call physician for a hospital was individually liable as an operator because he had authority to make admission decisions without following any institutional policy. *Hull* went on to set out the test to be used to determine if an individual is an operator under the ADA: (a) he or she is in a position of authority; (b) within the ambit of this authority he or she has both the power and discretion to perform potentially discriminatory acts; and (c) the discriminatory acts are the result of the exercise of the individual's own discretion, as opposed to the implementation of institutional policy or the mandates of superiors.¹⁸³

In the interpretation of the third element, discrimination based on the individual's disability, the *Woolfolk* court found that discrimination included denial of referrals to specialty and hospital care. The *Hull* court modified the *Pushkin/Glanz* burden-shifting analysis as followed in *Mayberry* to delete the *solely* requirement. The *Hull* court found that the *based on the individual's disability* element did not require that the discrimination be based solely on the plaintiffs disability, but only that the disability was a "motivating factor" in the discrimination.¹⁸⁴ *Morvant*, on the merits, followed *Pushkin/Glanz* modified-burden-shifting analysis as followed by *Mayberry*, but as modified by *Hull*, in that the discrimination need not be based solely on the disability.¹⁸⁵

Once the *prima facie* case has been presented, and the burden has shifted to the defendants, the courts hearing cases under the ADA have had an opportunity to hear medical opinions as to why a certain course of treatment was taken, or why other medical decisions were made, such as refusal to treat, referral, or denial of admission to an emergency room. These courts have not declined to judge these medical decisions nor have they declined to identify them as pretexts for discrimination. They have clarified the conditions under which the

¹⁸² 873 F. Supp. 779 (N.D. Ohio 1994).

¹⁸³ *Id.* at 77.

¹⁸⁴ *Id.* at 77-78.

¹⁸⁵ *Morvant*, No. 93-CA3251, 1995 WL 131093, at *5 (E.D. La. Mar. 22, 1995).

physician may refer or refuse to treat because the patient is a direct threat. The courts have thus defined under what circumstances these medical decisions would be considered a pretext for discrimination.

On the issue of referral, the *Hull* court found nothing in the ADA keeps a physician from referring a patient with a disability if the patient needs treatment beyond the defendant's capabilities.¹⁸⁶ The court went on that "[T]he test, whether the referring provider would similarly refer an individual without a disability, implies a contemporaneous analysis of the referring provider's subjective belief at the time of the referral. Thus a provider who believes that a disabled individual requires treatment beyond the provider's capability for a medical condition, that is unrelated to the disability, may refer that individual to another provider if the provider would likewise refer an individual without a disability in the same fashion."¹⁸⁷ In *Hull*, the court found that the reasons for referral were pretexts because the patient could have been treated in this hospital. In a footnote, however, it seems that there is a hint of the reasoning in *University Hospital*. The court states that there is a difference between cases where the patient's condition is unrelated to the disability, such as in this case where the patient had a drug reaction, and cases where the patient's condition is complicated by the disability.¹⁸⁸ This footnote seems to indicate that in the latter situation, the court could not as easily determine if the medical opinion was a pretext. The court specifically said it did not have to address this latter situation.

Based on the *Hull* court's test for referral, the question arises whether or not there would have been a violation of the Act if Dr. Hull had not made the discriminatory statement that he made, but rather told Dr. Reardon to transfer the patient based on the latter's diagnosis of a possible rare skin disease which would have been a condition complicated by the disability. Would the court have accepted the subjective belief of Hull at the time of the transfer?

Still dealing with referral, the *Morvant* court, on the merits, did not hesitate to judge the validity of medical opinion of the treating dentist by relying on the medical opinion of plaintiff's experts. The court specified that the requirements for referral would be that "1) the treatment being sought is outside the referring provider's area of specialization; and 2) in the normal course of operations the referring provider would make a similar referral for an individual without a disability who seeks or requires the same treatment or services."¹⁸⁹

¹⁸⁶ *Hull*, 873 F. Supp. at 79 (citing 28 C.F.R. § 36.302(b)(1) (1991)).

¹⁸⁷ *Id.* at 72, 80.

¹⁸⁸ *Id.* at 79 n.2.

¹⁸⁹ *Morvant*, No. 93-CA3251, 1995 WL 131093, at *4 (E.D. La. Mar. 22, 1995).

The court accepted the opinions of the plaintiff's experts and found that no dental specialty was recognized in the treatment of HIV- infected patients, nor was any specialized treatment called for because the CDC's universal precautions were required in the treatment of all patients.

On the direct threat defense, the *Morvant* court set a test to be followed using the same test established in *Arline* for "significant risk." The determination of direct threat is a determination of the significant risk which is to be made by an individual assessment using current medical knowledge or on the best objective evidence as to the nature, duration, and severity of the risk, the probability of an actual injury, and whether reasonable accommodations can be made to mitigate the risk.¹⁹⁰ This test was derived from the *Arline* test for otherwise qualified individual with a disability. If the individual, after individual assessment, presented a significant risk which could not be eliminated through reasonable accommodations, he or she was not otherwise qualified. The court found that Dr. Morvant had not made an individual assessment; nevertheless, according to plaintiff's experts, while HIV and AIDS present a severe risk, that of death, the CDC universal precautions are universally accepted as reasonable modifications which will significantly mitigate the risk. The CDC guidelines require universal precautions to be used in the treatment of all patients. The dentist's defense of direct threat was, therefore, a pretext.

This finding in *Morvant* creates a dichotomy. The CDC guidelines designate certain procedures which cannot be performed by HIV-positive health care workers because these workers pose a significant risk to the patient which cannot be reasonably accommodated in exposure-prone procedures, even by following the CDC guidelines, unless an expert review panel agrees that a certain procedure may be done, and particularly sets out the circumstances under which the procedures can be performed. On the other hand, the same exposure-prone procedures performed on an HIV-positive patient, either are not of significant risk to the health care worker or they can be reasonably accommodated by following the CDC guidelines. The effect of the guidelines is to create a higher standard which must be met by HIV-positive health care workers. In order for the significant risk to be accommodated in exposure-prone procedures, these workers must secure the consent of a review panel and refrain from performing certain procedures. The *Morvant* court accepted expert testimony that HIV-positive patients, on the other hand, can be accommodated by

¹⁹⁰ *Id.* at *9.

following the CDC guidelines, even in exposure-prone procedures. This difference discriminates against the health care worker and results in a reduction of the number of available health care workers available to treat HIV-positive patients.¹⁹¹ The courts have refused to excuse discrimination under the ADA under the rational basis test in the context of contagious patients' access to care, yet it seems that they have accepted the rational basis test in allowing discrimination against the contagious health care providers' right to employment.

In *Woolfolk v. Duncan*¹⁹² the court dealt with the question of whether or not medical opinion of the treating physician should be judged by the court and found itself at odds with *University Hospital* and *Toney*. *Woolfolk* held that it was possible for a jury to determine if a treatment plan was discriminatory because it was based on a patient's disability.

In *the Matter of Baby K*,^m on a motion for summary judgment under the Rehabilitation Act, the court rejected the hospital's reliance on *University Hospital* that the benefit could be denied because of the intrinsic relation of the disability with the condition.¹⁹⁴ However, on the ADA claim, the court found that the otherwise qualified element required under the Rehabilitation Act, was simply not required under the ADA. It seems, however, that the court did not have to consider, because of the facts of the case, that the *Arline* otherwise qualified test has been incorporated into the ADA. It has been used to determine if there is a direct threat. An ADA claimant can be not otherwise qualified if they are a direct threat, a significant risk to the health and safety of others.

VI. PRESENT STAND AND FUTURE DIRECTION OF THE COURTS

In summary, the present stand of the courts has given great force to the ADA in two regards. First, the private health care provider can now be held individually liable under the ADA for refusal to treat an individual with a disability. The courts have not allowed the corporate veil, or independent contractor theories, to shield health care providers from personal liability. Second, the burden of proof used by most courts allows the plaintiff to rebut the medical opinion given for

¹⁹¹ Neugarten, *supra* note 20, at 1326-28.

¹⁹² 872 F. Supp. 1381 (E.D. Pa. 1995).

¹⁹³ 830 F. Supp. 1022 (E.D. Va. 1993).

¹⁹⁴ *Id.* at 1028-29.

refusal to treat in order to try to show that it is a pretext for discrimination.

Courts have ordered the posting of signs in an office¹⁹⁵ and a hospital¹⁹⁶ notifying individuals with disabilities of their rights under the ADA, and the government has been allowed to seek damages for initially unidentified persons aggrieved when there has been a discriminatory pattern or practice and when the initial suit is filed, the government does not know who the aggrieved are.¹⁹⁷ In the ADA's relation to state law, damages have been allowed for the reckless infliction of mental distress for discrimination under the ADA, and the government can sue for damages in tort on behalf of an aggrieved person who has died if the law of the forum state considers discrimination under the ADA as tort and allows survivors' actions.¹⁹⁸

A few aspects of the ADA remain slightly out-of-focus. There still may be some hesitation by some courts in allowing the plaintiff to rebut the defendant's reasons for the chosen medical treatment plan, including referral, when the disability is closely connected to the medical condition being treated. On rebuttal, the plaintiff has a less difficult case if the disability is unrelated to the condition to be treated. In this situation, the health care provider either normally treats this condition or not, and so the referral defense can be easily defeated. It is in the situations where the disability *is* the condition to be treated or truly complicates the condition to be treated that the rebuttal is more difficult. This is often the situation when the disability is a contagious disease such as tuberculosis, or HIV-positive or AIDS. From the cases examined, however, it seems that most courts are willing to judge the health care provider's treatment plan by the use of experts and an examination of the medical record. The courts will decide whether the plaintiff was otherwise qualified for treatment. This, of course, is the end that the court in *University Hospital*, sought to avoid.¹⁹⁹

As to the direct threat defense, when the disability is a contagious disease, the courts have tended to find the defense of direct threat to be ineffective. They have accepted the fact that there is no significant risk for the health care provider when universal precautions are used. Also, because universal precautions must be used for all patients in exposure-prone situations, there is no need for any modifications by the health care provider for the contagious individual, and,

¹⁹⁵ *Morvant*, No. 93-CA3251, 1995 WL 131093, at *11 (E.D. La. Mar. 22, 1995).

¹⁹⁶ *Hull*, 873 F. Supp. at 80.

¹⁹⁷ *U.S. v. Morvant*, 843 F. Supp. 1092, 1096 (E.D. La. 1994).

¹⁹⁸ *Id.* at 1095.

¹⁹⁹ *University Hospital*, 729 F.2d at 156—57.

therefore, no need to show that the modifications are reasonable accommodations. The problem is that the same standard has not been applied in the reverse situation where the health care provider has a contagious disease. In this circumstance, the universal precautions do not seem to eliminate the significant risk. As a result, some health care providers are prevented from performing procedures which they would normally perform. Under this stand by the courts, the contagious patients will have less access to health care, and contagious health care providers may continue to be the subjects of employment discrimination.