



Office of the
Assistant Attorney General

Washington, D.C. 20530

JUN 20 1986

MEMORANDUM FOR RONALD E. ROBERTSON
General Counsel
Department of Health and Human Services

Re: Application of Section 504 of the Rehabilitation Act to Persons with AIDS, AIDS-Related Complex, or Infection with the AIDS Virus

In a letter of March 11, 1986, you asked this Office to consider a variety of questions concerning the application of section 504 of the Rehabilitation Act of 1973, 29 U.S.C. 794, to individuals who have (or are regarded as having) Acquired Immune Deficiency Syndrome ("AIDS") or AIDS-related complex ("ARC") or who test positive for AIDS antibodies.¹ Section 504 prohibits discrimination based solely on handicap against any otherwise qualified handicapped person in any program that is conducted by the federal government or that receives federal financial assistance. You have informed us that your Department's Office of Civil Rights has received complaints in which workers employed in hospitals or clinics allege that they have been discriminated against by their employers because they fall within or are regarded as falling within these categories.

After carefully examining these difficult questions, we have concluded that section 504 prohibits discrimination based on the disabling effects that AIDS and related conditions may have on their victims. By contrast, we have concluded that an individual's (real or perceived) ability to transmit the disease to others is not a handicap within the meaning of the statute and, therefore, that discrimination on this basis does not fall within section 504. This conclusion is compelled not only by the stat-

¹ The Department of Justice has responsibility for coordinating the implementation and enforcement of section 504 by executive agencies. See Exec. Order No. 12250 § 1-201(c), 3 C.F.R. 298 (1981), reprinted in 42 U.S.C. 2000d-1 note.

ute's language, but also by sound and frequently invoked principles of statutory interpretation. In particular, we find it highly significant that Congress, in enacting section 504, gave no indication that it intended to disturb the venerable body of federal and state law giving public health officials broad powers to prevent the spread of communicable diseases. We accordingly are convinced that no such change was intended.

This opinion is limited to an examination of section 504, which serves the highly important, but limited, role of prohibiting discrimination based on handicap in covered programs and activities. We have not examined any other federal, state, or local laws that may extend broader protections in this field.

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I. DESCRIPTION OF AIDS

AIDS is a viral disease involving the breakdown of the body's immune system. The "full-blown" syndrome (see pages 7-8, infra),² is believed to be both incurable and almost inevitably fatal, striking most frequently among certain high-risk groups, such as male homosexuals, intravenous drug users, recipients of

² See NIH Conference--The Acquired Immunodeficiency Syndrome: An Update, 102 Annals of Internal Medicine 802 (1985) ("NIH Conference") ("No patient who has unequivocal acquired immunodeficiency syndrome has yet been cured of this invariably fatal disease."); Council Report: The Acquired Immunodeficiency Syndrome, 252 JAMA 2037, 2041 (1984) ("Council Report") ("At present, there are no cases of AIDS in which the immune system has been reported to have recovered. Thus far, most patients with AIDS have eventually succumbed."). As of June 2, 1986, of the 21,303 patients in the United States identified since June 1, 1981, as meeting the case definition of AIDS -- see The Case Definition of AIDS Used by CDC for National Reporting 1-3 (Aug. 1, 1985) (Attachment A to this Memorandum) -- 11,645, or 55%, had died. See Wash. Post, June 5, 1986, at A15, col. 1. Prospects for discovery of a vaccine against AIDS are uncertain. See Wall St. J., Apr. 14, 1986, at 31, col. 3; N.Y. Times, Apr. 10, 1986, at A1, col. 2. A major concern is that rapid mutation of the virus may thwart immunological strategies. See Teaming Up Against AIDS, N.Y. Times Mag., Mar. 2, 1986, at 42 ("There isn't just one AIDS virus but a score that we know of -- and countless others, because it mutates at a hundred times the rate of other viruses.") (quoting Myron Essex, chairman of the department of cancer biology at the Harvard School of Public Health); Osborn, The AIDS Epidemic: An Overview of the Science, 2 Issues in Science and Technology 55 (1986) ("The possibility of antigenic change with subsequent invalidation of natural and medical immunologic strategies is also a serious concern, given that other retroviruses have shown that striking property in their animal host species.").

blood transfusions, and hemophiliacs.³ The incidence of AIDS is increasing, although at a somewhat slower rate than in past years,⁴ and indications that the disease may have a lengthy incubation period (seven years or longer)⁵ and that exposure to the AIDS virus is widespread⁶ suggest that the incidence of new

³ Among adult patients, "94% . . . can be placed in groups that suggest a possible means of disease acquisition: men with homosexual or bisexual orientation who have histories of using intravenous (IV) drugs (8% of cases); homosexual or bisexual men who are not known IV drug users (65%); heterosexual IV drug users (17%); persons with hemophilia (1%); heterosexual sex partners of persons with AIDS or at risk for AIDS (1%); and recipients of transfused blood or blood components (2%). The remaining [patients] have not been classified by recognized risk factors for AIDS." Update: Acquired Immunodeficiency Syndrome--United States, 35 Centers for Disease Control: Morbidity and Mortality Weekly Report ["MMWR"] 18 (Jan. 17, 1986) ("Update") (footnote omitted). Ninety four percent of the cases involving pediatric AIDS patients (under 13 years old) can also be classified as part of a high-risk group. See id. at 19. Difficulties in data collection probably account for most of the unclassified 6% in both categories. See id. at 18-19.

⁴ See id. at 20.

⁵ See ibid.

⁶ See NIH Conference, supra note 2, at 801. Estimates of the number of people exposed to the virus have typically been in the range of 500,000 to 1 million, but some estimates have run as high as 2 million. See The AIDS Conflict, Newsweek, Sept. 23, 1985, at 18. See also Sivak & Wormser, How Common Is HTLV-III Infection in the United States?, 313 New Eng. J. Med. 1352 (1985) (extrapolating from evidence of incidence rates in the various risk groups, it can be estimated that 1,765,470 Americans are infected with HTLV-III/LAV) (correspondence). The number of persons infected could double or triple in the next five to ten years. See N.Y. Times, Jan. 14, 1986, at C1, col. 3.

Evidence from central and eastern Africa indicates that the rate of incidence in that region may be ten times that found in the United States. See N.Y. Times, Apr. 6, 1986, at A14, col. 4. Reliable data on the African experience, however, has been difficult to obtain. See Wash. Post, June 2, 1986, at A18, cols. 2-3.

cases could reach the tens of thousands in the near future.⁷

Medical researchers have now concluded that AIDS is caused by a retrovirus⁸ known as human T-lymphotropic virus type

⁷ See NIH Conference, supra note 2, at 801-802. A February 1985 analysis of six studies suggested that 400,000 people in the United States may then have been infected with the AIDS virus; that 4%-19% of those exposed to the virus will eventually develop AIDS; and that an additional 25% of those exposed will develop ARC. See Wall St. J., Feb. 21, 1985, at 22, col. 3. Estimates of exposure are now several times that high, see note 6, supra, and it has been suggested that up to 40% of those infected will eventually develop AIDS. See N.Y. Times, Jan. 14, 1986, at C1, col. 3. See also note 20, infra.

⁸ Retroviruses are distinguished from other viruses by their chromosome structure and mode of replication. See Laurence, The Immune System in AIDS, Scientific American, Dec. 1985, at 88; NIH Conference, supra note 2, at 807.

III/lymphadenopathy-associated virus or HTLV-III/LAV.⁹ The virus inhibits the body's ability to resist diseases by infecting white blood cells called T-lymphocytes, which are an integral part of the human immune system. Specifically, the disease selectively destroys, and generates qualitative abnormalities in, the patient's T-helper/inducer cells, which enable other components of the immune system to function and thus comprise "the T-lymphocyte subset primarily responsible for the generation of most specific human immune responses."¹⁰ As a result, "the immune systems of patients with the acquired immunodeficiency syndrome are characterized by functional defects in virtually

⁹ "What was uncertain and the subject of wide speculation 2 years ago is now clearly established: the acquired immunodeficiency syndrome is caused by a human T lymphocyte-tropic retrovirus." NIH Conference, supra note 2, at 800. Researchers are confident that HTLV-III/LAV is the causative agent for AIDS and AIDS-related complex because of its "almost absolute association with these diseases despite its relatively rare occurrence in nature and its in-vitro biologic effect on immune cells." Id. at 806. In May 1984, American researchers reported identifying the AIDS virus as a member of a family of viruses known as human T-lymphotropic retroviruses, or HTLV. See Gallo, Salahuddin & Popovic, et al, Frequent Detection and Isolation of Cytopathic Retroviruses (HTLV-III) from Patients with AIDS and at Risk for AIDS, 224 Science 500 (1984); see generally NIH Conference, supra note 2, at 800. This classification has not been universally accepted. See Grutsch & Robertson, The Coming of AIDS, Am. Spectator, Mar. 1986, at 13 n.2; Teaming Up Against AIDS, supra note 2, at 78. Somewhat earlier, French researchers had similarly isolated from AIDS patients a lymphadenopathy virus, designated LAV. See Barre-Sinoussi, Chermann & Rey, et al, Isolation of a T-lymphotrophic Retrovirus from a Patient at Risk for Acquired Immune Deficiency Syndrome (AIDS), 220 Science 868 (1983); see generally Council Report, supra note 2, at 2038. Because HTLV-III and LAV are essentially identical, see NIH Conference, supra, note 2, at 809, the AIDS virus is now referred to as HTLV-III/LAV. See id. at 800. More recently, researchers identified a third agent called AIDS-related virus, or ARV, which is also fundamentally the same as the other two viruses. See Osborn, supra note 2, at 48. Controversy over credit for discovering the virus has now reached the courts. See N.Y. Times, Apr. 12, 1986, at A8, col. 2.

¹⁰ NIH Conference, supra note 2, at 809. See also Lane, et al, Qualitative Analysis of Immune Function in Patients with the Acquired Immunodeficiency Syndrome, 313 New Eng. J. Med. 79, 82 (1985) ("The helper/inducer T lymphocyte is the central cell type in the immune system and is responsible for the induction and regulation of virtually all cellular immune functions at both the T-cell and the B-cell levels.").

all limbs of the immune system."¹¹ This suppression of the immune system exposes patients to a variety of "opportunistic" infections and malignant conditions that generally do not afflict otherwise similarly situated individuals without AIDS. The most frequently encountered malignancy is Kaposi's sarcoma, a form of cancer very rarely found in persons under 60 years of age in the absence of AIDS.¹² The most common life-threatening infection is P. carinii pneumonia,¹³ although other opportunistic diseases are frequently implicated.¹⁴ There is also growing evidence that HTLV-III/LAV can¹⁵ directly cause damage to the brain and central nervous system.

A person is not considered to have AIDS merely because tests show him to be generating antibodies to the AIDS virus, i.e., to

¹¹ NIH Conference, supra note 2, at 809. For an accessible overview of the operation of the immune system and the role of HTLV-III/LAV in its suppression, see generally Laurence, supra note 8.

¹² See Update, supra note 3, at 18; NIH Conference, supra note 2, at 804-805.

¹³ See Update, supra note 3, at 17-18; NIH Conference, supra note 2, at 802-803.

¹⁴ See generally Attachment A; Update, supra note 3, at 18; NIH Conference, supra note 2, at 802; Council Report, supra note 2, at 2037.

¹⁵ See Resnick, et al, Intra-Blood-Brain-Barrier Synthesis of HTLV-III-Specific IgG in Patients with Neurologic Symptoms Associated with AIDS or AIDS-Related Complex, 313 New Eng. J. Med. 1498, 1502-1503 (1985); Ho, et al, Isolation of HTLV-III From Cerebrospinal Fluid and Neural Tissues of Patients with Neurologic Syndromes Related to the Acquired Immunodeficiency Syndrome, 313 New Eng. J. Med. 1493, 1493, 1496-1497 (1985). See generally AIDS-Related Brain Damage Unexplained, 232 Science 1091 (1986).

be "seropositive."¹⁶ Indeed, a person is not considered to have AIDS even if he is seropositive and also displays a number of symptoms characteristic of the disease. Rather, an essential element of the definition of AIDS used for reporting purposes by the Centers for Disease Control ("CDC") is affliction with one or more of the opportunistic diseases that take advantage of the patient's suppressed immune system.¹⁷ The formal CDC case definition of AIDS, as of August 1, 1985, is attached to this Memorandum as Attachment A.

This narrow definition of AIDS¹⁸ has led to the creation of a separate classification for patients in high-risk groups "who manifest a constellation of signs and symptoms that are suggestive of the syndrome but do not manifest the secondary complications of the disease."¹⁹ These patients are often said to have

¹⁶ See Provisional Public Health Service Inter-Agency Recommendations for Screening Donated Blood and Plasma for Antibody to the Virus Causing Acquired Immunodeficiency Syndrome, 34 MMWR 1, 1 (1985) ("Screening Recommendations"). A single positive test for antibodies is of course not conclusive as to infection with the virus because of the possibility of a "false positive" response. See Recommendations for Preventing Transmission of Infection with Human T-Lymphotropic Virus Type III/Lymphadenopathy-Associated Virus in the Workplace, 34 MMWR 682, 691 (1985) ("Workplace Recommendations"). But see Handsfield, Screening for HTLV-III Antibody, 313 New Eng. J. Med. 888 (1985) ("Until definitive information to the contrary is available, all seropositive persons must be assumed to be infectious.") (correspondence).

¹⁷ See Update: Acquired Immunodeficiency Syndrome (AIDS)--United States, 32 MMWR 389 n.* (1983). See also Friedland, et al, Lack of Transmission of HTLV-III/LAV Infection to Household Contacts of Patients with AIDS or AIDS-Related Complex with Oral Candidiasis, 314 New Eng. J. Med. 344, 344 (1986) (utilizing the CDC definition). There has been speculation as to whether additional evidence that HTLV-III/LAV can directly cause brain damage (see page 7, supra) will require a substantial revision in this definition. See Grutsch & Robertson, supra note 9, at 12, 13 n.2; N.Y. Times, Dec. 12, 1985, at A27, col. 1.

¹⁸ "Persons meeting the AIDS case definition are only a small percentage of all persons infected with HTLV-III/LAV." Update, supra note 3, at 21.

¹⁹ NIH Conference, supra note 2, at 800. These symptoms can include "generalized lymphadenopathy, unintentional weight loss, fever, chronic diarrhea, malaise and lethargy, lymphopenia, leukopenia, anemia, idiopathic thrombocytopenia, immunologic abnormalities characteristic of acquired immunodeficiency syndrome, and oral thrush." Id. at 801.

AIDS-related complex, or ARC, although the term as yet has no uniform definition and has not been formally endorsed by the CDC.²⁰

Both popular and medical attention has focused on the question of the communicability of the AIDS virus. The dynamic nature of knowledge in this area has made definitive conclusions difficult, and we are aware of no researcher who claims that the mechanisms of transmission of the virus are completely understood. Nonetheless, we will briefly summarize what we understand to be the state of the literature as of the writing of this Memorandum.

HTLV-III/LAV has been isolated in a wide range of body fluids,²¹ including blood, semen, saliva, tears, breast milk, and urine, and it has been widely recognized that risks of communicability exist with respect to all of the following activities involving the transfer of blood, semen, or other body fluids:

²⁰ Cf. Friedland, supra note 17, at 344 (defining ARC in adult patients as "the presence of (1) unexplained generalized lymphadenopathy . . . , or unexplained oral candidiasis . . . , and (2) two laboratory abnormalities--a low absolute number of helper T cells . . . and a low T-helper/T-suppressor . . . ratio"). Medical experts disapprove of use of the once-popular term "pre-AIDS," because there is not as yet any way to predict which seropositive people will go on to develop the full-blown syndrome. See NIH Conference, supra note 2, at 800; Council Report, supra note 2, at 2037; note 7, supra (estimates of the percentage of those exposed to HTLV-III/LAV who will go on to develop AIDS range from 4 to 40%). Given researchers' limited experience with AIDS, this lack of consensus as to the likelihood of eventually developing the disease is not surprising. Indeed, it is not impossible that all of those infected with the virus may eventually develop AIDS, including the vast majority who now harbor the virus but are asymptomatic. See N.Y. Times, Nov. 5, 1985, at C8, col. 4 (" '[I]t's clear that the majority of people infected so far have had no consequences for their health at all,' said Dr. Peter Drotman, an epidemiologist at the Centers for Disease Control. 'But whether they'll stay that way for the rest of their natural lives we truly don't know.' ").

²¹ See Workplace Recommendations, supra note 16, at 682.

sexual contact, both homosexual and heterosexual;²² parenteral (i.e., non-intestinal) exposure to infected blood or blood components,²³ generally through use of contaminated needles²⁴ or, less frequently, transfusions;²⁵ and contact between infected mothers and their children either before or just after birth.²⁶ In November 1985, the CDC reported that "epidemiological evidence

²² See Friedland, supra note 17, at 344; Workplace Recommendations, supra note 16, at 682; Heterosexual Transmission of Human T-Lymphotropic Virus Type III/Lymphadenopathy-Associated Virus, 34 MMWR 561, 561 (1985) ("Heterosexual Transmission"); Screening Recommendations, supra note 16, at 2. Homosexual or bisexual men remain most highly at risk; members of these groups with no other risk factors represent nearly two-thirds of the reported AIDS cases. See Update, supra note 3, at 18. However, heterosexual transmission from men to women has been well established, see Heterosexual Transmission, supra, at 561, and recent evidence provides support for the possibility of female-to-male transmission. See Calabrese & Gopalakrishna, Transmission of HTLV-III Infection From Man to Woman to Man, 314 New Eng. J. Med. 987 (1986) (correspondence). This latter possibility is reinforced by the extensive spread of the disease among heterosexuals in central and eastern Africa. See NIH Conference, supra note 2, at 802; Wash. Post, June 2, 1986, at A18, col. 1; N.Y. Times, Apr. 6, 1986, at A14, col. 5 ("heterosexual transmission should be assumed" as a means of spreading AIDS") (quoting Dr. James W. Curran of the CDC).

²³ See Friedland, supra note 17, at 344; Workplace Recommendations, supra note 16, at 682; Heterosexual Transmission, supra note 22, at 561; Screening Recommendations, supra note 16 at 2.

²⁴ See Friedland, supra note 17, at 346. Because of the possibility that needles may have traces of contaminated blood, intravenous drug users are one of the highest risk groups for AIDS. See Update, supra note 3, at 18.

²⁵ The role of blood transfusions in the transmission of AIDS was noted before the HTLV-III/LAV virus was identified. See Possible Transfusion-Associated Acquired Immune Deficiency Syndrome (AIDS)--California, 31 MMWR 365-366 (1982). Procedures were promptly recommended and adopted for screening blood and encouraging potential donors in high risk groups to avoid donating or to undergo testing. See Screening Recommendations, supra note 16, at 1-3. These efforts have substantially reduced the risk of AIDS transmission through transfusions. See Update, supra note 3, at 20.

²⁶ See Workplace Recommendations, supra note 16, at 682; Heterosexual Transmission, supra note 22, at 561; Screening Recommendations, supra note 16, at 2.

has implicated only blood and semen in transmission."²⁷ Subsequent to this report, however, the CDC published research suggesting other modes of transmission. In December 1985, it related an instance of apparent transmission of the virus to a nursing child through breast milk.²⁸ Consideration has also been given to the possibility of transmission from contact between infected blood or other body fluids and mucosal surfaces, such as the mouth, nose, and eyes, or with open skin lesions.²⁹ A recent study reports on two cases possibly evidencing such transmission in health care settings involving extensive, and probably unhygienic, contact with infected fluids.³⁰ Other reported instances of what appear to be occupational transmissions of the virus to health care workers have been attributed to accidental needlestick injuries, i.e., parenteral blood-to-blood transmission.³¹ New research has indicated that "[t]he AIDS virus remains active

²⁷ Workplace Recommendations, supra note 16, at 682 (emphasis added).

²⁸ See Recommendations for Assisting in the Prevention of Perinatal Transmission of Human T-Lymphotropic Virus Type III/Lymphadenopathy-Associated Virus and Acquired Immunodeficiency Syndrome, 34 MMWR 721, 722 (1985).

²⁹ See Update: Evaluation of Human T-Lymphotropic Virus Type III/Lymphadenopathy-Associated Virus Infection in Health-Care Personnel--United States, 34 MMWR 575, 576-577 (1985) ("Health Care Personnel Update"); Education and Foster Care of Children Infected with Human T-Lymphotropic Virus Type III/Lymphadenopathy Associated Virus, 34 MMWR 517, 518 (1985) ("Education and Foster Care of Children"); Council Report, supra note 2, at 2042.

³⁰ See Apparent Transmission of Human T-Lymphotropic Virus Type III/Lymphadenopathy-Associated Virus from a Child to a Mother Providing Health Care, 35 MMWR 76, 76-78 (1986). The report concludes that this constitutes some evidence that the virus "may, on rare occasions, be transmitted during unprotected contact with blood or other potentially infectious body secretions or excretions in the absence of known parenteral or sexual exposure to these fluids," id. at 78, but adds that "[a]dherence to published guidelines for health-care workers should prevent [such] transmission." Ibid. (footnote omitted). The CDC workplace guidelines, issued prior to publication of this research, prescribe precautions for dealing with possible transmission through mucosal contact. See Workplace Recommendations, supra note 16, at 685, 691.

³¹ See Health Care Personnel Update, supra note 29.

outside the body much longer than previously believed,"³² although it can be neutralized with common disinfectants.³³ The authors of these findings caution that "it is important not to ignore any potential implications regarding possible transmission of virus by contaminated needles and syringes or in clinical situations involving contact with patient tissues or body fluids."³⁴

There is currently no epidemiological evidence of transmission of HTLV-III/LAV through casual contact with or proximity to infected persons.³⁵ Based on this epidemiological data, the CDC concluded in November 1985 that "[t]he kind of nonsexual person-to-person contact that generally occurs among workers and clients or consumers in the workplace does not pose a risk for transmission of HTLV-III/LAV."³⁶ It has been suggested, however, that

³² N.Y. Times, Apr. 9, 1986, at A15, col. 5. See Resnick, et al, Stability and Inactivation of HTLV-III/LAV Under Clinical and Laboratory Environments, 255 JAMA 1887, 1890 (1986) ("Infectious cell-free virus could be recovered from dried material after up to three days at room temperature, and in an aqueous environment, infectious virus survived longer than 15 days at room temperature").

³³ See Resnick, supra note 37, at 1891.

³⁴ Id. at 1890.

³⁵ See Friedland, supra note 17, at 348 ("This study supports the view that transmission of the infection requires injection of blood or blood products or intimate sexual contact, and that longstanding household exposure to patients with AIDS is associated with little or no risk of transmission of HTLV-III/LAV infection."); Laurence, supra note 8, at 84 ("All epidemiological evidence indicates that food, water, insects and casual contact do not spread AIDS."); Workplace Recommendations, supra note 16, at 682 ("casual contact with saliva and tears does not result in transmission of infection"); id. at 683 ("HTLV-III/LAV has [not] been shown to be transmitted by casual contact in the workplace, contaminated food or water, or airborne or fecal-oral routes."); Screening Recommendations, supra note 16, at 2 ("[No] cases have been documented to occur through such common exposures as sharing meals, sneezing or coughing, or other casual contact."); Prospective Evaluation of Health-Care Workers Exposed via Parenteral or Mucous-Membrane Routes to Blood and Body Fluids of Patients with Acquired Immunodeficiency Syndrome, 33 MMWR 181, 181 (1984) ("There is no evidence of transmission through casual contact with affected individuals or by airborne spread").

³⁶ Workplace Recommendations, supra note 16, at 682.

conclusions of this character are too sweeping.³⁷ Harvard researcher Prof. William Haseltine, for instance, was recently reported to have declared that "[a]nyone who tells you categorically that AIDS is not contracted by saliva is not telling you the truth There are sure to be gases . . . of proved transmission through casual contact." ³⁸

Because the AIDS virus is widely thought to be similar to hepatitis B virus in many ways, including probable modes of transmission, the CDC has suggested that guidelines for preventing the accidental spread of the latter will also be effective with respect to the former.³⁹ The CDC has issued guidelines for infection control in hospitals addressing both the AIDS and hepatitis B viruses.⁴⁰ These guidelines focus on preventing accidental needlestick injuries, avoiding contact with contami-

³⁷ See Parry, AIDS as a Handicapping Condition (pt. 1), 9 Physical & Mental Disability L. Rep. 402, 403 (1985) ("[W]hile it is unlikely that AIDS can be contracted from personal interactions other than the types identified so far, no one can say categorically that other types of transmissions are impossible. Those experts who have attempted to give the public the impression that the medical profession is certain how AIDS is transmitted and that no one outside the high-risk groups should worry may have gone too far in attempting to quell the public's fears."). Cf. Teaming Up Against AIDS, supra note 2, at 42 ("'[T]he C.D.C. . . . has been trying to inform the public without overly alarming them But we outside the Government are freer to speak. The fact is that the dire predictions of those who have cried doom ever since AIDS appeared haven't been far off the mark.'") (quoting Myron Essex, chairman of the department of cancer biology at the Harvard School of Public Health).

³⁸ Dershowitz, Emphasize Scientific Information, N.Y. Times, Mar. 18, 1986, at A27, col. 2. See also Grutsch & Robertson, supra note 9, at 14 ("If, like the other lentiviruses, the Aids virus can be transferred to ungulates [hoofed animals], then we must face the fact that it could be spread in cows' milk (just as it is in breast milk), in bronchial secretions transmitted as aerosols by coughing (as is maedivisna), and, potentially, by insect vectors, if only mechanically (as is equine infectious anemia."); Lapointe, et al, Transplacental Transmission of HTLV-III Virus, 312 New Eng. J. Med. 1325 (1985) ("Epidemiologic studies of the acquired immunodeficiency syndrome (AIDS) indicate a horizontal transmission primarily through blood, semen, and possibly saliva.") (correspondence).

³⁹ See Workplace Recommendations, supra note 16, at 682-683.

⁴⁰ See Williams, Guidelines for Infection Control in Hospital Personnel 7-9 (1983).

nated blood or other bodily fluids, and following sound hygienic practices. Similar but more detailed guidelines have been published for preventing transmission of AIDS in the workplace,⁴¹ particularly among health care workers and patients,⁴² and for dealing⁴³ with infected children in schools or day-care institutions. With respect to health care workers, the guidelines conclude that workers "known to be infected with HTLV-III/LAV who do not perform invasive procedures need not be restricted from work unless they have evidence of other infection or illness for which any [health care worker] should be restricted."⁴⁴ The guidelines similarly recommend that other workers known to be infected with the AIDS virus "should not be restricted from work solely based on this finding. Moreover, they should not be restricted from using telephones, office equipment, toilets, showers, eating facilities, and water fountains."⁴⁵

The CDC has recently issued guidelines covering health care workers engaged in invasive procedures, such as surgery, dental procedures in which bleeding might occur, and vaginal or cesarean-section deliveries.⁴⁶ In all such procedures, gloves, masks, eye coverings, and other "barrier precautions" should be routinely used. The CDC concluded that routine serologic testing of health-care personnel for evidence of HTLV-III/LAV infection is

⁴¹ See Workplace Recommendations, supra note 16.

⁴² See id. at 682-686, 691-693. These recommendations apply to health care personnel other than those who perform invasive procedures (such as surgeons and dentists), see id. at 682, and supplement previously published guidelines for dental care personnel and morticians and for clinical and laboratory staff personnel. See Acquired Immunodeficiency Syndrome (AIDS): Precautions for Health-Care Workers and Allied Professionals, 32 MMWR 450 (1983); Acquired Immune Deficiency Syndrome (AIDS): Precautions for Clinical and Laboratory Staffs, 31 MMWR 577 (1982).

⁴³ See Education and Foster Care of Children, supra note 29.

⁴⁴ Workplace Recommendations, supra note 16, at 691.

⁴⁵ Id. at 694.

⁴⁶ See Recommendations for Preventing Transmission of Infection with Human T-Lymphotropic Virus Type III/Lymphadenopathy-Associated Virus during Invasive Procedures, 35 MMWR 221 (1986) ("Invasive Procedures Guidelines").

⁴⁷ See id. at 222.

not necessary,⁴⁸ but cautions personnel to "use extraordinary care to prevent injuries to hands caused by needles, scalpels, and other sharp instruments or devices during procedures; when cleaning used instruments; during disposal of used needles; and when handling sharp instruments following procedures."⁴⁹ If an accident occurs in which the patient is exposed to the blood of a health care worker, "the patient should be informed of the incident,"⁵⁰ and if there is reason to believe that the worker was infected with HTLV-III/LAV, the patient should be tested and monitored in accordance with procedures set forth in the earlier workplace guidelines.⁵¹

II. STATUTORY AND REGULATORY FRAMEWORK

Section 504 of the Rehabilitation Act of 1973, 29 U.S.C. 794, generally proscribes discrimination against the handicapped in programs or activities that are conducted by federal agencies or that receive federal funds. In relevant part, the statute provides:

No otherwise qualified handicapped individual in the United States, as defined in section 706(7) of this title, shall, solely by reason of his handicap, be excluded from the participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance or under any program or activity conducted by any Executive agency or by the United States Postal Service.

This provision has five elements. First, an individual claiming discriminatory treatment under section 504 must be a "handicapped individual" as defined in the Act. Second, the person must be "otherwise qualified" for the equal treatment being sought. Third, the handicapped person must be excluded from participation in, be denied the benefits of, or otherwise be subjected to

⁴⁸ See *id.* at 223. See also Wash. Post, Apr. 11, 1986, at A37, col. 6 (although some health experts favored screening, " 'it was very much a minority view' ") (quoting Dr. James M. Hughes of the CDC).

⁴⁹ Invasive Procedures Guidelines, *supra* note 46, at 222.

⁵⁰ *Ibid.*

⁵¹ See *ibid.* See also Workplace Guidelines, *supra* note 16, at 685-686.

discrimination under a covered program or activity. Fourth, the contested treatment must be "solely by reason of . . . handicap." And fifth, the discrimination must occur in a program or activity conducted or funded by the federal government.⁵² See Doe v. New York University, 661 F.2d 761, 774-775 (2d Cir. 1981). In the present context, the application of the third and fifth elements seems entirely straightforward, and consequently we will not address them in this Memorandum. Each of the other elements of a section 504 cause of action are addressed in detail below.

A. "Handicapped Individual"

The Rehabilitation Act defines a "handicapped individual" for purposes of section 504 as "any person who (i) has a physical or mental impairment which substantially limits one or more of such person's major life activities, (ii) has a record of such an impairment, or (iii) is regarded as having such an impairment."⁵³ 29 U.S.C. 706(7)(B). Thus, a person can qualify as handicapped under section 504 if he actually suffers from a disabling impairment, has recovered from a previous impairment or was misclassified as having such a condition, or is regarded as having such a condition whether or not he does so in fact. See S. Rep. No. 1297, 93d Cong., 2d Sess. 38-39 (1974); S. Rep. No. 1270, 93d Cong., 2d Sess. 26 (1974); H.R. Rep. No. 1457, 93d Cong., 2d Sess. 26 (1974).

The elements of this definition are explained, in turn, by regulations promulgated by the Secretary of the Department of Health, Education, and Welfare in 1977. See 42 Fed. Reg. 22676 (1977). The regulations define a physical or mental impairment as follows:

(A) any physiological disorder or condition, cosmetic disfigurement, or anatomical loss affecting one or more of the following body systems: neurological; musculoskeletal; special sense organs; respiratory, including speech organs; cardiovascular; reproductive, digestive,

⁵² In order to satisfy this element, a plaintiff would have to demonstrate federal funding of the program or activity in question in accordance with Grove City College v. Bell, 465 U.S. 555, 571-574 (1984), and North Haven Board of Education v. Bell, 456 U.S. 512, 535-540 (1982). See Consolidated Rail Corp. v. Darrone, 465 U.S. 624, 635-636 (1984).

⁵³ This definition is also applicable to other statutory provisions regarding employment of the handicapped by the federal government and by federal contractors. See 29 U.S.C. 791, 793.

genito-urinary; hemic and lymphatic; skin; and endocrine; or (B) any mental or psychological disorder, such as mental retardation, organic brain syndrome, emotional or mental illness, and specific learning disabilities.

45 C.F.R. 84.3(j)(2)(i).⁵⁴ When this definition was promulgated as a final regulation, the Secretary's accompanying analysis provided a list of covered diseases and conditions but stressed that the list was not comprehensive.⁵⁵ The Secretary deliberately chose not to limit impairments to "traditional" handicaps,⁵⁶ although the requirement that there be a (real or perceived) physical or mental impairment precludes a claim under the regulation based on environmental, cultural, and economic disadvantage, prison record, age, or homosexuality. See 45 C.F.R. Pt. 84, App. A at 310.

The regulations specify that the term "major life activities" includes but is not limited to "functions such as caring for one's self, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning, and working." 45 C.F.R.

⁵⁴ An identical definition is found in the Justice Department's regulations implementing Executive Order 12250. See 28 C.F.R. 41.31(b)(1).

⁵⁵ The listed diseases and conditions are "orthopedic, visual, speech, and hearing impairments, cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, mental retardation, emotional illness, and . . . drug addiction and alcoholism." 45 C.F.R. Pt. 84, App. A at 310.

⁵⁶ "The Department continues to believe . . . that it has no flexibility within the statutory definition to limit the term to persons who have those severe, permanent, or progressive conditions that are most commonly regarded as handicaps." *Ibid.* This view finds support in the fact that the term "severe handicap" is explicitly defined elsewhere in the Rehabilitation Act to mean a "disability which requires multiple services over an extended period of time and results from amputation, blindness, cancer, cerebral palsy, cystic fibrosis, deafness, heart disease, hemiplegia, mental retardation, mental illness, multiple sclerosis, muscular dystrophy, neurological disorders (including stroke and epilepsy), paraplegia, quadriplegia and other spinal cord conditions, renal failure, respiratory or pulmonary dysfunction, and any other disability specified by the Secretary in regulations he shall prescribe." 29 U.S.C. 706(13). It is thus clear that "handicapped," as the term is used in 29 U.S.C. 706(7)(B), extends more broadly than its common usage might suggest.

84.3(j)(2)(ii).⁵⁷

In considering whether particular individuals are "handicapped" within the meaning of section 504, the courts have generally construed the term quite broadly. However, courts have held that particular physical characteristics do not constitute impairments, and thus handicaps, under section 504. See de la Torres v. Bolger, 781 F.2d 1134, 1138 (5th Cir. 1986) (left-handedness "is a physical characteristic, not a chronic illness, a disorder or deformity, a mental disability, or a condition affecting . . . health"); Tudymen v. United Airlines, 608 F. Supp. 739, 745-746 (C.D. Cal. 1984) (muscular build not an impairment even though plaintiff could not meet airline's weight

⁵⁷ See also 28 C.F.R. 41.31(b)(2). The term "substantially limits" is not defined in the regulations because the Secretary did not consider a definition to be possible. See 45 C.F.R. Pt. 84, App. A at 310.

The regulations explain that the statutory phrase "ha[ving] a record of such an impairment" means "ha[ving] a history of, or ha[ving] been misclassified as having a mental or physical impairment that substantially limits one or more major life activities." 45 C.F.R. 84.3(j)(2)(iii). See also 28 C.F.R. 41.31(b)(3). Finally, the regulations explain that being "regarded as having such an impairment" (29 U.S.C. 706(7)(B)(iii)) means

(A) [having] a physical or mental impairment that does not substantially limit major life activities but that is treated by a recipient [of Federal financial assistance] as constituting such a limitation; (B) [having] a physical or mental impairment that substantially limits major life activities only as a result of the attitudes of others toward such impairment; or (C) [having] none of the impairments defined in paragraph (j)(2)(i) of this section but [being] treated by a recipient as having such an impairment.

45 C.F.R. 84.3(j)(2)(iv). This definition

includes many persons who are ordinarily considered to be handicapped but who do not technically fall within the first two parts of the statutory definition, such as persons with a limp. This part of the definition also includes some persons who might not ordinarily be considered handicapped, such as persons with disfiguring scars, as well as persons who have no physical or mental impairment but are treated by a recipient as if they were handicapped.

45 C.F.R. Pt. 84, App. A at 311.

requirements); Stevens v. Stubbs, 576 F. Supp. 1409, 1414 (N.D. Ga. 1983) (transitory illnesses with no permanent effect on plaintiff's health not an impairment). Cf. Jasany v. United States Postal Service, 755 F.2d 1244, 1250 n.6 (6th Cir. 1985) (crossed-eyes may be "so minor that [they do] not rise to the level of a physical impairment") (dictum). These courts have rejected -- correctly in our view -- the "bootstrapping" argument that a condition qualifies as an impairment whenever an employer regards it as relevant to the plaintiff's job qualifications. Rather, the condition must either be an impairment, in the sense described above, or must be regarded by the employer as an impairment -- i.e., the condition falsely perceived by the employer, if real, would constitute an "impairment" and thus meet the statutory definition. See de la Torres v. Bolger, 781 F.2d at 1138 ("de la Torres' supervisors may have had a bias against left-handed persons. There was no proof, however, that they viewed this trait as an 'impairment,' as the Act defines that term."); Tudymen v. United Airlines, 608 F. Supp. at 746 (a "bootstrapping" theory would "make the term handicapped a meaningless phrase"); Stevens v. Stubbs, 576 F. Supp. at 1414 ("[A]t best the record reflects only that plaintiff's superiors were concerned about plaintiff's excessive use of sick leave and his inability to perform his job functions. Nowhere in the record is there evidence that plaintiff's supervisors regarded plaintiff as having an impairment as that term is defined in the regulations.").

B. "Otherwise Qualified"

The second pertinent element of section 504 requires the handicapped individual to be "otherwise qualified" to participate in or receive the benefits of the covered program or activity. The Supreme Court addressed this element in Southeastern Community College v. Davis, 442 U.S. 397 (1979), in which a hearing-impaired applicant claimed that section 504 required her admission to a nursing program. The Court concluded (id. at 406) that "[a]n otherwise qualified person is one who is able to meet

all of a program's requirements in spite of his handicap."⁵⁸

This conclusion, standing alone, might suggest that section 504 never requires modifications in covered programs to accommodate the handicapped. And, indeed, the Court went on to state (*id.* at 410) that a regulation requiring educational institutions to make accommodating "modifications" in their programs⁵⁹ did not encompass the kind of alteration that would be needed for the plaintiff in that case.⁶⁰ As the Court observed, "[i]f [the] regulations were to require substantial adjustments in existing programs beyond those necessary to eliminate discrimination against otherwise qualified individuals . . . , they would constitute an unauthorized extension of the obligations imposed by [section 504]." *Ibid.*⁶¹ The Court also observed, however, that "[i]t is possible to envision situations where an insistence on continuing past requirements and practices might arbitrarily deprive genuinely qualified handicapped persons of the opportunity to participate in a covered program," *id.* at 412, and that "situations may [thus] arise where a refusal to modify an

⁵⁸ The Court elaborated (442 U.S. at 405) (footnote omitted):

Section 504 by its terms does not compel educational institutions to disregard the disabilities of handicapped individuals or to make substantial modifications in their programs to allow disabled persons to participate. Instead, it requires only that an "otherwise qualified handicapped individual" not be excluded from participation in a federally funded program "solely by reason of his handicap," indicating only that mere possession of a handicap is not a permissible ground for assuming an inability to function in a particular context.

⁵⁹ See 45 C.F.R. 84.44(a).

⁶⁰ "[N]othing less than close, individual attention by a nursing instructor would be sufficient to ensure patient safety if respondent took part in the clinical phase of the nursing program." 442 U.S. at 409.

⁶¹ See also *id.* at 411-412 ("Here, neither the language, purpose, nor history of section 504 reveals an intent to impose an affirmative-action obligation on all recipients of federal funds. Accordingly, we hold that even if HEW has attempted to create such an obligation itself, it lacks the authority to do so.") (footnote omitted). In Alexander v. Choate, 105 S.Ct. 712, 721 n.20 (1985), the Court made clear that the term "affirmative action" as used in Southeastern Community College v. Davis means positive conduct to change the nature of a program, not "a remedial policy for the victims of past discrimination." 105 S.Ct. at 721 n.20.

existing program might become unreasonable and discriminatory." Id. at 412-413. On the facts before it, the Court held that admission of the hearing-impaired student was not required because "[s]ection 504 imposes no requirement upon an educational institution to lower or to effect substantial modifications of standards to accommodate a handicapped person." Id. at 413 (emphasis added).⁶²

Courts are divided on the important question of how much deference should be given to program administrators in determining whether applicants or employees are "otherwise qualified." Some courts grant substantial deference to the judgment of administrators, absent proof of naked discriminatory intent. See, e.g., Doe v. Region 13 Mental Health-Mental Retardation Commission, 704 F.2d 1402, 1410, 1412 (5th Cir. 1983); Doe v. New York University, 666 F.2d at 775-776. Other courts have ruled that decisions of program administrators must be scrutinized more rigorously. See, e.g., Arline v. School Board of Nassau County, 772 F.2d 759, 765 (11th Cir. 1985), cert. granted, No. 85-1277 (Apr. 21, 1986); Mantolite v. Bolger, 767 F.2d 1416, 1422 (9th Cir. 1985) (section 501); Bentivegna v. Department of Labor, 694 F.2d 619, 622-623 (9th Cir. 1982); Pushkin v. Regents of Univ. of Colorado, 658 F.2d 1372, 1383 (10th Cir. 1981). See generally Comment, Section 504 of the Rehabilitation Act: Analyzing Employment Discrimination Claims, 132 U. Pa. L. Rev. 867, 884-888 (1984).

C. Discrimination "Solely by Reason of . . . Handicap"

The third pertinent element of a cause of action under section 504 -- that plaintiff be discriminated against on the basis of his handicap -- has not generally been a subject of contention in litigation under section 504. However, in its recent decision in Bowen v. American Hospital Ass'n, No. 84-1529 (June 9, 1986), the Supreme Court emphasized the need to consider

⁶² See also 45 C.F.R. 84.3(k)(2), (3) (defining an otherwise qualified individual with respect to educational services). With respect to employment, the regulations construe an otherwise qualified individual to be "a handicapped person who, with reasonable accommodation, can perform the essential functions of the job in question." Id. at 84.3(k)(1). The regulation specifies that the applicant need only be able to perform the "essential functions" of a job, because "handicapped persons should not be disqualified simply because they may have difficulty in performing tasks that bear only a marginal relationship to a particular job." 45 C.F.R. Pt. 84, App. A at 312.

this element of the statute very carefully. See id., slip op. at 19 (opinion of Stevens, J.). As is demonstrated below, this element plays an especially significant role in the present analysis.

III. ANALYSIS

A. Statutory Language

We now take up the task of applying the pertinent elements of section 504 to individuals who suffer from AIDS, suffer from ARC, test positive for antibodies to HTLV-III/LAV but exhibit no symptoms, or fit none of the above categories but are wrongly regarded as doing so. In considering these questions, it is important to keep in mind that section 504 is limited to the prevention of discrimination based solely on handicap. It does not reach other forms of discrimination, and it certainly is not a general prohibition against irrational decisionmaking by employers or others who may fall within the coverage of the statute.

1. "Handicapped Individual"

In applying section 504 to the problems addressed in this opinion, the initial question is whether any of the persons mentioned above are "handicapped" within the meaning of section 504. As previously noted, the Rehabilitation Act provides (29 U.S.C. 706(7)(B)) that a person is handicapped if he

- (i) has a physical or mental impairment which substantially limits one or more of such person's major life activities, (ii) has a record of such an impairment, or (iii) is regarded as having such an impairment.

a. Applying this definition to persons suffering from AIDS, we have little difficulty concluding that the disabling effects of the disease on its victims qualify as handicaps. First, the effects of AIDS on its victims constitute "impairments." In the terminology of HHS's interpretive regulation (45 C.F.R. 84.3(j)(2)(i)), AIDS is a "physiological disorder or condition" affecting the "hemic and lymphatic" systems and possibly affecting the brain and central nervous system as well. This impairment substantially limits the major life activity of resisting disabling and ultimately fatal diseases and may directly cause

brain damage and disorders.⁶³ Moreover, it should be noted that AIDS by definition involves the presence of an opportunistic disease, such as P. carinii pneumonia, that frequently will entail substantial limitations on major life activities.⁶⁴

Although AIDS victims are handicapped in the ways noted above, it does not necessarily follow that every aspect of the disease constitutes a handicap within the meaning of the statute. In particular, a separate analysis is required to determine whether the ability of a victim to communicate the disease to another person constitutes a handicap. The need for such an analysis is highlighted because the disabling effects of a contagious disease do not always go hand in hand with the ability to transmit the disease to others. Some individuals, while personally immune to the effects of the disease, may nevertheless be carriers⁶⁵ able to spread it. Other persons, while still suffering from the effects of a communicable disease, may no longer be able to transmit it to others. Finally, some individuals may both suffer from the effects of the disease and be able to transmit it.

We therefore turn to the question of whether the ability to transmit a disease is by itself enough to render the carrier handicapped within the meaning of the statute. In examining this question, it is helpful to hypothesize the case of a carrier who is personally immune to the disease. This hypothetical isolates as purely as possible the communicable feature of the disease from any adverse effects it may ordinarily have on a host.

It is clear to us that an immune carrier does not fall within the statutory definition of a person handicapped in fact -- i.e., one who "has a physical or mental impairment which substantially limits one or more of such person's major life

⁶³ Because AIDS limits the major life activity of resisting diseases, our analysis indicates that AIDS victims are handicapped even if the secondary infections or brain damage have only partially progressed. If the substantial limitation on major life activities was instead viewed as the physical weakening of the afflicted individual, it would be a factual question whether any particular stage of the illness satisfied the statutory requirement.

⁶⁴ Furthermore, if AIDS patients are believed to be substantially limited in their major life activities, this would render them handicapped under the third statutory criterion of that term -- i.e., being regarded as having a qualifying impairment.

⁶⁵ Of course, our use of the term "carrier" does not suggest any particular degree of communicability. Nor does it indicate under what circumstances or by what mechanisms an infectious agent is transmissible.

activities." 29 U.S.C. 706(7)(B)(i). An immune carrier does not have "a physical or mental impairment," because the carrier's condition -- the presence within his body of the active infectious agent -- has no adverse physical consequences for him.⁶⁶ See de la Torres v. Bolger, 610 F. Supp. 593, 596 (N.D. Tex. 1985) ("The Court is of the opinion that 'impairment' cannot be divorced from its dictionary and common sense connotation of a diminution in quality, value, excellence or strength."), aff'd, 781 F.2d 1134 (5th Cir. 1986); E. E. Black, Ltd. v. Marshall, 497 F. Supp. 1088, 1098 (D. Hawaii 1980) (defining "impairment" as "any condition which weakens, diminishes, restricts, or otherwise damages an individual's health or physical or mental activity").

Second, even if the carrier has an "impairment," it does not substantially limit any major life activity. The carrier is fully capable of performing all major life activities, including those listed in the HHS regulations -- i.e., "caring for [him]self, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning, and working." 45 C.F.R. 84.3(j)(2)(ii). The carrier may be analogized to a perfectly healthy person carrying a test tube containing the infectious agent. This person may possess the ability to spread the disease to others, but there is no basis for arguing that he is handi-

⁶⁶ The HHS regulation defines an "impairment" in pertinent part as "any physiological disorder or condition, cosmetic disfigurement, or anatomical loss affecting one or more of [numerous] body systems." 45 C.F.R. 84.3(j)(2)(i). It can be argued that this regulation encompasses any physiological condition that has any effect, whether or not adverse, on any of the specified body systems. This interpretation, however, would be flatly inconsistent with the ordinary meaning of the statutory term "impairment." See Webster's Third International Dictionary 1131 (1976) ("impair" means "to make worse: diminish in quality, value, excellence, or strength: do harm to"). In addition, this interpretation would reach conditions that Congress cannot reasonably have wished to classify as impairments. For example, 20/20 vision is a "physiological condition" affecting a "special sense organ[]." Similarly, acute muscular development achieved by body building is a physiological condition affecting the musculoskeletal system. It is far-fetched to assume that Congress -- or, for that matter, the drafters of the regulations -- intended to include such conditions in a category with "physiological disorder[s]" and "anatomical loss[es]." Instead, it is obvious that the regulatory term "affecting" means "adversely affecting."

capped.⁶⁷

To be sure, a carrier of a contagious disease may suffer adverse social and professional consequences. Persons susceptible to the disease may be reluctant to associate with him, but a person cannot be regarded as handicapped simply because others shun his company. Otherwise, a host of personal traits -- from ill-temper to poor personal hygiene -- would constitute handicaps, a conclusion which the drafters of the regulations recognized to be untenable. See 45 C.F.R. Pt. 84, App. A at 310.

In light of our conclusion that an immune carrier cannot qualify as handicapped on the ground that he has an impairment

⁶⁷ Some district courts have assumed that there can be a substantial limitation on the major life activity of earning a living whenever a large enough number of employers, for whatever reasons, consider an impairment to be a relevant job selection criterion. See Tudyman v. United Airlines, 608 F. Supp. at 745 n.6; E. E. Black, Ltd. v. Marshall, 497 F. Supp. at 1100-1101. This position is supported by the HHS regulation providing that a person is handicapped if he "has a physical or mental impairment that substantially limits major life activities only as a result of the attitudes of others toward such impairment." 45 C.F.R. 84.3(j)(2)(iv)(B).

Even if the regulation is valid, it would not circumvent the need (assumed to be met by this discussion) to prove a real or perceived impairment. All three components of the regulatory definition of the phrase "is regarded as having such an impairment," see 45 C.F.R. 84.3(j)(2)(iv), depend upon plaintiff having or being regarded as having an impairment, as that term is independently defined. See note 69, infra. Infection with a communicable virus, without more, is not an impairment, and the perception of such infection, without more, is not the perception of an impairment.

We doubt whether this "bootstrapping" regulation can be squared with the plain language of 29 U.S.C. 706(7)(B)(iii), which provides that an individual is handicapped if he is regarded as having an "impairment which substantially limits major life activities" (emphasis added). This language requires a causal connection between the substantial limitation on major life activities and the impairment. That is, if the impairment is real, it must either actually cause the limitation or be perceived to cause the limitation. And if the impairment itself is only perceived, the limitation must still be causally connected to it, either in the sense that it would result if the perceived impairment really existed, or because it is perceived to result from the perceived impairment. The regulation clearly goes a step beyond this language to encompass limitations not causally connected in either fact or perception to an impairment, and thus appears to be invalid. See Southeastern Community College v. Davis, 442 U.S. at 410.

that substantially limits his major life activities, see 29 U.S.C. 706(7)(B)(i), it follows that he cannot qualify on the ground that he "has a record of such an impairment" or "is regarded as having such an impairment." *Id.* at 706(7)(B)(ii), (iii). Since the ability to transmit a disease is not an impairment, the fact that an individual was able to transmit the disease in the past (or was misclassified as having had such an ability) does not mean that he has "a record of . . . an impairment." *Id.* at 706(7)(B)(ii).⁶⁸ Likewise, the perception that the individual is able to spread the disease does not mean that he "is regarded as having . . . an impairment," *id.* at 706(7)(B)(iii),⁶⁹ for the perceived condition, even if actual, is not an impairment within the meaning of the statute.

In sum, it seems clear that a person who carries but is personally immune to a communicable disease cannot on that basis qualify as handicapped under section 504. Of course, such a person may qualify as handicapped on some other grounds. For example, he may have another condition (e.g., blindness) that constitutes a handicap; he may have a record of such an impairment; or he may be regarded as having such an impairment. See 29 U.S.C. 706(B)(7). But the mere fact that he is, was, or is thought to be able to communicate a debilitating disease, standing alone, is not enough.

⁶⁸ Under the HHS regulation (45 C.F.R. 84.3(j)(2)(iii)), the phrase "has a record of such an impairment" is defined to mean "has a history of, or has been misclassified as having, a mental or physical impairment that substantially limits one or more major life activities." Accordingly, under this definition, an individual would not have a record of an impairment if he merely had or was misclassified as having the ability to transmit a disease.

⁶⁹ Under the HHS regulation (45 C.F.R. 84.3(j)(2)(iv)), the phrase "[i]s regarded as having an impairment" is defined to mean (emphasis added):

(A) has a physical or mental impairment that does not substantially limit major life activities but that is treated by a recipient [of Federal financial assistance] as constituting such a limitation; (B) has a physical or mental impairment that substantially limits major life activities only as a result of the attitudes of others toward such impairment; or (C) has none of the impairments defined in paragraph (j)(2)(i) of this section but is treated by a recipient as having such an impairment.

Since the ability to transmit a disease is not an impairment, this definition does not encompass an individual whose claim of handicap is based on this ability or the belief of others that he possesses this ability.

If, as we have concluded, the ability of an immune carrier to spread a contagious disease is not itself a handicap, there is no basis for reaching a different conclusion with respect to communicability when the person carrying the disease is not immune and in fact suffers from its disabling effects. Communicability alone is not a handicap in the former situation, and it does not become a handicap in the latter simply⁷⁰ because it is accompanied by the disease's disabling effects. Accordingly, we conclude with respect to AIDS sufferers (a) that the disabling effects of the disease on its victims qualify as handicaps but (b) that the ability of the victims to spread the disease to others is not a handicap.

b. Persons suffering from ARC present a somewhat different question. Because of the definitional imprecision of this condition (see pages 8-9, *supra*), it does not appear possible to set down a uniform rule for ARC patients. Instead, the question of whether the disabling effect(s) of ARC amount to a handicap under section 504 -- that is, whether it constitutes an impairment substantially limiting a major⁷¹ life activity -- must be determined on a case-by-case basis.

The issue of communicability is the same for ARC patients as it is for those with AIDS. As noted above, communicability alone -- whether present or past and whether real or merely perceived -- is not a handicap.

c. We now consider persons who do not have AIDS or ARC but are "seropositive," *i.e.*, test positive for antibodies to the AIDS virus. Individuals who are asymptomatic but infected with

⁷⁰ In *Arline v. School Board of Nassau County*, 772 F.2d 759, 764 (11th Cir. 1985), cert. granted, No. 85-1277 (Apr. 21, 1986), the only appellate decision holding that section 504 reaches discrimination based on concern about contagion, the court concluded that discrimination against Arline was within section 504 because tuberculosis "can significantly impair respiratory functions as well as other major body systems." 772 F.2d at 764. This analysis, however, leads only to the conclusion, with which we agree, that discrimination based on the respiratory impairment caused by tuberculosis (or the history or perception of such impairment) is cognizable under section 504. Arline was not discharged on this ground. Instead, she was discharged because of her ability to transmit the disease, *id.* at 761, and as we have shown, communicability is not a handicap under section 504.

⁷¹ Even if the effects of ARC do not render a particular individual handicapped, the individual may be protected by section 504 if he can show that he suffered discrimination because he was regarded as suffering from the disabling effects of AIDS.

HTLV-III/LAV⁷² are much like the hypothetical immune carrier previously discussed; they cannot claim on the basis of infection alone to have "a physical or mental impairment which substantially limits [any] major life activities." 29 U.S.C. 706(7)(B)(i). By definition, persons who are merely seropositive have not yet suffered any substantial adverse health consequences due to the virus or else they would properly be diagnosed as having AIDS or ARC. It may be that the presence of the virus in the body of such a person portends that AIDS or ARC will eventually develop, but until that occurs it cannot be said that the individual has⁷³ an impairment that substantially limits any major life activity.

Even though a person who tests positive for HTLV-III/LAV antibodies does not have an impairment that substantially limits any major life activity, this person may still be handicapped under section 504 if he is perceived as suffering from the disabling effects of AIDS or ARC. But for the reasons previously explained, neither the ability to communicate the disease nor

⁷² As noted earlier (see note 16, supra), because of the slim possibility of false positive responses to antibody testing, it may well be that not all persons who are seropositive are infected with HTLV-III/LAV. But since, as shown below, mere infection with HTLV-III/LAV is not a handicap, it follows a fortiori that seropositivity without more is not a handicap. Accordingly, any discrepancy between seropositivity and infectiousness is not relevant for purposes of section 504 analysis, and we henceforth treat these two conditions as equivalent. Compare City of Los Angeles Dep't of Water & Power v. Manhart, 435 U.S. 702, 707-710 (1978) (in drawing distinctions based on factors within the scope of Title VII (i.e., gender), pension plan cannot use even accurate sex-based actuarial generalizations); Connecticut v. Teal, 457 U.S. 440, 455 (1982) ("We recognized in [Manhart] that fairness to the class of women employees as a whole could not justify unfairness to the individual female employee because the 'statute's focus on the individual is unambiguous.' ") (quoting City of Los Angeles Dep't of Water & Power v. Manhart, 435 U.S. at 708).

⁷³ In our view, a physical condition cannot be regarded as an impairment or as substantially limiting a major life activity simply because it is a statistical predictor of some future disability or a shortened life span. The statutory definition of "handicapped" requires an actual, not merely a potential, "impairment." 29 U.S.C. 706(B)(7). Similarly, the key statutory language -- "substantially limits one or more . . . major life activities" -- is couched in the present, not the future, tense. Moreover, an actuarial interpretation of this language would lead to absurd results. For example, an elevated level of blood cholesterol, or even being moderately overweight, would be a handicap. We cannot believe that Congress intended such results.

the incorrect belief that the individual can communicate the disease constitutes a handicap.

d. Persons who do not have AIDS or ARC and who test negative for antibodies to the AIDS virus quite plainly do not have any impairment that substantially limits a major life activity. However, if such an individual is inaccurately perceived as suffering from the disabling effects of AIDS or ARC -- perhaps because of membership in a high-risk group⁷⁴ -- this perceived impairment would constitute a handicap. But, once again, the belief that the individual carries and may spread these diseases is not a handicap.

2. Discrimination "Solely by Reason of . . . Handicap"

a. As we have already observed, section 504 prohibits discrimination against handicapped persons only when the discrimination is on account of handicap; it does not reach discrim-

⁷⁴ In the context of these inquiries, it is important to be clear about the several possible ordinary-language meanings of "having AIDS." It seems doubtful whether most people would be familiar with the CDC case definition of AIDS; therefore, what most people mean by "having AIDS" may bear very little relation to the actual disease. Hence, when a claim under section 504 is premised on the employer believing that the plaintiff "had AIDS," one cannot automatically assume that he therefore perceived the person to be handicapped simply because AIDS is a handicap. For example, if what a person means by "having AIDS" is being infected with a potentially communicable virus, and nothing more, the perception that the person "has AIDS" is in reality a perception that the person is infected with, and thus able to communicate, HTLV-III/LAV, which is not in and of itself a handicap. On the other hand, if the person means something like, "the victim has no capacity to resist diseases," then one can say that the perception of "AIDS" is the perception of a handicap. (For that matter, if someone thinks that AIDS substantially interferes with the functioning of the respiratory system, a perception that someone has "AIDS" in this sense would be the perception of a handicap.) Accordingly, when an aggrieved employee seeks to establish his handicap on the ground that he is regarded as "having AIDS," he must establish that the perception is really of AIDS (i.e., of the full-blown syndrome), or of something comparably disabling, rather than merely a generalized perception of an infectious and contagious condition.

ination based on other grounds.⁷⁵ Thus, for example, a handicapped person denied a job on the basis of his religion or his race would not have a cause of action under section 504 (though he would likely have an action under other federal, and no doubt state, laws). Accordingly, claims brought by handicapped persons under section 504, no less than claims brought under other federal nondiscrimination statutes, require a factual inquiry into the basis for the alleged discrimination.⁷⁶ In most section 504 cases, this inquiry is not difficult, for the defendant usually concedes that the plaintiff is handicapped and was treated differently for that reason, but defends his action on the ground that he had good reason to single out the plaintiff for different treatment (*i.e.*, the plaintiff was not "otherwise qualified" to participate in the program or activity). See Doe v. New York University, 666 F.2d at 776.

By contrast, where the defendant claims to have based his allegedly unlawful decision on a characteristic or factor other than handicap -- especially a characteristic that non-handicapped persons can equally possess -- a more subtle factual inquiry is needed. This factual inquiry is particularly important in the present context because of our conclusions, as a matter of law, (1) that the disabling physical or mental effects of AIDS (and perhaps ARC) constitute handicaps, but (2) that the ability to transmit the disease to others is not itself a handicap. Therefore, if as a factual matter a plaintiff with AIDS (and perhaps ARC) is excluded from a federally funded program because the defendant believes that the plaintiff cannot participate in the program as a result of the disabling effects of the disease, the defendant's conduct may be governed by section 504. On the other hand, if the plaintiff is excluded because of fear that he will spread the disease, section 504 does not apply.

As we have seen, infection with HTLV-III/LAV (seropositivity), without more, is not a handicap within the meaning of section 504. Accordingly, a person who is discriminated against because he is (or is regarded as) seropositive has no claim under

⁷⁵ Indeed, section 504 applies only when the discrimination is based directly on handicap, and not when it is based on another factor that is in turn related to handicap. See Bowen v. American Hospital Ass'n, No. 84-1529, slip op. at 19 (June 9, 1986) ("If, pursuant to its normal practice, a hospital refused to operate on a black child whose parents had withheld their consent to treatment, the hospital's refusal would not be based on the race of the child") (opinion of Stevens, J.) (emphasis in original).

⁷⁶ Claims brought under section 504 by non-handicapped persons will obviously fail at an even earlier threshold.

⁷⁷ See note 72, supra.

section 504. Nor can he challenge the reasonableness of the defendant's judgment about the risk that he will spread the disease; defendants are not prohibited by section 504 from making incorrect, and even irrational, decisions so long as their decisions are not based on handicap.⁷⁸

Persons who are seropositive (or are thought to be infected with HTLV-III/LAV) can, of course, be handicapped in numerous real or perceived ways. Assume, for example, (1) that the plaintiff is seropositive and thus capable of transmitting the AIDS virus, (2) that he suffers from a handicap other than AIDS⁷⁹ -- blindness, let us say -- and (3) that the defendant's discrimination is proved to have been based on fear of contagion rather than on the plaintiff's blindness. Although the plaintiff is handicapped, he was not discriminated against by reason of his handicap; had he not been blind, the defendant's decision would have been the same. His claim under section 504, therefore,

⁷⁸ See Tudyman v. United Airlines, 608 F. Supp. at 745 n.6:

Only if the employer's restriction or requirement discriminates against handicapped persons is it illegal, no matter how stupid or objectionable the restriction or requirement may be in general. Using the curly hair/straight hair example ["people with straight hair are inferior, and thus I require all job applicants to have curly hair," E. E. Black, Ltd. v. Marshall, 497 F. Supp. at 1100], unless plaintiff can demonstrate that . . . straight haired individuals are generally perceived as limited in some way, so that the plaintiff is handicapped, the curly hair requirement is not prohibited.

⁷⁹ If ARC is severe enough to be a handicapping condition, it should be analyzed like AIDS. If it is not a handicapping condition, it should be analyzed like seropositivity.

fails.⁸⁰

A more complicated case is presented by the plaintiff who has (or is regarded as having) AIDS. If the defendant discriminates against him based on the disabling physical effects of AIDS, section 504 applies just as it would to any non-contagious disabling disease; the discrimination is obviously based on handicap, and the inquiry proceeds to the question whether the plaintiff is otherwise qualified to participate in the covered program. But if the defendant's discriminatory decision is based on concern about contagion rather than on the adverse effects of the disease on its host, section 504 is not violated. From this defendant's standpoint, the plaintiff who both carries and suffers from the effects of a disease is indistinguishable from the asymptomatic or immune carrier. Like blindness in the previous example, the handicap caused by AIDS is entirely irrelevant to the defendant's discriminatory action; had the plaintiff not been afflicted with AIDS (*i.e.*, had he only been seropositive), the defendant's decision would have been the same. Thus, in the context of contagious diseases, the key inquiry under section 504 is the factual inquiry whether the alleged discrimination in fact occurred by reason of handicap. Examination of some paradigmatic cases will help focus the inquiry that a court or agency must undertake.

⁸⁰ This is simply a restatement of the familiar "but-for" test, in which a decision based in part on an improper consideration is nonetheless not actionable if the defendant can show that the same decision would have been reached even in the absence of the improper consideration. See NLRB v. Transportation Management Corp., 462 U.S. 393, 401-405 (1983) (an employer who takes adverse action against an employee and who was motivated by antiunion animus does not violate the National Labor Relations Act if he can demonstrate that he would have taken the same action regardless of his forbidden motivation); Mt. Healthy City School District Board of Education v. Doyle, 429 U.S. 274, 287 (1977) (plaintiff having shown that his exercise of First Amendment rights was a motivating factor in the school board's decision not to rehire him, "the District Court should have gone on to determine whether the Board had shown by a preponderance of the evidence that it would have reached the same decision as to [plaintiff's] reemployment even in the absence of the protected conduct"). The proper application of the "but-for" test in the context of Title VII litigation is unsettled. Compare Bibbs v. Block, 778 F.2d 1318 (8th Cir. 1985) (en banc), with id. at 1325 (Lay, C.J., concurring), with id. at 1330 (Ross, J., dissenting). The language of section 504, however, pretermits any controversy; the requirement that discrimination occur "solely by reason of . . . handicap" (emphasis added) means at a minimum that handicap must be a but-for cause of the challenged decision.

b. Consider the case of the captain of a naval vessel who, upon learning of an outbreak of typhoid fever in a port in which the vessel is docked, has all returning sailors tested for antibodies to the typhoid bacillus and segregates those who test positive as well as those who exhibit the symptoms of the disease. The class of affected sailors includes those who are suffering from the disabling effects of the disease and may thus be handicapped, as well as those who merely test positive for the antibodies and thus are not handicapped. The segregated sailors who are not handicapped plainly could not complain that they were subjected to discrimination solely on the basis of handicap. More significantly, neither can the sailors who are (or are regarded as) handicapped with the effects of the disease. The captain segregated everyone, whether handicapped or not, shown to have the characteristic -- communicability -- he seeks to control. The captain, accordingly, would be readily able to demonstrate that his segregation of a sailor with the disabling effects of typhoid fever was based entirely on communicability, and not on the sailor's handicap. Absent countervailing proof establishing that the asserted basis for his action -- communicability -- was in truth a pretext for excluding persons because of the disabling effects of typhoid,⁸¹ handicap discrimination would not be present.

In contrast, if the captain gives an antibody test⁸² but segregates only those sailors who test positive and suffer from the effects of typhoid, the ineluctable inference is that his motive concerned the effects of typhoid (i.e., handicap) and not fear of contagion. By segregating some sailors known to be contagious, but not others who are known to be equally contagious, the captain renders any assertion that his decisions were based on communicability transparently pretextual.

⁸¹ Of course, the less reasonable is the fear of contagion, the less credible is the assertion that such a fear truly formed the basis for the challenged conduct. Cf. Pushkin v. Regents of Univ. of Colorado, 658 F.2d at 1383 ("application of the rational basis test may be used to lend credence to the proposition that no discriminatory action has been taken").

⁸² We have used hypotheticals involving antibody testing for purposes of clarity of illustration only. We do not mean to suggest that a program administrator, to avoid section 504 liability, must use antibody testing, or any other state-of-the-art techniques for detecting the presence of communicable diseases. To the contrary, so long as the hypothetical program administrator can demonstrate that he does or would treat equally all program participants -- whether handicapped or not -- who become known to him to carry the communicable virus, it cannot be said that he is basing his decisions on handicap.

c. It should be noted that the reasonableness of an employer's concern about the spread of disease is relevant only to the extent it bears on the question of pretext. As we have shown, section 504 simply does not reach decisions based on fear of contagion -- whether reasonable or not -- so long as it is not in truth a pretext for discrimination on account of handicap. An employer, for example, who makes hiring decisions based on an unreasonable concern about contagion is no different from an employer whose hiring decisions rest on any other unreasonable basis that lies outside section 504's limited reach. To illustrate this point, consider an employer who has the bizarre belief that persons with curly hair make better employees than persons with straight hair. See Tudymen v. United Airlines, 608 F. Supp. at 845 n.6. Section 504 does not prohibit the employer from making hiring decisions based on this wholly unreasonable basis. Straight hair is not a handicap; nor is discrimination against such persons conceivably a pretext masking discrimination against the handicapped. Therefore, discrimination against persons with straight hair, as irrational and deplorable as it may be, is not

within section 504's scope.⁸³

Consequently, there is no a priori reason to presume that assertions of fear of contagion of AIDS are especially likely to be pretextual. Whatever the medical facts regarding transmissibility might be, a constellation of factors make it intuitively plausible that a person claiming fear of contagion genuinely discriminated on that basis rather than by reason of handicap.⁸⁴ The consequences of contracting the virus are severe; there is a substantial chance, possibly even approaching 100%, that the infected individual will eventually contract the disease. And the disease itself is both incurable and fatal -- it appears that everyone who contracts it will die. In common experience, even a very low probability of contracting a contagious virus with consequences of this magnitude is likely to call forth a strong-

⁸³ Of course, not every instance of discrimination on the basis of a characteristic not directly protected by section 504 will escape coverage of the statute. For example, an employer is not prohibited by section 504 from discriminating against job applicants on the basis of incompetence, even if his judgment about the competence of a particular applicant is inaccurate. If he concludes, however, that a particular applicant is incompetent by virtue of a false handicap-based stereotype (e.g., all handicapped persons are incompetent), he has violated section 504, just as discrimination grounded on a race-based stereotype would violate Title VI of the 1964 Civil Rights Act. This type of stereotypical judgment, even if sincerely believed, is based solely on the prohibited criterion -- handicap -- and was intended to be reached by section 504. See S. Rep. No. 1297, 93d Cong., 2d Sess. 32 (1974); accord Mantolite v. Bolger, 767 F.2d at 1422.

This point, however, has no application to the question posed here. The right secured to handicapped persons by section 504 is a right to equal, or handicap-neutral, treatment. See Bowen v. American Hospital Ass'n, slip op. at 29. That is, a handicapped person is entitled to be treated by the administrator of a covered program in precisely the same manner as a similarly situated non-handicapped person. As we have shown, in the case of AIDS, the ability to transmit the disease is handicap-neutral. Accordingly, in this context the section 504 analysis is not affected by an argument that concern about the communicability of the AIDS virus is so medically unwarranted as to constitute a stereotype; any such stereotype is not handicapped-based, and thus is not within the proscription of section 504. So long as handicapped carriers of the disease receive precisely the same treatment as similarly situated non-handicapped carriers (i.e., exclusion by reason of communicability), that is all the statute requires.

⁸⁴ To be sure, the specific evidence in any particular case might well show otherwise.

ly-felt response.⁸⁵ In addition, there are a number of questions regarding AIDS on which the medical community does not speak with one voice. Knowledge of the disease is growing and, in some respects, changing rapidly. The mechanisms of transmission are still not fully understood, and epidemiological evidence does not permit the kind of categorical statements about risk that would make one doubt the legitimacy of claims of fear. These considerations must inform any analysis engaged in by a factfinder to determine whether discrimination truly occurred by reason of handicap,⁸⁶ and thus counsel against an initial presumption of pretext.

3. "Otherwise Qualified"

If, as we believe, the ability to communicate AIDS or any other contagious illness is not itself a handicap, it follows that the question whether the plaintiff is "otherwise qualified" to participate in the covered program is never reached in cases

⁸⁵ See Freedman, Wrong Without Remedy, ABA Journal, June 1, 1986, at 38 (" 'Our clients have said, 'I'm not willing to expose my workforce to even a very small chance of contagion, and unless you can convince me that there's absolutely no chance, with all due respect, I have to do what I think is appropriate.' ' ") (quoting Michael Cecere, New York attorney).

⁸⁶ This conclusion cannot be avoided through the use of "disparate impact" analysis. In Alexander v. Choate, 105 S. Ct. 712 (1985), while assuming for the sake of argument that section 504 does not invariably require proof of intentional discrimination, the Supreme Court emphatically rejected "the boundless notion," *id.* at 720, that any showing of disparate impact on the handicapped constitutes a prima facie showing of discrimination. Rather, the Court inquired "whether the disparate effect [alleged in that case was] the sort of disparate impact that federal law might recognize." *Ibid.*

Here, it seems abundantly clear that any disparate impact on the handicapped associated with a measure designed to prevent the spread of contagion is not the "sort of disparate impact that federal law might recognize." As we will demonstrate (see pages 44-49, *infra*), Congress quite clearly did not intend for section 504 to regulate measures designed to prevent the spread of communicable diseases. It would be anomalous in the extreme if the congressional intent that section 504 not intrude in such matters could be circumvented and frustrated through the use of disparate impact analysis. This seems to us a quintessential example of "the sort of disparate impact" that section 504 was not meant to reach.

involving discrimination based on communicability.⁸⁷ If communicability, standing alone, is construed to be a handicap, however, the "otherwise qualified" issue would be presented, and we therefore address some general considerations that should inform this factual inquiry.

Courts have uniformly recognized that health and safety concerns are a legitimate defense to a suit under section 504. See Strathie v. Department of Transportation, 716 F.2d at 232; Mantolete v. Bolger, 767 F.2d at 1422; Doe v. New York University, 666 F.2d at 775. In other words, a person is not "otherwise qualified" to participate in a covered program or activity if his participation will put the health or safety of other participants (or, indeed, himself) at risk. Cf. Southeastern Community College v. Davis, 442 U.S. at 407 (a hearing-impaired person is not eligible to participate in a nursing program because "the ability to understand speech without reliance on lipreading is necessary for patient safety during the clinical phase of the program"). The final resolution of this inquiry in any particular case is one of fact and thus cannot be answered in the abstract, but the calculus will in general focus on the likelihood that the injury-causing event will occur, and the extent of the harm if it does. In the context of contagious illnesses, the injury-causing event is transmission of the illness, and its likelihood depends on the means by which, and circumstances under which, the illness can be transmitted. The extent of the harm is measured not only by the adverse effects of the illness on the health of the person who contracts it, but also by the fact that the infected person can spread the illness to yet more people.

Obviously, the extent of the harm that would be caused by a contagious disease bears an inverse relationship to the degree of risk of transmission that a normal person would be willing, or can be required, to assume. For example, the common cold is highly contagious, and the mechanism of its transmission is well known and commonly understood. Its consequences, however, are typically temporary and not severe, and most people will not go to extraordinary lengths to avoid exposure to a significant risk of infection. At the other end of the spectrum would be a contagious disease that is incurable, highly painful, and ultimately fatal. The typical human response to such a disease is to take substantial measures to avoid exposure to even the slightest risk of infection. This natural tendency to "err on the safe side" when dealing with such a disease is compounded when, as with

⁸⁷ Under our analysis, this question would be reached only if a person suffered discrimination based on his perceived inability to function due to the disabling effects of AIDS or ARC. The question then would be whether the individual, in spite of those disabling effects, could function effectively. This would be a factual question analytically similar to the "otherwise qualified" inquiry in other section 504 cases.

AIDS, the state of medical knowledge concerning it is still in an early stage of development, and the mechanisms of the disease's transmission are not fully understood.

We do not believe that Congress intended enactment of section 504 substantially⁸⁸ to rearrange human conduct with regard to contagious illnesses. Accordingly, we believe that a person capable of communicating the AIDS virus is not "otherwise qualified" to participate in a covered program or activity unless the risk that he poses to the health of other participants can be calculated with a high degree of medical certainty and is low

⁸⁸ The problem of how to allocate health and safety risks in the face of scientific uncertainty is not unique to section 504. In Industrial Union Department, AFL-CIO v. American Petroleum Institute, 448 U.S. 607 (1980), a three-justice plurality and four-justice dissent each addressed the Occupational Safety and Health Administration's requirement that the textile industry "prove, apparently beyond a shadow of a doubt, that there is a safe level for [occupational] benzene exposure." 448 U.S. at 652 (emphasis in original) (opinion of Stevens, J.). Although written in the context of a particular statute, the plurality and dissenting opinions both rely on rules of construction of general applicability, and thus provide some enlightenment on the issue posed here. Significantly, both analyses support the view that the risk of medical uncertainty must be borne by the plaintiff in section 504 suits.

The plurality disagreed with the agency's allocation of the burden of proof to the manufacturer, because "it is [ordinarily] the proponent of a rule or order who has the burden of proof in administrative proceedings." Id. at 653. That is, the burden of proof lies with the party seeking to challenge the judgment of the party subject to regulation; in a section 504 suit, therefore, the burden is on the plaintiff. The dissent, while accepting the agency's position, did so on the ground that the plurality's approach "would place the burden of medical uncertainty squarely on the shoulders of the American worker, the intended beneficiary of the Occupational Safety and Health Act." Id. at 690 (Marshall, J., dissenting). See also id. at 714-717. Under the dissent's rationale, therefore, the burden of uncertainty again falls on the plaintiff, for it is clear that the "otherwise qualified" requirement of section 504 was intended to protect employers, other workers, and the general public from health and safety hazards that might be posed by employment of handicapped workers in some circumstances. While the terms of any particular statute can of course indicate a different allocation of burdens, see EDF, Inc. v. EPA, 548 F.2d 998, 1015-1018 (D.C. Cir.), cert. denied, 431 U.S. 925 (1977), the language and structure of section 504, under which "otherwise qualified" is a necessary element of a cause of action, suggest clearly that the burden is on the plaintiff.

enough, without "substantial modifications in the[] programs,"⁸⁹ to be safely disregarded.⁹⁰ Application of this standard to any particular program, of course, will have to await presentation of concrete facts and circumstances.

B. Congressional Intent as Illuminated by the Background of Laws Dealing with Contagion

Our conclusion that section 504 does not reach discrimination based on communicability finds emphatic support in the statute's legislative history, particularly when viewed against the background of existing laws dealing with this subject.

⁸⁹ Southeastern Community College v. Davis, 442 U.S. at 405.

⁹⁰ The one case that addressed communicability in the "otherwise qualified" context is New York State Ass'n for Retarded Children, Inc., v. Carey, 612 F.2d 644 (2d Cir. 1979). The court rejected the New York City Board of Education's claim that mentally retarded students carrying hepatitis B should be segregated from other students because of the risk of contagion on the ground that "[t]here has never been any definite proof that the disease can be communicated by non-parenteral routes such as saliva." 612 F.2d at 650. The court also noted that, rather than "identify all the children in the public schools, or even all the retarded children in the public schools, who might be carriers of hepatitis B," ibid., the Board "merely tested the 450 children who happened to be in the classrooms that included known hepatitis B carriers, a policy that casts doubt on the Board's sense of how critical the problem was." Ibid.

Without passing judgment on the outcome of that case, we disagree with its reasoning to the extent that it required the Board to produce "definite proof" regarding the means by which the virus could be transmitted. In our view, this requirement improperly shifted the risk of uncertainty regarding communicability to the Board and to healthy students; in a section 504 case, the plaintiff has the burden of demonstrating that he is otherwise qualified for the benefits sought, and uncertainty counsels in favor, rather than against, deference to the decisions of program administrators. See note 88, supra. Nor do we believe that the Board's decision to limit its testing to students known to have been exposed to the infection casts doubt on the Board's asserted fear of the spread of contagion. Concentrating resources where the risk is greatest hardly evidenced a lack of seriousness. See note 82, supra.

1. State and Federal Regulation of Contagious Diseases

Because of the enormous damage wrought by epidemics of contagious diseases, "[m]easures to prevent the spread of dangerous communicable diseases . . . are practically as old as history." Rock v. Carney, 216 Mich. 280, 296, 185 N.W. 798, 799 (1921) (Wiest, J., concurring). For centuries, Anglo-American law has given public health officials broad authority to deal with communicable diseases through quarantine and other measures. The very first crime discussed by William Blackstone in the chapter of his Commentaries on the Law of England dealing with offenses against the public health, police, or economy is disobedience of a quarantine order. See 4 W. Blackstone, Commentaries on the Law of England 161-162 (1769). By statute, local officials of Blackstone's era could order people infected with the plague or living in infected dwellings to remain in their houses. Violation of such an order by a person actually infected was a felony, see id. at 161, which generally carried the death penalty. See id. at 98. Another statute in force at the time required ships coming from infected countries to be quarantined for 40 days, and violation of quarantine constituted a "felony without benefit of clergy." Id. at 162.

Similar, if less draconian, statutes were commonplace in the states at the time of the Nation's founding and before.⁹¹ Today, state and local governments retain broad powers to deal with communicable diseases⁹² through health and safety regulations,⁹³

⁹¹ See, e.g., 4 Henning [Va.] 99, 8 Geo. I, ch. II (1722) (providing for quarantine of incoming ships from plague areas); 1 Shepherd [Va.] 368 (1795) (extending quarantine to infected areas within Virginia); Vt. Rev. Stat., ch. 36 (1797) (providing for quarantine of persons with smallpox); R.I. Rev. Stat. 38 (1798 & 1810 Supp.) (same).

⁹² See generally 39A C.J.S. Health & Environment § 18 (1976); 39 Am. Jur. 2d Health § 26 (1968).

⁹³ Reporting requirements are among the most common regulations. See, e.g., Ariz. Rev. Stat. Ann. §§ 36.621 to 36.623 (1986); Cal. Health & Safety Code §§ 3122, 3124-3125 (West 1979); Colo. Rev. Stat. §§ 25-1-647, 25-1-649, 25-4-402 (1982). See generally 39A C.J.S. Health & Environment §§ 19-20; 39 Am. Jur. 2d Health §§ 23, 26, 32-33.

closing of public places or quarantine,⁹⁴ denial of marriage licenses to persons with venereal diseases,⁹⁵ and compulsory immunization,⁹⁶ particularly of schoolchildren.⁹⁷

Less well known is the fact that communicable diseases are the only public health problem to be a subject of federal statutes from the origin of the country to the present. Congress first addressed the control of communicable diseases in 1796, when it authorized the President to direct federal officials to aid in the execution of quarantining⁹⁸ and to assist states in the enforcement of their health laws. This law was replaced in 1799 with a more comprehensive scheme for assisting states, quarantining vessels⁹⁹, and protecting federal officials from the risk of contagion. Federal statutes relating to communicable diseases, including provisions for data collection and grants to states, persisted through the next century. See generally Morgenstern, The Role of the Federal Government in Protecting Citizens from Communicable Diseases, 47 U. Cinn. L. Rev. 537, 541-546

⁹⁴ See, e.g., Ala. Code §§ 22-11-3, 22-11-15, 22-12 (1975); Conn. Gen. Stat. Ann. §§ 19a-207, 19a-221 (West 1986); Del. Code Ann., tit. 16, §§ 505-508 (1983). See generally 39A C.J.S. Health & Environment §§ 21, 23-25; 39 Am. Jur. 2d Health §§ 28-31.

⁹⁵ See, e.g., Fla. Stat. Ann. §§ 741.051 to 741.0593 (West Supp. 1986); Ga. Code Ann. § 19-3-40 (1982); Hawaii Rev. Stat. § 572-7 (1984 Supp.) (rubella). See generally 52 Am. Jur. 2d Marriage § 25 (1970).

⁹⁶ See Jacobson v. Massachusetts, 197 U.S. 11 (1905); 39A C.J.S. Health & Environment § 22; 39 Am. Jur. 2d Health § 27.

⁹⁷ See, e.g., Alaska Stat. §§ 14.30.065, 14.30.125 (1962); Ark. Stat. Ann. §§ 80-1548 to 80-1550 (1980); Idaho Code §§ 39-4801 to 39-4802 (1985). See generally 68 Am. Jur. 2d Schools §§ 277-280 (1973); Morgenstern, The Role of the Federal Government in Protecting Citizens from Communicable Diseases, 47 U. Cinn. L. Rev. 537, 545 n.62 (1978) ("By September 1976, 47 of the 50 states required at least one type of immunization prior to school entry.").

⁹⁸ See Act relative to Quarantine, ch. 31, 1 Stat. 474 (1796). The first reference to communicable diseases was actually two years earlier, when Congress authorized the President to change the location for sessions of Congress when the regular location was suffering from an outbreak of a contagious disease. See Act to authorize the President of the United States in certain cases to alter the place for holding a session of Congress, ch. 17, 1 Stat. 353 (1794) (codified as amended at 2 U.S.C. 27).

⁹⁹ See Act respecting Quarantines and Health Laws, ch. 12, 1 Stat. 619 (1799).

(1978).¹⁰⁰ As late as 60 years ago, Title 42 of the United States Code -- which in the 1982 edition spans two volumes and 3022 pages -- consisted of twelve pages, seven of which pertained to quarantine, leprosy, and serums and antitoxins, and three of which pertained to the administration of the Public Health Service. See 42 U.S.C. (1925 ed.) 1-193.¹⁰¹

This venerable statutory policy continues today in updated form. The Secretary of HHS (or the Surgeon General with the approval of the Secretary) has broad power to promulgate regulations for the control of communicable diseases, see 42 U.S.C. 243, 264, including power to apprehend or detain persons to prevent the spread of certain diseases designated by the President. See 42 U.S.C. 264(b).¹⁰² (The Secretary of the Interior has comparable powers with respect to Indians. See 25 U.S.C. 198, 231.) The Secretary is directed to cooperate with state health authorities in their efforts to suppress communicable diseases. See 42 U.S.C. 243. And under 42 U.S.C. 247b(a), the Secretary is authorized to make grants to states and state subdivisions "to assist them in meeting the costs of establishing and maintaining preventive health service programs," a provision which grew out of prior statutes authorizing grants for communi-

¹⁰⁰ In the early part of this century, the federal government intervened, at the behest of the state of Louisiana, to help combat yellow fever in the South. See Walz, Federal Regulation of Quarantine, 4 Mich. L. Rev. 189 (1905).

¹⁰¹ The only other substantive subject addressed in the 1925 code is infant and maternal hygiene. See 42 U.S.C. (1925 ed.) 161-175.

¹⁰² Upon the recommendation of the Surgeon General and the National Advisory Health Council, the diseases presently designated by the President under this statute are "cholera or suspected Cholera, Diphtheria, infectious Tuberculosis, Plague, suspected Smallpox, Yellow Fever, and suspected Viral Hemorrhagic Fevers (Lassa, Marburg, Ebola, Congo-Crimean, and others not yet isolated or named)." Exec. Order No. 12452, 3 C.F.R. (1984 ed.) 224, reprinted in 42 U.S.C. (1983 Supp.) 264 note.

cable disease control programs.¹⁰³

Regulations have been promulgated on a variety of subjects, including restrictions on interstate travel by those suffering from designated communicable diseases, see 21 C.F.R. 1240.40, 1240.50, 1240.54, 1240.55, the reporting of such diseases by conveyers of interstate traffic, *id.* at 1240.45, and reporting and quarantine requirements in the event of suspected entry of communicable diseases from a foreign country. See 42 C.F.R. 71.1 to 71.35. The travel and reporting restrictions do not apply to military personnel, see 21 C.F.R. 1240.57, who are covered by the services' own regulations. In the Army, for example, having "[a]ny acute pathological condition, including acute communicable diseases" (emphasis in original), is cause for denying a person appointment, enlistment, or induction, see AR 40-501, § 2-39(b), admission to the military academy, see *id.* at § 5-25, or mobilization, see *id.* at § 6-36(b). A serviceman can be dismissed if, "[i]n view of the member's physical condition, his retention in the military service would prejudice the best interests of the

¹⁰³ The Public Health Service Act, ch. 373, 58 Stat. 682 (1944), authorized the Secretary to provide grants and services to states for the control of venereal disease and tuberculosis. See 42 U.S.C. (1946 ed.) 246. The Comprehensive Health Planning and Public Health Services Amendments of 1966, Pub. L. No. 89-749, 80 Stat. 1180, replaced this section with a general program of grants for health planning. However, the Vaccination Assistance Act of 1962, Pub. L. No. 87-868, 76 Stat. 1155, added provisions for grants for immunization against diseases such as diphtheria and whooping cough. See 42 U.S.C. (1964 ed.) 247b. This was broadened in 1970 to encompass grants to states for communicable disease control programs, which included but were not limited to programs to control venereal disease, tuberculosis, whooping cough, and other diseases that had been the subject of more specific provisions. See Communicable Disease Control Amendments of 1970, Pub. L. No. 91-464, 84 Stat. 988. The provision was amended two years later, *inter alia*, to exclude venereal diseases -- now separately addressed by 42 U.S.C. 247c, which also includes authority to make grants for the prevention and control of AIDS, see Preventive Health Amendments of 1984, Pub. L. No. 98-555, 98 Stat. 2854 -- and to require that federal grants under 42 U.S.C. 247b be limited to programs to control diseases of national significance. See Communicable Disease Control Amendments Act of 1972, Pub. L. No. 92-449, 86 Stat. 748. In 1976, the grant program was extended to disease control programs in general, although priority in grant applications was to be given to disease control programs for communicable diseases. See Disease Control Amendments of 1976, Pub. L. No. 94-317, Title II, 90 Stat. 700. Section 247b assumed its present form, without explicit reference to communicable diseases, only in 1978. See Health Services and Centers Amendments of 1978, Pub. L. No. 95-626, § 202, 92 Stat. 3551, 3574.

government (e.g., a carrier of communicable disease who poses a health threat to others)." Id. at § 3-36(c)(3).

2. Absence of Indications in the Statutory
History of Intent to Alter the Existing Scheme
of Regulation

a. Against this background, the statutory history of section 504 is as revealing as Sherlock Holmes' famous dog that did not bark in the night.¹⁰⁴ If section 504 applied to discrimination based on communicability, the entire, long-established body of state and federal law dealing with communicable diseases would be called into question in unforeseeable ways. Sound canons of statutory interpretation teach that such results should never be assumed in the absence of very clear proof to the con-

¹⁰⁴ See A. Doyle, Silver Blaze, in The Memoirs of Sherlock Holmes 27 (1893):

" . . . [T]he curious incident of the dog in the night-time."

"The dog did nothing in the night-time."

"That was the curious incident," remarked Sherlock Holmes.

trary.¹⁰⁵ See Bowen v. American Hospital Ass'n, slip op. at 32.

There is no such proof here. Neither when section 504 was originally enacted in 1973 nor when the definition of a "handicapped individual" was amended in 1974 did Congress or the President suggest that this measure was intended to affect the settled law governing the control of communicable diseases.

b. It is quite clear that section 504 as originally enacted in 1973 did not apply to discrimination based on contagion. The Rehabilitation Act initially defined a "handicapped individual" as "any individual who (i) has a physical or mental disability which for such individual constitutes or results in a substantial handicap to employment and (ii) can reasonably be expected to benefit in terms of employability from vocational rehabilitation services." 29 U.S.C. (1973 Supp.) 706(7)(A). This definition obviously excluded communicability, since vocational rehabilitation is not likely to alleviate the employment problems resulting from concern about contagion. Moreover, the legislative history of section 504 contains no hint that Congress intended to disturb the established body of law dealing with problems of contagion. See H.R. Rep. No. 244, 93d Cong., 1st Sess. 35 (1973); H.R. Rep. No. 42, 93d Cong., 1st Sess. 42 (1973); S. Rep. No. 48, 93d Cong., 1st Sess. 53, 80 (1973); H.R. Rep. No. 1581, 92d Cong., 2d Sess. 78 (1972); S. Rep. No. 1135, 92d Cong., 2d Sess. 49, 77 (1972); 119 Cong. Rec. 7114 (Mar. 8, 1973) (statement of Rep. Vanik). See also Rehabilitation Act of 1973: Statement by the

¹⁰⁵ The Eleventh Circuit employed precisely the opposite reasoning in Arline v. School Board of Nassau County, *supra*. See note 70, *supra*. Based on its erroneous view that discrimination on the basis of contagion falls within the plain meaning of section 504, the court searched for extrinsic evidence that Congress did not intend such coverage. The court completely overlooked the significance of the preexisting body of federal and state law dealing with the unique problems of contagion.

Moreover, the approach of the court of appeals is inconsistent with the principles set down by the Supreme Court in Pennhurst State School and Hospital v. Halderman, 451 U.S. 1 (1981). In that case, the Court indicated that where Congress uses its spending power to impose conditions that will apply to agencies of a state, "it must do so unambiguously." 451 U.S. at 17. See also *id.* at 25 ("The crucial inquiry . . . [is] whether Congress spoke so clearly that we can fairly say that the State could make an informed choice."). Since many of the parties affected by section 504 are state agencies, one must inquire whether Congress "spoke so clearly" on the subject of communicability that a state could make an "informed choice" as to whether the burdens on its regulatory scheme are outweighed by the benefits of federal funding.

President Upon Signing the Bill Into Law, 9 Weekly Comp. Pres. Doc. 1197-1198 (Sept. 26, 1973).

In 1974, Congress enacted a new definition of "handicapped individual," applicable to the Act's anti-discrimination provisions, but there is no evidence that this amendment was intended to bring questions of communicability within the reach of section 504. The new definition -- the present 29 U.S.C. 706(7)(B) -- was not part of the proposed 1974 House amendments to the Act, see 120 Cong. Rec. 15,739-15,740 (1974) (H.R. 14225, 93d Cong., 2d Sess.), but was added by the Senate Labor and Public Welfare Committee, see 120 Cong. Rec. 30,525 (1974) (S. 3108, 93d Cong., 2d Sess.), and agreed upon at conference. See S. Rep. No. 1270 at 1; H.R. Rep. No. 1457 at 1.

In explaining this change, the Conference Report stated that the original definition of a handicap, with its focus on vocational rehabilitation, was too narrow for purposes of the anti-discrimination laws:

[A] test of discrimination against a handicapped individual under section 504 should not be couched either in terms of whether such individual's disability is a handicap to employment, or whether such individual can reasonably be expected to benefit, in terms of employment, from vocational rehabilitation services. Such a test is irrelevant to the many forms of potential discrimination covered by section 504.

S. Rep. No. 1270, 93d Cong., 2d Sess. 25 (1974); H.R. Rep. 1457, 93d Cong., 2d Sess. 25 (1974). See also 120 Cong. Rec. 30,531 (1974) (statement of Sen. Cranston) ("[T]he new definition . . . is meant to include a broader group of handicapped persons who suffer from discrimination practices in employment, and participation in certain services and programs even though their handicap may not effect [sic] job performance."). The Conference Report mentioned the following examples of persons who were wrongly excluded from section 504's coverage under the old definition but were included following the amendment:

physically and mentally handicapped children who may be denied admission to Federally-supported school systems on the basis of their handicap; handicapped persons who may be denied admission to Federally-assisted nursing homes on the basis of their handicap; those persons whose handicap is so severe that employment is not feasible but who may be denied the benefits of a wide range of Federal programs; and those persons whose vocational rehabilitation is complete but who may nevertheless be discriminated against in certain Federally-assisted activities.

S. Rep. No. 1270 at 25-26; H.R., Rep. No. 1457 at 25-26. The new definition was also designed to make clear that a person can be

handicapped if he has a history of, or is falsely perceived as, being handicapped. See S. Rep. No. 1270 at 26; H.R. Rep. No. 1457 at 26. Thus, while it is clear that the 1974 amendments sought to expand the coverage of section 504 to include persons who could not benefit from vocational training, there is nothing in the Act's legislative history to suggest that Congress intended to disturb the well-established body of federal and state law addressing the unique, age-old problems presented by communicable diseases.¹⁰⁶

3. Implications of Congressional Silence

a. The lesson of this legislative history is unmistakable, for it is impossible to believe that Congress would enact a measure calling into question the continued validity of the established body of federal and state law dealing with the spread of communicable diseases without mentioning that it was taking this step and without bothering to specify, or even inquire into, the effects that section 504 would have in this field. The latter point is especially significant, because if the ability to transmit a communicable disease is itself a handicap under section 504, the wording of the statute provides little guidance regarding the statute's effect in this context. Plainly, section 504's nondiscrimination requirement, if construed to reach decisions based on communicability, would have some effect on these preexisting statutes, but it is simply impossible from the face of the statute to determine what those effects might be. Hence, under an interpretation of section 504 that brings discrimination based on communicability within its scope, the two words "otherwise qualified," and whatever gloss is placed on them by agencies and courts, would in essence take the place of the entire body of public health law that would otherwise have governed. But if Congress enacted and the President approved section 504 on this understanding, some such explanation would surely appear somewhere in the statutory history.

¹⁰⁶ The 1974 amendments were enacted over a presidential veto; the accompanying veto message did not make reference to the new definition. See Veto of Rehabilitation Act Amendments, 10 Weekly Comp. Pres. Doc. 1389 (Oct. 29, 1974).

Following passage in 1973 of the Rehabilitation Act, oversight hearings were held to assess the administration of the Act's vocational rehabilitation provisions. See Vocational Rehabilitation Services: Oversight Hearing before the Select Subcomm. on Education of the House Comm. on Education and Labor (pts. 2-3), 93d Cong., 1st & 2d Sess. (1973-1974). Our review of these hearings, not surprisingly given their subject, reveals no discussion of communicability.

b. This discussion takes on added significance in view of the Supreme Court's decision in Bowen v. American Hospital Ass'n, *supra*. Despite the substantial federal role in the control of communicable diseases, the subject is principally a matter of state and local concern. As noted above, interpreting section 504 to include communicable diseases could well operate as a major de facto preemption of many state efforts to regulate and control communicable diseases. Citing the well-established rule of construction that "Congress . . . 'will not be deemed to have significantly changed the federal-state balance' -- or to have authorized its delegates to do so -- 'unless otherwise the purpose of the Act would be defeated,'" Bowen v. American Medical Ass'n, slip op. at 32 (citations and footnote omitted) (opinion of Stevens, J.), the plurality opinion found an insufficient administrative record to justify federal interference with a functioning state system of infant medical care. See *id.* at 32-34. The Court noted Congress' failure to indicate, "either in the statute or in the legislative history, that it envisioned federal superintendence of treatment decisions traditionally entrusted to state governance." *Id.* at 32. Significantly for our inquiry, the Court made reference to a long line of cases stating that statutes should not be construed to interfere with the exercise of traditional state powers unless such an intent is clearly expressed. See *id.* at 32 n.33. Here, there is not a hint, much less clear affirmative evidence, of a legislative intent to extend section 504's nondiscrimination command to the ability to transmit a disabling disease, as opposed to the disabling effects of the disease on its host, and thereby potentially to disrupt the statutory and regulatory plans of all fifty states.¹⁰⁷

In sum, Congress' silence on the subject of communicability reinforces the conclusion compelled by the language of section 504 and the preexisting body of law dealing with this subject: section 504 simply does not address the subject of communicability. In this field, section 504 left the law precisely as it found it.

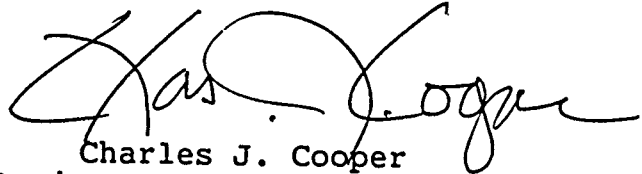
c. In relying in the present case on congressional silence, we hasten to make certain that our reasoning is not misunderstood. We believe that section 504's broad, literal reach should be fully recognized. We also believe that the term "handicapped" should be generously construed and should not be limited to traditional handicaps. Nor do we believe that section 504 must

¹⁰⁷ A number of states are now determining whether their own antidiscrimination statutes include communicable diseases such as AIDS. See generally Leonard, Employment Discrimination Against Persons with AIDS, 10 U. Dayton L. Rev. 681 (1985). The statutes in at least two states specifically exclude communicable diseases from their definitions of "handicap." See Ga. Code Ann. § 34-6a-3(b) (1982); Ky. Rev. Stat. Ann. § 207.140(2)(c) (Baldwin 1981).

always be limited to those handicaps, groups, or situations that find mention in the statute's legislative history. Rather, our reasoning in this section is based on a combination of factors -- the statutory language, the venerable, established body of federal and state law dealing with contagion, the inevitable but unpredictable effect on these laws if section 504 is construed to prohibit discrimination based on communicability, and the absence in the statutory history of any indication of an intent to overhaul these preexisting laws. Under these circumstances, we do not see how the conclusion reached in this Memorandum can reasonably be avoided.

IV. CONCLUSION

For the foregoing reasons, we conclude that discrimination based on the disabling effects of AIDS on its victims may violate section 504, but that the statute does not restrict measures taken to prevent the spread of the disease. This Memorandum, of course, does not purport to answer all questions concerning the relationship between section 504 and AIDS, but we trust that our analysis will be helpful to you in resolving the difficult questions that you face.



Charles J. Cooper
Assistant Attorney General
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August 1, 1985

**The Case Definition of AIDS
Used by CDC for National Reporting
(CDC-reportable AIDS)**

For the limited purposes of national reporting of some of the severe late manifestations of infection with human T-lymphotropic virus, type-III/lymphadenopathy-associated virus (HTLV-III/LAV) in the United States, CDC defines a case of "acquired immunodeficiency syndrome" (AIDS) as an illness characterized by:

- I. one or more of the opportunistic diseases listed below (diagnosed by methods considered reliable) that are at least moderately indicative of underlying cellular immunodeficiency, and
- II. absence of all known underlying causes of cellular immunodeficiency (other than HTLV-III/LAV infection) and absence of all other causes of reduced resistance reported to be associated with at least one of those opportunistic diseases.

Despite having the above, patients are excluded as AIDS cases if they have negative result(s) on testing for serum antibody to HTLV-III/LAV*, do not have a positive culture for HTLV-III/LAV, and have both a normal or high number of T-helper (OKT4 or LEU3) lymphocytes and a normal or high ratio of T-helper to T-suppressor (OKT8 or LEU2) lymphocytes. In the absence of test results, patients satisfying all other criteria in this definition are included as cases.

This general case definition may be made more explicit by specifying:

- I. the particular diseases considered at least moderately indicative of cellular immunodeficiency, which are used as indicators of AIDS, and
- II. the known causes of cellular immunodeficiency, or other causes of reduced resistance reported to be associated with particular diseases, which would disqualify a patient as an AIDS case.

This specification is as follows:

- I. Diseases at least moderately indicative of underlying cellular immunodeficiency:

In the following list of diseases, the required diagnostic methods with positive results are shown in parentheses. "Microscopy" may include cytology.

* A single negative test for HTLV-III/LAV may be applied here if it is an antibody test by ELISA, immunofluorescent, or Western Blot methods, because such tests are very sensitive. Viral cultures are less sensitive but more specific, and so may be relied on if positive but not if negative. If multiple antibody tests have inconsistent results, the result applied to the case definition should be that of the majority. A positive culture, however, would over-rule negative antibody tests.

A. Protozoal and Helminthic Infections:

1. Cryptosporidiosis, intestinal, causing diarrhea for over 1 month. (on histology or stool microscopy)
2. Pneumocystis carinii pneumonia, (on histology, or microscopy of a "touch" preparation, bronchial washings, or sputum)
3. Strongyloidosis, causing pneumonia, central nervous system-infection, or infection disseminated beyond the gastrointestinal tract, (on histology)
4. Toxoplasmosis, causing infection in internal organs other than liver, spleen, or lymph nodes (on histology or microscopy of a "touch" preparation)

B. Fungal Infections:

1. Candidiasis, causing esophagitis (on histology, or microscopy of a "wet" preparation from the esophagus, or endoscopic or autopsy findings of white plaques on an erythematous mucosal base, but not by culture alone)
2. Cryptococcosis, causing central nervous system or other infection disseminated beyond lungs and lymph nodes (on culture, antigen detection, histology, or India ink preparation of CSF)

C. Bacterial Infections:

1. Mycobacterium avium or intracellulare (Mycobacterium avium complex), or Mycobacterium kansasii, causing infection disseminated beyond lungs and lymph nodes (on culture)

D. Viral Infections:

1. Cytomegalovirus, causing infection in internal organs other than liver, spleen, or lymph nodes (on histology or cytology, but not by culture or serum antibody titer)
2. Herpes simplex virus, causing chronic mucocutaneous infection with ulcers persisting more than 1 month, or pulmonary, gastrointestinal tract (beyond mouth, throat, or rectum), or disseminated infection (but not encephalitis alone)(on culture, histology, or cytology)
3. Progressive multifocal leukoencephalopathy (presumed to be caused by Papovavirus)(on histology)

E. Cancer:

1. Kaposi's sarcoma (on histology)
2. Lymphoma limited to the brain (on histology)

F. Other Opportunistic Infections with Positive test for HTLV-III/LAV*:

In the absence of the above opportunistic diseases, any of the following diseases is considered indicative of AIDS if the patient had a positive test for HTLV-III/LAV*:

1. disseminated histoplasmosis, (on culture, histology, or cytology)
2. bronchial or pulmonary candidiasis, (on microscopy or visualization grossly of characteristic white plaques on the bronchial mucosa, but not by culture alone)
3. isosporiasis, causing chronic diarrhea (over 1 month), (on histology or stool microscopy)

G. Chronic lymphoid interstitial pneumonitis:

In the absence of the above opportunistic diseases, a histologically confirmed diagnosis of chronic (persisting over 2 months) lymphoid interstitial pneumonitis in a child (under 13 years of age) is indicative of AIDS unless test(s) for HTLV-III/LAV are negative.* The histologic examination of lung tissue must show diffuse interstitial and peribronchiolar infiltration by lymphocytes, plasma cells with Russell bodies, plasmacytoid lymphocytes and immunoblasts. Histologic and culture evaluation must not identify a pathogenic organism as the cause of this pneumonia.

H. Non-Hodgkin's Lymphoma with Positive Test for HTLV-III/LAV*:

If the patient had a positive test for HTLV-III/LAV*, then the following histologic types of lymphoma are indicative of AIDS, regardless of anatomic site:

1. Small noncleaved lymphoma (Burkitt's tumor or Burkitt-like lymphoma), but not small cleaved lymphoma,
2. Immunoblastic sarcoma (or immunoblastic lymphoma) of B-cell or unknown immunologic phenotype (not of T-cell type). Other terms which may be equivalent include: diffuse undifferentiated non-Hodgkin's lymphoma, large cell lymphoma (cleaved or noncleaved), diffuse histiocytic lymphoma, reticulum cell sarcoma, and high-grade lymphoma.

Lymphomas should not be accepted as indicative of AIDS if they are described in any of the following ways: low grade, of T-cell type (immunologic phenotype), small cleaved lymphoma, lymphocytic lymphoma (regardless of whether well or poorly differentiated), lymphoblastic lymphoma, plasmacytoid lymphocytic lymphoma, lymphocytic leukemia (acute or chronic), or Hodgkin's disease (or Hodgkin's lymphoma).

* A positive test for HTLV-III/LAV may consist of a reactive test for antibody to HTLV-III/LAV or a positive culture (isolation of HTLV-III/LAV from a culture of the patient's peripheral blood lymphocytes). If multiple antibody tests have inconsistent results, the result applied to the case definition, should be that of the majority done by the ELISA, immunofluorescent, or Western Blot methods. A positive culture, however, would over-rule negative antibody tests.

II. Known Causes of Reduced Resistance:

Known causes of reduced resistance to diseases indicative of immunodeficiency are listed in the left column, while the diseases that may be attributable to these causes (rather than to the immunodeficiency caused by HTLV-III/LAV infection) are listed on the right:

Known Causes of Reduced Resistance

1. Systemic corticosteroid therapy

Diseases Possibly Attributable to the Known Causes of Reduced Resistance

Any infection diagnosed during or within 1 month after discontinuation of the corticosteroid therapy, unless symptoms specific for an infected anatomic site (e.g., dyspnea for pneumonia, headache for encephalitis, diarrhea for colitis) began before the corticosteroid therapy

or any cancer diagnosed during or within 1 month after discontinuation of more than 4 months of long-term corticosteroid therapy, unless symptoms specific for the anatomic sites of the cancer (as described above) began before the long-term corticosteroid therapy

2. Other immunosuppressive or cytotoxic therapy

Any infection diagnosed during or within 1 year after discontinuation of the immunosuppressive therapy, unless symptoms specific for an infected anatomic site (as described above) began before the therapy

or any cancer diagnosed during or within 1 year after discontinuation of more than 4 months of long-term immunosuppressive therapy, unless symptoms specific for the anatomic sites of the cancer (as described above) began before the long-term therapy

3. Cancer of lymphoreticular or histiocytic tissue such as lymphoma (except for lymphoma localized to the brain), Hodgkin's disease, lymphocytic leukemia, or multiple myeloma

Any infection or cancer, if diagnosed after or within 3 months before the diagnosis of the cancer of lymphoreticular or histiocytic tissue

Known Causes of Reduced Resistance

4. Age 60 years or older at diagnosis
5. Age under 28 days (neonatal) at diagnosis
6. Age under 6 months at diagnosis
7. An immunodeficiency atypical of AIDS, such as one involving hypogammaglobulinemia or angio-immunoblastic lymphadenopathy; or an immunodeficiency of which the cause appears to be a genetic or developmental defect, rather than HTLV-III/LAV infection
8. Exogenous malnutrition (starvation due to food deprivation, not malnutrition due to malabsorption or illness)

Diseases Possibly Attributable to the Known Causes of Reduced Resistance

Kaposi's sarcoma, but not if the patient has a positive test for HTLV-III/LAV

Toxoplasmosis or herpes simplex virus infection, as described above

Cytomegalovirus infection, as described above

Any infection or cancer diagnosed during such immunodeficiency

Any infection or cancer diagnosed during or within 1 month after discontinuation of starvation