

Bragdon Versus Abbott: A Dissenting Opinion

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In *Bragdon v Abbott*¹ the Supreme Court addressed the issue of whether individuals who are HIV-infected but asymptomatic are considered “disabled” under the Americans with Disabilities Act (ADA). In a closely watched decision, the Supreme Court held that these HIV-infected patients are disabled within the meaning of the ADA. The American Medical Association, organizations representing disabled individuals, and others have lauded this decision as protecting the rights of patients. Certainly this decision is important because it raises issues about the responsibilities and obligations of health care providers to treat asymptomatic HIV-infected patients. However, the Supreme Court has taken a significant misstep in its efforts to protect patients, and this decision may have detrimental consequences in the current health care delivery climate, which focuses on managing costs rather than on patient care.²

THE AMERICANS WITH DISABILITIES ACT

The ADA is a federal statute that attempts to eliminate discrimination against disabled persons by those individuals who operate places of “public accommodation.”³ However, the critical terms within the statute are specific legal definitions. For example, the term *public accommodation* includes places such as dentist and physician offices.⁴ The term *disabled* is specifically defined and

...[M]eans, with respect to an individual—(A) a physical or mental impairment that substantially limits one or more major life activities; (B) a record of such an impairment; or (C) being regarded as having such an impairment⁵

Furthermore, the term *major life activities* includes “functions such as caring for one’s self, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning, and working.”⁶

Although quite prescriptive, the ADA and its regulations do have some limitations. If a disabled person poses a “direct threat”—ie, “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”—the public accommodation is not required to “permit [such] an individual to participate in or benefit from”

the activities, goods, or services offered.⁷ To determine if an individual poses a direct threat, regulations require that the public accommodation

[M]ake an individualized assessment, based on reasonable judgment that relies on current medical knowledge or on the best available objective evidence, to ascertain: the nature, duration, and severity of the risk; the probability that the potential injury will actually occur; and whether reasonable modifications of policies, practices, or procedures will mitigate the risk⁸

The broad terminology used in the ADA and its regulations has spawned much litigation in an effort to determine exactly what constitutes a disability and a major life activity and what evidence must be provided to assess if the disabled person is a direct threat to health. The case of *Bragdon v Abbott* raises these issues.

THE CASE OF BRAGDON VERSUS ABBOTT

On September 16, 1997, Ms. Sidney Abbott arrived at the office of Dr. Randon Bragdon in Bangor, ME, for a scheduled dental appointment. She was given a patient registration form on which she indicated that she was infected with HIV. At that time, Ms. Abbott was asymptomatic. Dr. Bragdon examined Ms. Abbott and discovered a cavity near her gum line. He indicated to Ms. Abbott that, on the basis of his infectious disease policy, he would not fill her cavity in the office and would only treat her in a hospital setting. He would charge his normal fee; however, she would be responsible for the associated hospital costs.

Ms. Abbott refused Dr. Bragdon’s offer of treatment and subsequently sued him in federal court, claiming that Dr. Bragdon violated the ADA by refusing to treat her in his office. Both the federal district court⁹ and the Court of Appeals for the First Circuit¹⁰ decided in favor of Ms. Abbott. Dr. Bragdon appealed, and the Supreme Court agreed to hear the case.

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The Supreme Court decided in favor of Ms. Abbott and held that asymptomatic HIV infection is a disability under the ADA. The Court indicated that the term *asymptomatic HIV* is not appropriate nomenclature to describe these patients; although these HIV-infected patients are able to live their daily lives in relative normalcy, they still have a variety of medical conditions associated with HIV infection (eg, dermatologic disorders, oral lesions, bacterial infections).

The Supreme Court then indicated that reproduction is a major life activity that is impaired for asymptomatic HIV patients. Reproduction is deemed a major life activity because it cannot be considered "any less important than working and learning." The Court concluded that, as an asymptomatic HIV-positive patient, Ms. Abbott is disabled in terms of reproduction because the risks are substantial that a female sexual partner will infect a male sexual partner during unprotected and protected intercourse as well as infect a child during birth.

In addition, the Supreme Court remanded the case (ie, returned the case to a lower court with instructions on further proceedings) to determine if Dr. Bragdon's claim that treating Ms. Abbott would pose a direct threat to his health and safety was valid for the time at which Ms. Abbott sought his services. The Court emphasized that, although the existence of a significant risk in the context of the direct threat defense is determined from the perspective of the health care professional who refuses to treat the patient, the determination must be based on medical or other objective, scientific evidence available to the health care provider and profession at the time, not upon the good faith belief of the health care provider that a significant threat existed for the particular patient. Thus, guidelines such as those issued by the Centers for Disease Control and Prevention are key to assessing whether objective, scientific evidence supports the health care provider's decision.

POLICY CONSIDERATIONS

Bragdon v Abbott highlights the difficulties of health care providers who provide care to individuals who have an incurable, infectious disease. The medical, dental, and managed care communities as well as AIDS rights groups and organizations representing disabled individuals will note the significance of this case and its progeny.

Because the Supreme Court held that asymptomatic HIV infection confers "disabled" status upon asymptomatic HIV-infected persons on the basis of reproduction as a major life activity, all providers and managed care organizations must closely assess and adjust their practice policies and standards. A health care provider's poli-

cies and standards must adhere to objective public health and scientific pronouncements regarding the types of care that safely can, and therefore must, be provided in these specific settings.

Adherence to these standards may be beneficial for certain patients and may relieve them from a potentially high degree of variability in medical treatment that is based on anecdote rather than data. A significant concern, however, is that the drive toward minimizing costs will make public health and scientific pronouncements the ceiling rather than the floor (ie, the highest standard available rather than the basis for developing better standards) for precautions used to diagnose and treat asymptomatic HIV-infected patients. The justification will be that additional precautions will violate the ADA.

In addition, other patient care issues are affected. Under this Supreme Court decision, health care providers may believe that their individual autonomy to judge the most effective method of treating their patients is being eroded by a judiciary that does not understand how medical practice works. This decision could spur health care providers to concentrate more on following the perceived terms of the ADA rather than placing the individual needs of each patient first. The Supreme Court's decision appears to eliminate the physicians' and other medical providers' ability to render care using their own knowledge of their own capacities as well as the individual patient's responses to diagnosis and treatment. Clearly, the Court contemplates that population data and conclusions thereof should be applied rigidly to individual patients. However, this use of such information is highly questionable.^{11,12} For example, if an individual patient is highly sensitive to pain and reacts strongly or if an individual provider is not experienced in treating infectious patients, then the provider would appear to have an ethical duty to account for these factors in the treatment plan in order to provide the best possible care for the patient. The treatment plan may thus require additional precautions or adjustments that accommodate these individual patient and provider concerns. Under the Supreme Court's decision, however, these adjustments may be in violation of the ADA and subject the provider to potential legal sanctions.

Finally, there are unique and important considerations in this debate and the medical arena that do not apply in other ADA cases: Will the patient's health care needs be optimally fulfilled by forcing a reluctant health care provider to treat? Will the patient's needs be fulfilled by creating a patient-physician relationship that is not based upon trust? The Supreme Court must strike a delicate balance between the rights of asymptomatic HIV-infected patients and the good faith judgment of

the health care professionals who will be caring for these patients. A provider who refuses to treat a patient for unfounded, prejudicial reasons, although morally reprehensible, is simply not the best provider to treat that particular patient. However, a provider who, in good faith, refuses to treat the patient under population-based conditions because the provider does not deem these conditions appropriately safe or effective for the individual patient should not be broadly categorized in the same manner. Unfortunately, the Supreme Court has not made this essential distinction.

CONCLUSION

Bragdon v Abbott has indicated that asymptomatic HIV-infected patients are included in the purview of the ADA. Thus, health care providers cannot require additional precautions or adjustments in the care of these patients unless supported by population-based studies and public health pronouncements. This conclusion is a shortsighted view of how medical care should be deliv-

ered in the United States and drives a deeper wedge between the individual health care provider and the patient.

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