

Winter 1995

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### Recommended Citation

Jack P. DeSario & James D. Slack, The Americans with Disabilities Act and Refusals to Provide Medical Care to Persons with HIV/AIDS, 27 J. Marshall L. Rev. 347 (1994)

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# THE AMERICANS WITH DISABILITIES ACT AND REFUSALS TO PROVIDE MEDICAL CARE TO PERSONS WITH HIV/AIDS

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Real and imagined fears of catching the human immunodeficiency virus (HIV), the retrovirus which causes Acquired Immunodeficiency Syndrome (AIDS), have caused many people to question the nature of social and professional relationships. "Safer sex" is the watchword of the 1990s, replacing "free" and "uncomplicated" sex of an earlier time. Government regulations and organizational policies for handling blood-related situations have emerged in just about every setting, ranging from professional basketball games, to the arrests of criminals, to the conduct of business in hospital emergency rooms. In essence, the AIDS epidemic has made us much more cautious about how we interact with our neighbors than was the case just a decade or so ago. More than any other health crisis since the outbreak of bubonic plague in the Middle Ages, the AIDS epidemic has contributed to a fundamental reshaping of the way people think about, and interact with, other people.

As the number of HIV-challenged individuals increases, so does the realization that anyone can contract the retrovirus if they are not careful. There are nearly 350,000 reported cases of HIV/AIDS

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in the United States.<sup>1</sup> The rate of reported HIV/AIDS cases has doubled in the last twelve month period, rising from 18.2 to 37.5 persons per 100,000 people.<sup>2</sup> Both the rate and the number of reported HIV/AIDS cases are increasing throughout all regions and residential settings in the United States. This includes rural areas which have not had much experience in dealing with the many ramifications of the retrovirus. Moreover, conservative estimates predict that there are several hundred thousand asymptomatic seropositive Americans, most of whom are unaware of their own HIV status.<sup>3</sup>

The purpose of the Americans with Disabilities Act (ADA) of 1990 is to protect people with disabilities from discriminatory practices in many aspects of society. Although Congress did not originally intend to address the social ramifications of the HIV retrovirus, courts interpreting the law have held that it specifically addresses this issue. The ADA protects people who are in the HIV spectrum, whether they are asymptomatic seropositive or have full-blown AIDS. This Article examines the ADA from the perspective of medical care refusals for the HIV-challenged individual. The first section provides an overview of the ADA as it relates to medical care access. The second section explores the factors which may prompt some physicians to deny medical care access, or to alter drastically the nature of health care delivery, to people with HIV/AIDS. The success of the ADA in health care depends not only upon the judicial enforcement of its provisions, but also upon health care professionals who may have to set aside stereotypes and fears surrounding the HIV/AIDS epidemic.

#### ADA AND MEDICAL CARE ACCESS

The right of individuals, including people in the HIV spectrum, to have access to medical care in the United States is well established and pre-dates the enactment of the ADA. The Vocational Rehabilitation Act of 1973 makes it unlawful for an individual health care provider or a health care organization to deny access to medical services if either receives funding from the federal government.<sup>4</sup> It also prohibits discriminatory practices by health care facilities which fall under the jurisdiction of state and local

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1. 5 CENTERS FOR DISEASE CONTROL AND PREVENTION, HIV/AIDS SURVEILLANCE REPORT, PART 2, at 3 (July 1993).

2. The quoted statistics are based on comparison of the July 1991 to June 1992 reporting period and the July 1992 to June 1993 reporting period. *Id.*

3. Cheryl Clark, *Is County Steering Some Away from AIDS Tests? Doctor Says 'Low Risk' Dissuaded to Save Funds*, SAN DIEGO UNION TRIB., Oct. 26, 1992, at B1.

4. See 29 U.S.C. § 794 (1988) (providing an extensive inventory of the organizations covered by the Vocational Rehabilitation Act).

governments.<sup>5</sup>

A recent case, *Miller v. Spicer*,<sup>6</sup> represents an important decision within this context for a number of reasons. First, this case provides a dramatic illustration of the type of blatant medical discrimination experienced by those infected with HIV/AIDS or those individuals even suspected of having this disease. Second, the *Miller* court develops important legal standards and distinctions which apply in the determination of whether discrimination exists, and, if it does, whether a particular individual or organization is liable for these discriminatory acts. Third, this case highlights how the ADA extends governmental protection from discriminatory medical practices to persons within the HIV spectrum.

In *Miller*, the plaintiff, Rod Miller, injured his foot and sought medical treatment at Beebe Medical Center's emergency room. Dr. Paul Emory, a Beebe physician, diagnosed Miller's injury as a lacerated tendon which required immediate surgery or else Miller's ability to walk "could be permanently impaired."<sup>7</sup> Dr. Robert Spicer then did the emergency room consultation regarding Miller's treatment. Dr. Emory informed Dr. Spicer that from his observations he believed Miller was a homosexual.<sup>8</sup>

Based upon this information, Dr. Spicer asked Miller if he had AIDS. Miller indicated that he had taken an HIV antibody test but didn't know the results. Dr. Spicer, disturbed by this response, refused to perform the surgery and arranged for a helicopter to transport Miller to the "District of Columbia because 'they take care of gay people.'"<sup>9</sup> Miller protested being labeled a homosexual and questioned whether this determination was the basis for his transfer.<sup>10</sup> When confronted with this situation, Dr. Spicer claimed that his refusal to provide treatment arose solely from the fact that he did not perform tendon repairs.<sup>11</sup> Subsequently, Dr. Spicer admitted that he performed thousands of tendon repairs.<sup>12</sup> After his transfer to George Washington Medical Center, Miller's new physicians told him the foot was too swollen for surgery.<sup>13</sup> Surgery performed eight days later could not prevent the permanent injury to Miller's foot.<sup>14</sup>

As a result of this incident, Rod Miller filed an action against Beebe Medical Center and Dr. Spicer alleging violations of the Re-

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5. 29 U.S.C. § 794(b)(1)(B).

6. 822 F. Supp. 158 (D. Del. 1993).

7. *Id.* at 160.

8. *Id.*

9. *Id.* at 161.

10. *Id.*

11. *Miller*, 822 F. Supp. at 161.

12. *Id.*

13. *Id.*

14. *Id.*

habilitation Act of 1973, intentional infliction of emotional distress, and breach of contract. For the purposes of this analysis, this section focuses upon the court's resolution of the discrimination claims made pursuant to section 504 of the Rehabilitation Act. The Rehabilitation Act prohibits all federally funded programs from discriminating upon the basis of handicap or perceived handicap.<sup>15</sup> The defendants responded, in a motion to dismiss, that even if the plaintiff could make out a prima facie case, no private cause of action existed for damages under section 504.

In resolving the issue of whether Miller established a prima facie case of discrimination under the dictates of the Rehabilitation Act, the court developed a four-prong test. For the plaintiff to make out a case of discrimination, he must show:

- (1) that he is handicapped under the Act;
- (2) that he is otherwise qualified;
- (3) that the relevant program received federal financial assistance; and
- (4) that the defendants' refusal to perform surgery impermissibly discriminated against him on the basis of his physical handicap.<sup>16</sup>

Although the Supreme Court has not specifically determined whether the Rehabilitation Act applies to situations involving people with HIV/AIDS, its decision in *School Board of Nassau County v. Arline*<sup>17</sup> suggests that it does. In fact, the Ninth Circuit Court of Appeals cited *Arline* when it held that HIV/AIDS is a handicap within the coverage of the Rehabilitation Act.<sup>18</sup> In recognition of past precedent, neither of the defendants in *Miller* questioned whether HIV/AIDS qualified as a handicap under the Act. However, Dr. Spicer asserted that the plaintiff could not prove the third element of the discrimination standard as it related to him.<sup>19</sup> Dr. Spicer maintained that he was not an employee of Beebe Medical Center but rather an independent contractor.<sup>20</sup> Therefore, he asserted that for him to be liable, Miller must have shown the doctor (rather than Beebe Medical Center) received federal funding.<sup>21</sup> Based upon this employment distinction, the court dismissed the plaintiff's Rehabilitation Act discrimination claim against Dr. Spicer, citing the lack of evidence demonstrating that Spicer received any federal funds.<sup>22</sup>

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15. 29 U.S.C. § 794.

16. *Miller*, 822 F. Supp. at 163.

17. 480 U.S. 273 (1987).

18. See *Chalk v. United States Dist. Court*, 840 F.2d 701, 704-09 (9th Cir. 1988) (finding that the Rehabilitation Act applies to HIV/AIDS because HIV/AIDS was not contagious so as to fall under the Supreme Court's test in *Arline*).

19. *Miller*, 822 F. Supp. at 163.

20. *Id.*

21. *Id.*

22. *Id.*

Beebe Medical Center, which did receive federal funding, filed a motion for summary judgment to dismiss the claims under the Rehabilitation Act because it claimed that Miller could not prove the fourth prong of the court's test. Miller allegedly failed to show that Beebe Medical Center's refusal to perform surgery impermissibly discriminated against the plaintiff on the basis of his handicap. The essence of this defense was "that as a hospital, it lacks the physical ability to perform surgery, as surgery can only be performed by a skilled human being . . . because only Dr. Spicer's actions constituted discrimination and because an independent contractor relationship existed between Spicer and Beebe, Dr. Spicer's discrimination cannot be attributed to Beebe."<sup>23</sup>

In rejecting defendant Beebe's motion for summary judgment, the court asserted that Beebe had an affirmative obligation or duty to act to prevent discrimination. Specifically, the court held:

[T]here [was] evidence in the record that Beebe employees knew or should have known that the cause of Mr. Miller's transfer from the hospital was not inability to treat, but plaintiff's perceived sexual preference and HIV status. Armed with this knowledge Beebe did nothing to prevent the transfer of plaintiff for discriminatory rather than medical reasons.<sup>24</sup>

Furthermore, the court ruled that a defendant's combination of acts and omissions could amount to discrimination in violation of section 504 of the Rehabilitation Act.<sup>25</sup> Having found that Miller's claim against Beebe was valid under the Rehabilitation Act, the court also concluded that "money damages [were] an available remedy for intentional violations of section 504."<sup>26</sup>

*Miller* is significant because it established an affirmative duty upon public employees to avoid discriminatory practices. Passive acceptance of the actions of others is not a valid defense to discrimination claims. Rather, the court suggests that medical care providers have a legal obligation and duty to actively dismantle discriminatory treatment plans. The ADA reduces the impact of the court's decision to dismiss the claims against Dr. Spicer because he was an independent contractor.

The ADA takes some of the basic protections of the Vocational Rehabilitation Act of 1973 and adds the findings of court cases, such as *Arline* and *Chalk v. United States District Court*,<sup>27</sup> that deal with the rights of people with contagious diseases and AIDS, respectively. The ADA differs from the Vocational Rehabilitation

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23. *Id.* at 164.

24. *Miller*, 822 F. Supp. at 164.

25. *Id.*

26. *Id.* at 168.

27. 840 F.2d 701 (9th Cir. 1988).

Act in at least two ways.<sup>28</sup> While it does not require employers and businesses to engage in affirmative action practices, the ADA is a much more comprehensive piece of legislation than the Vocational Rehabilitation Act because it covers organizations that have no funding or jurisdictional ties with the federal government. Specifically, the Act applies to "all employers engaged in an industry affecting commerce which have 15 or more employees for each working day in each of 20 or more calendar weeks in the current or preceding calendar year."<sup>29</sup> Therefore, patients who are victims of discrimination will no longer have to demonstrate that the medical provider is a recipient of federal funding. As a result, the ADA expands federal protections against discrimination emanating from private as well as public employees.

Title II and Title III of the ADA are the primary sections which protect HIV/AIDS patients from discriminatory denials of access to medical care. Title II covers public accommodations and services provided by public entities.<sup>30</sup> Some examples of public entities within the ADA are as follows: federal, state, and municipal hospitals; tax-supported emergency medical services; and public health departments.<sup>31</sup> Title II states that a public entity must provide the same services to qualified disabled persons as it provides to non-disabled individuals. According to Title II, the term "qualified individual with a disability" means:

[A]n individual with a disability who, with or without reasonable modifications to rules, policies, or practices, the removal of architectural, communication, or transportation barriers, or the provision of auxiliary aids and services, meets the essential eligibility requirements for the receipt of services or the participation in programs or activities by a public entity.<sup>32</sup>

Title III of the ADA protects the rights of the HIV-challenged seeking public accommodations offered in the private sector, such as hotels, restaurants, theaters, grocery stores, clothing stores, barbershops, libraries, and schools. Title III includes as public accommodations the professional offices of health care providers and hospitals.<sup>33</sup> While the focus is on architectural barriers, the ADA

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28. See generally GARY S. MARX & GARY G. GOLDBERGER, *DISABILITY LAW COMPLIANCE MANUAL* (1991) (providing an excellent comparison of the two pieces of legislation).

29. 42 U.S.C. § 12111(5)(a) (Supp. 1991) (emphasis added). The Commerce Clause and the Fourteenth Amendment provide the Congressional authority for this type of action. See *Heart of Atlanta Motel, Inc. v. United States*, 379 U.S. 241 (1964) (holding that the Commerce Clause gave Congress the power to enact civil rights legislation).

30. 42 U.S.C. §§ 12131-12165.

31. See 42 U.S.C. § 12131(1) (defining those entities covered by subchapter II of the ADA).

32. 42 U.S.C. § 12131(2).

33. 42 U.S.C. § 12181(7)(F).

also offers protection from discriminatory practices in the delivery of services. Title III of the ADA states the following:

No individual shall be discriminated against on the basis of disability in the full and equal enjoyment of the goods, services, facilities, privileges, advantages, or accommodations of any place of public accommodation by any person who owns, leases (or leases to), or operates a place of public accommodation.<sup>34</sup>

The impact of the ADA has been immediate and drastic. According to the Department of Justice, as of July 6, 1993, individuals had already filed 1,358 complaints alleging violations of Title II and an additional 1,466 complaints alleging violations of Title III.<sup>35</sup> The manner in which the judicial system resolves these cases will significantly impact the legal relationship between HIV-challenged individuals and medical practitioners.

#### WHO DOES THE ADA PROTECT?

The ADA uses the same language to define "disability," as found in Section 504 of the Vocational Rehabilitation Act. A disabled person is someone with:

- (A) a physical or mental impairment that substantially limits one or more of the major life activities of such individual;
- (B) a record of such an impairment; or
- (C) being regarded as having such an impairment.<sup>36</sup>

In order to understand how an HIV-challenged individual falls within the coverage of the ADA, it is important to understand the nature of the retrovirus. Typically there are four stages to the disease.<sup>37</sup>

The first stage is known as acute HIV infection.<sup>38</sup> This occurs between six days and six weeks after the person contracts HIV. The person can experience a wide variety of mononucleosis-like symptoms—fever, myalgia or arthralgia,<sup>39</sup> lymphadenopathy,<sup>40</sup> nausea, and diarrhea. This stage lasts for a varying amount of time, but typically only from a couple days to perhaps a week or two.<sup>41</sup> Because of its brevity and common symptoms, most individ-

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34. 42 U.S.C. § 12182(a).

35. *ADA Statistics*, Prentice Hall Law and Business, Aug. 16, 1993.

36. 42 U.S.C. § 12102(2).

37. See MIRKO D. GRMEK, *HISTORY OF AIDS* 47-83 (Russell C. Mavlitiz & Jacalyn Duffin trans., 1990) (providing an in-depth discussion of the medical aspects of HIV infection and the onset of AIDS).

38. Michael Hoenig, *HIV and AIDS Related Issues*, N.Y. L.J., Feb. 8, 1993, at 3, 5.

39. These symptoms involve muscle pain and pain in the joints. JEFFREY T. HUBER, *DICTIONARY OF AIDS RELATED TERMINOLOGY* 18, 101 (1993).

40. Lymphadenopathy is a glandular inflammation. Hoenig, *supra* note 38, at 5.

41. See MICHAEL L. CLOSEN ET AL., *AIDS: CASES AND MATERIALS* 13 (1989) (describing the progression of HIV-infection).



uals are unaware that they are experiencing acute HIV infection.<sup>42</sup>

The second stage, the asymptomatic period, is characterized by routine and normal health.<sup>43</sup> A person may acquire an occasional cold or perhaps the flu, but such afflictions are generally unrelated to being infected with the retrovirus.<sup>44</sup> An HIV-challenged individual can remain asymptomatic for an indefinite amount of time, typically for a period lasting from two years to over a decade.<sup>45</sup>

The third stage, classified as persistent generalized lymphadenopathy (PGL), marks the beginning of the deterioration of the immune system.<sup>46</sup> Its clinical features center on the enlargement of a variety of lymph nodes for a prolonged period of time.<sup>47</sup> Lymph nodes enlarge in response to CD4 T-cells fighting the HIV infection.<sup>48</sup> But the lymph nodes remain swollen because the retrovirus begins to eliminate these special T-cells. Depending on the initial health of the individual and whether the person continues to abuse the immune system, PGL typically lasts for a period ranging from two to four years.

The fourth stage is "full-blown" AIDS.<sup>49</sup> A clinical diagnosis may arise in either of two ways. First, the level of the HIV-challenged individual's CD4 T-cells falls to a count of 200 or less.<sup>50</sup> This occurrence prompts a diagnosis of full-blown AIDS regardless of the existence of any actual physical symptoms. Second, a person may experience one or many AIDS-related opportunistic diseases, regardless of the exact CD4 T-cell count.<sup>51</sup> The more common opportunistic diseases include: pyogenic bacterial infections,<sup>52</sup> such as salmonella or neisseria meningitis; mycobacterium infections, like tuberculosis; fungal infections, such as aspergillosis,<sup>53</sup> candidiasis<sup>54</sup> or histoplasmosis;<sup>55</sup> viral infections, like cyto-

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42. *Id.*

43. Hoenig, *supra* note 38, at 5.

44. CLOSEN ET AL., *supra* note 41, at 131.

45. Hoenig, *supra* note 38, at 5.

46. *Id.*

47. *Id.*

48. *Id.* CD4 T-cells are critical to the human immune system's ability to fight off infection and disease. *Id.*

49. See Alexandra M. Levine, *Acquired Immunodeficiency Syndrome: The Facts*, 65 S. CAL. L. REV. 423, 431 (1991) (describing the progression of the virus).

50. Hoenig, *supra* note 38, at 5. A non-seropositive person's CD4 T-cell count is typically between 700 and 1,300 CD4 cells per milliliter of blood. *Id.*

51. See *id.* (describing general HIV related illnesses and resulting T-cell counts).

52. Naiel N. Nassar & Ruth M. Lawrence, *HIV-Infection: Predicting and Managing Disease Caused by Opportunistic Organisms*, 33 CONSULTANT 131, 131 (Feb. 1993). Heat or fever can cause pyogenic bacterial infections. *Id.*

53. Molds may cause aspergillosis which is a fungal infection. DORLAND'S ILLUSTRATED MEDICAL DICTIONARY 156 (27th ed. 1988).

54. Candidiasis is a yeast-like infection that may occur in the throat. HUBER, *supra* note 39, at 30.

galovirus (CMV);<sup>56</sup> protozoan infections,<sup>57</sup> like pneumocystis carinii pneumonia (PCP) or toxoplasmosis<sup>58</sup>; and malignancies, such as Kaposi's Sarcoma (KS).<sup>59</sup> As with the other stages, full-blown AIDS can be of varying duration, but it typically lasts from one to three years.<sup>60</sup> Full-blown AIDS inevitably ends in death.

It is important to understand the stages of HIV/AIDS because someone in the HIV spectrum can qualify as a disabled individual by utilizing each of the three definitions provided in Section Three.<sup>61</sup> Someone with either PGL symptoms or CMV, for instance, qualifies as a disabled person because he or she actually has "a physical or mental impairment that substantially limits one or more of the major life activities."<sup>62</sup>

Quite often, however, HIV/AIDS patients temporarily recover from opportunistic diseases. For instance, medication might help control and reduce the amount of thrush which results from candidiasis. The individual may also fully recover from a single bout with PCP. The cancer KS may very well go into remission for a period of time. In all of these cases, the HIV-challenged person can claim to be a disabled individual because he or she has a "record of such impairment."<sup>63</sup>

Finally, a person in the HIV spectrum can also qualify as a disabled American under a third definition of "disabled": "being regarded as having such an impairment."<sup>64</sup> This would include anyone who is asymptomatic seropositive as well as anyone who has a CD4 T-cell count of less than 200 (full-blown AIDS) but has not yet developed any symptoms. Medical professionals regard

55. Histoplasmosis is a respiratory disease which results from the inhalation of a yeast cell. *Id.* at 74.

56. CMV causes a cellular enlargement of salivary glands, brain, kidneys, liver, and lungs. *Id.* at 44.

57. Protozoan infections stem from parasites. John J. Goldman, *Tennis Great Arthur Ashe Reveals He Has AIDS*, L.A. TIMES, Apr. 9, 1992, at A1.

58. Toxoplasmosis is a major cause of neurological mortality among AIDS patients. Sandra G. Boodman, *Recent Advances Combat Two Deadly Infections*, WASH. POST, Feb. 9, 1993, at Z13. Toxoplasmosis led to the death of tennis star Arthur Ashe, who contracted HIV during open heart surgery. *Id.* Major transmitters of toxoplasmosis are domestic cats and uncooked meats. Hoenig, *supra* note 38, at 5.

59. Kaposi Sarcoma (KS) produces lesions which occur throughout the external and internal parts of the body. HUBER, *supra* note 39, at 89.

60. See GRMEK, *supra* note 37, at 94 (describing the life-span of full-blown AIDS patients).

61. The one exception is someone who has Acute HIV. An HIV-challenged person with acute HIV cannot claim to have a disability under the ADA because HIV antibody blood tests are not sufficiently sensitive to measure the virus at that stage. A person must wait at least three months to test HIV-positive and, by then, would no longer experience acute HIV symptoms.

62. 42 U.S.C. § 12102(2)(A).

63. 42 U.S.C. § 12102(2)(B).

64. 42 U.S.C. § 12102(2)(C).

seropositive asymptomatic members of the HIV spectrum as having a substantial physical or mental impairment because of the accompanying physical and mental trauma which normally occurs with this fatal disease.<sup>65</sup>

#### THE BURDEN OF PROOF AND HIV/AIDS PATIENTS

To gain protection under the ADA, the burden of proof rests with the HIV-challenged individual. The person must notify the health care provider of his or her HIV status, and the verifying documentation must accompany such notification.<sup>66</sup> One consequence for the HIV-challenged individual, in having to notify and document, is that he or she must forego the safety and comfort of taking an anonymous HIV-antibody blood test because test results must provide a verifiable link to the person in question. In order to receive protections under the ADA, therefore, the HIV-challenged patient must "go public" to a significant extent. Given the history of discrimination and the stigma often attached to having HIV/AIDS, this is not always an easy task for people within the HIV spectrum.

#### MOTIVES FOR DENIAL OF ACCESS TO MEDICAL CARE

As is so often the case, the law *seems* fairly straightforward. Someone in the HIV spectrum is a disabled American and the ADA will protect him or her from discriminatory practices. Protection includes the right of access to health care facilities and services, regardless of whether the offender who provides those public accommodations is a public or private entity. Physicians and health care delivery organizations, such as hospitals and emergency medical service units, cannot refuse health care access to the HIV-challenged person. Doing so violates the ADA and, in all likelihood, a variety of other federal and state laws.<sup>67</sup>

So why is the history of HIV/AIDS cluttered with so many examples of discriminatory practices?<sup>68</sup> This is especially troubling in

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65. See generally MARY CATHERINE BATESON & RICHARD GOLDSBY, THINKING AIDS (1988) (providing a good discussion of the mental and physical trauma of the HIV-challenged).

66. See 29 C.F.R. § 1630 (1993) (laying out guidelines for implementation of and compliance with the ADA).

67. If the health care provider receives federal funding, such as medicare or other welfare reimbursements, or if the health care provider is directly under the jurisdiction of state and local government, then the Vocational Rehabilitation Act comes into play. 29 U.S.C. § 794. Furthermore, most states have enacted civil rights legislation which covers equal access to the delivery of goods and services. See, e.g., CAL. CIV. CODE §§ 54-55.1 (Supp. 1994); HAW. REV. STAT. §§ 347-1 to 347-20 (Supp. 1992); IOWA CODE ANN. §§ 216.1-216.20 (Supp. 1993); MINN. STAT. ANN. §§ 363.01-363.15 (West Supp. 1994).

68. HIV/AIDS discrimination cases have reached the courts in a number of contexts. See *Little v. Bryce*, 733 S.W.2d 937 (Tex. Ct. App. 1987) (ruling on HIV/AIDS slander allegations); see also, e.g., RANDY SHILTS, AND THE BAND

the medical field, given the context of the Hippocratic Oath.<sup>69</sup> It is most troubling that discriminatory acts and tendencies still exist in the medical field after the passage of the ADA.

As with so many other pieces of legislation, particularly those dealing with anti-discrimination issues,<sup>70</sup> the effectiveness of implementing the ADA is not simply a function of astute and proactive lawyers or a compassionate and watchful judicial system.<sup>71</sup> Rather, compliance with both the letter and spirit of the law is more a function of the willingness of those individuals and organizations immediately responsible for implementing the law in each specific setting. Outside the realm of litigation, two factors seem to have the greatest effect on the willingness of health care providers to comply with the ADA in the age of AIDS. Both real fears and unfounded fears help to shape their views on providing medical care to HIV-challenged people.

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PLAYED ON 311 (St. Martins 1987) (describing the social backlash against people with HIV/AIDS); RONALD BAYER, *PRIVATE ACTS, SOCIAL CONSEQUENCES* (1989). Home Box Office converted *AND THE BAND PLAYED ON* to a full feature television movie in 1993. One of the more popular films in early 1994 documents a discrimination case brought by a former associate against his law firm after the firm dismissed him due to his HIV-infection. PHILADELPHIA (TriStar 1993).

69. Furthermore, the American Medical Association recognizes that HIV/AIDS patients deserve medical care without discrimination. See AMA Council on Ethical and Judicial Affairs, *Ethical Issues Involved in the Growing AIDS Crisis*, 259 JAMA 1360, 1360 (Mar. 4, 1988) ("AIDS patients are entitled to competent medical service with compassion and respect for human dignity and to the safeguard of their confidences within the constraints of the law."). Dr. John H. Burkhardt, of the AMA Council on Ethical and Judicial Affairs, once wrote:

Physicians who refuse to treat HIV-infected patients risk being expelled by their state medical society if its ethical and judiciary body decides that such refusal is an unethical act. According to the American Medical Association, "a physician may not ethically refuse to treat a patient solely because the patient is HIV-seropositive."

Unethical behavior is grounds for expulsion from membership in most—if not all—local and state medical organizations. In light of the current atmosphere of confusion, uncertainty, and fear surrounding AIDS, such expulsion may well be controversial and even contestable, but it remains a definite risk nonetheless.

MEDICAL ASPECTS OF HUMAN SEXUALITY 21 (Feb. 1989).

70. Many authorities address government action regarding anti-discrimination efforts. See, e.g., JAMES D. SLACK, *AIDS AND THE PUBLIC WORK FORCE* (1991); CHARLES S. BULLOCK AND CHARLES U. LAMB, *IMPLEMENTATION OF CIVIL RIGHTS POLICY* (1984); James D. Slack, *The Americans with Disabilities Act and the Workplace: Observations about Management's Responsibilities in AIDS-Related Situations* (manuscript available from author); Peter C. Bishop and Augustus J. Jones, Jr., *Implementing the Americans with Disabilities Act of 1990: Assessing the Variables of Success*, 53 PUB. ADMIN. REV. 121 (1993).

71. See generally ROBERT T. NAKAMURA & FRANK SMALLWOOD, *THE POLITICS OF POLICY IMPLEMENTATION* (1980); JEFFREY L. PRESSMAN & AARON B. WILDAVSKY, *IMPLEMENTATION* (1973).

*Fears Grounded in Reality*

Two fears felt by many health care providers are very real. First, there is always a chance of contagion through blood-to-blood contact. This fear resonates among the many hospital employees associated with emergency rooms and HIV/AIDS wards, and among public safety officials whose responsibility is to provide immediate medical assistance to people in need. Surgeons are also very aware of the dangers of blood-to-blood contact with patients in the HIV spectrum.<sup>72</sup>

However, given the model workplace policy developed by the Centers for Disease Control (CDC) and the workplace safety regulations imposed by the Occupational Safety and Health Administration (OSHA), the fear of contagion should be slight. The CDC and OSHA designed these procedures to protect employees who come into contact with blood in the workplace.<sup>73</sup> In part because of compliance with these procedures, the chance of contracting HIV/AIDS at any workplace in the United States is minimal.<sup>74</sup> The figures hold especially true in the medical workplace. To date, only thirty-seven health care employees have contracted HIV/AIDS at the work-place.<sup>75</sup> Unless one's profession includes having unprotected sex or injecting drugs through shared needles, the American work-site is perhaps the safest place to be if you do not want to "catch AIDS."

The second fear, also very real, stems from the actual cost of HIV/AIDS. It is a fear shared by many people, including both private practice physicians and medical care organizations. While the costs of HIV/AIDS may vary, one thing is certain: it is not an inexpensive proposition. The annual cost for acyclovir, needed to combat CMV, is \$5,115 for a 3200 milligram daily dose.<sup>76</sup> The annual cost for both AZT and ddI, the major antiviral drugs on the market, is approximately \$16,000.<sup>77</sup> Based on one study, the average work-

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72. See Kristina Campbell, *Surgeon Pays for Bias*, WASH. BLADE, Aug. 20, 1993, at 30.

73. 29 C.F.R. § 1910.1030 (1993). However, the effect of these guidelines depends greatly upon compliance within the health care industry and emergency services. See Margery M. Tamburro, Note, *The New AIDS "Look Back" Statute: Contact Tracing in the Health Care Setting—A Step in the Wrong Direction*, 25 J. MARSHALL L. REV. 769, 776 (1993) (noting the failure of many health care professionals to follow universal infection control guidelines).

74. See generally James D. Slack, *Responding to the Global Epidemic of AIDS: Cultural and Political Challenges Facing Governments*, 20 POL'Y STUD. J. 24 (1992) (providing a comparative analysis of risks in the workplace in China and the United States).

75. CENTERS FOR DISEASE CONTROL AND PREVENTION, *supra* note 1, at 13.

76. Telephone Interview with anonymous volunteer counselor, San Francisco AIDS Hotline (Jan. 14, 1994).

77. Telephone interview with anonymous volunteer counselor, Gay Men's Health Crisis (Jan. 14, 1994).

place cost for an HIV-challenged employee, earning \$25,000 a year and living for 10 years, is over \$270,000.<sup>78</sup> For physicians and many health care workers with salaries greater than \$25,000, sick day utilization and insurance costs will be much greater.<sup>79</sup>

Physicians and other health care professionals are not immune from contracting HIV and, because of their income brackets, their personal expenses may be greater than poor and middle class people. Those that contract the virus, however, do so in the same manner as other Americans: having sex and sharing needles with people who are HIV-positive. As with the fear of contagion, the fear of expense is not job-related.

The success of current protective regulations outweighs the probability of catching and paying for HIV/AIDS at the workplace. The minimal risk of transmission in the health care setting does not justify denying health services to HIV-challenged patients. Therefore, this fear must not interfere with the delivery of health care and treatment to persons in the HIV spectrum.

### *Unfounded Fears*

Unfounded fears about HIV/AIDS also have a tremendous impact on the decision of whether to provide access to medical care, as well as the nature and quality of that care, for the HIV-challenged individual. On the surface it seems incredible that physicians comprise one group that is perhaps least knowledgeable about the AIDS epidemic. This is particularly true in tertiary settings, smaller towns which have had only minimal contact with the epidemic and other settings which are either technologically isolated or geographically distant from the ongoing activities of major medical research centers.

Physicians in these areas tend to rely on dated information made available by local health educators, many of whom are equally unaware of changes in the knowledge-base of HIV/AIDS.<sup>80</sup> In these settings, physicians tend neither to subscribe to sources which provide updated HIV/AIDS related information nor do they normally attend seminars and workshops on the subject.<sup>81</sup>

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78. JACK P. DESARIO, ET AL., LOCAL GOVERNMENT INFORMATION AND TRAINING NEEDS IN THE 21ST CENTURY (Quorum Books, forthcoming 1994).

79. *Id.*

80. In Las Cruces, New Mexico, the state's second-largest city with a population of nearly 70,000, HIV/AIDS educators still warn about the dangers of kissing someone who is HIV-positive. The mainstream AIDS community discarded such information nearly ten years ago. See Jeanne Gatoura, *Facing Reality Gender A Factor to Consider in the Spread of AIDS*, CHI. TRIB., Feb. 2, 1992, at Womenews 11 (dismissing the kissing theory as a myth).

81. For instance, not one physician attends the quarterly meetings of the New Mexico Red Cross AIDS Information Network. Telephone Interview with Ann Schuzneveldt, AIDS Information Network Coordinator (Mar. 9, 1994).

The consequences of these antiquated views about AIDS, especially about the modes of transmission, are two-fold for the HIV-challenged individual. These old fears detrimentally affect the health care options of HIV-challenged men and women. They also tend to affect the behavior of health care workers to the extent that the HIV-challenged individual feels uncomfortable.

Retention of such antiquated fears about HIV/AIDS threaten HIV patients by reducing available medical services. They contribute to a health care professional's refusal to provide medical care. Because physicians are increasingly aware that they live in a litigious world, such refusals often take subtle forms. For instance, the person with HIV/AIDS may find it very difficult to get an appointment to see the physician. It is also not too uncommon for physicians to claim ignorance about the treatment of HIV/AIDS and seek to refer the patient to "an expert"—even for routine medical needs unrelated to HIV/AIDS, like physical examinations, treatment for the flu or the common cold, or surgery.<sup>82</sup>

Although physicians and health facilities may not actually refuse medical care, they may alter the delivery of services in such ways as to make the HIV-challenged patient feel sufficiently uncomfortable. By doing so, the health care provider hopes that he or she will encourage the HIV-challenged individual to seek medical care elsewhere.<sup>83</sup> This approach, too, may take numerous and subtle forms. For instance, the doctor may only grant appointments during evening hours, very early in the morning, or at other inconvenient times to avoid non-seropositive patients. The receptionist may also begin to treat the patient differently upon learning of his or her HIV status. The receptionist may stare coldly at the patient or may whisper to others—adding to the psychological burden incumbent for people in the HIV spectrum when they visit health care providers.<sup>84</sup> The physician's assistant may suddenly begin to wear surgical gloves when handling the patient's file, making the erroneous assumption that the retrovirus is transmissible through touch.<sup>85</sup> The physician may refrain from touching the patient and from shaking his or her hand at the conclusion of the appointment. Once again, this erroneously assumes that HIV is transmissible

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82. This was the situation in *Miller v. Spicer*, 822 F. Supp. at 158, 161 (D. Del. 1993). In *Miller*, the court found that a doctor transferred a patient and postponed urgent care because the patient may have had HIV/AIDS. *Id.*

83. A public entity which treats an HIV-challenged patient differently from non-seropositive patients violates the ADA. 28 C.F.R. § 35.130 (1993).

84. Upon learning of a patient's HIV status, one receptionist discarded the pen used by one HIV-challenged person to complete the initial medical questionnaire. This incident occurred in the not-so-isolated area of Bay Village, Ohio—a suburb of Cleveland.

85. HIV is a fragile virus and dies soon after it leaves the environment of the human body. AIDS PRACTICE MANUAL: A LEGAL AND EDUCATIONAL GUIDE II-3 (Paul Abert et al. eds., 1988).

through casual contact.<sup>86</sup>

Given the rapid increase in the number of HIV/AIDS cases in rural and tertiary settings—nearly 100% in the last year<sup>87</sup>—the need for eliminating unfounded fears about modes of transmission is as critical to the success of the ADA as providing information and guidelines about the legislation. Especially since the number of heterosexual HIV/AIDS cases has increased so rapidly in the last year,<sup>88</sup> a lack of current knowledge about the epidemiology of HIV/AIDS is simply resulting in discriminatory practices against an increasingly larger array of patients. Physicians and health care organizations must make HIV-positive patients feel comfortable in their waiting rooms as well as in the examination rooms. Only then will compliance with the spirit of the ADA be possible.

### CONCLUSION

Protecting the rights of the HIV-challenged individual can not rest solely on the shoulders of the legal system. Particularly in tertiary areas of the country, there may be as many lawyers with a limited understanding of the applicability of the ADA in the HIV/AIDS setting as there are physicians with limited knowledge about the disease. Regardless of the rural or urban setting, both the physician and lawyer may also share biases against members of selected groups in society which have been hit with the initial brunt of the epidemic.<sup>89</sup> Such prejudices will necessarily hinder all professionals in performing their duties within the framework of the ADA.

Bigotry and misinformation are the hallmarks of discriminatory practices. In the age of HIV/AIDS, there are no exceptions to this rule. Greater efforts must be made to educate health care providers about HIV/AIDS and the ADA. At the same time, health care workers should make an effort to educate themselves further.

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86. HIV-challenged individuals throughout the United States report these same behaviors.

87. The rate for non-metropolitan areas (communities with less than 50,000 inhabitants) rose from 5.0 per 100,000 between July 1991-June 1992 to 8.7 per 100,000 between July 1992-June 1993. CENTERS FOR DISEASE CONTROL AND PREVENTION, *supra* note 1, at 5. The total number of HIV/AIDS cases reported in non-metropolitan areas was 15,596. *Id.* Nearly one-third of these cases were reported in the last twelve months. *Id.*

88. 4,041 heterosexual cases were reported between July 1991 and June 1992. *Id.* at 6. 7,547 heterosexual cases were reported between July 1992 and June 1993. *Id.* The total number of women reported with HIV/AIDS during the same time periods are 6,136 and 12,372 respectively. *Id.* A total of 315,390 cases of HIV/AIDS, 38,914 involving women, have been reported since the beginning of the epidemic. *Id.* at 11.

89. While the number of heterosexual cases is increasing, HIV/AIDS has had a greater effect on male homosexuals (55% of all cases). CENTERS FOR DISEASE CONTROL, *supra* note 1, at 11. African Americans make up 28% of all cases, *id.*, while Hispanic Americans form 16% of the HIV/AIDS caseload. *Id.*



This should improve appropriate medical care and attention for all HIV-challenged persons. Knowledge of both HIV/AIDS as a disease pandemic and the ADA as a shield from discrimination are quintessential in combating the many health care ramifications of the pandemic.