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The Supreme Court, 1997 Term -- Leading Cases -- Federal Statutes and Regulations -- Americans with Disabilities Act -- Asymptomatic HIV

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to make clear its preemptive intent or lack thereof.[69] When the Court's own poorly defined doctrine is at issue, the Court should not require more.[70]

Kiowa Tribe therefore stands as an example of unjustified inaction parading in the rhetoric of deference. The Court's interpretive inaction was not warranted; the Court has the unique ability to interpret its own case law. Despite the Court's defense of deference to a more qualified branch, its decisional inaction was also unwarranted. Ideally, Congress soon will legislate a comprehensive, well-balanced resolution to the complex problem of tribal immunity. Historically, however, when confronted with a tribal immunity question the Court has not waited idly for Congress to put the whole of Indian law on its agenda. The Court created the doctrine of tribal immunity, and that act of creation confers interpretive and decisional obligations on the Court until such time as Congress acts to appropriate control over the doctrine for itself.

III. FEDERAL STATUTES AND REGULATIONS

A. Americans with Disabilities Act

Asymptomatic HIV. — Congress enacted the Americans with Disabilities Act (ADA)[1] to provide enforceable federal standards designed to eliminate discrimination against the disabled.[2] Rather than cataloguing the disabilities covered by the Act,[3] Congress instead defined "disability" as a physical or mental impairment that substantially limits a major life activity, a record of such an impairment, or being "regarded as having" such an impairment.[4] Notwithstanding this definition, however, a health-care provider may still refuse to treat a patient

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69 The Court has held that there is a strong presumption against preemption of state power. *See, e.g.*, Cipollone v. Liggett Group, Inc., 505 U.S. 504, 523 (1992) ("[The Court] must fairly but — in light of the strong presumption against pre-emption — narrowly construe the precise language of [the statute] and ... look to each of petitioner's common-law claims to determine whether it is in fact pre-empted.").

70 The Court's decision does not make sense as a clear statement rule because the presumption behind the decision is not clear — the holding does not clarify whether, or in what way, suits pertaining to off-reservation commercial activities are different from those pertaining to taxation and regulation. The Court's apparent strategy — leaving a doctrinal area murky to force Congress to legislate — is inappropriate to a doctrine born in and developed exclusively by the courts.

1 42 U.S.C. §§ 12101–12213 (1994).

2 *See id.* § 12101(b)(1)–(2).

3 Congress did catalogue those disabilities *not* covered under the ADA. *See, e.g., id.* § 12210 (illegal use of drugs); *id.* § 12211(a) (homosexuality and bisexuality); *id.* § 12211(b)(2) ("compulsive gambling, kleptomania, or pyromania").

4 *Id.* § 12102(2)(A), (B), (C) [hereinafter the "actual disability," "record of," and "regarded as" prongs respectively].

if he poses a "direct threat to the health or safety of others."[5] Lower courts have divided over whether the asymptomatic stage of Human Immunodeficiency Virus infection ("asymptomatic HIV")[6] constitutes a "disability,"[7] and if so, whether it represents a "direct threat" to the health or safety of health-care workers.[8] Last Term, in *Bragdon v. Abbott*,[9] the Supreme Court held that asymptomatic HIV was a disability under the ADA and remanded the case to determine whether asymptomatic HIV poses a "significant" threat to health or safety.[10] Although *Bragdon* resolved the circuit split over the classification of asymptomatic HIV as a disability, the Court failed to address the different standards used in lower court cases involving HIV-infected patients and cases concerning HIV-infected health-care workers. This failure leaves these workers in the curious position of being required to treat HIV-infected patients while they are themselves unprotected from employment discrimination should they contract HIV from their patients.

In 1994, Sidney Abbott, who was HIV-positive but asymptomatic,[11] went to Dr. Randon Bragdon's dental office for a scheduled appointment.[12] After Abbott disclosed her HIV infection,[13] Bragdon examined her teeth and diagnosed a cavity.[14] Bragdon refused to fill Abbott's cavity in his office but offered do so in a hospital,[15] at no extra charge, although Abbott would have to pay the hospital to use its facilities.[16] Abbott refused Bragdon's offer and filed suit against him.[17]

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5 *Id.* § 12182(b)(3) (indicating that a "direct threat" is a significant risk "that cannot be eliminated by a modification of policies, practices, or procedures or by the provision of auxiliary aids or services").

6 Asymptomatic HIV refers to the period during which an HIV-infected individual has not yet developed the symptoms associated with HIV. *See* Yunzhen Cao et al., *Virologic and Immunologic Characterization of Long-Term Survivors of Human Immunodeficiency Virus Type 1 Infection*, 332 NEW ENG. J. MED. 201, 201 (1995).

7 *Compare* Abbott v. Bragdon, 107 F.3d 934, 939–43 (1st Cir. 1997) (holding that asymptomatic HIV is a disability under the "actual disability" prong), *with* Runnebaum v. Nationsbank of Md., 123 F.3d 156, 167–74 (4th Cir. 1997) (en banc) (holding that asymptomatic HIV is not a disability under either the "actual disability" or "regarded as" prongs).

8 *See Abbott*, 107 F.3d at 943–49.

9 118 S. Ct. 2196 (1998).

10 *See id.* at 2213.

11 *See id.* at 2200–01.

12 *See id.* at 2201.

13 *See id.*

14 *See* Abbott v. Bragdon, 912 F. Supp. 580, 584 (D. Me. 1995).

15 *See id.* Bragdon was concerned "that the use of high-speed drills and surface cooling with water created a risk of airborne HIV transmission," and that the availability of "air filtration, ultraviolet lights, respirators, and other safety measures [in the hospital] would reduce the risk." *Bragdon*, 118 S. Ct. at 2211–12.

16 *See Bragdon*, 118 S. Ct. at 2201. The cost of using the hospital facilities would have been approximately $165. *See* John Gibeaut, *Filling a Need*, 83 A.B.A. J. 48, 50 (July 1997).

17 *See Abbott*, 912 F. Supp. at 583–84.

The trial court held that Abbott was "disabled" under the actual disability prong of the ADA, concluding that asymptomatic HIV substantially limited the major life activity of reproduction.[18] Consequently, the court required Bragdon to treat Abbott in his office because the increased risk to Bragdon from performing the procedure there instead of at the hospital was not significant enough to invoke the "direct threat" exception.[19] In assessing the significance of the risk, the trial court purported to follow *School Board v. Arline*[20] by "defer[ring] to the reasonable medical judgment of public health officials."[21] Because Bragdon, unlike Abbott, failed to buttress his position with judgments from public health officials,[22] the district court found that Bragdon could not show a "direct threat" and granted summary judgment for Abbott.[23]

The United States Court of Appeals for the First Circuit affirmed.[24] The appeals court held that asymptomatic HIV was a "physical impairment" under the "actual disability" prong[25] of the Act.[26] The court next relied on the "plain meaning" of the word "major,"[27] prior legislative use of the phrase "major life activities,"[28] and the regulations promulgating the ADA,[29] to conclude that reproduction was a major life activity under the ADA.[30] The appeals court then concluded that the limitation that asymptomatic HIV places on the major life activity of reproduction is "substantial."[31]

The First Circuit framed the "direct threat" question as whether Bragdon had "the right to deny entirely routine dental treatment to pa-

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18 *See id.* at 585–87.

19 *See id.* at 587–91.

20 480 U.S. 273 (1987).

21 *Abbott*, 912 F. Supp. at 589.

22 *See id.* at 588–89.

23 *See id.* at 591, 595.

24 *See* Abbott v. Bragdon, 107 F.3d 934, 949 (1st Cir. 1997).

25 *See id.* at 938–39. Under the "actual disability" prong, the plaintiff must prove that she has a physical impairment, that the impairment limits a "major life activity," and that this limitation is substantial. *See id.* The appeals court declined to consider whether Abbott was also disabled under the "regarded as" prong. *See id.* at 938 n.2.

26 *See id.* at 939.

27 *See id.* at 939–40. The First Circuit's review of dictionary definitions led it to conclude that "the touchstone for determining an activity's inclusion under the statutory rubric is its *significance*." *Id.* at 940 (emphasis added).

28 *Id.* at 940.

29 *See id.* (reasoning that because the regulations define "physical impairment" to include reproductive disorders, reproduction must itself be considered a major life activity) (citing 28 C.F.R. § 36.104 (1996)).

30 *See id.* at 941. The appeals court rejected Bragdon's argument that Abbott had to make a specific showing that reproduction was a major life activity *for her*. *See id.* at 942.

31 *See id.* at 942–43 (discussing the risks that Abbott would pass HIV to her child and that she would not live long enough to raise a child to adulthood).

tients with HIV."[32] The court of appeals rejected a rule of "absolute capitulation" to the views of public health authorities, and instead favored a rule assigning their views "prima facie force,"[33] but providing for their rebuttal "by persuasive evidence adduced from other recognized experts in a given field."[34] The appeals court also maintained that one could not "prove or disprove the direct threat defense by relying on medical evidence not available when treatment was refused."[35] Applying this standard, the First Circuit concluded that Bragdon's proffered evidence failed to rebut the presumption, created by Abbott's evidence, that filling the cavities of an HIV-positive patient at an office does not pose a "direct threat" to the attending dentist's health.[36] The appeals court opined that "a service provider . . . can rely upon the direct threat defense only in response to *significant* risks," and distinguished cases upholding discharges of HIV-infected health-care workers on the ground that "*any risk at all* to patients is deemed unacceptable."[37]

In a 5–4 decision, a fragmented Supreme Court affirmed in part,[38] but a unanimous Court vacated and remanded the judgment.[39] Writing for the Court, Justice Kennedy[40] held that asymptomatic HIV is a disability under the ADA, and vacated and remanded on the question whether Bragdon's proffered evidence was sufficient to invoke the "direct threat" provision.[41] Justice Kennedy analyzed the "disability" question under the "actual disability" prong.[42] Justice Kennedy first remarked that the ADA provides at least as much protection as do the Rehabilitation Act[43] and its implementing regulations,[44] which state, inter alia, that disorders affecting the hemic and lymphatic systems are physical impairments.[45] Justice Kennedy reasoned that the disease at every stage constitutes a "physical impairment" because of the imme-

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[32] *Id.* at 943 n.4. Because Bragdon characterized the offer as "gratuitous," the appeals court found it "legally irrelevant" that Bragdon offered to treat Abbott in a hospital and thus left open "whether it is illegal under the ADA for dentists to take additional precautions when treating HIV-infected patients." *Id.*

[33] *Id.* at 944–45.

[34] *Id.* at 945.

[35] *Id.* at 944.

[36] *Id.* at 948.

[37] *Id.* (emphasis added).

[38] *See Bragdon*, 118 S. Ct. at 2213.

[39] *See id.*; *id.* at 2216 (Rehnquist, C.J., concurring in the judgment in part and dissenting in part); *id.* at 2218 (O'Connor, J., concurring in the judgment in part and dissenting in part) It is unclear whether the Chief Justice wanted to vacate and remand, or only to vacate. *See id.* at 2216 (Rehnquist, C.J., concurring in the judgment in part and dissenting in part).

[40] Justices Stevens, Souter, Ginsburg, and Breyer joined Justice Kennedy's opinion.

[41] *See Bragdon*, 118 S. Ct. at 2213.

[42] *See id.* at 2201.

[43] 29 U.S.C. §§ 706, 791, 793, 794a (1994).

[44] *See Bragdon*, 118 S. Ct. at 2202 (quoting 42 U.S.C. § 12201(a)).

[45] *See id.* (quoting 45 C.F.R. § 84.3(j)(2)(i) (1997)).

diate and constant harm it imposes on these systems.[46] Relying on the First Circuit's definition of "major,"[47] Justice Kennedy concluded that reproduction qualifies as an ADA-triggering "major life activity"[48] that the HIV virus substantially limits because of the risk of infection to one's partner and child.[49] Justice Kennedy punctuated his argument by noting that courts and administrative agencies have uniformly held asymptomatic HIV to be a disability under the Rehabilitation Act of 1973, which also used the phrase "major life activity."[50]

Justice Kennedy next addressed the "direct threat" question. In weighing the evidence, the Court held that the views of public health officials possess "special weight and authority" but can be rebutted by "citing a credible scientific basis for deviating from the accepted norm."[51] Justice Kennedy concluded that the court of appeals had erred in its weighing of three key pieces of evidence: the Court rejected the First Circuit's conclusion that compliance with the precautions prescribed by the Centers for Disease Control (CDC) reduced the risk of HIV infection for health-care workers to an acceptable level; impeached the credibility of the 1991 American Dental Association Policy on HIV by terming it a professional organization's pronouncement on ethical duties rather than an objective risk assessment; and expressed concern that some of the information about the safety of in-office treatment of HIV-positive dental patients became available only after the incident at issue.[52] Accordingly, Justice Kennedy concluded that the proper course was to vacate and remand the case to the court of appeals to reconsider this evidence.[53]

Justice Stevens, who joined in Justice Kennedy's opinion, wrote a separate concurrence.[54] Justice Stevens thought it unnecessary to remand because he considered the court of appeals's opinion to be perfectly consistent with the standard set forth in Justice Kennedy's opinion, and because the evidence proffered by Bragdon was insufficient to withstand a motion for summary judgment.[55] Nonetheless, he joined Justice Kennedy's opinion to ensure that there would be a ma-

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46 *Id.* at 2204.

47 *See supra* note 27.

48 *Bragdon*, 118 S. Ct. at 2205. Justice Kennedy admitted that HIV infection might affect other "major life activities," but limited his discussion to reproduction because this was the way in which the issue had been considered by the lower courts and certified for review. *See id.* at 2204–05.

49 *See id.* at 2206.

50 *Id.* at 2207–09 ("[R]epetition of [language from an existing statute] in a new statute indicates, as a general matter, the intent to incorporate its administrative and judicial interpretations as well.").

51 *Id.* at 2211.

52 *See id.* at 2211–12.

53 *See id.* at 2213.

54 Justice Breyer joined in Justice Stevens's opinion.

55 *See Bragdon*, 118 S. Ct. at 2213 (Stevens, J., concurring).

jority for the opinion whose legal reasoning he found most acceptable.[56]

Justice Ginsburg, who joined in Justice Kennedy's opinion, also wrote a separate concurrence. Justice Ginsburg strongly supported the remand, emphasizing the importance of the decision to health-care workers and noting that if the courts are to err on this issue, they should do so "on the side of caution."[57]

Chief Justice Rehnquist concurred in the judgment in part and dissented in part.[58] In his view, reproduction was not a "major life activity" because it was different in kind from the illustrative list of activities in the Rehabilitation Act regulations.[59] The Chief Justice also contested the majority's equation of "major" with "important," conceding that reproduction was "important" to one's life, but noting that "so are decisions" regarding whom "to marry, where to live," and which career to pursue.[60] The Chief Justice asserted that "importance . . . is not the common thread linking the statute's listed activities," but "rather [the thread is] that the activities are repetitively performed and essential in the day-to-day existence of a normally functioning individual."[61] The Chief Justice found that, even assuming that reproduction was a major life activity, HIV did not place a substantial limit on reproduction because individuals infected with HIV are physically "able to engage in sexual intercourse, give birth to a child," and rear a child.[62] In addition, the Chief Justice contended that the ADA requires individualized inquiries and noted that there was no evidence that, absent her infection with HIV, Abbott would have even considered having children.[63]

The Chief Justice then addressed the "direct threat" question. He took issue with the "special weight and authority" accorded to the

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[56] *See id.*

[57] *Id.* at 2214 (Ginsburg, J., concurring).

[58] Justices Scalia and Thomas joined Chief Justice Rehnquist's opinion in full, and Justice O'Connor joined his opinion in part.

[59] *See Bragdon*, 118 S. Ct. at 2215 (Rehnquist, C.J., concurring in the judgment in part and dissenting in part) (listing "caring for one's self, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning, and working" as illustrated activities (quoting 45 C.F.R. § 84.3(j)(2)(ii) (1997)).

[60] *Id.*

[61] *Id.*

[62] *Id.* at 2215–16. In Chief Justice Rehnquist's view, the plaintiff's argument that the mother will not live long enough to see her child to adulthood, "taken to its logical extreme, would render every individual with a genetic marker for some debilitating disease 'disabled' here and now because of some possible future effects." *Id.* at 2216. In a separate opinion, Justice O'Connor indicated that she would have refrained from addressing whether HIV status imposes a substantial limitation on the ability to reproduce and would have avoided discussion of other aspects of intimate relations not raised in the case. *See id.* at 2217–18 (O'Connor, J., concurring in the judgment in part and dissenting in part).

[63] *See id.* at 2214–15 (Rehnquist, C.J., concurring in the judgment in part and dissenting in part).

views of public health authorities and contended that the credentials of the scientists and the soundness of their studies "must stand on their own."[64] Applying this standard, the Chief Justice concluded that Bragdon's introduction of the CDC report documenting seven possible transmissions of HIV to dental workers and forty-two known incidents of transmission to health-care workers was sufficient to withstand summary judgment.[65]

One could criticize the Court for "awkwardly and artificially stretch[ing] the definition of the phrase 'substantially limits one or more of the major life activities' to the limits of credibility"[66] by analyzing the issue under the "actual disability" prong, which may exponentially increase the number of conditions brought under the ADA.[67] The result, however, is consistent with congressional understanding[68] and gives those allegedly discriminated against because of their HIV status their day in court.[69] Moreover, the result would undoubtedly have been the same — indeed broader — if analyzed under the "regarded as" prong of the ADA definition, which protects persons who are perceived as having a disability.[70]

Far more troubling, though, is the *Bragdon* Court's failure to address the different standards used in lower court cases involving HIV-infected patients and in those cases involving HIV-infected health-care providers. Left undisturbed, these cases stand for the proposition that, under the ADA, an HIV-positive patient has the right to be treated by

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64 *Id.* at 2217.

65 *See id.*

66 Elizabeth C. Chambers, *Asymptomatic HIV as a Disability Under the Americans with Disabilities Act*, 73 WASH. L. REV. 403, 419 (1998).

67 Already, lower courts have relied on *Bragdon* to expand the ADA's scope. *See, e.g.*, Erjavac v. Holy Family Health Plus, No. 97C 1107, 1998 WL 400500, at *9–*11 (N.D. Ill. July 13, 1998) (relying on *Bragdon* to conclude that *treated* diabetes is a disability because an individual taking insulin must eat particular foods and must urinate frequently, thereby affecting the "major" activities of eating and waste elimination); Gabriel v. City of Chicago, No. 96 C 7123, 1998 WL 386156, at *5–*8 (N.D. Ill. July 7, 1998) (relying on *Bragdon*'s conclusion that reproduction is a major life activity to conclude that abnormal pregnancy is a disability).

68 *See, e.g.*, 136 CONG. REC. H4623 (daily ed. July 12, 1990) (statement of Rep. Owens) ("[T]he ADA will offer critical protection to people . . . along the full spectrum of HIV infection — *asymptomatic HIV infection*, symptomatic HIV infection or full-blown AIDS. These individuals *are covered under the first prong* of the definition of disability." (emphasis added)); 136 CONG. REC. H2626 (daily ed. May 22, 1990) (statement of Rep. McDermott) ("[I]ndividuals who have . . . *asymptomatic HIV infection . . . are covered under the first prong* of the definition of disability." (emphasis added)).

69 *See, e.g.*, Disanto v. McGraw-Hill, Inc., No. 97-1090, 1998 U.S. Dist. LEXIS 12382, at *10 (S.D.N.Y. Aug. 11, 1998) (post-*Bragdon* case refusing to dismiss claim of employment discrimination against employee with asymptomatic HIV).

70 For a thorough analysis of asymptomatic HIV under the "regarded as" prong, see Chambers, cited above in note 66, at 423, who argues that courts have erred in analyzing the question under the "actual disability" prong because this analysis would exclude those with HIV, such as children, post-menopausal women, and celibate monks, who do not, or cannot, engage in reproduction.

a provider if the risk to the provider is not "significant"; if that provider becomes infected with HIV as a result of providing the treatment, however, the provider's employer is entitled to fire him, even if the risk that he will transmit HIV to patients is *equal to or less than* the "insignificant" risk that he would contract HIV from a patient in the first place.[71] Such an anomalous construction of the ADA is both contrary to the statute's plain language and legislative history, and is logically unsustainable.

At trial, Dr. Bragdon cited a line of cases in which courts have held that firing or reassigning health-care workers infected with HIV does not constitute discrimination under Title I of the ADA or under the comparable standards of section 504 of the Rehabilitation Act of 1973.[72] These cases held that although the actual risk of a patient contracting HIV from a provider may be quite low, the overall risk is unacceptable because the consequences of contracting HIV are so catastrophic.[73] However, the trial court found these cases "inapposite" and asserted that "[t]he health care provider-patient relationship . . . is not symmetrical."[74] In distinguishing these cases, the trial court focused on statements in the opinions that sounded more in medical ethics than in law[75] and for which those courts provided no support.[76] From these unsupported opinions, the trial court drew its own unsupported conclusion that the health-care worker and the patient are not similarly situated because only the health-care worker can control the level of risk by deciding the extent to which he will comply with recommended precautions.[77] The court of appeals did not rely only on this asymmetry-of-control-of-risk-reduction rationale to distinguish the cases, but also on the more remarkable ground that there is no need to

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[71] Indeed, this anomalous result may already have occurred. *See* Doe v. University of Md. Med. Sys. Corp., 50 F.3d 1261, 1262, 1266 (4th Cir. 1995) (upholding the dismissal of a neurosurgery resident who tested positive for HIV after having been stuck with a needle while treating someone who may have been HIV-positive).

[72] *See* Abbott v. Bragdon, 912 F. Supp. 580, 589 (D. Me. 1995). The trial court erroneously referred to these cases as addressing discrimination under Title III of the ADA. *See id.*

[73] *See, e.g.*, *University of Md. Med. Sys. Corp.*, 50 F.3d at 1262, 1266; Mauro v. Borgess Med. Ctr., 886 F. Supp. 1349, 1353–55 (W.D. Mich. 1995), *aff'd sub nom.* Estate of Mauro v. Borgess Med. Ctr., 137 F.3d 398, 398 (6th Cir. 1998) (upholding the dismissal of a surgical technician after hospital officials became aware that he may have been infected with HIV); Doe v. Washington Univ., 780 F. Supp. 628, 633–35 (E.D. Mo. 1991) (upholding a university committee's disenrollment of an HIV-positive dental student).

[74] *Abbott*, 912 F. Supp. at 590.

[75] Indeed, reliance on an assessment of ethical duties rather than on an objective assessment of the risks involved runs contrary to Justice Kennedy's opinion in *Bragdon*. *See Bragdon*, 118 S. Ct. at 2211–12.

[76] *See, e.g.*, *Mauro*, 886 F. Supp. at 1353 (agreeing with the defendant's claim that exposing patients to a risk of acquiring fatal disease is "fundamentally inconsistent" with the mission of patient care); *Washington Univ.*, 780 F. Supp. at 633 ("It is the stated goal of the medical profession to heal, and its secondary axiom, if healing is not possible, is not to harm.").

[77] *See Abbott*, 912 F. Supp. at 590.

determine how high the risk is when the provider is infected with HIV because "*any risk at all* to patients is deemed unacceptable."[78] At oral argument before the Supreme Court, Bragdon's attorney argued that the holdings in these "reverse cases," coupled with the fact "that it's easier to transmit HIV from a patient to a doctor than it is from a doctor to a patient," compelled the conclusion that providers are not required by the ADA to put themselves at risk of contracting HIV.[79] Unfortunately, the Court failed to confront this issue.

The plain language of the statutory provisions suggests that the lower courts' distinction is contrary to congressional intent. Title I of the ADA provides employers with a defense to a charge of discrimination when the employer imposes "a requirement that an individual shall not pose a direct threat to the health or safety of other individuals in the workplace,"[80] with the term "direct threat" defined as "a *significant* risk to the health or safety of others that cannot be eliminated by reasonable accommodation."[81] Title III of the ADA provides that "[nothing] in [Title III] shall require an entity to permit an individual to participate in . . . services . . . of such entity where such individual poses a direct threat to the health or safety of others," with the term "direct threat" defined as "a *significant* risk to the health or safety of others that cannot be eliminated by a modification of policies, practices, or procedures or by the provision of auxiliary aids or services."[82] Thus, both titles provide a defense under the same circumstances — when the risk is *significant* — and neither title indicates that the standard differs in the health-care setting.[83]

In addition to the statute's plain language, the congressional reports and floor debates assuage any doubt that the same standard should be applied in both the employment and public accommodations settings. Congressional reports outlining the provisions of the ADA explain that the "direct threat" provision under Title III "*is identical* to one added in the employment section, and the discussion of this issue there applies here as well."[84] Moreover, nothing in the legislative his-

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[78] Abbott v. Bragdon, 107 F.3d 943, 948 (1st Cir. 1997) (emphasis added).

[79] Transcript of Oral Argument, *Bragdon*, 118 S. Ct. 2196 (1998) (No. 97-156), *available in* 1998 WL 141165, at *52–*53 (Mar. 30, 1998).

[80] 42 U.S.C. § 12113(b) (1994).

[81] *Id.* § 12111(3) (emphasis added).

[82] *Id.* § 12182(b)(3) (emphasis added).

[83] Title I covers virtually all employers with 15 or more employees. *See id.* § 12111(5). Title III specifically includes hospitals and professional offices of health-care providers. *See id.* § 12181(7)(F).

[84] H.R. REP. NO. 101-485 (III), at 62 (1990), *reprinted in* 1990 U.S.C.C.A.N. 445, 485 (emphasis added); *see also* 136 CONG. REC. E1918 (daily ed. June 13, 1990) (statement of Rep. Hoyer) ("This provision is analogous to one added in the employment title.").

tory suggests that the standard is different or asymmetric in the health-care setting.[85]

Maintaining different standards for patient-to-provider transmission and provider-to-patient transmission is also logically unsustainable. For example, if a provider complies with the requirement that he treat an infected patient when there is some risk, albeit not a *legally* "significant" one, he necessarily violates the standard that he must not expose his other patients to *any* risk of contracting HIV from him, because by treating the HIV-infected patient, he clearly exposes himself to *some* risk of contracting HIV.

Using different standards also makes little sense from a policy standpoint. It would be an odd antidiscrimination statute that outlaws discrimination against HIV-infected persons in general, but leaves health-care providers, who put themselves at great personal risk to serve the statutory goal of antidiscrimination, unprotected from employment discrimination should they contract HIV by caring for HIV-infected patients. A cynic might suggest that the reason for this discrepancy is that society "feels good" about treating HIV-infected persons equally under the law, as long as someone else bears the risk. One might question the nobility of America's antidiscrimination goals were this an accurate interpretation of congressional — and societal — intent. The courts ought not assume such an ignoble purpose, particularly when faced with substantial evidence to the contrary. Hopefully, the Court declined to address the "direct threat" standard for HIV-infected health-care providers merely because that issue was not squarely presented to the Court, and will, when directly confronted with that question, extend the *Bragdon* rationale to the employment setting.

Although not addressing the "reverse cases" directly, Justice Ginsburg's brief concurrence may provide the clearest and most sensible standard for lower courts to use in applying the "direct threat" provision. Recognizing both the HIV-infected person's "need . . . to obtain health care" and "the 'importance [of the issue] to health care workers,'" Justice Ginsburg determined that the wisest course would be to remand for a fully informed determination of risk, "*erring, if at all, on the side of caution.*"[86] Under this standard, antidiscrimination would remain the underlying goal, but unresolved scientific questions would appear to be resolved in favor of the uninfected person. Presumably, this same standard would apply whether the infected person was a pa-

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[85] *See, e.g.*, 136 CONG. REC. H5885–86 (daily ed. July 30, 1990) (statement of Rep. Burton) (noting that under the ADA, if an HIV-positive health-care worker is prevented from "taking care of patients' wounds . . . , that hospital or the doctor that moved [the patients] . . . can be held liable, *even though there is definitely a risk*" (emphasis added)).

[86] *Bragdon*, 118 S. Ct. at 2214 (Ginsburg, J., concurring) (second alteration in original) (emphasis added) (quoting *Bragdon*, 118 S. Ct. at 2213).

tient or a provider, and if so, would harmonize *Bragdon* with the "reverse cases."

Moreover, given that "[n]either Congress nor the Supreme Court has informed us what the norm is" in determining whether a given level of risk is significant or not,[87] it is questionable whether it is ever appropriate to grant summary judgment when, as in *Bragdon*, reasonable minds could differ. In *Bragdon*, the Justices differed substantially on whether the risk was significant,[88] but none of them explained what a "significant" risk is, which implies that they only "know it when [they] see it."[89] Without a clear and uniform standard, trial court judges finding no significant risk as a matter of law will undoubtedly be relying more on their own personal perspectives than on articulated legal standards. When, as here, the question can literally be one of life and death, defendants are entitled to the collective perspectives of a jury of their peers rather than the views of a single person — especially if personal perspectives rather than legal standards are being used.

The Court's decision in *Bragdon* ensures that individuals at all stages of HIV infection are protected against discrimination. However, the Court's failure to confront the lower courts' double standard for dealing with HIV infection in the health-care setting leaves the nation in the curious position of having an antidiscrimination statute that declares all individuals with HIV to be equal under the law, but with some "more equal than others."[90]

B. Antitrust

Vertical Maximum Price Fixing. — For several years, courts and commentators have been tolling the death knell of the per se rule against vertical maximum price fixing,[1] which had been in place since the Supreme Court's 1968 decision in *Albrecht v. Herald Co.*[2] Indeed, the Supreme Court itself has been chipping away at this prohibition

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87 Estate of Mauro v. Borgess Med. Ctr., 137 F.3d 398, 410–11 (6th Cir. 1998) (Boggs, J., dissenting).

88 *Compare Bragdon*, 118 S. Ct. at 2213 (Stevens, J., concurring) (finding the risk too insignificant to withstand summary judgment), *with id.* at 2217 (Rehnquist, C.J., concurring in the judgment in part and dissenting in part) ("At a minimum, petitioner's evidence was sufficient to create a triable issue.").

89 Jacobellis v. State of Ohio, 378 U.S. 184, 197 (1964) (Stewart, J., concurring).

90 GEORGE ORWELL, ANIMAL FARM 133 (Signet 1996) (1946) ("ALL ANIMALS ARE EQUAL BUT SOME ANIMALS ARE MORE EQUAL THAN OTHERS").

1 *See, e.g.*, Jack Walters & Sons Corp. v. Morton Bldg., Inc., 737 F.2d 698, 707 (7th Cir. 1984); Frank H. Easterbrook, *Maximum Price Fixing*, 48 U. CHI. L. REV. 886, 890 & n.19 (1981). "Vertical maximum price fixing," or "maximum resale price maintenance," refers to an agreement between actors at different market levels — usually manufacturers or suppliers and distributors or retailers — to fix a price above which the manufacturer's product may not be sold to consumers.

2 390 U.S. 145 (1968).