

Public Health Powers: The Imminence of Radical Change

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EDITOR'S NOTE

One of the most controversial public policy challenges of recent times has been crafting policy that balances the public interest and individual rights in relation to persons with HIV and AIDS. Lawrence O. Gostin explores the convergence of the traditional exercise of public-health powers, which requires persons to be treated unequally because of communicable medical conditions, and the antidiscrimination mandate of ADA, which requires reasonable accommodation as a component of equitable treatment for persons with disabilities. Gostin concludes by proposing a set of standards that could be applied in individual cases to determine whether to draw the line on the side of public interest or individual civil rights.

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Legal controls over the unfettered exercise of public health powers have long been regarded as ineffective and idiosyncratic (Burris 1985;1989; Merritt 1986; Parmet 1989). Public health statutes (many written before the sciences of virology, bacteriology, and epidemiology had fully come of age) delegate wide-ranging powers to officials (Gostin 1987). The major check on the exercise of these powers has been constitutional review by the judiciary. The courts, however, are reluctant to interfere in public health decision making, and have not yet developed a cogent set of criteria for establishing effective boundaries around the proper exercise of public health authority.

In this article, I will argue that constitutional review—long the standard bearer for judicial activity in the public health realm—is quietly, but effectively, being replaced with a more cogent statutory review provided by the Americans with Disabilities Act (ADA). This landmark legislation will unleash a powerful review mechanism that will set effective boundaries on the historic exercise of public health powers. Ultimately, the ADA will provide a much needed impetus for states to reform fundamentally outdated statutes relevant to communicable and sexually transmitted disease (Gostin 1987). This reformation will bring state statutes into conformity with the letter and spirit of the ADA.

I will be suggesting a new way of looking at the ADA and public health law. Even some of the most astute observers do not yet recognize that, seen through the lens of the ADA, public health regulation may be regarded as discrimination against persons with disabilities. In order for public health officials to justify treating people with communicable diseases differently, they must meet strict scientific standards. In the ADA, Congress clearly asserted the preeminence of science over irrational fear and prejudice.

First, I will carefully examine the key concepts in the ADA as they apply to communicable disease. This section will reveal the clear intention of Congress to include communicable disease, even asymptomatic infection, as a disability. Second, I will explain the new "direct threat" standard in the ADA. This section will analyze how the courts and Congress have used the concept of "significant risk" as a new yardstick for reviewing public health powers. Third, I will examine how the

concept of reasonable accommodations can be applied to persons with communicable disease. Finally, I will propose a systematic standard of review under the ADA for the future regulation of public health powers.

COMMUNICABLE DISEASE AS A DISABILITY

The Americans with Disabilities Act of 1990¹ (ADA) and the corpus of antidiscrimination legislation² appear to be unlikely sources of law to fill the doctrinal void left by deferential constitutional standards. Anti-discrimination law, on its face, is concerned with what I refer to as “pure discrimination.” Pure discrimination occurs when a public or private entity treats a person unfairly, not because she lacks adequate skill, qualifications, or experience, but because of her disability. The nation’s goals, according to the framers of the ADA, are to assure equality of opportunity, full participation, equal living and self-sufficiency to allow people with disabilities to compete on an equal basis.³

Public health regulation of communicable disease does not fit comfortably within the ADA’s rubric of pure discrimination. Certainly, the annals of public health are replete with examples of pure discrimination against “discrete and insular” minorities such as prostitutes (Brandt 1985), drug-dependent people (Musto 1973), gays (Bayer 1989), and racial minorities.⁴ The exercise of public health powers such as testing, screening, reporting, vaccination, treatment, isolation, and quarantine are, however, qualitatively different from the ADA’s paradigm of pure discrimination: the state is regulating public health, not refusing jobs, benefits, or services because of a disability; the motive is health related, not grounded in prejudice; and the usual qualification standards of education, skill, or experience are not pertinent. Persons are treated unequally in public health regulation because of communicable medical conditions, not as a direct result of pure prejudice.

Despite the qualitative differences between a communicable disease (e.g., tuberculosis, syphilis, or hepatitis B) and a physical disability (e.g., sight, hearing, or mobility impairments), the ADA applies to each equally. The ADA, moreover, does not merely prohibit discrimination against persons with disease in employment and public accommodations. Title II of the ADA applies to public services, which are

defined broadly to encompass all actions by state and local government, including those of public health departments. To demonstrate the applicability of the ADA to communicable disease, I will analyze the relevant definitions, legislative history, and standards.

PHYSICAL OR MENTAL IMPAIRMENT

Disability is defined broadly in the ADA to mean “a physical or mental impairment that substantially limits one or more of the major life activities, a record of such impairment, or being regarded as having such an impairment.” Physical or mental impairment includes (1) any physiological disorder or condition, disfigurement or anatomical loss affecting any of the major bodily systems; or (2) any mental or physiological disorder such as mental retardation or mental illness. The legislative history,⁵ as well as the prior case law,⁶ reveal that “disability” includes diseases and infections that are communicable (e.g., tuberculosis,⁷ hepatitis,⁸ and HIV⁹) as well as those that are not (e.g., heart disease,¹⁰ cerebral palsy,¹¹ arthritis,¹² diabetes, and epilepsy¹³).

The legislative history of the Rehabilitation Act barely mentions infectious disease.¹⁴ In *School Board of Nassau County, Florida v. Arline*, the question arose for the first time in the Supreme Court¹⁵ whether discrimination on the basis of contagiousness constitutes discrimination “by reason of . . . handicap.” The Court held that a teacher who had been hospitalized with tuberculosis that affected her respiratory system had a “record” of substantial physical impairment. The fact that a person with a record of impairment is also contagious does not remove her from protection as a person with disability.

The *Arline* Court observed that, in defining a person with disability, the contagious effects of a disease cannot be meaningfully distinguished from the disease’s physical effects. “It would be unfair to allow an employer to seize upon the distinction between the effects of a disease on others and the effects of a disease on a patient and use that distinction to justify discriminatory treatment.”¹⁶ Citing the example of cosmetic disfigurement, the Court argued that Congress was as concerned about the effects of impairment on others as it was about its effects on the individual.¹⁷

The inclusion of contagious conditions in the definition of disability was, according to *Arline*, consistent with the basic purpose of disability law to protect people against the prejudiced attitudes and ignorance of others. “Society’s accumulated myths and fears about disability and

disease are as handicapping as are the physical limitations that flow from impairment. Few aspects of handicap give rise to the same level of public fear and misapprehension as contagiousness.”¹⁸

“RECORD” OF OR “REGARDED” AS BEING IMPAIRED

A person is disabled if he or she has a “record” of or is “regarded” as being disabled or is perceived to be disabled, even if there is no actual incapacity.¹⁹ A “record” indicates that the person has had a history of impairment, or has been misclassified as having had an impairment. This provision is designed to protect persons who have recovered from a disability or disease that previously impaired their life activities.²⁰ By including those who have a record of impairment, Congress acknowledged that people who are no longer suffering the effects of conditions such as epilepsy or cancer still face discrimination based upon prejudice and irrational fear.²¹

The term “regarded” as being impaired includes individuals who do not have limitations in their major life functions, but are treated as if they did. This concept protects people who are discriminated against in the false belief that they are disabled. It would be inequitable for a defendant who intended to discriminate on the basis of disability to raise successfully the defense that the person was not, in fact, disabled. This provision is particularly important for individuals who are perceived to have stigmatic conditions that are viewed negatively by society. It is the reaction of society, rather than the disability itself, that deprives the person of equal enjoyment of rights and services. Persons with infectious diseases are particularly prone to irrational fears by those who are misinformed about the modes and relative risks of transmission. Persons with disfiguring conditions such as leprosy or severe burns may also suffer from negative attitudes and misinformation because they are perceived to be disabled.²²

ASYMPTOMATIC INFECTION AS A DISABILITY

The fact that a record or perception of disability is included within the ADA is vitally important in determining whether pure asymptomatic infection can be regarded as a disability. The abiding interest at the time of *Arline* was whether an asymptomatic carrier of a contagious infection such as human immunodeficiency virus (HIV) could be regarded as having a disability. A Justice Department memorandum in June 1986 concluded that although the disabling effects of AIDS may

constitute a disability, contagiousness—the ability to transmit infection to others—is not covered within the Act.²³ The *Arline* court, in its widely studied footnote 7, stated that the facts of the case “do not present, and we therefore do not reach, the question whether a carrier of a contagious disease such as AIDS could be considered to have a physical impairment.”²⁴

The Presidential Commission on the HIV Epidemic recommended that all stages of HIV infection should be covered under disability law.²⁵ On July 29, 1988, C. Everett Koop, the surgeon general, wrote to the Justice Department seeking a fresh opinion in light of *Arline* and the growing scientific understanding that HIV infection is the starting point of a single disease process.²⁶ In response, the Justice Department withdrew its previous opinion, concluding that “section 504 protects symptomatic as well as asymptomatic HIV-infected individuals against discrimination.” The person is protected only if he or she “is able to perform the duties of the job and does not constitute a direct threat to the health or safety of others.”²⁷

The applicability of asymptomatic infection to disability status had already been clarified in amendments to the Rehabilitation Act. The Civil Rights Restoration Act of 1987²⁸ states that a person with a contagious disease or *infection* is disabled if he or she does not “constitute a direct threat to health or safety” and is able to “perform the duties of the job.”²⁹ Since *Arline*, the courts have consistently held that HIV-related diseases, including asymptomatic HIV infection, are covered disabilities.³⁰

DIRECT THREAT: AN EVOLVING QUALIFICATION STANDARD

The antidiscrimination principle in the ADA applies only to “qualified individuals.”³¹ A “qualified” person must be capable of meeting all of the performance or eligibility criteria for the particular position, service, or benefit.³² There is, moreover, an affirmative obligation to provide “reasonable accommodations”³³ or “reasonable modifications”³⁴ if they would enable the person to meet the performance or eligibility criteria. Employers are not required to provide reasonable accommodations if they would impose an undue hardship on the operation of the business.³⁵

The key concepts of “qualification” and “reasonable accommodations” or “modifications,” on their face, apply only to a person’s ability to do a job or participate in public programs, with or without adaptations or modifications by the employer or public entity. A ban specifically of discrimination against persons with disabilities who are “qualified,” without better established limits, might require covered entities to integrate persons in jobs, accommodations, and services, even if they posed a risk of transmission of disease. This prospect led some Congressmen to ask whether employers could be required to employ persons with AIDS if they risked “exposing others to tuberculosis, cytomegalovirus, and other AIDS-associated illness?”³⁶

It does defy established public health practice to suggest that persons with readily transmissible airborne conditions such as measles, influenza, or active tuberculosis could not be excluded from a particular job or from enclosed public spaces such as movie theaters; that persons with foodborne diseases could not be prevented from working in kitchens or as waiters in restaurants; or that public health departments could not set reasonable rules for the control of sexually transmitted disease in bathhouses. In short, the essence of public health regulation is that persons may be treated differently based upon a rigorous scientific assessment of the risk of transmission.

Congress anticipated this problem as it affected employment and public accommodations. Titles I and IV of the ADA state expressly that qualification standards can include a requirement that a person with a disability “not pose a direct threat to the health or safety of others”³⁷ if reasonable accommodations or modifications will not eliminate that direct threat. The ADA clearly provides a right to take action to protect the health and safety of all persons in employment and public accommodations.³⁸

The question arises whether the same standard is similarly applicable to title II, as the concept of “direct threat” is not expressly extended to public services. Title II is of seminal importance in the regulation of public health because it is concerned with activities of state and local government. If taken at face value, title II could appear to undermine rules, regulations, and practices of public health departments that exclude persons from services, programs, or activities because of a communicable disease. A defense of direct threat is not expressly available under title II. Congress clearly did not intend to impede valid public health measures based upon rigorous scientific determinations of a significant risk to the public. In the words of one court, “It would be

unreasonable to infer that Congress intended to force institutions to accept or readmit persons who pose a significant risk of harm to themselves or others.”³⁹ Accordingly, future regulations should specifically apply the “direct threat” standard to title II.

Title II applies only to “qualified” individuals. Although that term is not defined in title II, it can reasonably be taken to have the same meaning as in title I. Indeed, in discussing the qualification standards for public services, the House Committee on Energy and Commerce referred to the Rehabilitation Act principle that a person must meet “the basic eligibility requirements of the program,” and could not pose “a significant risk to the health or safety of others that could not be eliminated by reasonable accommodation.”⁴⁰

REASONABLE ACCOMMODATIONS FOR PERSONS WITH COMMUNICABLE DISEASE

The ADA follows a long tradition⁴¹ in disability law by requiring reasonable accommodations or modifications for otherwise qualified individuals, unless they would pose an undue hardship.⁴² The need for accommodations for persons with physical disabilities is straightforward: adaptation of facilities to make them accessible, modification of equipment to make it usable, and job restructuring to provide more flexible schedules for persons who need medical treatment.⁴³

The kinds of accommodations reasonably necessary to assist persons with communicable diseases, however, are not self-evident. The concepts of reasonable accommodations and “direct threat” are related.⁴⁴ A person who poses a significant risk of communicating an infectious disease to others is qualified if reasonable accommodations will eliminate that risk.⁴⁵ Employers may, for example, be required to provide infection-control training and equipment to prevent bloodborne diseases in order to accommodate persons infected with hepatitis B virus (HBV). An employer, however, is not forced to endure an undue hardship that would alter the fundamental nature of the business or would be disproportionately costly.^{46,47} The Eighth Circuit Court of Appeals held that a school for persons with mental retardation was not obliged to vaccinate employees in order to reasonably accommodate a student who was an active carrier of HBV. The vaccination program that had

been ordered by the lower court was unduly costly and unable to eliminate the significant risk of transmission.⁴⁸

The Eighth Circuit's decision to uphold the exclusion from school of students with mental retardation who were active HBV carriers is directly at odds with the Second Circuit's decision in a case with essentially the same set of facts.⁴⁹ Each court had a different perception of the meaning of "significant risk" and "reasonable accommodation." The standards proposed below should clarify how the ADA ought to be applied in the public health realm.

THE ADA AND THE FUTURE OF PUBLIC HEALTH REGULATION

HOW SIGNIFICANT MUST HEALTH RISKS BE?

By utilizing the Supreme Court's term "direct threat," Congress codified *Arline*.⁵⁰ Although the direct-threat criterion was limited to persons with contagious disease in the Senate bill, it was extended in conference to all individuals with disabilities.⁵¹ The ADA defines direct threat consistently with the *Arline* decision: "a significant risk to the health or safety of others" that cannot be eliminated by reasonable accommodation in employment,⁵² or reasonable modification of policies, practices, or procedures, or by the provision of auxiliary aids or devices in public accommodations.⁵³

"Significant risk," therefore, becomes the standard against which public health regulation must now be measured. The question now becomes which risks are significant? It is possible to arrive at a rather sophisticated jurisprudential and public health understanding of the concept of significant risk by piecing together the language in *Arline* and the ADA's rich legislative history.

First, the determination of significant risk is a public health inquiry.⁵⁴ Relevant evidence must be provided by the multiple disciplines of public health, including medicine, virology, bacteriology, and epidemiology. The science of public health provides the sole basis for determining modes of transmission, probability levels for transmission, efficacy of policies and practices for avoiding transmission, and the likelihood and severity of risk. Disability law has been thoughtfully crafted to replace reflexive actions based upon irrational fears, specula-

tion, stereotypes, or pernicious mythologies,⁵⁵ with carefully reasoned judgements based upon well-established scientific information.⁵⁶

Second, significant risk must be determined on a case-by-case basis, and not under any type of blanket rule, generalization about a class of persons with disabilities, or assumptions about the nature of disease. This requires health officials to conduct a fact-specific, individualized inquiry resulting in a "well-informed judgement grounded in a careful and open-minded weighing of risks and alternatives."⁵⁷ A specific determination must be made that the person is in fact a carrier of a communicable disease and that the disease is readily transmissible in the environment in which he or she will be situated. In the context of behavioral risks, health officials must identify the specific conduct and provide credible evidence that the person is likely to engage in dangerous behavior. For example, if a person with mental illness or mental retardation were to be excluded from school or a job because he or she posed a "direct threat," health officials must present objective evidence that a recent dangerous act was committed.⁵⁸ If a person with a needle-borne or sexually transmitted infection were to be denied equal employment or housing opportunities, evidence that the person is likely to share needles or engage in sexual activity in that setting must be offered.

Third, the risk must be "significant," not speculative, theoretical, or remote. The ADA sets a "clear, defined standard, which requires actual proof of significant risk to others."⁵⁹ This is derived from the highly regarded footnote 16 in *Arline*: "A person who poses a significant risk of communicating an infectious disease to others in the workplace will not be otherwise qualified for his or her job if reasonable accommodation will not eliminate that risk."⁶⁰ The court illustrated its point by observing that a school board would not be required to place a teacher who has active, contagious tuberculosis with elementary-school children.

Several distinct issues emerge from the concept of significant risk: what is the standard of proof, who bears the burden of proof, and what level of risk is required? These are critically important questions that ought to be clarified in regulations on the ADA and comparable state statutes.

The *standard of proof* goes to the issue of the weight of evidence required. The standard of proof is not specified in the ADA, but should be based upon clear and convincing evidence. The public health position taken should be consistent with the clear weight of scientific

evidence. Restrictions on liberty ought not be based upon a minority medical opinion. A single physician's view, for example, that HIV might be transmitted casually or from a bite is not sufficiently persuasive when compared with all the accumulated data based on scientific evidence. The proof of risk, on the other hand, need not be conclusive or decisive. "Little in science can be proved with complete certainty, and section 504 does not require such a test."⁶¹

The *burden of proof* should fall on the entity seeking to demonstrate significant risk. This is consistent with the fact that "direct threat" is a defense in title I.⁶² Thus, an employer, public health department, or public accommodation must be able to offer evidence substantiating its decision to treat persons with disabilities inequitably because they pose a threat to others. It would be difficult, if not impossible, for a person with a communicable disease to prove that transmission cannot occur or is unlikely to occur.

The *level of risk* varies depending upon the severity of the harm and the probability of it occurring. For example, minor or inconsequential infections might require a higher risk of transmission than lethal or fatal infections. Significant risk is not a remote risk, possibly not even an "elevated risk."⁶³ There must be a material, real, or substantial possibility that the disease can be transmitted.

The factors to be used in determining significant risk are increasingly well understood.⁶⁴ The decision maker must determine significant risk based upon reasonable medical judgments and current scientific understanding as outlined below:

1. *Mode of Transmission.* The mechanism of transmission of most diseases is well established by epidemiologic research. A significant risk should be based upon a primary mode of transmission, not an unestablished or highly inefficient one. A bloodborne disease, for example, could conceivably be transmitted through a bite,⁶⁵ through rough play among children,⁶⁶ or by bleeding into food.⁶⁷ Yet the "significant risk" test would not be met if personal restrictions were based on such speculative mechanisms of transmission.

2. *Duration of Risk.* A person can be subject to compulsory public health powers only if he or she is actually contagious, and only for the period of time of contagiousness. A fundamental principle of public health law,⁶⁸ often breached in early cases,⁶⁹ is the requirement that the subject must be proven by medical examination or testing to be carrying an infectious agent. "The mere possibility that persons may have been exposed [to a disease] is not sufficient . . . They must have been

exposed to it, and the conditions actually exist for a communication of contagion.”⁷⁰ The person must also be actively infectious. The key factual determination in *Arline* was whether a teacher was actively contagious and currently capable of transmitting tuberculosis through casual contact.⁷¹

3. *Probability of Risk*. The authority of the public health department to impose restrictions grows as the probability of the risk of transmission increases. The probability that a person will transmit disease is a scientific calculation that can be made with relative degrees of confidence. The range of probability that a person will contract HBV or HIV from a percutaneous exposure (e.g. a needle stick or cut), for example, is well established by prospective studies.⁷² The level of risk from a single sexual relationship is much more difficult to calculate. Substantial probabilities of transmission based upon firm scientific calculations provide the best justification for public health powers.

4. *Severity of Harm*. The seriousness of harm to third parties represents an important calculation in public health regulations. In assessing the validity of public health powers, a rough inverse correlation exists between the seriousness of harm and the probability of it occurring. As the seriousness of potential harm to the community rises, the level of risk needed to justify the public health power decreases.

Central to the understanding of the “significant risk” criterion is the fact that even the most serious potential for harm does not justify public health regulation in the absence of a reasonable probability that it will occur. Parents of school children, for example, have difficulty comprehending why courts would uphold the exclusion of children from school who are infested with lice, but not those infected with HIV. The reason is that a very high probability exists that other children will become infested with lice, whereas the risk of contracting HIV in that setting is highly remote.

5. *Human Rights Burdens*. Although human rights burdens are often missing from public health calculations,⁷³ they are of central importance. The nature, severity, and duration of the personal restrictions must be weighed against the efficacy of the public health power. Substantial public benefit would be required to justify restrictions of great severity and/or duration. A requirement to report an infectious condition to a public health department that maintained strict confidentiality would not usually impose significant human burdens. A short period of exclusion from school due to measles or influenza might similarly be reasonable. On the other hand, isolation for a disease

without a finite period of infectiousness would be burdensome both in the degree and the duration of human deprivation. A decision to indefinitely separate a child or adult with mental retardation from the rest of her classmates would be stigmatic and would psychologically wound her.⁷⁴

Courts must first determine if the health risk is significant. This ought to be followed by a careful weighing of efficacy (will the public health power reduce a serious health threat?) and burdens (at what human, social, and economic cost will the public health benefit be achieved?).⁷⁵ Wherever possible, public health officials should use the least restrictive or invasive power capable of achieving the public health goal. The concept of the "least intrusive alternative" is consistent with the ADA's duty to provide reasonable accommodations for modifications. By providing services for education, prevention, or treatment, the public health frequently can be protected without discrimination against persons with disabilities.

PUSHING THE ADA TO ITS LIMITS: THE CASE OF THE HIV-INFECTED HEALTH-CARE PROFESSIONAL

Although the foregoing proposed standards provide a clear framework for judicial decision making, they can be pushed to their limits in the most troublesome cases. Consider the application of the "direct threat" test to an HIV-infected health-care professional (Gostin 1989c). Although the risk of transmitting infection to the patient is highly remote, the consequence for any patient is grave.

A powerful argument can be made for the ADA to prohibit compulsory HIV testing or limitations in practice for infected professionals. Certainly, professionals engaged in noninvasive procedures would not pose a meaningful risk of infection for patients because comingling of the blood is virtually impossible. Thus, testing or restrictions on the right to practice for professionals engaged in noninvasive procedures would be inconsistent with the ADA. Still, the Fifth Circuit Court of Appeals in *Leckelt*⁷⁶ held that a hospital could compulsorily test a nurse suspected of being infected with HIV. The court found that Mr. Leckelt was "regarded" as having a disability, but was not qualified for his job because of his refusal to submit to an HIV test. Turning the obligation to provide reasonable accommodations on its head, the court concluded that the hospital was prevented from enforcing a program of infection

control, monitoring, and counseling by Leckelt's refusal to disclose his HIV status.

The U.S. Centers for Disease Control (CDC) may be on the verge of recommending that professionals infected with HIV could be tested and restricted in the practice of seriously invasive procedures such as surgery and perhaps even dentistry (Cimons 1990). One case of probable transmission from a dentist to his patient has already been identified (Centers for Disease Control 1990), and several health-care facilities have dismissed HIV-infected surgeons or dentists (Gostin 1990). Would CDC guidance, board of licensure standards, or health-care-facility practices that discriminated against HIV-infected surgeons or dentists violate the ADA? The ADA has transformed the legal and public health questions. Instead of asking whether restrictions on practice of invasive procedures would protect the patient's health, the courts may ask whether health-care facilities are depriving persons with disabilities of employment opportunities.⁷⁷

Applying the criteria proposed above, it is possible to conclude that limitations on the practice of seriously invasive procedures by HIV-infected health-care professionals would be lawful. A surgeon or dentist has her hands in a bodily cavity where there can be direct blood exposure, and studies show a high rate of torn gloves and cut hands (Cruse 1980). Thus, the mode of transmission is well established. The duration of risk is also long term, as one supposes the surgeon will practice for many years and on many patients. Although the risk that any one patient will be exposed to HIV is very low, the cumulative risk is within a range that the ADA would allow some reasonable public health regulation. The probability of the risk, to be sure, remains low, but the severity of the harm is high. The human rights burden on the individual is significant because, in the absence of retraining and reassignment, an entire career can be lost.

The ADA may sensitively handle even this perplexing case by requiring reasonable accommodations in order to allow the professional to continue practicing noninvasive medicine. This may require the health-care provider to offer the surgeon or dentist retraining to perform noninvasive or administrative functions and to provide reasonable compensation. Providers may also be required to accommodate HIV-infected professionals in the practice of non-invasive procedures by requiring counseling and monitoring of strict infection-control techniques.

THE FOOD-HANDLERS CONTROVERSY AND THE PREEMPTION CLAUSE: A FEDERALIST APPROACH

A dissenting view in the House Judiciary Committee stated that a person with AIDS should not be transferred to another job out of a food-handling position even if the employer continued to pay the same wages. This would be the "ultimate undue hardship." "Unfortunately, there are many Americans who panic at the mention of the AIDS and would refuse to patronize any food establishment if an employee were known to have the virus." This policy will "translate to no customers and no business at all."⁷⁸

Congress, therefore, was not simply concerned with the potential danger to the public of airborne disease, but also with the business interests of the food establishment. The argument that customer preference can justify discrimination has been thoroughly repudiated by the courts. Employers cannot accede to the prejudices of customers who prefer white people to black people, men to women, or able-bodied people to those in wheelchairs. Nor can the "repulsive" face of a person with neurofibromatosis ("elephant disease") or hatred of persons with drug dependency and AIDS justify discrimination.

The House amendment (the "Chapman Amendment") to the ADA, but not the Senate bill, specified that it shall not be a violation of the ADA for an employer to refuse to assign or continue to assign any employee with an infectious or communicable disease of public health significance to a job involving food handling, provided the employer makes reasonable accommodation to offer a comparable alternative employment opportunity.⁷⁹ The House acceded to the Senate with the following amendment: The Secretary of Health and Human Services must publish a list of infectious and communicable diseases that are transmitted through handling of the food supply, specifying the methods by which such diseases are transmitted, and widely disseminating the information about the dangers and their modes of transmission.⁸⁰

The ADA authorizes employers to refuse to assign individuals to a job involving food handling if they have a presently infectious condition that is listed as transmissible through the food supply.⁸¹

The Chapman Amendment contained a misconception of disability law that it is permissible to fire an employee if the reason for the discrimination is not the employer's biases, but protection of the business from the irrational fears of patrons. The courts do not allow employers to succumb to customers' wholly unsubstantiated fears as a

justification for discrimination, even if this involves picketing the establishment,⁸² a large increase in health insurance or other benefits costs,⁸³ or adverse publicity.⁸⁴ Exclusion of HIV-infected food handlers was not condoned under the Rehabilitation Act and state disability law because there was no evidence that infection could be transmitted through food.⁸⁵

The purpose of the food-handlers compromise was to ensure the American public that “valid scientific and medical analysis, using accepted public health methodologies and statistical practices regarding risk of transmission” will be brought to bear in analyzing foodborne transmission of disease.⁸⁶ This is the same standard that ought to be applied to future public health decision making.

What emerged as a problem of significant import was the interaction between the ADA and state or municipal public health statutes. Federal laws, unless they specify otherwise, preempt state and local statutes with comparable coverage. The ADA specifies that state or local law that creates “*greater* protection for the rights of individuals with disabilities” is not preempted.⁸⁷ The question arises whether public health laws that *restrict* the rights of a person with a disability more than the ADA allows is preempted. The simple answer is that all state and local public health law restricting the rights of persons with communicable diseases in ways that are inconsistent with the ADA will be invalidated by federal courts. Although the preemption provision in section 103(c)(3) applies only to food handlers, it illustrates clearly the interaction of the entire ADA with public health law. That section specifies that state, county, or local law or regulation designed to protect the public health from individuals who pose a significant risk of contamination of the food supply is not overruled or modified by the ADA.

The House Conference Report emphasizes that section 103(c)(3) “clearly defines certain types of existing and prospective state and local public health laws that are not preempted by the ADA.”⁸⁸ The public health law must be designed to protect the community from significant public health risks that cannot be eliminated by reasonable accommodation. This preemption strategy supports legitimate state and local laws and regulations designed to protect the public from communicable disease, thus carrying out “both the letter and the spirit” of the ADA,⁸⁹ and promising a future of a more enlightened public health regulation.

A superficial examination of the ADA might lead to the conclusion that it interferes with the classic constitutional principle that the state

has sole police-power authority to preserve the public health. True federalism, however, provides states with ample authority to regulate public health, but only within national guidelines ensuring that decisions are based upon rigorous public health evidence, rather than on false perception, unsubstantiated fears, or pure prejudice. Properly understood, the ADA strikes a constitutional balance that can only generate better and more consistent public health decision making.

CONCLUSION AND IMPLICATIONS FOR REGULATION WRITERS

The Americans with Disabilities Act emerges as far more effective than deferential constitutional analysis in reviewing public health powers. The standard of review proposed here should be reflected in future regulations on the ADA and comparable state statutes. The concept of direct threat should be expressly extended to include public services (title II). In construing "direct threat," regulations should explicitly place the burden of proof on public health authorities. Public health officials would have the burden of demonstrating significant risk by rigorous scientific assessment. The following elements would have to be established:

1. The mode of transmission is well established.
2. The person is currently contagious and is likely to remain so for the duration of the control measure.
3. A reasonable likelihood exists that the person will actually transmit the disease if the control measures are not applied.
4. The transmission of disease may result in serious harm.
5. The costs and human rights burdens are not disproportionate to the public health benefit to be achieved.

This regulatory standard is exacting and requires the public health department to have a clear basis for the exercise of its powers. The reason for the more focused review is that the ADA re-states the fundamental question that courts must ask of public health regulators. No longer must the courts ask what risks an uninformed, perhaps prejudiced, public is prepared to tolerate; or whether some loose nexus exists between the compulsory power and the public health objective.

Instead, courts must search for scientifically convincing evidence of harm to the public to justify depriving persons with disabilities of equal opportunities. Once the issue is framed as coming with the corpus of anti-discrimination law, rather than the vague and undifferentiated traditions of the police powers, a whole new way of thinking about public health law becomes possible.

NOTES

1. P.L. 101-336, 104 Stat. 327, 42 U.S.C. 12101 et seq. 101st Cong.: an act to establish a clear and comprehensive prohibition of discrimination on the basis of disability.
2. The ADA does not repeal the body of antidiscrimination legislation that preceded it. The Federal Rehabilitation Act of 1973 proscribes discrimination against persons with "handicaps" (defined almost identically to "disability") by entities that are in receipt of federal financial assistance and does not reach into the purely private sector. The principal application of the Rehabilitation Act in the post-ADA era will be to protect those employees of the federal government who have disabilities because they are not covered by the ADA (§101[5][B][i]).
 Discrimination against persons with disabilities in housing is dealt with under the Federal Fair Housing Amendments of 1988. See *Baxter v. Belleville*, 1989 U.S.D.C. LEXIS 10298 (S.D. Ill. 1989).
 The Education for All Handicapped Children Act, 20 U.S.C. para. 1400 et seq. gives all school-aged handicapped children the right to a free public education in the least restrictive environment appropriate to their needs. See *Martinez v. School Board of Hillsborough County, Florida*, 861 F.2d 1502 (11th Cir. 1988), reversing 711 F. Supp. 1293 (M.D.Fla. 1989); *Community High School District v. Denz*, 124 Ill. App. 3d 1291, 463 N.E.2d 998 (2d Dist. Ill, 1984) (legislation and the judicial decisions construing them are referred to as the corpus of antidiscrimination law).
3. P.L. 101-336, §2(a)(8),(9).
4. See *Jew Ho v. Williamson*, 103 F.10 (C.C.N.D. Cal. 1900).
5. Id. at 22. Indeed, the House Energy and Commerce Committee rejected an amendment offered by Congressman Dannemeyer that would have expressly excluded currently contagious and sexually transmitted diseases or infections from the definitions of "disability." U.S. House of Representatives, May 15, 1990: *The Americans with Disabilities Act of 1989: Report of the Energy and Commerce Committee*, no. 101-485, part 4 (to accompany H.R. 2273), Washington. (Hereafter called Energy Report.)
6. See, e.g., *Strathis v. Department of Transportation*, 716 F.2d 227, 232-234 (3d Cir. 1983); *Doe v. New York University*, 666 F.2d 761, 775 (2d Cir. 1981).
7. *School Board of Nassau County, Florida v. Arline*, 480 U.S. 273 (1987) (school

- teacher with tuberculosis was handicapped within the meaning of section 5.4 of the Rehabilitation Act).
8. *New York State Association for Retarded Children v. Carey*, 612 F.2d 644 (2d Cir. 1979) (mentally retarded children who are carriers of serum hepatitis B could not be excluded from public school because they were handicapped and did not pose a health hazard); *Jeffrey S., a minor by Ernest S., his father v. State Board of Education of Georgia*, 896 F.2d 507 (11th Cir. 1990) (ordered trial on the merits in case involving alleged exclusion from school because, inter alia, child was a carrier of hepatitis B); *Lussier v. Dugger*, 904 F.2d 661 (11th Cir. 1990) (Civil Rights Restoration Act of 1987 applied to corrections officer who alleged discrimination because he had infectious hepatitis disease); *Kohl v. Woodhaven Learning Center*, 865 F.2d 930 (8th Cir. 1989), reversing in part 672 F. Supp. 1221 (W.D. M.O. 1987) (inoculation of school staff for hepatitis not a "reasonable accommodation.")
 9. See, e.g., *Doe v. Centinela Hospital*, 57 U.S.L.W. 2034 (C.D. Cal. 1988); *Chalk v. United States District Court*, 840 F.2d 701 (9th Cir. 1988).
 10. *Bey v. Bolger*, 540 F. Supp. 910 (E.D. Pa. 1982).
 11. *Alexander v. Choate*, 469 U.S. 287 (1985).
 12. The Supreme Court in *Arline* cited remarks of Senator Mondale describing a case in which a woman "crippled by arthritis" was denied a job *not* because she could not do work, but because "college trustees [thought] 'normal students shouldn't see her.'" 118 Cong. Rec. 36761 (1972).
 13. U.S. Senate, August 30, 1989: *The Americans with Disabilities Act of 1989: Report of the Labor and Human Resources Committee*, no. 101-116 at 24, Washington. (Hereafter called Labor Report.) This report cited examples of individuals with controlled diabetes or epilepsy "often denied jobs for which they are qualified. Such denials are the result of negative attitudes and misinformation." In an appendix to the regulations on the Rehabilitation Act, the Department of Health and Human Services specifically listed a number of diseases to which the Act applied, including epilepsy, cerebral palsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, and diabetes. 45 CFR, part 84, App. A, at 310 (1985).
 14. *School Board v. Arline*, 107 S.Ct. 1123, 1134 (1987). Rehnquist J., dissenting.
 15. Lower courts had already found that contagious diseases were handicaps. See, e.g., *New York State v. Carey*, 612 F.2d 644 (2d Cir. 1979).
 16. *School Board v. Arline*, 480 U.S. 273, 282 (1987).
 17. *Id.* at 318.
 18. *Id.* at 284.
 19. This concept derives from *Southeastern Community College v. Davis*, 442 U.S. 397 (1979).
 20. Labor Report at 23, *supra* note 13.
 21. *School Board v. Arline*, 480 U.S. 273, 284 (1987).
 22. Labor Report at 24, *supra* note 13.
 23. Opinion of Charles J. Cooper, Assistant Attorney General, Office of Legal Counsel, for Ronald E. Robertson, General Counsel, Department of Health and Human Services, June 23, 1986.

24. *Id.* at 282, note 7.
25. Report of the Presidential Commission on the Human Immunodeficiency Virus (June 24, 1988).
26. Letter from C. Everett Koop to Douglas Kamiec, Acting Assistant Attorney General, July 29, 1988.
27. Memorandum for Arthur B. Calvahouse, Jr., Counsel to the President, from Douglas W. Kamiec, Acting Assistant Attorney General, Office of the Legal Counsel, re Application of Section 504 of the Rehabilitation Act to HIV-Infected Individuals, September 27, 1988. The concept of "direct threat" as a qualification standard is discussed below.
28. P.L. 100-259.
29. Civil Rights Restoration Act of 1987, P.L. 100-259, para. 557 (March 22, 1988).
30. See, e.g., *Doe v. Centinela Hospital*, 57 U.S.L.W. 2034 (D.C. Cal. 1988). See also Gostin (1990).
31. P.L. 101-336, §§102, 202.
32. Title I requires qualification standards, employment tests, or other selection criteria to be "job related" and "consistent with business necessity." See P.L. 101-336, §102 (b)(6). Title II requires the disabled person to meet the "essential eligibility requirements" for the receipt of services or the participation in programs or activities.
33. P.L. 101-336, §102 (b) (5).
34. *Id.*, § 201 (2).
35. *Id.*, §102 (b)(5)(A).
36. See Barton, Dannemeyer, and Ritter in Energy Report at 126, *supra* note 5.
37. P.L. 101-336, §§103(b), 302 (b)(3).
38. See U.S. House of Representatives, July 12, 1990: *The Americans with Disabilities Act of 1989: Conference Report*, no. 101-596 (to accompany S. 933) at 11, Washington. (Hereafter called Conference Report.)
39. *Doe v. New York University*, 666 F.2d 761, 777 (2d Cir. 1981).
40. Energy Report at 37, *supra* note 5.
41. See *Southeastern Community College v. Davis*, 442 U.S. 397 (1979).
42. P.L. 101-336, §§102(b)(5), 302(b)(2)(A)(ii).
43. P.L. 101-336, §101(9); Committee on Labor and Human Resources (to accompany S.933), August 30, 1989, at 31.
44. *Kohl v. Woodhaven Learning Center*, 865 F.2d 930 (8th Cir. 1989).
45. *Arline*, 107 S.Ct. at 1131, note 16.
46. P.L. 101-336, §101(10).
47. *Supra*, note 41.
48. *Supra*, note 44.
49. *New York State v. Carey*, 612 F.2d 644 (2d Cir. 1979).
50. See U.S. House of Representatives, May 15, 1990: *The Americans with Disabilities Act of 1989: Report of the Judiciary Committee*, no. 101-485, part 3 (to accompany H.R. 2273), at 26, 51, 52, Washington (hereafter called Judiciary Report); U.S. House of Representatives, May 15, 1990: *The Americans with Disabilities Act of 1989: Report of the Education and Labor Committee*, no. 101-485, part 2 (to accompany H.R. 2273) at 121, Washington (hereafter

- called Education Report). The term "direct threat" is also found in the Civil Rights Restoration Act of 1988 and the Fair Housing Amendments of 1988.
51. Conference Report at 11, *supra* note 38. In the House, the standard of "direct threat" was extended by the Judiciary Committee to all individuals with disabilities, and not simply to those with contagious diseases or infection. U.S. House of Representatives. May 15, 1990. Judiciary Report at 51, *supra* note 50.
 52. P.L. 101-336, §101(3). The report of the Senate Labor and Human Resources Committee suggests that direct threat to property may also be sufficient. Labor Report, at 27, *supra* note 13.
 53. P.L. 101-336, §302(b)(3).
 54. See, e.g., Judiciary Report at 51 (direct threat must be based on objective and accepted public health guidelines). *Supra*, note 50.
 55. The legislative history is replete with statements that reject decision making based upon ignorance, misperceptions, and patronizing attitudes. See Labor Report at 27, *supra* note 20; Judiciary Report at 52, 153, *supra* note 50; Energy Report, at 38, *supra* note 5; Education Report at 77, 121, *supra* note 50.
 56. *School Board v. Arline*, 480 U.S. 273, 285 (1987).
 57. *Hall v. U.S. Postal Service*, 857 F.2d 1073, 1079 (6th Cir. 1988), quoting *Arline*. See also *Mantolote v. Bolger*, 757 F.2d 1416 (9th Cir. 1985); *Strathe v. Dept. of Transportation*, 716 F.2d 227 (3d Cir. 1983).
 58. See Judiciary Report at 52, *supra* note 50; Labor Report at 27, *supra* note 20; Education Report at 77, *supra* note 50.
 59. See Judiciary Report at 53, *supra* note 50.
 60. *School Board Arline*, 480 U.S. 273, 287 (1987).
 61. *Chalk v. U.S. District Court*, 840 F.2d 701 (9th Cir. 1988).
 62. Although the "direct threat" standard is not framed as a defense in title III, it is reasonable to conclude that Congress intended that the public accommodation should bear the burden of substantiating a direct threat.
 63. Judiciary Report at 53, *supra* note 50 ("the decision to exclude cannot be based on merely 'an elevated risk of injury'").
 64. The following discussion is based upon the amicus curiae brief of the American Medical Association in *Arline*, and the discussions in several of my previous works. (See Gostin 1986a; 1989a,b.)
 65. See, e.g., *United States v. Moore*, 846 F.2d 1163 (8th Cir. 1988). *affirming*, 669 F. Supp. 289 (D. Minn. 1987) (holding that the mouth and teeth of an HIV-infected person could be regarded as a "dangerous" or "deadly weapon"); *Indiana v. Haines*, 545 N.E. 2d 834 (Ind. App. 2d Dist. 1989) (reinstating a conviction for "attempted murder" for splattering emergency workers with HIV-contaminated blood).
 66. See, e.g., *Thomas v. Atascadero Unified School District*, 662 F. Supp. 376 (C.D. Cal. 1986) (unlawful to exclude HIV-infected kindergartner who bit another child and was labeled "aggressive").
 67. See, e.g., *People v. Dunn*, Florida Criminal Case, Associated Press release, September 28, 1987 reported in Gostin, Porter, and Sandomire (1990): prisoner convicted of introducing "contraband" into a state facility by lacing

- guards' coffee with HIV-contaminated blood. See further discussion of food workers in the section on the food-handlers controversy below.
68. This principle is discussed and a line of cases cited in Gostin (1987, at 467).
 69. *Id.*, at 80–483; ex parte Company 106 Ohio St. 50, 139 N.E. 204 (1922).
 70. *Smith v. Emery*, 11 A.D. 10, 42 N.Y.S. 258 (1896).
 71. *Arline*, 480 U.S. at 287, note 16.
 72. The range of risk for HIV transmission following a needle stick is between 0.03 to 0.9 percent, compared with 12–17 percent for HBV transmission. See Gostin (1989a).
 73. The AMA amicus brief in *Arline* is silent as to the impact of public health regulation on individual rights.
 74. *Martinez v. School Board of Hillsborough County, Florida*, 861 F.2d 1502 (11th Cir. 1988).
 75. This balancing of benefits and burdens is further explained in Brandt, Cleary, and Gostin (1990).
 76. *Leckelt v. Board of Commissioners of Hospital District 1*, 714 F. Supp. 1377 (E.D. La. 1989), *aff'd*, 909 F.2d 820 (5th Cir. 1990).
 77. Association of the Bar of NY City, letter to William Roper, Nov. 26, 1990; NY State AIDS Institute, letter to James Curran, Sept. 24, 1990.
 78. See Judiciary Report, at 146–47, *supra* note 50 (dissenting views of Hon. Chuck Douglas).
 79. See Conference Report, at 12–13, *supra* note 38.
 80. P.L. 101–336, §103(d)(1).
 81. P.L. 101–336, §103(d)(2).
 82. *Mosby v. Joe's Westlake Restaurant*, Cal. Super. Ct., San Francisco County, No. 865045, reported in Gostin (1990).
 83. *State Division of Human Rights v. Xerox Corporation*, 480 N.E. 2d 695, 697098 (Ct. App. N.Y. 1985).
 84. *Shannon v. Charter Real Hospital*, Human Rights Commission, Dallas, April 28, 1986.
 85. See, e.g., *Little v. Bryce and Randall's Food Market*, 733 E.2d 937 (Tex. App. Hous. 1st Dist. 1987); *Wolfe v. Tidewater Pizza*, Sup.Ct. of VA: January 1988.
 86. Conference Report at 14, *supra* note 38.
 87. P.L. 101–336, §501 (b) (emphasis added).
 88. Conference Report at 17–18, *supra* note 38.
 89. *Id.*

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