DEPARTMENT OF HEALTH AND HUMAN SERVICES

Departmental Appeals Board

In the Matter of:	
Westchester County Medical Center,	DATE: April 20, 1992
Respondent.	Docket No. 91-504-2 Decision No. 191

DECISION

The United States Department of Health and Human Services (the Department) charged Respondent, Westchester County Medical Center (Respondent), with violating Section 504 of the Rehabilitation Act of 1973 (Act), 29 U.S.C. § 794(a), and its implementing regulations, 45 C.F.R. Part 84. The Department seeks as a remedy termination of all federal financial assistance to Respondent.

Respondent timely requested a hearing. Prior to the hearing, Lambda Legal Defense and Education Fund, Inc. (Lambda) requested to participate in the case as amicus curiae. Respondent opposed the request. I granted Lambda's request, but limited its participation in the case to suggesting questions for me to ask at the hearing and to submitting posthearing briefs and proposed findings of fact and conclusions of law. 45 C.F.R. § 81.22(b).

I held a hearing in New York, New York, from August 5 - 12, 1991. The parties and Lambda timely complied with the posthearing briefing schedule which I established.

I have carefully considered the applicable law, the evidence adduced at the hearing, and the posthearing briefs and proposed findings and conclusions submitted by the parties and Lambda. I conclude that Respondent has engaged and continues to engage in unlawful discrimination. I order that federal financial assistance to Respondent be terminated until such time as Respondent satisfies the Department that it is in compliance with the Act.

ISSUES

The issues in this case are whether:

1. Respondent is engaging in unlawful discrimination in violation of section 504 of the Act; and

2. Whether all federal financial assistance to Respondent must be terminated until such time as Respondent satisfies the Department that it is in compliance with section 504 of the Act.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

As a convenience to the parties, I have organized the following Findings of Fact and Conclusions of Law (Findings) by subject headings. The headings are not Findings and they do not alter the meaning of my Findings.

A. The complaining party, John Doe

1. The complaining party, John Doe (Doe), is a graduate of the Johns Hopkins University (B.A. in Natural Sciences) and the University of Rhode Island (B.S. in Pharmacy) and is a licensed pharmacist who is registered to practice pharmacy in the State of New York. DHHS Ex. 1/40, /412.[1]

2. Doe is infected with the Human Immune Deficiency Virus (HIV). DHHS Ex. 1/132; I define HIV in Finding 61.

B. Respondent, Westchester County Medical Center

3. Respondent is a hospital and medical care center that annually treats over 22,000 inpatients and 100,000 outpatients and provides about 212,000 days of patient care. Tr. at 23, 910, 1298.

4. Respondent is a tertiary and acute care medical center serving a seven-county area of New York State known as the mid-Hudson Valley Region. Tr. at 910, 1299.

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[1] I refer to the Department's exhibits as "DHHS Ex. (number)/(page)." I refer to Respondent's exhibits as "R. Ex. (number)/(page)." I refer to the transcript as "Tr. at (page)."

5. A tertiary care institution is an institution which provides technologically advanced medical care which could not be provided at a smaller community facility. Tr. at 910 - 911.

6. Respondent has approximately 655 acute care and specialty beds and 400 extended care beds. Tr. at 1298.

7. Respondent serves a general medical and surgical population. Respondent has an open-heart surgery center; it provides organ transplant services; and it operates a comprehensive cancer care center, a pediatric intensive and critical care unit, a regional neonatal unit, a hemodialysis unit, and a Level I trauma center. Tr. at 910 - 911, 1300 - 1302.

8. Approximately 60 percent of Respondent's patients receive items or services which are reimbursed by either Medicare or Medicaid. Tr. at 24.

9. Respondent's annual budget is $252 million. Respondent receives about $107 million annually, or more than 40 percent of its total budget, from federal funds. Tr. at 24, 1299.

C. Respondent's pharmacy operations and the duties of pharmacists employed by Respondent

10. Respondent maintains a pharmacy department, which is divided into a main pharmacy and six satellite pharmacies. DHHS Ex. 7/906 - 908; Tr. at 919 - 924.

11. Respondent's satellite pharmacies are located both in Respondent's main hospital building and in other buildings which are part of Respondent's operations. DHHS Ex. 7/906 - 908; Tr. at 919 - 924.

12. Respondent's main pharmacy operates twenty-four hours a day, seven days a week; the satellite pharmacies operate on varying schedules. DHHS Ex. 7/908 - 909; Tr. at 928.

13. Respondent's pharmacies are open 365 days a year. Tr. at 928.

14. Respondent does not permit patients access to satellite pharmacies. DHHS Ex. 9/1154.

15. Respondent's main pharmacy is involved in the entire range of pharmacy activities provided by Respondent, including the preparation of parenteral products and bulk intravenous (IV) supplies. Tr. at 919.

16. "Parenteral products" are those pharmaceutical products that are administered to a patient by injection. Tr. at 154.

17. Respondent's satellite pharmacies include pharmacies that serve oncology patients, bone marrow transplant patients, renal transplant patients, general medical and surgical patients, and pediatric patients. Tr. at 921.

18. Respondent's oncology and pediatric satellite pharmacies are located directly adjacent to patient care facilities. Tr. at 922 - 923.

19. Respondent also maintains a psychiatric care satellite pharmacy which is located in a building separate from Respondent's main facility. Tr. at 923.

20. Respondent also maintains satellite pharmacies in its nursing home operation and correctional health facility. Tr. at 921.

21. Respondent employs 40 pharmacists, including supervisors. Tr. at 918.

22. The duties of all pharmacists employed by Respondent, including supervisors, include preparation of pharmaceutical products. DHHS Ex. 27; Tr. at 918.

23. Pharmacists who work for Respondent may be required to work at either Respondent's main pharmacy or at any of Respondent's satellite pharmacies. Tr. at 926.

24. A few pharmacists who work for Respondent have agreed to accept permanent work assignments in a specific area in Respondent's facilities. Tr. at 927.

25. Most of the pharmacists who work for Respondent are trained to work in every area of Respondent's pharmacy operations and are rotated regularly through all of Respondent's pharmacies. Tr. at 927.

26. Respondent's pharmacists are assigned to work one of three shifts: eight a.m. to four p.m., four p.m. to midnight, and midnight to eight a.m. DHHS Ex. 7/909; Tr. at 927.

27. Respondent assigns only one pharmacist to work on the midnight to eight a.m. shift. DHHS Ex. 7/909 - 910; Tr. at 928.

28. The duties of a hospital pharmacist at Respondent's facilities include reviewing physicians' orders to

identify potential errors in dosages, drug interactions, or allergies. DHHS Ex. 27; Tr. at 925.

29. The duties of a hospital pharmacist at Respondent's facilities include preparation of pharmaceutical products to be dispensed to patients. DHHS Ex. 27; Tr. at 918, 926.

30. Pharmacists who work for Respondent on the midnight to eight a.m. shift routinely are asked to fill prescriptions for parenteral products. Tr. at 928.

31. It would be difficult for Respondent to employ a pharmacist who is unable to fill prescriptions for parenteral products on the midnight to eight a.m. shift, because preparation of such products is a part of the duties of the pharmacist who is assigned to that shift. Tr. at 929.

32. Respondent could not employ a pharmacist who is unable to fill prescriptions for parenteral products on the midnight to eight a.m. shift without also employing another pharmacist on that shift who is capable of filling such prescriptions. Tr. at 929.

33. Preparation of parenteral products by pharmacists employed by Respondent involves the use of needles and syringes to transfer substances from one container to another. R. Ex. 145; R. Ex. 145A; R. Ex. 145B; Tr. at 1054.

34. The process of preparing parenteral products by pharmacists employed by Respondent involves the use of various sizes of needles ranging from comparatively large 18-gauge needles to comparatively small 25-gauge needles. R. Ex. 145; R. Ex. 145A; R. Ex. 145B; Tr. at 940 - 941, 1054, 1056.

35. In the course of preparing parenteral products, pharmacists employed by Respondent will insert needles through protective barriers and draw substances into syringes. R. Ex. 145; R. Ex. 145A; R. Ex. 145B; Tr. at 1054.

36. In the course of preparing parenteral products, pharmacists employed by Respondent will insert needles attached to syringes containing substances through protective barriers, into containers, and inject the contents of the syringes into those containers. R. Ex. 145; R. Ex. 145A; R. Ex. 145B; Tr. at 1057.

37. The process of preparing parenteral products at Respondent's pharmacies may include repetitive use of needles and syringes to transfer substances from one container to another. R. Ex. 145; R. Ex. 145A; R. Ex. 145B; Tr. at 1061 - 1062.

38. Parenteral products prepared at Respondent's pharmacies consists of a range of products, including nutritional substances and oncology drugs. Tr. at 926.

39. Preparation of parenteral products at Respondent's pharmacies sometimes, but not always, involves the wearing of gloves by pharmacists who prepare the parenteral products. Tr. at 943 - 944.

40. Some oncology drugs contain toxic substances, and pharmacists who prepare these drugs take precautions against coming into contact with them, including wearing gloves during preparation of the drugs. Tr. at 944.

D. Aseptic preparation of parenteral products

41. An objective ascribed to by pharmacists in preparing parenteral products is that the products be free of all living organisms and pyrogens, which are usually bacterial toxins capable of causing a fever. DHHS Ex. 71/4 - 5; DHHS Ex. 71A; Tr. at 744 - 745.

42. An objective also ascribed to by pharmacists in preparing parenteral products is that the products be relatively free of particles. DHHS Ex. 71/4; DHHS Ex. 71A.

43. Pharmacists employ aseptic technique in the preparation of parenteral products to assure that these products are free of living organisms and pyrogens and are relatively free of particles. DHHS Ex. 71/5; 71A; Tr. at 744 - 745.

44. "Aseptic technique" means the technique of preparing parenteral products without introducing contaminants. Tr. at 722.

45. Proper aseptic technique involves the use of laminar flow hoods to prevent contamination of parenteral products by airborne contaminants. DHHS Ex. 71/7 - 12; DHHS Ex. 71A.

46. If used properly, laminar flow hoods remove nearly all airborne contaminants from an environment. DHHS Ex. 71/12; DHHS Ex. 71A.

47. Proper hand washing by pharmacists to remove bacterial contaminants from the skin is an element of aseptic technique in preparing parenteral products. DHHS Ex. 71/12 - 13; DHHS Ex. 71A.

48. Aseptic technique also involves properly using syringes and needles. DHHS 71/13; DHHS Ex. 71A.

49. To maintain sterility of a syringe, a pharmacist should not touch the syringe tip or plunger. DHHS Ex. 71/14; DHHS Ex. 71A.

50. To maintain sterility of a needle, a pharmacist should not touch any part of the needle. DHHS Ex. 71/15; DHHS Ex. 71A.

51. Aseptic technique also involves proper handling of vials and ampules. DHHS Ex. 71/15 - 19; DHHS Ex. 71A.

52. Injectable medications are usually supplied in vials or ampules, each requiring different techniques for withdrawal of medication. DHHS Ex. 71/15; DHHS Ex. 71A.

53. A vial is a glass container with a rubber stopper secured by an aluminum band. The rubber stopper is usually protected by a flip-top cap or aluminum cover. DHHS Ex. 71/15 - 17; DHHS Ex. 71A.

54. In order to assure the sterility of the rubber stopper on a vial used in the preparation of a parenteral product, the pharmacist must spray or swab the vial with isopropyl alcohol. DHHS Ex. 71/17; DHHS Ex. 71A.

55. Ampules must be properly handled by pharmacists to avoid contamination of the products which they contain. DHHS Ex. 71/18 - 19; DHHS Ex. 71A.

56. Pharmacists employed by Respondent utilize aseptic technique in their preparation of parenteral products. R. Ex. 35; Tr. at 934, 939, 1082; See Tr. at 1102, 1104 - 1105, 1114, 1126.

57. It is possible for a pharmacist to inadvertently stick himself or herself with a needle while preparing parenteral products. Tr. at 936.

58. In order to comply with aseptic technique, a pharmacist who inadvertently touches a needle or sticks himself or herself with a needle should immediately discard the needle, the syringe to which the needle is attached, and any product which he or she might have contaminated as a result of having touched the needle or

having stuck himself or herself. Tr. at 208, 782 - 783, 939.

E. AIDS, its cause, the ways in which it may be transmitted, and the risk of contagion

59. Acquired Immune Deficiency Syndrome (AIDS) is a spectrum of diseases which reflects severe immunosuppression caused by HIV. DHHS Ex. 2/527; Tr. at 44.

60. Infection by HIV produces a wide spectrum of consequences, with AIDS representing the severe end of that spectrum. Tr. at 45.

61. HIV is a retrovirus that destroys T-4 lymphocytes, a type of white cell, and causes a suppression of the normal immune system. Tr. at 45, 143.

62. Persons infected with HIV may develop opportunistic infections during the course of their disease as a result of the weakening of their immune systems by HIV. Tr. at 104.

63. Opportunistic infections which are developed by people infected with HIV usually are caused by organisms which are latent within these persons' bodies and not by organisms which they acquire through exposure to external sources of infection. Tr. at 104 - 107.

64. Tuberculosis is one of the opportunistic infections which people infected with HIV sometimes manifest. Tr. at 106 - 107.

65. There is no credible evidence to show that a person infected with HIV is more likely to acquire tuberculosis from an external source than is an individual who is not infected with HIV. Tr. at 108.

66. There are presently between 800,000 and one million individuals in the United States who are infected with HIV. Tr. at 46.

67. It cannot be predicted reliably how long it will take for any individual who is infected with HIV to develop AIDS; however, the average length of time from infection to development of AIDS is ten years. Tr. at 144.

68. There is at least a 95 percent probability that an individual who is infected with HIV will eventually

develop AIDS and will die from the effects of the disease. Tr. at 255, 418.

69. There are three known ways by which HIV may be transmitted between individuals. They are:

a. parenterally, by the introduction of HIV into the bloodstream of an uninfected person by transfusion or the sharing of contaminated intravenous injection equipment (syringes and needles);

b. through sexual contact; and

c. perinatally, from mother to fetus.

DHHS Ex. 2/519; DHHS Ex. 3/580; DHHS Ex. 45/1125; Tr. at 45 - 46.

70. HIV has not been shown to be transmissible through close personal contact which does not involve any of the established methods of transmission. DHHS Ex. 2/521; DHHS EX. 5/731 - 736; DHHS Ex. 44; DHHS Ex. 4s/1132; DHHS Ex. 174; Tr. at 402.

71. HIV has not been shown to be transmissible through the sharing of implements which may bear traces of blood, such as toothbrushes and eating utensils. DHHS Ex. 44/103, Table 2; DHHS Ex. 174/641, Table 3; Tr. at 403.

72. There exist documented episodes in which health care workers have acquired HIV infection parenterally through injuries from needles or other instruments which are contaminated with blood containing HIV. Tr. at 68.

73. The likelihood of a health care worker acquiring HIV infection after having been injured by a needle or other instrument which is contaminated with blood containing HIV is between .3 and .5 percent. Tr. at 68, 191, 422.

74. Whether or not an individual acquires HIV infection after having been injured by a needle or other instrument which is contaminated with blood containing HIV depends on variable factors which include the volume of blood injected during the course of the in;ury, and the amount of HIV present in that blood. Tr. at 192 - 193.

75. Studies have not been performed to determine how long HIV would survive if added to parenteral products. Tr. at 202, 204, 1718; Tr. at 1606.

F. Accepted precautions to prevent transmission of HIV from health care workers to patients

76. The Centers for Disease Control (CDC), located in Atlanta, Georgia, is an agency of the Department of Health and Human Services whose responsibilities include publishing guidelines and recommendations to be used by health care providers and facilities in preventing the transmission of disease. See DHHS Ex. 87.

77. CDC has published universal precautions for prevention of transmission of HIV in health-care settings. DHHS Ex. 87; DHHS Ex. 201.

78. "Universal precautions" means precautions which are recommended to be employed at all times by health care providers who come into contact with blood and or blood products. Tr. at 48, 344.

79. CDC's conclusions as to the risks of HIV transmission by health care workers are credibly based on the evidence available to it and on the analysis of experts in disease transmission. DHHS Ex. 201; Tr. at 54 - 56.

80. Where health care providers follow universal precautions, and do not perform invasive procedures, there is no risk that they will transmit HIV to patients. DHHS Ex. 201; Tr. at 58.

81. Universal precautions for the prevention of HIV transmission by health care workers includes sterilizing equipment that enters patients' vascular systems or contacts patients' mucous membranes before use. DHHS Ex. 201.

82. "Invasive procedures" means procedures which cause a high degree of trauma to a patient which could provide a portal for entry of a virus into the patient's body. "Invasive procedures" includes surgery, repair of major traumatic injuries, and dental procedures. Tr. at 57 - 58.

83. Intramuscular injections, adding to intravenous solutions, or withdrawing blood from patients are not invasive procedures. Tr. at 64.

G. Risks of transmission of HIV or opportunistic infections by hospital pharmacists to patients in the performance of their duties

84. Hospital pharmacists do not perform invasive procedures in the course of their duties. Findings 33 - 40; Tr. at 65 - 66.

85. Preparation of pharmaceutical products by pharmacists is not an invasive procedure because it does not involve intrusion into a patient's body cavity. Tr. at 66.

86. There has never been a reported case of transmission of HIV to a patient by a pharmacist. Tr. at 71 - 72, 384, 785, 1133 - 1134.

87. It is extremely unlikely that a pharmacist could transmit HIV to a patient in the course of the performance of his or her duties, because pharmacists are not involved in direct patient care, including putting their hands into patients' body cavities. Tr. at 72.

88. The Hepatitis B virus (HBV) is analogous to HIV in the manner in which it infects individuals. Tr. at 56.

89. HBV is more easily transmissible from an infected to a non-infected individual than is HIV. Tr. at 67.

90. The chances of an individual acquiring HBV from an injury involving an HBV-contaminated instrument are approximately ten times greater than the chances of an individual acquiring HIV from an injury involving an HIV-contaminated instrument. Tr. at 67 - 68.

91. The likelihood that an HIV-infected health care worker would transmit HIV in the course of the performance of his or her duties can be inferred from studies which examine the incidence of transmission of HBV from infected health care workers. DHHS Ex. 201; Tr. at 67 - 68.

92. No incidence of transmission of HBV by a pharmacist to a patient in the course of the performance of the pharmacist's duties has ever been documented. Tr. at 72.

93. The risk for transmission of HIV from an infected health care worker to a patient associated even with exposure-prone invasive procedures is so small as not to be measurable. Tr. at 456.

94. An "exposure-prone invasive procedure" is an invasive procedure involving manipulation of a sharp instrument by a health care worker within a patient's body under circumstances where it is difficult for the health care worker to see what he or she is doing. Tr. at 63.

95. It is not possible to infer from studies concerning the risks of communication of HIV through the performance of invasive procedures, that similar risks are posed by preparation of pharmaceutical products, because pharmacists do not perform invasive procedures. Finding 87.

96. It is not beyond possibility that an HIV-infected pharmacist could contaminate a parenteral product with his or her blood and thereby transmit HIV to a patient. Tr. at 96.

97. In order for a patient to be infected with HIV acquired from a parenteral product contaminated by an HIV-infected pharmacist: (a) the pharmacist must breach aseptic technique, and (b) the HIV which contaminates the parenteral product must survive within that product long enough to infect the patient. Tr. at 97, 240 - 241; See Finding 75.

98. In order for a pharmacist to breach aseptic technique and contaminate a parenteral product with his or her own blood he or she would either have to disregard deliberately the product's contamination, or he or she would have to contaminate the product unknowingly. Finding 58.

99. Although it is possible, it is extremely unlikely that a pharmacist could, in the course of preparing a parenteral product, stick himself or herself with a needle sufficiently to draw blood and not be aware of that act. DHHS Ex. 16/1909; See Tr. at 781, 783, 938 - 939.

100. It is not possible to conclude that HIV would survive in a parenteral product long enough to infect a patient who is injected with that product, because no studies have been made to determine whether HIV can survive in parenteral products. Finding 75.

101. The possibility that a patient could acquire HIV from a parenteral product that has been contaminated by an HIV-infected pharmacist is so small as not to be measurable. Tr. at 240 - 243, 395, 406, 787 - 788; Findings 92 - 97.

102. The evidence does not establish that health care workers, including pharmacists, who suffer from opportunistic infections pose a measurable risk to communicate those infections to immunosuppressed patients. Tr. at 506.

H. Respondent's treatment of Doe's application for employment as a pharmacist

103. Doe applied for employment with Respondent as a pharmacist in 1983 and in 1985. DHHS Ex. 1/54, /58, /60; DHHS Ex. 21; DHHS Ex. 22; DHHS Ex. 7/917 - 918.

104. Doe's experience and education met Respondent's employment criteria for pharmacists. DHHS Ex. 27; Finding 1.

105. In the fall of 1986, Doe was contacted on behalf of Respondent and was advised that positions were opening in Respondent's pharmacy department. DHHS Ex. 1/67; DHHS Ex. 7/918.

106. Respondent's representative asked Doe if he was interested in becoming employed as a pharmacist for Respondent. DHHS Ex. 1/67.

107. On October 7, 1986, Doe filled out another application for employment with Respondent as a pharmacist. DHHS Ex. 1/72 - 73; DHHS Ex. 24.

108. On October 7, 1986, Doe met with Respondent's representatives to discuss the possibility of his becoming employed as a pharmacist by Respondent. DHHS Ex. 1/75 - 76; DHHS Ex. 7/918.

109. Doe and Respondent's representatives discussed Doe beginning work as a pharmacist at Respondent's main pharmacy and eventually performing assignments which included rotating among Respondent's satellite pharmacies. DHHS Ex. 1/77 - 78, /93, /173.

110. The job duties discussed between Doe and Respondent's representatives encompassed the entire scope of pharmacy practice at Respondent's facilities. DHHS Ex. 1/98.

111. Respondent's representatives advised Doe that the pharmacist job available to him involved working the shift which commenced at midnight and ended at eight a.m. DHHS Ex. 1/79; DHHS Ex. 7/919.

112. The midnight to eight a.m. shift included a five percent pay differential as additional compensation. DHHS Ex. 1/52, /175 - 176, /306 - 307; DHHS Ex. 25; Tr. at 1143.

113. Respondent's representatives advised Doe that they expected that, if Respondent hired him, his employment would commence in the middle of November 1986. DHHS Ex. 1/89.

114. At the end of the October 7, 1986 meeting, a representative of Respondent told Doe that there was no reason why she could not offer him a job as a pharmacist at Respondent's facility. DHHS Ex. 1/91.

115. Doe resigned his position with another employer in anticipation of being hired by Respondent. DHHS Ex. 1/49, /223 - 224.

116. On or about December 8, 1986, an employee of Respondent called Doe to advise him that the start date of his employment with Respondent would be December 15, 1986. DHHS Ex. 1/105 - 106, /179.

117. Doe was requested to schedule a pre-employment physical examination with Respondent's personnel office. DHHS Ex. 1/106 - 115, /179.

118. On December 10, 1986, Doe received a pre-employment physical examination at Respondent's facilities. DHHS Ex. 1/119, /145 - 146; DHHS Ex. 7/923.

119. The physician who examined Doe detected an enlarged cervical lymph gland, and expressed some concern about it. DHHS Ex. 1/145 - 146.

120. Before leaving Respondent's facility on December 10, 1986, Doe met again with the physician who had examined him. DHHS Ex. 1/155.

121. The physician told Doe that, based on medical records concerning Doe, which had been obtained from Respondent's files, the physician concluded that Doe suffered from Aids-Related Complex (ARC) and that he would not permit a pharmacist with ARC to begin employment with Respondent. DHHS Ex. 1/160, /168; DHHS Ex. 8/1024, /1033.

122. ARC is a term used to describe the condition of people who are infected with HIV and who manifest some of the signs and symptoms of AIDS but who do not manifest all of the signs and symptoms of AIDS. DHHS Ex. 5/716.

123. As of December 1986, Doe's personal physician had not diagnosed Doe to be suffering from either ARC or AIDS. DHHS Ex. 1/220; DHHS Ex. 38.

124. An HIV seropositive status coupled with enlarged lymph nodes does not support a diagnosis of ARC in the absence of other clinical signs or symptoms. DHHS Ex. 5/717 - 718.

125. After the physical examination, Doe called Respondent's representative to advise her that problems had arisen at his physical examination and that he had not been approved to begin employment with Respondent the following Monday. DHHS Ex. 1/202 - 203; DHHS Ex. 7/923 - 924.

126. Respondent's representative advised Doe that she would assess the situation and call Doe back. DHHS Ex. 1/203.

127. Respondent's representative did not call Doe back to report on her findings. DHHS Ex. 1/203.

128. In late December 1986, Doe advised a physician employed by Respondent that he had filed a complaint with the New York State Division of Human Rights charging employment discrimination. DHHS Ex. 1/189, /191 - 192.

129. In February 1987, Respondent's attorney told the New York State Division of Human Rights that, for medical reasons which Respondent considered to be compelling, Respondent declined to hire Doe for the position of hospital pharmacist. DHHS Ex. 37/1, /3; DHHS Ex. 101.

130. In November 1987, Respondent offered Doe employment as a pharmacist, subject to restrictions. DHHS Ex. 54/1; Tr. at 1336.

131. Respondent offered to employ Doe as a pharmacist, but restricted his work location to one of Respondent's satellite pharmacies. DHHS Ex. 54/1; Tr. at 1336.

132. Respondent's employment offer to Doe would have precluded him from preparing intravenous and hyperalimentation material. DHHS Ex. 54/1; Tr. at 1336.

133. Respondent's employment offer to Doe effectively would have precluded him from working on the night shift because pharmacists who work on the night shift are required to prepare intravenous products. Tr. at 1100; Findings 30 - 32.

134. Doe rejected this offer because it would have restricted him to a satellite pharmacy and would have denied him the opportunity to perform the full range of pharmacy practice. DHHS Ex. 1/392 - 394.

135. Respondent offered Doe restricted employment as a pharmacist at Respondent's facilities. Findings 130 - 133.

136. Respondent offered Doe restricted employment as a pharmacist at Respondent's facilities because of Doe's HIV-seropositive status and Respondent's perception that Doe exhibited signs and symptoms of ARC. Findings 119 - 124, 129.

137. In offering Doe restricted employment as a pharmacist at Respondent's facilities, Respondent's expressed concern was that Doe might, in the course of unrestricted performance of his duties: (a) transmit HIV to a patient at Respondent's facilities through contamination of a parenteral product with his own blood or other body fluid; (b) transmit an infectious disease other than HIV to an immunocompromised patient through direct contact with that patient; or (c) acquire an infectious disease other than HIV from a patient through direct contact with that patient. DHHS Ex. 14/1728; Tr. at 22.

138. The restrictions which Respondent proposes to place on Doe's duties as a pharmacist would deprive Doe of the opportunity to perform the full range of pharmacists' duties at Respondent's facilities. Findings 22 - 40.

139. The restrictions which Respondent proposes to place on Doe's duties as a pharmacist would deprive Doe of the opportunity for advancement to a supervisory position in Respondent's pharmacy operations. Findings 22 - 40.

140. The restrictions which Respondent proposes to place on Doe's duties as a pharmacist would deprive Doe of the opportunity to earn differential pay for work performed on the midnight to eight a.m. shift. Findings 27, 30 - 32, 112.

I. Procedural history of this case

141. On April 16, 1987, a complaint was filed on Doe's behalf with the Department's Office of Civil Rights (OCR), alleging that Respondent had discriminated against Doe on the basis of a handicap. DHHS Ex. 95.

142. Respondent answered the complaint by providing OCR with a copy of its February 9, 1987 letter to the New York State Division of Human Rights. DHHS Ex. 37/3; DHHS Ex. 101/3; Finding 129.

143. On March 23, 1990, OCR notified Respondent by a Letter of Findings that OCR had concluded that Respondent had unlawfully failed to hire Doe on the basis of a handicap. DHHS Ex. 136; Tr. at 644 - 647.

144. OCR advised Respondent that the corrective action it considered to be necessary to resolve Respondent's alleged violation consisted of: an offer to hire Doe as a hospital pharmacist at Respondent's main pharmacy with no restriction on either his duties or his opportunity to transfer to another pharmacy position on the same basis as any other pharmacist and compensation for lost wages. DHHS Ex. 136.

145. Respondent did not agree to engage in the corrective action which OCR stated to be necessary. DHHS Ex. 137 - 139; Finding 144.

146. On December 20, 1990, the Department commenced this action by filing an administrative complaint against Respondent. Respondent timely requested a hearing.

J. Conclusions of fact and law

147. This case is governed by section 504 of the Rehabilitation Act of 1973, 29 U.S.C. § 794(a) (Act), by related legislation, and by regulations contained in 45 C.F.R. Parts 81 and 84.

148. It is unlawful under section 504 of the Act for a program or activity receiving federal financial assistance to discriminate against an otherwise qualified individual with a handicap, solely on the basis of his or her handicap. 29 U.S.C. § 794(a).

149. Respondent is a recipient of federal funds within the meaning of the Act. Findings 8 - 9; 29 U.S.C. § 794(a).

150. Doe's HIV infection affects his hemic and lymphatic systems and is a physical impairment within the meaning of the Act. Findings 2, 59 - 68; 29 U.S.C. § 706(8)(B); 45 C.F.R. § 84.3(j)(2)(i).

151. Doe's HIV infection substantially impairs his ability to perform major life activities consisting of

procreation and sexual contact. Findings 59 - 68; 29 U.S.C. § 706(b); 45 C.F.R. § 84.3(j)(2)(ii).

152. Respondent's records classify Doe as being infected with HIV. Finding 121.

153. Doe is classified as having an impairment which substantially limits his performance of work and major life activities. Findings 152; 29 U.S.C. § 706(8)(B); 45 C.F.R. § 84.3(j)(2)(ii).

154. Respondent treated Doe's HIV infection as substantially limiting Doe's ability to perform work. Findings 121, 129, 135 - 140.

155. Respondent regarded Doe as having an impairment which substantially limits his performance of work and major life activities. Finding 154; 29 U.S.C. § 706(8)(B); 45 C.F.R. § 84.3(j)(2)(iii).

156. Doe's performance of the full range of duties of hospital pharmacist at Respondent would not, by reason of his infection with HIV, constitute a direct threat to the health or safety of other individuals. Findings 11 - 58, 62 - 75, 79 - 102; 29 U.S.C.A. § 706(8)(D) (West 1991).

157. Doe's performance of the full range of duties of hospital pharmacist at Respondent would not, by reason of his infection with HIV, pose a significant risk for the communication of HIV to employees or patients at Respondent. Finding 156.

158. Doe is an "individual with handicaps" within the meaning of section 504 of the Act. Findings 150 - 157; 29 U.S.C. § 706(8)(B); 29 U.S.C.A. § 706(8)(D) (West Supp. 1991); 45 C.F.R. § 84.3(j).

159. In denying Doe the opportunity to perform the full range of duties of hospital pharmacist, Respondent discriminated against Doe within the meaning of section 504 of the Act. Findings 121, 129 - 135, 138 - 140; 29 U.S.C. § 794(a).

160. In denying Doe the opportunity to perform the full range of duties of hospital pharmacist, Respondent discriminated against Doe solely by reason of Doe's handicap within the meaning of section 504 of the Act. Findings 121, 129, 136 - 140; 29 U.S.C. § 794(a).

161. The Department has been unable to secure Respondent's voluntary compliance with the terms of the Act. Findings 141 - 145; 42 U.S.C. § 2000d-1.

162. Respondent's discrimination against Doe is not limited to his case, but is part of a policy to discriminate against HIV-infected employees in the terms and conditions of their employment by Respondent. Tr. at 1093 - 1094, 1396 - 1399.

163. All programs at Respondent that are funded with federal financial assistance are affected by Respondent's policy of discriminating against HIV-infected employees. Finding 162.

164. All federal financial assistance to Respondent must be terminated until it complies with all applicable requirements of section 504 of the Act. 29 U.S.C. § 794(a); 42 U.S.C. § 2000d-1; 45 C.F.R. § 80.8(c); 45 C.F.R. § 84.3(h).

ANALYSIS

The question which lies at the heart of this case is whether Respondent may lawfully restrict the duties of a pharmacist who is infected with HIV by precluding him from preparing parenteral products (products which are injected into patients) or from coming into direct contact with patients whose immune systems are compromised. Respondent contends that the consequences of HIV infection are so horrible -- consisting of near-certain development of AIDS and, eventually, death -- that it may impose legitimately what it deems to be minimal job restrictions in order to avert even a remote possibility that the pharmacist may inadvertently infect Respondent's patients. The Department contends that, in this case, fear and superstition must give way to a rule of reason. It asserts that the chances of inadvertent communication of HIV by a hospital-based pharmacist in the performance of his or her duties are so minuscule as to be insignificant under the law. It argues that the employment restrictions imposed by Respondent are not minimal, and that, given the absence of meaningful risk of communication of HIV, the restrictions constitute unlawful discrimination by Respondent.

1. Background

The complainant, Doe, is a registered pharmacist who is licensed to practice in the State of New York. He possesses the training and credentials required by Respondent of pharmacists whom it employs. Doe is infected with HIV. There is no evidence that Doe has AIDS or any of the opportunistic infections that are associated with the disease.

Respondent is a major hospital located in one of New York City's suburbs. It receives substantial federal assistance both in the form of Medicare and Medicaid reimbursement. It treats a variety of patients, including cancer and surgical patients. It operates a main pharmacy and several satellite pharmacies in its facilities. These pharmacies are open 24 hours a day, 365 days a year, and provide products which are administered to Respondent's patients. Respondent's pharmacists do not directly treat patients, although their duties sometimes bring them into contact with patients.

The items provided by Respondent's pharmacies include parenteral products. The parenteral products which Respondent's pharmacists prepare consist of a variety of substances, including drugs used in the treatment of cancer, and nutritional products. Preparation of parenteral products by Respondent's pharmacists involves their use of needles and syringes to transfer substances between containers. Parenteral products are usually prepared in the main or satellite pharmacies. They are then transported to patients where they are administered by nurses or other hospital personnel.

Each of the 40 pharmacists employed by Respondent is trained to perform all of the duties which Respondent's pharmacists routinely perform, and this includes preparing parenteral products. Respondent's supervisory pharmacists also prepare items for consumption by patients, including parenteral products. Parenteral products are prepared on Respondent's midnight to eight a.m. shift, and on the other shifts, as well. Any pharmacist who is assigned to work the midnight to eight a.m. shift for Respondent must be capable of preparing parenteral products, inasmuch as Respondent assigns only one pharmacist to work that shift.

In October 1986, Respondent's representatives verbally offered to hire Doe as a pharmacist. In discussing the job, Doe and Respondent's representatives contemplated that Doe would be performing the full range of duties assigned to pharmacists who work for Respondent. Respondent's representatives were unaware that Doe was infected with HIV when they interviewed him for the job of pharmacist. Respondent's offer of employment was conditioned on Doe passing a pre-employment physical

examination.[2] At that examination, the examining physician learned that Doe was infected with HIV.[3]

Doe never received a formal notification from Respondent, either to report to work or that his application for employment had been rejected. In February 1987, Respondent's attorney advised the New York State Division of Human Rights that Respondent declined to hire Doe for medical reasons which it considered to be compelling. Finding 129. In November 1987, after Doe had filed complaints charging Respondent with unlawful discrimination, Respondent offered Doe a position as a pharmacist. Finding 130. However, the offer restricted Doe's employment to one of Respondent's satellite pharmacies. Finding 131. It precluded Doe from preparing parenteral products. Respondent has never subsequently offered to hire Doe without these restrictions on his duties. Finding 132.

Section 504 of the Act provides that:

> No otherwise qualified individual with handicaps . . . shall, solely by reason of her or 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 . . . .

29 U.S.C. § 794(a).

There is no dispute that Respondent is a recipient of federal financial assistance within the meaning of the Act. The dispute in this case centers around the issues of whether Doe is an "otherwise qualified individual with handicaps" who is therefore eligible for the protection under the Act, and, assuming Doe meets the Act's

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[2] The Department has not alleged that Respondent unlawfully utilized pre-employment physical examinations to discriminate against handicapped persons.

[3] Doe was a patient at Respondent's Infectious Disease Clinic, and his HIV-positive status was recorded in the clinic's records. The examining physician had access to these records. Doe has charged Respondent with unlawful use of the clinic records. DHHS Ex. 5/763, /781 - 782; DHHS Ex. 14/1749. The lawfulness of Respondent's use of Doe's medical records is not an issue in this case, and I make no finding as to whether Respondent made unlawful use of these records.

definition of an "otherwise qualified individual with handicaps," whether Respondent is discriminating against Doe solely by reason of his handicap.

The Department argues that Doe is a handicapped individual who is legally protected against employment discrimination. The Department contends that, in denying Doe unrestricted employment, Respondent is unlawfully discriminating against him based on his handicap. Respondent argues that Doe is not a handicapped individual within the meaning of the Act. It premises its contention in part on its assertion that Doe's infectious status presents a direct threat for communication of HIV in the course of unrestricted employment as a pharmacist. Respondent contends that it is lawfully balancing Doe's right to employment without discrimination against its own patients' rights to be free from the risk that Doe might, in the course of the unrestricted performance of a pharmacist's duties, infect them with HIV.[4] Respondent also argues that whatever restrictions it would place on Doe's employment are minimal and do not rise to the level of acts constituting discrimination under the Act.

2. Doe is an "individual with handicaps."

A central issue in this case is whether Doe is an "individual with handicaps" as is defined by the Act. The Department must satisfy two statutory tests to prove that Doe is an "individual with handicaps." First, the Department must prove that Doe is an "individual with handicaps" under any one of the Act's three general definitions of that term. Second, the Department must also prove that Doe meets the Act's special definition of an "individual with handicaps" which applies to an individual whose impairment consists of a currently contagious disease or infection. In order to prove that Doe is handicapped under the special definition, the Department must prove that Doe does not pose a direct

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[4] Respondent also argues that Doe never completed his pre-employment physical examination. Therefore, according to Respondent, Doe's employment application never reached a stage where Respondent either could offer or deny Doe employment. However, Respondent does not deny that it would impose restrictions on Doe's employment based on his infection with HIV and those restrictions would, at a minimum, consist of barring Doe from preparing parenteral products and performing work which involved direct contact with patients. Tr. at 22, 24.

threat to communicate a disease to other individuals by performing the unrestricted duties of a pharmacist at Respondent's facilities.

I find that the Department proved that Doe meets each of the three general definitions of an "individual with handicaps." Doe has an impairment which substantially limits one or more of his major life activities. He has a record of such an impairment. He is regarded as being impaired.

I also find that the Department proved that Doe meets the special definition of an "individual with handicaps" applicable to a person with a contagious disease or infection. The Department proved that Doe would not be a direct threat to communicate infectious diseases to other individuals in performing the unrestricted duties of a pharmacist at Respondent's facilities.

a. Doe is an "individual with handicaps" within the meaning of the Act's general definition of that term.

The Act generally defines an "individual with handicaps" to be a 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 impairment, or (iii) is regarded as having such an impairment.

29 U.S.C. § 706(8)(B). This definition has been incorporated in the Department's implementing regulations. 45 C.F.R. § 84.3(j)(1). The three definitions of an "individual with handicaps" are alternative definitions. An individual need only satisfy one of the three to meet the statutory test.

There is no dispute that Doe's HIV infection is a "physical impairment." Regulations define a "physical impairment" as "any physiological disorder or condition affecting one or more of the body systems, such as 'hemic' and 'lymphatic.'" 45 C.F.R. § 84.3(j)(2)(i). HIV is a virus which infects a person's immune system -- including that individual's hemic and lymphatic systems -- producing an impairment which leads to immunosuppression and opportunistic infections. Findings 59 - 68.

The parties vigorously contest whether Doe's physical impairment meets any of the three general definitions of a handicapping impairment. The Department asserts that

Doe meets all three of the definitions (although Doe needs only to satisfy one of them to meet the statutory test). Respondent contends that the Department has failed to meet its burden to prove that Doe meets any of the three definitions of an "individual with handicaps."

(1) Doe's HIV infection substantially limits one or more of his major life activities.

The parties disagree whether Doe's HIV infection substantially limits one or more of his major life activities. I find that, even though Doe's HIV infection is asymptomatic, his infection substantially limits his ability to engage in normal social relationships and procreation. These activities are "major life activities" within the meaning of the Act and its enabling regulations. Therefore, Doe is an "individual with handicaps."

The applicable regulation defines "major life activities" to include functions such as caring for one's self, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning, and working. 45 C.F.R. § 84.3(j)(2)(ii). The regulation's use of the phrase "such as" to preface the list of major life activities whose limitation would establish the presence of a handicap evinces the Secretary's intent to provide examples of such activities. Other activities which are of a character similar to those listed in the regulation also qualify as "major life activities."

The Department avers that asymptomatic infection with HIV substantially limits a person's major life activities, thereby satisfying the test. The Department argues that Doe's HIV infection, even though presently asymptomatic, limits him in performing major life activities such as socializing and procreation.

Respondent argues that the Department did not prove that Doe is substantially limited by his HIV infection. Therefore, according to Respondent, the Department did not prove that Doe has a handicapping impairment. Respondent argues that, under both the Act and its implementing regulation, a "major life activity" must relate to an individual's capacity to perform work in order to qualify as an activity whose limitation would demonstrate a handicap. Thus, according to Respondent, it is irrelevant that Doe's HIV infection might inhibit his social interactions, his sexual activity, or procreation.

Congress could logically have passed an Act, and the Secretary could have adopted enabling regulations, which specified that limitations that qualify an individual as handicapped must relate to that individual's ability to perform basic work activities. However, the phrase "major life activities" plainly subsumes a broader range of activities than activities which relate solely to work. Furthermore, courts and the Justice Department have interpreted broadly the definition of an "individual with handicaps" in cases involving individuals who are infected with HIV.

The question of whether asymptomatic HIV infection substantially limits an individual and is therefore a handicap within the meaning of the Act and regulations has not been resolved definitively by the courts. However, although this question has not been finally decided, the preponderant opinion is that even asymptomatic infection with HIV imposes substantial limitations on an infected individual's major life activities, thereby qualifying that person as an "individual with handicaps."

The Supreme Court has held that a person who is infected with a contagious illness may be handicapped within the meaning of the Act. School Bd. of Nassau County v. Arline, 480 U.S. 273, reh'g denied, 481 U.S. 1024 (1987) (Arline). However, the Supreme Court has not decided whether the presence of an asymptomatic infection would establish an individual to be handicapped. Id. at 281 n.6. In Arline, the discharged employee suffered from tuberculosis which left her with diminished physical capacities. Id. The Supreme Court decided that this individual was substantially limited by her infection, and was, therefore, handicapped. The Supreme Court explicitly declined to address the question of whether an asymptomatic infected individual might also be found to be substantially limited, and therefore, handicapped.

Several courts have accepted the premise that asymptomatic HIV infection is a handicapping impairment. Severino v. N. Fort Myers Fire Control Dist., 935 F.2d 1179, 1182 n.4 (11th Cir. 1991); Leckelt v. Bd. of Comm'rs of Hosp. Dist. No. 1, 714 F. Supp. 1377, 1385 n.4 (E.D. La. 1989), aff'd, 909 F.2d 820 (5th Cir. 1990); Glanz v. Vernick, 756 F. Supp. 632 (D. Mass. 1991). However, in these cases, the issue of whether asymptomatic HIV infection is a handicapping impairment was either not contested by the parties or the courts reached their conclusions based on facts which would have established that the aggrieved parties manifested reduced physical capacities as the consequence of their

infections. One lower federal court has concluded that HIV infection in and of itself substantially limits an individual within the meaning of the statutory definition. Thomas v. Atascadero Unified School Dist., 662 F. Supp. 376 (C.D. Cal. 1987) (Thomas). In Thomas, the court held that even asymptomatic HIV infection embodies abnormalities which make procreation and childbirth dangerous to infected individuals and to others. Id. at 379. The court found that such limitations are substantial limitations on major life activities within the meaning of the Act. Id. No court has concluded that asymptomatic infection with HIV would not establish substantial limitations on an individual's major life activities.

The United States Department of Justice has concluded that asymptomatic HIV infection substantially limits an infected individual's major life activities, thereby meeting the statutory definition of a handicapping impairment. Memorandum from Douglas W. Kmiec, Acting Assistant Attorney General, Office of the Legal Counsel, to Arthur B. Culvahouse, Jr., Counsel to the President, Fair Empl. Prac. Manual (BNA) No. 641, at 405:4, 405:6 - 7 (September 27, 1988) (Justice Department Opinion). The Justice Department Opinion concluded that, perhaps the most important major life activities affected by asymptomatic HIV infection are procreation and intimate personal relationships. Id.[5]

I am persuaded that Doe's ability to engage in major life activities is substantially limited by his HIV infection and that, therefore, he meets the Act's definition of a handicapped individual. Sexual contact and procreation are major life activities. One of the medically recognized ways in which HIV is transmitted is through sexual activities. Finding 69. An individual who is

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[5] The Justice Department Opinion concluded that:

> Because of the infection in their system[s] . . . [HIV infected individuals] will be unable to fulfill this basic human desire . . . [to have children]. There is little doubt that procreation is a major life activity and that the physical ability to engage in normal procreation -- procreation free from the fear of what the infection will do to one's child -- is substantially limited once an individual is infected with the AIDS virus.

Justice Department Opinion at 405:7.

infected with HIV and who is aware of the presence of infection would know that unprotected sex and procreation cannot be engaged in without the possibility that the infection would be communicated. That would pose a substantial inhibition on any responsible person from engaging in those activities.

(2) Doe has a record of having an impairment which substantially limits one or more of his major life activities.

The Department contends that Doe has a record of having an impairment which substantially limits one or more of his major life activities. It cites to the fact that Respondent's own files record Doe's status as an HIV-infected individual.

Respondent acknowledges that its files record Doe as being infected with HIV. It asserts that its record of Doe's status does not amount to a "record" of a handicapping condition, because its records do not reflect any substantial limitation of Doe's major life activities. Respondent's Reply Brief at 13.

The Department need not prove that Respondent's records state that Doe is substantially limited in a major life activity. The statutory test does not require that a record of a person's condition affirmatively state that the person is substantially limited in the performance of a major life activity in order to qualify as a "record" of a handicapping condition within the meaning of the Act. The Act's definition of a handicapping condition is satisfied where an individual is recorded as having an impairment, and where the impairment of record is one which meets the statutory test of a handicapping condition. 29 U.S.C. § 706(8)(B)(ii). The test is met here, because infection with HIV is a handicapping condition within the meaning of the Act, and because Doe has a record of being infected with HIV.[6]

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[6] The test would also be met if Doe were not infected with HIV, but if Doe had a record of being infected with HIV. Subparts (ii) and (iii) of 29 U.S.C. § 706(8)(B) were enacted to deal with circumstances where individuals were perceived by others as being handicapped. .

(3) Doe is regarded as having an impairment which substantially limits one or more of his basic life activities.

Even if Doe does not satisfy either of the first two general tests for an "individual with handicaps," he nevertheless satisfies the third test. Respondent regards Doe as having an impairment which substantially limits his ability to engage in work, a major life activity. 29 U.S.C. § 706(8)(B)(iii); 45 C.F.R. § 84.3(j)(2)(ii).

The third general test for an individual with handicaps does not require a party to prove that he has a handicapping impairment. All that must be shown is that others regard that individual as having such an impairment. In this case, Respondent concluded that Doe's HIV infection precluded him from engaging in significant work activities. Respondent's assumptions about Doe's condition prove that Respondent regards Doe as handicapped.

Respondent contends that it does not regard Doe as having an impairment which substantially limits his performance of a major life activity. Respondent avers that it views Doe's HIV infection merely as grounds for modifying his duties as a pharmacist so as to preclude his assignment to two out of a range of twenty-five tasks performed by pharmacists who are employed by Respondent. It characterizes these restrictions as minimal. Therefore, according to Respondent, the restrictions do not rise to a level of significance sufficient to prove that it considers Doe to be handicapped.

Respondent also argues that the Department must prove that Doe is generally perceived by employers to be handicapped. It is not sufficient, according to Respondent, for the Department to prove only that Respondent perceives Doe as handicapped. It asserts that the Department has not shown that Doe is generally considered to be limited by his impairment. It contends that the Department has not proven that Doe is incapable of finding work elsewhere. Therefore, according to Respondent, whatever limitations it may have perceived that Doe manifests do not arise to a general perception that Doe is handicapped.

I find that Respondent proposes to place major, not minor, restrictions on Doe's duties as a pharmacist. Respondent would deny Doe the opportunity to perform tasks which are central to the pharmacist's job by barring him from preparing parenteral products and by

limiting the location of his work to one of Respondent's satellite pharmacies. Respondent would deny Doe any meaningful opportunity for career advancement while employed by Respondent. The limitations Respondent would place on Doe's duties would affect his employability elsewhere. The restrictions which Respondent would impose demonstrate how profoundly limited Respondent considers Doe to be.

The preparation of parenteral products at Respondent's pharmacies is not merely one of many job duties performed by pharmacists. It is, in fact, a major element of the job of pharmacist.[7] All of Respondent's 40 pharmacists, including supervisors, are trained in the preparation of parenteral products. Evidence offered by Respondent showed that the preparation of parenteral products at its pharmacies is a complex, technically involved, and time consuming process. R. Ex. 145; R. Ex. 145A; R. Ex. 145B. Any pharmacist employed by Respondent on its midnight to

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[7] Respondent avers that Doe characterized the preparation of parenteral products at Respondent's pharmacies to be a "minor" part of the job of pharmacist. Respondent's Reply Brief at 12; See DHHS Ex. 1/400. Doe did not testify in the hearing which I conducted. The cited reference is from Doe's testimony in a hearing before the New York State Division of Human Rights. Close reading of the transcript establishes that Doe did not characterize preparation of parenteral products to be a minor element of the job of pharmacist. He testified that he considered preparation of IV admixture and hyperalimentation (some of the many parenteral products prepared at Respondent's pharmacies) to be a minor part of the duties performed on the midnight to eight a.m. shift at Respondent's pharmacies. His characterization of those duties on that shift as "minor" was made in the context of the following testimony:

> I don't consider myself a second class pharmacist who should be limited in scope of his pharmacy practice. I would like to be able to make IV preparation and hyper[a]l[i]mentation. I do not want to be set aside as low man on some satellite pharmacy, which would not be a choice of mine.

DHHS Ex. 1/400.

eight a.m. shift must be capable of preparing parenteral products.[8]

Respondent's intent to limit Doe's work site to one of its satellite pharmacies would deny Doe the opportunity to perform the broad range of assignments generally performed by pharmacists employed by Respondent. Pharmacists who work in Respondent's pharmacies ordinarily are not limited in their assignments to a particular satellite pharmacy. Respondent's pharmacists generally rotate among Respondent's main and satellite pharmacies. In the course of their varied assignments, they are exposed to a broad spectrum of pharmacy operations, ranging from preparation of psychiatric medications to oncology medications.

The restrictions which Respondent would impose on Doe therefore would preclude him from engaging in tasks which are central to the duties of a pharmacist at Respondent. The intended restrictions prove that Respondent considers Doe to be incapable of performing such central tasks. I cannot envision Doe having any meaningful opportunity for career advancement at Respondent if he is restricted as Respondent intends. Doe would be precluded from attaining a supervisor's job if he is precluded from performing basic tasks or if Respondent's main pharmacy is off limits to him. Furthermore, the restrictions would affect Doe's ability to advance to supervisory jobs at other facilities, because Doe would be unable to demonstrate to those facilities that he had acquired the broad range of experience at Respondent that a hospital pharmacist would normally acquire.

Respondent cites several judicial decisions involving the Act or analogous State statutes to support its contention that it did not perceive Doe to be handicapped. These

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[8] Respondent's proposed restriction of Doe's duties as a pharmacist would preclude Doe from working on the midnight to eight a.m. shift, because it is necessary for the pharmacist who works that shift to be able to prepare parenteral products. Findings 30 - 32. Thus, while preparation of parenteral products on the midnight to eight a.m. shift may be a "minor" part of a pharmacist's duties on that shift, it is nevertheless a necessary duty. Doe would suffer a measurable pecuniary loss as a result of being prohibited from preparing parenteral products, inasmuch as pharmacists assigned by Respondent to work the midnight to eight a.m. shift receive a five percent addition to their regular pay. Findings 112, 133.

decisions are distinguishable from the present case. Unlike this case, the cases cited by Respondent all involve individuals whose impairments were neither significantly limiting nor which were perceived as being significantly limiting.

In Jasany v. U.S. Postal Serv., 755 F.2d 1244 (6th Cir. 1985) (Jasany), an employee with a mild visual impairment (slightly crossed eyes) was discharged by his employer because he refused to operate a mail sorting machine which he had been hired to operate. The court noted that, prior to his employment, the individual had never contended that his condition limited him, nor had he manifested any limitations resulting from his condition. The court found the employee's impairment to be only a minor limitation, not rising to the level of a handicap under the Act. It found that the fact that the employee might be incapable of performing a very limited task, operating a particular piece of machinery, was not proof of a substantial limitation of his ability to work.

In de la Torres v. Bolger, 710 F. Supp. 593, aff'd, 781 F.2d 1134 (5th Cir. 1986) (de la Torres), the plaintiff argued that his left-handedness limited his ability to work as a probationary mail carrier. The district court found that, while plaintiff's ability to do a particular job might be affected by his condition, his ability to perform work in general was not affected. Therefore, his condition was not a substantial limitation on a major life activity within the meaning of the Act.

In Miller v. AT & T Network Systems, 722 F. Supp. 633 (D. Or. 1989), aff'd, 915 F.2d 1404 (9th Cir. 1990) (Miller), a telephone installer claimed that his employer had discriminated against him due to its failure to accommodate his inability to perform work in temperatures exceeding 90 degrees. The plaintiff made his claim pursuant to an Oregon statute which is similar to the Act. The district court held that plaintiff was not handicapped within the meaning of the statute. While plaintiff may have shown that his condition interfered with his ability to perform one particular job with one particular employer, he did not prove that his condition significantly decreased his ability to obtain satisfactory employment as a telephone installer with another employer. Id. at 639 - 640.

The impairments which the plaintiffs had in Jasany, de la Torres, and Miller (mildly crossed eyes, left-handedness, intolerance to high temperatures, respectively) may have limited these individuals, but they limited them in the performance of a narrow spectrum of duties that were

uniquely related to particular jobs with particular employers. The courts found that the Act's broad protections should not extend to individuals whose conditions limited them minimally. By contrast, Respondent does not regard Doe's condition as imposing only minimal limitations on the performance of a narrow range of duties. That is obvious from the basic restrictions it proposes to impose on him. They constitute a fundamental limitation on the performance of a pharmacist's duties at Respondent's facilities.

The Jasany, de la Torres, and Miller decisions state that, as an element of proving the presence of a handicapping condition, an individual must prove that the condition affects his or her ability to find work in general and not just to perform the specific task or job which is at issue. Respondent relies on this aspect of these decisions to assert that the Department must show that, not only did Respondent perceive Doe to be handicapped, but other employers would share that perception. Under Respondent's analysis, restrictions which Respondent might impose on Doe are irrelevant as evidence that Doe is perceived as being handicapped unless the Department can prove that all employers would restrict Doe similarly.

Respondent would have me apply Jasany, de la Torres, and Miller in a way which would emasculate the Act. Respondent's advocated test would enable any employer who engages in discrimination against a handicapped individual to dodge liability by asserting that the individual might be employed by other employers who did not discriminate against that individual. It amounts to a license for a particular employer to discriminate against an individual based on either that individual's actual limitations or the employer's perceptions of those limitations. I do not read the cases cited by Respondent to require proof that all employers would perceive an individual to be limited significantly by an impairment as a prerequisite to proving the presence of a handicapping condition. The Act is plainly written to protect individuals from discrimination by individual employers. An individual will establish that he is perceived as being handicapped if he proves that an allegedly discriminating employer perceives him to be substantially limited.

It makes sense to require an individual alleging discrimination under the Act to show more than that he or she manifests some minimal limitation which would disqualify the individual from performing a unique or highly specialized job with a particular employer. The

plaintiffs in Jasany, de la Torres, and Miller proved only that they were disqualified by their impairments from performing highly specialized work. This evidence did not amount to proof either that the plaintiffs were substantially limited or that their employers perceived them to be substantially limited. Under those circumstances, the courts logically asked whether these plaintiffs would be limited generally by their impairments.

The facts of this case are very different. Here, Respondent perceives Doe to be substantially limited. Its perception of Doe's impairment answers the question of whether Doe is perceived to be substantially limited. There is no need in this case to consider how Doe's impairment might be treated by other employers in other contexts. Thus, the decisions relied on by Respondent do not suggest that, where an employer treats an impairment as being significantly limiting -- as is the case here -- that the aggrieved individual would have to prove that all employers would react similarly.

b. Doe is an "individual with handicaps" within the meaning of the Act's test for individuals who are infected with contagious diseases.

The Civil Rights Restoration Act of 1987, Pub. L. No. 100-259 (1988) qualified the Act's definition of an "individual with handicaps" by adding that, for purposes of employment, that term:

> does not include an individual who has a currently contagious disease or infection and who, by reason of such disease or infection, would constitute a direct threat to the health or safety of other individuals or who, by reason of the currently contagious disease or infection, is unable to perform the duties of the job.

29 U.S.C.A. § 706(8)(D) (West Supp. 1991). This amendment to the Act creates a second part of the definition of an "individual with handicaps" applicable to those individuals who have currently contagious diseases or infections.

The Department therefore must prove that Doe neither constitutes a direct threat to the health or safety of other individuals, nor, because of his infection, is unable to perform the duties of pharmacist in Respondent's facilities. I find that the Department met its burden.

In its posthearing briefs, the Department seemed to contend at times that Respondent bore the burden of proving that Doe is not a direct threat to others and that Doe's infection does not preclude him from performing the duties of pharmacist. See Department's Post Hearing Memorandum at 30. Respondent argued that the Department had the burden of proof on this issue. Respondent's Reply Brief at 16 - 17. I agree with Respondent that the Department has the burden of proving a prima facie case that Doe is not excepted from the definition of an "individual with handicaps" by virtue of his HIV infection. The 1988 amendment to the Act was an amendment to the Act's definition of an "individual with handicaps." The burden of proving that an aggrieved individual meets the Act's definition of an individual who is protected by the Act lies with the party charging discrimination. Pushkin v. Regents of Univ. of Colorado, 658 F.2d 1372, 1387 (10th Cir. 1981).

However, the Department's burden of proof does not require it to disprove every scenario that an employer might invent to describe ways in which an infected individual might transmit a disease. An aggrieved party establishes a prima facie case that he or she is not a "direct threat" to communicate a disease by offering credible evidence that he or she is will not communicate that disease in the course of performing the duties of a particular job. That shifts the burden to the employer to rebut that evidence.

As I shall discuss infra, the Department offered credible proof in this case that Doe is not a "direct threat" to communicate HIV or other infections during the performance of the job duties of a pharmacist at Respondent's facilities. That evidence consisted of the expert opinions of physicians who are charged with public health responsibilities. That evidence shifted the burden of proof to Respondent. Respondent sought to reply with its own expert testimony to support a scenario showing how Doe might infect patients during the performance of his duties as a pharmacist. Respondent had the burden of proving that scenario in order to rebut the Department's prima facie case.

(1) The "significant risk" test in Arline is synonymous with the "direct threat" test of the Act.

Congress did not define the term "direct threat." However, it is reasonable to conclude that Congress intended that language to incorporate as part of the Act's definition of an "individual with handicaps" the qualifying factors which the Supreme Court recognized in

Arline as applying to individuals with contagious diseases who sought protection under the Act. Justice Department Opinion at 405:10 - 405:12.[9]

The Arline case involved a school teacher who had been dismissed from her duties after suffering recurrent bouts of tuberculosis. The issue before the Supreme Court in Arline was whether an individual who was infected with a contagious illness met the Act's definition of an "individual with handicaps." The Supreme Court held that a contagious illness could be a handicap within the meaning of the Act. Id. at 289. However, it held that a handicapping condition consisting of a contagious illness did not give an individual an unqualified right to employment.

> A person who poses a significant risk of communicating an infectious disease to others in the workplace will not be otherwise qualified for his or her job if reasonable accommodation will not eliminate that risk.

Id. at 287 n.16. The Supreme Court concluded that the determination of whether an individual who was infected with a contagious illness posed a "significant risk" to others in the workplace which could not be eliminated by reasonable accommodation should focus on four factors, consisting of:

> (a) the nature of the risk (how the disease is transmitted), (b) the duration of the risk (how long is the carrier infectious), (c) the severity of the risk (what is the potential harm to third parties) and (d) the probabilities the disease will be transmitted and will cause varying degrees of harm.

Id. at 288 (citing Brief for American Medical Association as amicus curiae at 19). The Supreme Court held further

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[9] As the Justice Department Opinion notes, the amendment to the definition of an "individual with handicaps" was a floor amendment. Therefore, there are no committee reports containing legislative history which might clarify Congress' purpose in enacting the amendment. However, statements by sponsors of the amendment, during the floor debate on the legislation of which the amendment is a part, suggest a legislative intent to codify the holding of Arline. See 134 Cong. Rec. 383 - 384 (1988). Statements by other members of Congress support this view. Id. at 2937, 3043.

that "[i]n making these findings, courts normally should defer to the reasonable medical judgments of public health officials." Id. Finally, the Supreme Court found that the determination should include findings whether an employer could reasonably accommodate an individual who is infected with a contagious illness. Id.

As I find above, in adopting the "direct threat" test for individuals with contagious diseases, Congress has incorporated the "significant risk" standard of Arline into the definition of an "individual with handicaps." For purposes of analysis, the "significant risk" standard is synonymous with the "direct threat" amendment to the definition of "individual with handicaps." An individual claiming that he or she is handicapped by virtue of a contagious illness therefore makes a prima facie case that he or she is not a "direct threat" to the health or safety of other individuals by proving that he or she does not constitute a "significant risk" for the spread of contagion.

One apparent difference between the Supreme Court's approach in Arline and Congress' approach in the 1988 amendment is that the Supreme Court considered the "significant risk" standard to be an application of the "otherwise qualified" requirement of the Act, whereas Congress incorporated the standard into the definition of an "individual with handicaps." There is no practical consequence to these different approaches. Whether the Arline standard is part of the definition of an "individual with handicaps" or an application of the term "otherwise qualified," there nevertheless remains a requirement that the individual claiming the Act's protection must show that he or she meets the criteria which would entitle him or her to that protection. Therefore, although I treat the "significant risk" issue as part of the issue of whether Doe is an "individual with handicaps," my analysis of the evidence and the parties' respective burdens would not change if I had analyzed the "significant risk" issue in terms of whether Doe is "otherwise qualified" under the Act.

Both the Department and Respondent offered expert testimony addressing the factors identified by the Supreme Court in Arline. The expert witnesses who testified on behalf of the Department -- Drs. Guinan and Henderson -- are not only medical experts, but are

charged with public health responsibilities.[10] I find their testimony to be credible and authoritative. I rely on their testimony in making my findings concerning the Arline factors.[11]

I have also considered the testimony of Respondent's principal medical expert, Dr. Peter W.A. Mansell. Dr. Mansell is a physician in private practice in Houston, Texas.[12] There was remarkably little difference of opinion in the testimony of Drs. Guinan, Henderson, and Mansell on certain key points. All three physicians agreed generally as to the consequences of HIV infection, the mechanisms by which HIV is transmitted, and the likelihood of transmission through accidental contact with infected body fluids. On close analysis, Drs. Guinan, Henderson, and Mansell did not even disagree meaningfully as to the probability that Doe might transmit his HIV infection to patients during the course

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[10] Dr. Mary Guinan is the Special Assistant for Evaluation for the Deputy Director of HIV at the Centers for Disease Control, Atlanta, Georgia. Dr. David K. Henderson is the Associate Director for Quality Assurance in Hospital Epidemiology at the Clinical Center at the National Institutes of Health, Bethesda, Maryland.

[11] That is not to say that I gave uncritical deference to these experts' testimony. I find that it was both credible and buttressed by the foundation evidence on which these experts relied and to which they cited in their testimony.

[12] In Arline, the Supreme Court noted that:

> This case does not present, and we do not address, the question whether courts should also defer to the reasonable medical judgments of private physicians on which an employer has relied.

Id. at 288 n.18. Dr. Mansell is a "private physician" whose testimony I admitted and have considered as relevant to the issues in this case. I give greater weight to the testimony of Drs. Guinan and Henderson than to that of Dr. Mansell not simply because Drs. Guinan and Henderson are public health officials and Dr. Mansell is a private physician, but because, on balance, I find Drs. Guinan's and Henderson's testimony to be more authoritative. My conclusion is based on the three physicians' backgrounds and experience, and on their answers to questions posed by counsel for the parties.

of performing his duties as a pharmacist, including the preparation of parenteral products.

Where these experts disagreed was on the public health implications of the evidence. Drs. Guinan and Henderson expressed the opinion that, where there was no meaningful risk that an infected health care worker could transmit HIV to a patient, there was no need to place restrictions on the health care worker's duties. Dr. Mansell asserted that any possibility, no matter how slight, that an infected health care worker might transmit HIV in the performance of his or her duties justified restrictions being placed on the health care worker's performance of his or her duties.

(2) The risk posed by Doe's HIV infection AIDS is caused by infection with HIV, a communicable virus.

HIV is a virus which infects cells which are part of the human immune system. Infection with HIV compromises the immune system and almost invariably results in the disease known as AIDS. The disease process generally is slow. An HIV-infected individual may remain asymptomatic for years. There presently are between 800,000 and one million individuals in this country who are infected with HIV.

AIDS is a disease which inevitably is fatal. There are medications which may hold in abeyance some of the disease's effects, but there is no cure for AIDS. AIDS is characterized by infections which arise by virtue of the infected individuals' compromised immune systems. The infections which typify AIDS usually are caused by organisms which are normally present in individuals but which remain latent. However, in HIV-infected individuals, such organisms within their systems are capable of becoming active and of causing debilitating and eventually fatal infections, because these individuals' immune systems eventually become weakened and thus unable to hold the organisms in check.

There are three known ways in which an individual may become infected with HIV. First, an individual may become infected through sexual contact with an infected individual. Second, an individual may become infected through parenteral transmission of HIV, that is, through the transmission of HIV-infected blood or body fluids into the individual's bloodstream. Finally, an unborn child may become infected with HIV directly from the blood of his or her mother. There is no evidence that HIV may be communicated by casual contact, such as

touching or sharing of household items like toothbrushes or eating utensils.

This case involves the issue of whether Doe might inadvertently transmit HIV to patients of Respondent through parenteral infection. Respondent does not contend that Doe poses a threat to transmit HIV in any other way. Thus, a very broad conclusion as to the nature of the risk posed by Doe's potential employment by Respondent is that he might somehow inadvertently transmit HIV by parenteral means to Respondent's patients. Respondent also argues that Doe, through occasional contact with patients who are themselves infected with various diseases, might acquire those diseases from the patients. That is so, according to Respondent, because Doe's weakened immune system might render him more susceptible to contracting infections from other individuals.

There is no credible evidence to support this allegation. The evidence does not prove that whatever damage Doe's immune system has so far sustained as a result of his HIV infection makes him more susceptible to acquiring infections from other individuals than an individual who is not infected with HIV. DHHS Ex. 14/1700 - 1701; Tr. at 142, 1577. There is not conclusive evidence to show that individuals who are infected with HIV, or even those who have progressed to AIDS, are more likely to contract illnesses from outside sources than are individuals who are not infected with HIV. Respondent's assertion that Doe presently is a candidate for infection resulting from occasional patient contact is, therefore, speculative.

Respondent additionally asserts that Doe could communicate to Respondent's patients infections that he has either acquired from external sources or which were previously latent within Doe, but which have become active by virtue of Doe's weakened immune system. Respondent raises the specter of Doe transmitting an infection, such as tuberculosis, to a patient whose own immune system is weakened (such as a patient who is receiving chemotherapy for cancer). I also find this contention to be speculative and without meaningful support in the evidence. There is no evidence here that Doe presently manifests infections, other than HIV, which he might transmit to others. For example, there is

nothing in the record of this case which suggests that Doe harbors tuberculosis.[13]

Doe will be a potential source of HIV infection for the rest of his life. The evidence establishes that, once an individual is infected with HIV, he or she remains infected. The evidence does not make clear whether Doe's infectiousness will increase, decrease, fluctuate, or remain constant. The evidence is equivocal as to whether the volume of HIV virus in an infected individual's system may be higher at times than at others, thereby increasing or decreasing the likelihood that the individual might be capable of transmitting the virus to other individuals. There is no evidence in this case as to the volume of HIV in Doe's system.

There is no question here as to the severity of the risk posed by Doe inadvertently infecting an individual with HIV. As I find above, HIV infection almost certainly causes the infected individual to develop AIDS, and AIDS eventually causes death.

(3) There is no meaningful likelihood that Doe will transmit HIV to Respondent's patients in the course of performing his duties as a pharmacist.

Much of the experts' testimony in this case focused on the issue of the probability of Doe inadvertently transmitting HIV to Respondent's patients in the course of performing his duties as a pharmacist. Respondent's contention that Doe could infect patients through parenteral products which he had inadvertently contaminated with his body fluids is the essence of its defense to the Department's charge of discrimination.

The evidence does not eliminate all possibility that Doe somehow could transmit HIV via contaminated parenteral products. None of the experts who testified in this case could absolutely rule out that possibility. However, the weight of the evidence, including the reasonable medical judgments of public health officials, establishes that the likelihood of Doe transmitting HIV through his preparation of parenteral products is so small as not to be measurable.

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[13] If there were evidence that Doe was infected by some other contagious disease than HIV, I would separately analyze that evidence under the Arline standard to decide whether Doe posed a significant risk for transmitting that disease to other individuals.

Both Drs. Guinan and Henderson testified that the risk that Doe might infect a patient with HIV in the performance of his duties as a pharmacist is so small as to be unquantifiable. I find these experts' conclusions to be credible, and to be buttressed strongly by the evidence which they relied on. I am therefore convinced from the evidence in this case that the Department has established that Doe's preparation of parenteral products creates no meaningful risk that he would inadvertently communicate HIV to patients.

Drs. Guinan and Henderson testified that the findings of public health experts concerning the transmissibility of HIV by infected health care providers was based on experience both with incidents involving HIV, and with incidents involving the Hepatitis B Virus (HBV). HBV is transmitted in the same way that HIV is transmitted. It is, for undetermined reasons, easier to transmit than is HIV. Experts can draw inferences as to the likelihood of HIV transmission based on their experiences with HBV.

The evidence establishes that there has never been a single episode documented of a pharmacist transmitting either HIV or HBV through a contaminated parenteral product. Based on their studies of transmission of HBV and HIV, experts at the Centers for Disease Control (CDC) have concluded that noninvasive procedures, including the preparation of parenteral products, pose no risk for the transmission of HIV.

Those procedures where CDC's experts have identified some risk of transmission of HIV by infected health care workers are limited to exposure-prone invasive procedures. These are procedures involving invasion of body cavities by infected health care workers (such as surgery) where the area being worked on is difficult to visualize and where sharp instruments are involved. Even in these circumstances, CDC has not been able to quantify a probability that HIV could be communicated.

There are three aspects of exposure-prone invasive procedures which, in the judgment of the experts, create at least a minimal risk for communication of HIV by infected health care workers who perform such procedures. First, the procedures are performed inside patients' body cavities. Therefore, there exists a potential for direct exposure of patients to a health care worker's blood. Second, the procedures involve the use of sharp instruments, such as scalpels, thereby creating the risk that a health care worker employing such instruments could inadvertently cut himself and bleed directly into a patient's body cavity. Third, the procedures involve

situations where the instruments may be poorly visualized -- that is, hard for the health care worker to observe -- thereby heightening the likelihood of an accidental injury and bleeding.

As Drs. Guinan and Henderson testified, preparation of parenteral products by a pharmacist is not an exposure-prone invasive procedure. It falls outside of those procedures which CDC has concluded pose some risk for communication of HIV by infected health care workers. The differences between exposure-prone invasive procedures and noninvasive procedures, including preparation of parenteral products, rule out any likelihood that the minimal risks of infection present with invasive procedures are similarly present with the preparation of parenteral products. Unlike invasive procedures, preparation of parenteral products does not involve invasion of patients' body cavities by pharmacists. Preparation of parenteral products does not involve direct contact with patients. Therefore, there is no risk that patients who receive parenteral products will be exposed directly to pharmacists' blood. Although preparation of parenteral products does involve the use of sharp instruments (needles), the process does not involve circumstances where the needles would be hard to observe, which is the case with invasive procedures.

Respondent sought to rebut the Department's evidence essentially by advocating a scenario which establishes a mechanism whereby Doe might inadvertently transmit some of his blood, containing HIV, to a patient. I am not convinced that there exists any meaningful risk that Respondent's scenario could come to pass. Respondent derives its scenario from speculation about a possible chain of events, without proof that there is a likelihood that the events in Respondent's scenario would or even could occur. Unproven speculation as to what might happen is not credible evidence of what is likely to happen.

The scenario envisioned by Respondent in which Doe inadvertently might transmit HIV to a patient is as follows. During the course of preparing a parenteral product, Doe might, without being aware that he had done so, prick himself with one of the needles he used to transfer substances from one container to another. Doe might then use that needle, contaminated with his blood, to transfer substances between containers. That act could transfer Doe's blood (and HIV) to a container holding a parenteral product to be administered to a patient. Ultimately, the contaminated parenteral product

would be administered to a patient, and the patient might become infected by the HIV present in the product.

There is no evidence that Doe would use a needle to prepare a parenteral product knowing that the needle might have been contaminated by his personal contact. Nor is there any evidence that Doe would allow a parenteral product to be administered to a patient knowing that it may be contaminated as the result of it having been prepared with a needle that Doe had touched. Doe is a licensed and registered pharmacist. To ignore contamination of a needle (and, possibly, resulting contamination of a product) would violate professional standards.

Pharmacists -- including pharmacists employed by Respondent -- are supposed to follow a process known as "aseptic technique" in preparing parenteral products. Aseptic technique is intended to avoid contamination of products with foreign substances, including particles or bacteria. Aseptic technique proscribes pharmacists from even touching needles to be used in preparing parenteral products. Pharmacists who touch a needle are required to discard the needle immediately, and also to discard the syringe to which it is attached, and any products which might have been contaminated by the needle. Therefore, if Doe were aware that he had touched a needle used to prepare parenteral products (let alone that he had injured himself with that needle) Doe would immediately discard the needle, the syringe to which it was attached, and any product which might have become contaminated.

Respondent argues that infection control procedures such as aseptic technique are not always complied with by health care professionals. Therefore, according to Respondent, it cannot rely on Doe's compliance with aseptic technique to assure that he would not contaminate products that he prepared. The evidence offered by Respondent does show that aseptic technique may not always be complied with by its pharmacists. R. Ex. 145, R. Ex. 145A, R. Ex. 145B. However, as Respondent acknowledges, and indeed, as its own policies confirm, it intends that all pharmacists who work for it comply with aseptic technique. The solution to occasional breaches of aseptic technique by Respondent's pharmacists is for Respondent to provide training and to enforce its policies. Furthermore, Respondent has not offered any evidence to show that Doe -- as opposed to other pharmacists on its staff -- might not comply with aseptic technique.

Thus, Respondent's scenario depends, first, on Doe inadvertently pricking his finger with a needle and not being aware that he had done so. I find Respondent's assertion that Doe might injure himself with a needle while preparing parenteral products and not be aware that he had done so to be highly speculative at best, and unsupported by the evidence. I am not concluding that it is beyond any possibility that such an injury could occur. I do conclude, however, that Respondent has failed to establish any meaningful likelihood that Doe would injure himself with a needle, sufficient to contaminate the needle with his own blood, and not be aware of that fact.

The starting point for Respondent's scenario is the undisputed fact that, occasionally, pharmacists do accidentally prick themselves with needles. But this fact by itself only raises the possibility that pharmacists might injure themselves with needles and not be aware that they had done so. It does not establish that such unnoticed injuries actually occur.

Respondent's witnesses averred that inadvertent and unrecognized injuries with needles did occur in pharmacies, but were unable to offer more than personal anecdotes to support this contention. See Tr. at 937 - 939. The Department's witnesses were unaware of such events occurring in their personal experience. There are no studies showing that inadvertent and unnoticed injuries with needles occur with meaningful frequency in the course of preparing parenteral products.[14] Respondent did not produce any surveys or studies showing that its own pharmacists reported such injuries.

The second element in Respondent's scenario is that in the highly unlikely event that Doe were to prick himself with a needle, sufficient to draw blood, and not be aware of it, the blood which contaminated the needle would have to contain a sufficient quantity of HIV to pose a threat

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[14] Respondent cites testimony by Dr. Henderson as support for its contention that accidental and unnoticed injuries with needles may occur in the course of preparing parenteral products. Tr. at 405 - 406. Dr. Henderson acknowledges that medical literature documents episodes of unnoticed self-injury incurred by surgeons working in operating theaters. Id. The episodes referred to by Dr. Henderson are distinguishable from preparation of parenteral products in that they involve surgical procedures where there may be poor visualization.

of infection to a person to whom that blood is transmitted. That is not very likely. The experts who testified in this case (including Respondent's expert, Dr. Mansell) agreed that, while HIV may be transmitted through contact with a contaminated needle, not every contact with a contaminated needle will result in infection. The likelihood of acquiring HIV from injury by a needle which has been contaminated with HIV-infected blood is very small, ranging in the order of probability of between three and five chances in a thousand. Thus, there is only a small chance that a needle inadvertently contaminated by Doe with his own blood even poses a reasonable potential for transmitting HIV to a patient through transference of Doe's blood to a parenteral product and then to a patient.[15]

The third element of Respondent's scenario is that a quantity of Doe's blood containing HIV sufficient to transmit an infection would have to be transmitted from the inadvertently contaminated needle to the parenteral product. Again, it is not beyond all possibility that this could happen. However, no studies have been performed to show whether it is likely to happen. There are factors which might serve to exclude a significant quantity of contaminated blood from being injected into a parenteral product. In preparing parenteral products, pharmacists do not inject substances into open containers. Substances are introduced through barriers which are intended to maintain product sterility.

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[15] Both the Department and Respondent offered considerable evidence concerning the probability of an individual acquiring an HIV infection from an injury by a needle which had been contaminated with HIV-infected blood. As I find, the chance of HIV being communicated through such injuries is very small, ranging in the order of from three to five chances per one thousand injuries. It is not possible to find from this evidence that the likelihood that Doe would communicate HIV to a patient as the result of preparing a parenteral product with a needle that he had inadvertently contaminated is even remotely related to the risk of acquiring HIV from an injury by an HIV-contaminated needle. So-called needlestick communication of HIV involves direct injury of an uninfected individual with a contaminated needle. In Respondent's scenario, Doe's inadvertent contamination of a needle is only the first stage. There are many additional variable facts which must be accounted for between the injury and administration of a parenteral product to a patient for Respondent's scenario to present even a theoretical possibility for transmission of HIV.

Contaminating substances which are on the outer surface of a needle might well be wiped off by any barriers through which that needle is inserted.

Finally, any HIV finding its way into a parenteral product in the scenario described by Respondent would have to survive long enough to infect a patient to whom the product is administered. No studies have been performed to determine the survivability of HIV in parenteral products. However, it is known that HIV does not survive for long in mediums other than human tissues or tissue products. Furthermore, many parenteral products, such as cancer chemotherapy drugs, are toxic substances. In the absence of any evidence showing that HIV would survive in a parenteral product, it is simply speculative to say that it could survive. As with the other variables in Respondent's scenario, I do not conclusively rule out the possibility that HIV could survive long enough in a parenteral product to infect a patient. However, the evidence does not satisfy me that there is a meaningful likelihood that this would occur.

Respondent urges me to conclude that its infection scenario is given weight by the opinion of its expert, Dr. Mansell, and by the testimony of two physicians who have served on Respondent's staff, Drs. Zalman Arlen and Iradge Argani.[16] These witnesses expressed concern that Doe could communicate HIV through contamination of parenteral products prepared by him. None of these witnesses, including Dr. Mansell, could do more than speculate as to a theoretical chain of events by which Doe might communicate the virus. None of these witnesses could point to a study or studies which verified that Respondent's infection scenario represented anything more than a theoretical possibility. None of these witnesses could identify evidence that showed that there was a realistic probability that Doe would ever contaminate a parenteral product with his own blood.

I do not disagree with Respondent or its witnesses that there may be a theoretical possibility that Doe could contaminate a parenteral product and thereby communicate HIV to a patient. But, as I hold above, Respondent's scenario is mere speculation, unsupported by credible

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[16] Drs. Arlen and Argani did not testify in the hearing which I conducted. However, excerpts from their testimony in the hearing conducted by the New York State Division of Human Rights concerning Doe's complaint to that agency are in evidence. DHHS Ex. 9; DHHS Ex. 10. I have read this testimony.

evidence that there is any risk that it would happen. The opinions of the three physicians do not transform Respondent's scenario from speculative even to remotely probable.

All three of these physicians also testified that they were concerned that Doe could transmit an infection other than HIV through casual contact with immunocompromised patients. As I hold, supra, there is no evidence that Doe harbors any infections other than HIV which he could transmit to Respondent's patients. Therefore, these witnesses' concerns are speculative.

Furthermore, not all experts affiliated with Respondent consider Doe to constitute a meaningful risk for contagion in performing the unrestricted duties of a pharmacist on Respondent's staff. Dr. Gary Wormser, Respondent's chief of Infectious Diseases and an infectious disease specialist, concluded that Doe's HIV infection did not preclude him from performing duties as a pharmacist. DHHS Ex. 14/1678 - 1680, 1732 - 1734.[17]

(4) Doe does not pose either a "significant risk" or a "direct threat" to transmit HIV to patients in performing a pharmacist's duties for Respondent.

If the evidence were to show that Doe posed a "significant risk" under the Arline standard for transmission of HIV to Respondent's patients through his preparation of parenteral products, then he would constitute a "direct threat" for communication of HIV within the meaning of the Act. In that event, I would find that Doe neither met the definition of an "individual with handicaps" nor was "otherwise qualified" under the Arline standard. In light of the inevitably fatal consequence of HIV infection, I would find a "direct threat" or "significant risk" of infection if there was even a slight measurable risk that Doe might infect Respondent's patients through his preparation of parenteral products.

The evidence in this case shows that it is theoretically possible for Doe to inadvertently communicate HIV in the course of preparing parenteral products. However, the evidence also shows that there is no meaningful risk that such transmission of HIV would occur. A finding of

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[17] As was the case with Drs. Arlen and Argani, Dr. Wormser did not testify in the hearing which I conducted. Excerpts of his testimony before the New York State Division of Human Rights are contained in DHHS Ex. 14.

"significant risk" of transmission of HIV based on this evidence would be tantamount to a finding that, under Arline and the Act, the "significant risk" and "direct threat" standards meant any risk of transmission in the case of an individual who is infected with HIV. I do not read Arline or the Act so broadly. See Chalk v. U.S. Dist. Court Cent. Dist. of California, 840 F.2d 701 (9th Cir. 1988); Glover v. Eastern Nebraska Community Office of Mental Retardation, 686 F. Supp. 243 (D. Neb. 1988), aff'd, 867 F.2d 461 (8th Cir. 1989), cert. denied, 493 U.S. 932 (1989); Thomas, 622 F. Supp. 376, 380; New York State Ass'n for Retarded Children v. Carey, 466 F. Supp. 479 (E.D.N.Y. 1978), aff'd, 612 F.2d 644 (2d Cir. 1979).

Any individual who is infected with HIV could potentially transmit the virus to others. Given that, a scenario can be invented for any work setting within or outside of the health care industry which could envision an HIV-infected employee infecting his or her coworkers, or other individuals with whom he or she comes into contact. Even clerical workers occasionally sustain cuts while working. People can theoretically come into contact with other people's blood in any employment setting.

Both the Supreme Court in Arline and Congress intended that, in cases involving individuals infected with contagious diseases, the restrictions imposed against these individuals by their employers should be balanced against the consequences of allowing the individuals to work in the absence of restrictions. Arline and the Act permit an employer to build a margin of safety into an employee's duties, either where an individual is highly contagious, or where the individual is not very contagious, but where the consequences of infection are serious. This is a classic rule of reason analysis.

However, neither the Supreme Court nor Congress intended that employers could refuse to hire HIV-infected individuals, or restrict the duties of HIV-infected employees, based on speculative or fanciful infection scenarios. Restrictions on HIV-infected employees may only be justified where there is some meaningful, albeit slight, risk that in the absence of restrictions, such employees pose a threat to communicate the HIV virus.

If Arline or the Act were read to enable employers to restrict the duties of employees without evidence of a meaningful risk of transmission of HIV, both the Supreme Court's decision and the Act would be rendered meaningless. The "serious risk" standard of Arline and the Act's "direct threat" standard would, in the case of an individual infected with HIV, translate to a per se

right of an employer to restrict that employee's duties or to refuse to hire an infected individual.

The scenario by which Doe might transmit HIV in the course of his preparing parenteral products is, as I have found, fanciful. There is no meaningful risk that he will transmit the virus in performing his duties for Respondent. I conclude that Doe does not pose either a "significant risk" or a "direct threat" to transmit HIV in the course of his employment. I find that he is an "otherwise qualified" handicapped person under the Arline test. He meets the Act's definition of an "individual with handicaps."

3. Doe is a "qualified handicapped" individual.

Regulations define a "qualified handicapped" individual to be a person who, with reasonable accommodation, can perform the essential functions of a particular job. 45 C.F.R. § 84.4. Under Arline, reasonable accommodation in the case of an employee with a contagious illness would mean conditions of employment which rationally relate to eliminating a significant risk of contagion. Id. at 288.

The restrictions which Respondent would impose on Doe's duties cannot be rationalized as a reasonable accommodation of Doe's HIV infection. The restrictions are arbitrary because there is no legitimate purpose to restricting Doe as Respondent would restrict him. Doe poses no significant risk to communicate HIV through his performance of the unrestricted duties of pharmacist at Respondent's facilities.

I am not suggesting by this conclusion that Respondent must blind itself to the fact that Doe is infected with HIV. The only theoretical possibility for Doe communicating the virus in the course of performing his duties would be via a breach in aseptic technique. Therefore, Respondent can act legitimately to assure that Doe is trained in aseptic technique, even as it should act to assure that every pharmacist whom it employs is trained in aseptic technique. Respondent can also provide Doe with normal supervision and reminders to assure that he follows aseptic technique. But there is no evidence in this case to support a conclusion that Respondent must treat Doe differently from other pharmacists whom it employs in order to assure that Doe is not a risk to communicate HIV. In this case, reasonable accommodation of Doe's handicap simply means that Respondent should treat Doe as it would treat any professional pharmacist on its staff.

4. Respondent is unlawfully discriminating against Doe based solely on his handicap.

It follows from my analysis that the restrictions Respondent would place on Doe's employment constitute unlawful discrimination under the Act. There is no rational justification for these restrictions. They solely emanate from Doe's handicap or from Respondent's perception of that handicap.

Respondent asserts that it cannot employ Doe absent the restrictions it would impose without conflicting with New York law, which ostensibly bars it from employing actively infected individuals. I am not satisfied that Doe would be excluded from employment or that Respondent would be required to restrict his duties under New York law. As the Department notes, the New York State Division of Human Rights found that Respondent was discriminating against Doe.

However, I do not understand the Act or implementing regulations to permit parties who discriminate against handicapped individuals to defend their actions by asserting that they were acting in compliance with State laws. The regulations specifically impose an obligation on parties to comply with the Act which is not obviated by the existence of any State or local law or other requirement. 45 C.F.R. § 84.10(a). Where a conflict may exist between a duty to comply with a State law and the Act, the Act must prevail. See Florida Lime & Avocado Growers, Inc. v. Paul, 373 U.S. 132, 142 - 143, reh'g denied, 374 U.S. 858 (1963).

Respondent also contends that its actions amount to a reasonable balancing of the rights of employees under the Act, including Doe, against its ethical duty to protect the rights of patients against the risk that Doe might infect them. "A small but palpable risk of transmitting a lethal disease gives rise to the ethical responsibility to avoid that risk." Respondent's Reply Brief at 37. I do not disagree with the general proposition stated by Respondent. If I were to find that Doe posed even a "small but palpable" risk for transmitting HIV during the course of performing his duties, then I would not hesitate to affirm that Respondent could take reasonable measures to protect against that risk. But, as I find supra, there is no proof in this case that Doe constitutes even a "small but palpable" risk to transmit HIV. Given that, the restrictions Respondent would impose against Doe are arbitrary, and they constitute discrimination in violation of the Act.

Respondent relies on Estate of Behringer v. Medical Center at Princeton, 592 A.2d 1251 (N.J. Sup. Ct. Law Div. 1991) (Behringer) to support its contention that the restrictions it would impose on Doe are an element of Respondent's ethical duty to its patients. Behringer is distinguishable from this case. The Behringer case involved the issue of whether a hospital could suspend the staff privileges of a surgeon with AIDS. The court found that there was a reasonable probability that a surgeon, performing poorly visualized invasive procedures, could injure himself and communicate HIV through accidental bleeding into a patient's body cavity. Id. at 1265. The surgeon in Behringer was performing precisely those procedures which the CDC has identified as manifesting some (albeit, immeasurably small) risk for communication of HIV when performed by an HIV-infected health care worker. Doe's pharmacist duties would not involve such procedures. For the reasons which I have described supra, the noninvasive preparation of parenteral products is not comparable with the performance of exposure-prone invasive procedures by a surgeon for purposes of assessing the risk that HIV might be communicated by the pharmacist.

5. The Department has been unable to obtain voluntary compliance with the Act from Respondent.

The Department's regulations provide that its procedures for implementing the Act are the same as the procedures for implementing Title VI of the Civil Rights Act of 1964. 45 C.F.R. § 84.61. The applicable procedures are found in 45 C.F.R. §§ 80.6 through 80.10 and in 45 C.F.R. Part 81.

The regulations provide, in effect, that the Department may take action against a recipient of federal funds to obtain compliance with the Act if it determines that a dispute concerning the recipient's compliance cannot be informally resolved. 45 C.F.R. §§ 80.7(d), 80.8(a). I interpret these regulations as requiring me to find, as a prerequisite to imposing a remedy in any case which I hear under the Act, that the Department has been unable to secure compliance with the Act by informal, voluntary means.

The Department proved that it has not been able to secure voluntary compliance from Respondent. Findings 141 - 146, 161. Prior to issuing the administrative complaint against Respondent, the Department's Office of Civil Rights (OCR) made attempts to informally resolve the matter with Respondent. Discussions with Respondent did not lead to a satisfactory result. Respondent refused to

hire Doe as a pharmacist without restrictions at any time prior or subsequent to the issuance of the administrative complaint in this case.

Respondent asserts that, in fact, it offered to enter into a voluntary compliance agreement with the Department which made informal resolution of this case possible. Therefore, according to Respondent, there was never a basis for the Department to issue its administrative complaint against Respondent. However, it is apparent from review of Respondent's proposal to resolve this matter that Respondent never offered to do the one thing which it is required by law to do, to employ Doe without discriminating against him based on real or perceived handicaps.

The proposed compliance agreement offered by Respondent would have reserved to Respondent the right to modify Doe's duties under Respondent's Communicable Disease Policy and Occupational Safety and Health Administration guidelines. R. Ex. 119/3. The Communicable Disease Policy Guidelines, dated September 28, 1987, were attached to the proposed agreement. R. Ex. 119/8. At first glance, these guidelines incorporate the "significant risk" standard of Arline. There is a difference, however, which is important, given the history of Respondent's dealings with Doe. The Arline criteria provide that courts should normally defer to the expert opinions of public health officials in assessing whether an individual poses a significant risk for contagion in an employment setting. Id. at 288. By contrast, Respondent's proposed agreement would reserve to its medical directors and Employee Health Service staff the right to determine how to modify an employee's duties under the Arline criteria.

On its face, this may not be an unreasonable way for Respondent to resolve problems concerning the employment of contagious individuals. The Act does not require employers to consult with public health officials every time they confront the issue of whether, and under what circumstances, to employ an individual who is infected with a contagious illness. But it is also apparent from Respondent's proposed agreement that it would create a mechanism whereby Respondent could continue to discriminate against Doe. Respondent would be in literal compliance with its proposed agreement if, after review of Doe's case, its medical directors and Employee Health Service staff affirmed the very restrictions which are at issue here. The agreement would permit Respondent to continue to discriminate against Doe, or against any other HIV-employee, so long as the discrimination were

reviewed and approved pursuant to Respondent's Communicable Disease Policy Guidelines.

I find that the Department was within its rights in concluding that the proposed agreement placed form over substance. Respondent did not offer to cease its discrimination against Doe and the Department was not obligated to accept Respondent's offer of compliance.

6. Termination of federal financial assistance to Respondent is the reasonable remedy in this case.

The regulations provide that termination of federal financial assistance to a recipient of federal funds is an appropriate remedy for refusal to comply with the Act. 45 C.F.R. § 80.8(a). The term "federal financial assistance" includes grants, loans, contracts (other than procurement contracts or contracts of insurance or guaranty), or any other arrangements by which the Department makes available funds, services of federal personnel, or real and personal property or any interest in or use of such property. 45 C.F.R. § 84.3(h). The regulations provide procedural prerequisites to the termination of financial assistance in the case of noncompliance with the Act.[18] The regulations also provide that any action to suspend, terminate, or refuse to grant federal assistance to a recipient for failing to comply with the Act shall be limited to the particular program or part of a particular program, in which noncompliance has been found. 45 C.F.R. § 80.8(c)(3).

Respondent is a recipient of funds under Medicare and Medicaid. There is no question that the federal funds which Respondent receives directly from Medicare, and indirectly from Medicaid, are "federal financial assistance" within the meaning of the regulations. Respondent has not asserted that these monies do not constitute federal financial assistance. The Department contends, and Respondent does not dispute, that federal

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[18] These include an attempt to attain compliance by voluntary means and a finding on the record after opportunity for a hearing of the recipient's failure to comply with the Act. 45 C.F.R. § 80.8(c)(1), (2). The regulations also provide that termination of federal funds will not become effective until the expiration of 30 days after the Secretary has filed with the committees of the House and Senate having legislative jurisdiction over the program involved, a full written report of the circumstances and the grounds for termination of federal funds. 45 C.F.R. § 80.8(c)(3).

financial assistance which Respondent receives in the form of Medicare and Medicaid payments flows throughout Respondent and supports all of its operations. Nor does Respondent deny that a substantial percentage of the funds it receives from the Department support Respondent's employment of staff. However, Medicare and Medicaid payments to Respondent are not earmarked for staff support. They constitute reimbursement for items or services provided by Respondent, out of which Respondent extracts funds to compensate its staff.

The Department argues that Respondent's discrimination against Doe constitutes more than an isolated act of discrimination against one individual. I agree with the Department's contention. Respondent's discrimination against Doe is an aspect of a policy adopted by Respondent in which it expressly reserves authority to impose restrictions against HIV-infected employees. See R. Ex. 119/8. So long as Respondent contends that the actions that it took in Doe's case are reasonable, the potential exists for Respondent to impose similarly arbitrary restrictions against any HIV-infected employee or job applicant.

It is not possible for me to segregate Respondent's acts of discrimination against Doe from Respondent's employment policies, nor is it possible for me to extract from the federal funds paid to Respondent monies which are earmarked only for pharmacy operations, for pharmacists' compensation, or even for staff compensation. Federal funds paid to Respondent by the Department become commingled with other funds once Respondent receives and deposits them. I have no recourse but to order that all federal financial assistance to Respondent be terminated, inasmuch as it is not possible for me to identify specific federal payments to Respondent as payments which Respondent uses in activities which discriminate against handicapped individuals.[19]

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[19] In its posthearing memorandum, the Department at times requested that I order the termination of "federal financial assistance" to Respondent. Department's Post Hearing Memorandum at 62. At other times it requested that I order termination of "all DHHS funds" to Respondent. Id. The former request might subsume federal payments other than those made by the Department. The latter would seem to be confined only to Department-funded programs, such as Medicare and Medicaid. The remedy which I order provides for termination of "federal financial assistance," as is provided for by the applicable regulation. 45 C.F.R. § 80.8(a). I make no

The remedy which I impose is in no sense punishment for Respondent's discrimination against Doe or for its policies in general. Respondent can at any time avert the imposition of this remedy by complying with the Act.

CONCLUSION

I conclude that Respondent is engaging in unlawful discrimination in violation of the Act. I order that federal financial assistance to Respondent be terminated until it satisfies the responsible Department officials that it is in compliance with the Act.

/s/

Steven T. Kessel
Administrative Law Judge

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[19](...continued)
applicable regulation. 45 C.F.R. § 80.8(a). I make no finding in this decision whether the Secretary has authority to order termination of payments to a recipient other than payments made by the Department pursuant to programs which it administers.