No. 06-3278

IN THE
UNITED STATES COURT OF APPEALS
FOR THE SEVENTH CIRCUIT

EQUAL EMPLOYMENT OPPORTUNITY COMMISSION, Plaintiff – Appellant, v. LEE'S LOG CABIN, INCORPORATED, Defendant – Appellee	)	Appeal from the United States District Court, Western District of Wisconsin No. 05 C 507 The Honorable Barbara B. Crabb, Judge Presiding

BRIEF OF *AMICI CURIAE*

AIDS RESOURCE CENTER OF WISCONSIN,
AMERICAN ACADEMY OF HIV MEDICINE,
ASSOCIATION OF NURSES IN AIDS CARE,
HIV MEDICINE ASSOCIATION, and
HOWARD BROWN HEALTH CENTER

IN SUPPORT OF PLAINTIFF-APPELLANT, URGING REVERSAL

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CIRCUIT RULE 26.1 DISCLOSURE STATEMENT

Appellate Court No: 06-3278

Short Caption: EEOC v. Lee's Log Cabin, Inc.

To enable the judges to determine whether recusal is necessary or appropriate, an attorney for a non-governmental party or amicus curiae, or a private attorney representing a government party, must furnish a disclosure statement providing the following information in compliance with Circuit Rule 26.1 and Fed. R. App. P. 26.1 .

The Court prefers that the disclosure statement be filed immediately following docketing; but, the disclosure statement must be filed within 21 days of docketing or upon the filing of a motion, response, petition, or answer in this court, whichever occurs first. Attorneys are required to file an amended statement to reflect any material changes in the required information. The text of the statement must also be included in front of the table of contents of the party's main brief. **Counsel is required to complete the entire statement and to use N/A for any information that is not applicable if this form is used.**

(1) The full name of every party that the attorney represents in the case (if the party is a corporation, you must provide the corporate disclosure information required by Fed. R. App. P. 26.1 by completing the item #3):

AIDS Resource Center of Wisconsin, American Academy of HIV Medicine, Association of Nurses in AIDS Care, HIV Medicine Association, and Howard Brown Health Center

(2) The names of all law firms whose partners or associates have appeared for the party in the case (including proceedings in the district court or before an administrative agency) or are expected to appear for the party in this court:

American Civil Liberties Union Foundation, and American Civil Liberties Union of Wisconsin Foundation, Inc.

(3) If the party or amicus is a corporation:

i) Identify all its parent corporations, if any; and

N/A

ii) list any publicly held company that owns 10% or more of the party's or amicus' stock:

N/A

Attorney's Signature: /s/ John A. Knight Date: December 19, 2006

Attorney's Printed Name: John A. Knight

Please indicate if you are Counsel of Record for the above listed parties pursuant to Circuit Rule 3(d). Yes X No _____.

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N/A

Attorney's Signature: /s/ Laurence J. Dupuis Date: December 19, 2006

Attorney's Printed Name: Laurence J. Dupuis

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INTRODUCTION

This case raises important questions about the medical understanding of HIV infection and its terminal manifestation, AIDS, and about the legal implications of drawing a false dichotomy between them. The EEOC appeals from a summary judgment ruling for Lee's Log Cabin ("Lee's"), a restaurant that chose not to hire Korrin Krause Stewart ("Stewart") after an assistant manager wrote "HIV+" on Stewart's job application. The EEOC alleged in its complaint that Lee's failed to hire Stewart because she is disabled, in violation of the Americans with Disabilities Act ("ADA"), and then Lee's moved for summary judgment prior to the taking of any discovery. Lee's asserted that the EEOC's complaint was deficient and that no evidence was in the record to show that Stewart was a qualified individual with a disability or to make out a *prima facie* case of discrimination against Lee's.

The District Court granted summary judgment to Lee's because it found that the EEOC had asserted that Stewart was disabled from *HIV* in its complaint but introduced evidence that she was disabled because of *AIDS* in opposing summary judgment. Because it determined that the assertion of disability due to AIDS was a "gross departure" from EEOC's original HIV disability allegation that amounted to a "new cause of action," the court refused to consider the ample evidence offered by the EEOC of the disabling symptoms of Stewart's AIDS. Additionally, the court concluded that the EEOC had offered no evidence that Lee's knew Stewart had AIDS, as opposed to HIV.

Amici, a group of organizations specializing in medical care and other services for people with HIV disease, submit this brief to explain that HIV/AIDS medical research shows that HIV disease is a single disease with multiple stages, the last of which is called AIDS. The symptoms of AIDS, and the resulting limitations of major life activities, are not qualitatively different from

those of HIV and are often the same as those of persons with pre-AIDS HIV. In addition, research about stigma against persons with HIV strongly suggests that the stigma is based on fears (many times irrational) about HIV infection and on irrational bias against the groups who have traditionally been infected with HIV. Such stigma, and the discrimination that results from it, makes no distinction between those persons with pre-AIDS HIV and those with a formal AIDS diagnosis. Consequently, distinguishing between HIV and AIDS disability under the ADA fails to comport with the medical understanding of the illness and its symptoms. Equally, a distinction between HIV discrimination and AIDS discrimination ignores the nature of the prejudice motivating HIV/AIDS discrimination.

STATEMENTS OF INTEREST OF *AMICI*

The AIDS Resource Center of Wisconsin ("ARCW") is a statewide, nonprofit, non-stock corporation organized in 1985. The ARCW employs 120 people and serves over 3,000 individuals with HIV/AIDS in the state of Wisconsin by providing health, housing, social, legal and prevention services. Since its inception, the ARCW's legal program has offered essential legal services to individuals with HIV/AIDS, including defending the rights of individuals with HIV/AIDS when such persons have been treated discriminatorily based on their HIV status. This case raises just such an issue in the context of a potential employer refusing to hire an individual based on her HIV status. In basing its decision on the distinction between HIV and AIDS, the District Court has confused long-understood notions of what it means to be HIV positive and to have AIDS. The ARCW therefore has a significant interest in the proper resolution of this case.

The American Academy of HIV Medicine ("AAHIVM") is an independent organization of AAHIVM HIV Specialists™ and others dedicated to promoting excellence in HIV/AIDS

care. Through advocacy and education, AAHIVM is committed to supporting health care providers in HIV medicine and to ensuring better care for those living with AIDS and HIV disease. As the largest independent organization of HIV frontline providers, its 2,000 members provide direct care to more than 340,000 HIV patients (more than two thirds of the patients in active treatment for HIV disease). AAHIVM has a diverse membership composed of infectious disease, internal medicine, family practitioners and general practice specialists as well as nurse practitioners and physician's assistants.

The Association of Nurses in AIDS Care ("ANAC") is the only national professional association specifically for HIV/AIDS nurses. It is a nonprofit organization with an annual membership of more than 2,500 committed to fostering the individual and collective professional development of nurses involved in the delivery of health care to persons infected or affected by HIV and to promoting the health, welfare, and rights of all HIV-infected persons.

The HIV Medicine Association ("HIVMA"), nested within the Infectious Diseases Society of America (IDSA), represents more than 2,700 physicians and other health care providers who practice HIV medicine. HIVMA's members represent forty-nine states, the District of Columbia, Puerto Rico, the Virgin Islands, and thirty-six countries outside of the United States.

As organizations that represent health care providers who treat persons with HIV/AIDS, AAHIVM, ANAC and HIVMA are concerned that courts use accurate medical and scientific information about HIV/AIDS and its symptoms and that employment discrimination laws are properly enforced to help prevent inequitable treatment of persons with HIV/AIDS because of their disease.

Howard Brown Health Center is the Midwest's premier lesbian, gay, bisexual, and transgender (LGBT) health care organization and leads the region in addressing the comprehensive health care needs of people in the LGBT community. Howard Brown currently provides primary medical care to approximately 1,700 persons living with HIV/AIDS, making it one of the largest providers of HIV care services in the Midwest. It also provides HIV testing and prevention, HIV/AIDS case management and support services, and counseling and psychotherapy for people living with HIV/AIDS.

SUMMARY OF ARGUMENT

The District Court's distinction between HIV and AIDS, which was central to its grant of summary judgment, gets some basic facts very wrong. First, it gets the medical science wrong. HIV and AIDS are not separate diseases; AIDS is simply one stage of HIV disease. A whole host of major life activities are affected by the symptoms of HIV disease, and there is no clear dividing line between the symptoms of HIV and those of AIDS. Both people with an HIV diagnosis and those with an AIDS diagnosis are often disabled by the same symptoms of the disease.

Second, the court gets the law wrong. The ADA focuses on whether a physical or mental condition substantially limits a major life activity, not on the name of the condition or the stage of the disease. As a result, the District Court should not have rejected the EEOC's evidence of disability. A correct application of the ADA to the facts about HIV means that an allegation of HIV disability is not materially different from an assertion of disability due to AIDS. Similarly, proof that a person's major life activities are substantially limited due to AIDS is not materially different from the proof that someone is disabled due to HIV.

Third, the District Court misapprehends the nature of the stigma and bias behind HIV/AIDS discrimination. HIV and AIDS are closely connected in the popular understanding of the disease. Courts reviewing the motives behind HIV/AIDS discrimination, as well as social science research, have found that the stigma and discrimination that arise from knowing that someone has HIV is no different from that caused by knowing someone has AIDS. As a result, proof of discrimination based on an employee's HIV status is sufficient to prove discrimination against a person with AIDS. The ADA itself was aimed at redressing discrimination based on just this kind of irrational stigma.

In short, the distinction that was at the core of the District Court's opinion disregards what makes a person disabled under the ADA, emphasizes a dichotomy between HIV and AIDS even though medical science treats HIV disease as a continuum, and ignores the reality that many people have the same irrational fear of people with every stage of HIV disease, including AIDS and pre-AIDS HIV. The Court should reject the distinction as legally irrelevant, reverse the judgment, and remand for further proceedings.

ARGUMENT

I. Health Care Professionals Consider HIV And AIDS The Same Disease.

The District Court's conception of HIV and AIDS as distinct and virtually unrelated diseases finds no support in medical science. The health care professionals who conduct research about HIV and AIDS and who treat persons with HIV and AIDS treat the two designations as specific aspects or stages of the same progressive and incurable disease rather than a bright line distinction either between two diseases or between those who are debilitated and those who are not. As the Presidential Commission on the HIV Epidemic unequivocally stated in 1988, "[t]he term 'AIDS' is obsolete. . . . Continual focus on AIDS rather than the

entire spectrum of HIV disease has left our nation unable to deal adequately with the epidemic." *Report of the Presidential Commission on the HIV Epidemic*, June 24, 1988, Washington, D.C.: GPO, 1988: 87-9 (GPO pub. no. 0-214-701:QL3),

HIV, the human immunodeficiency virus, is responsible for AIDS, acquired immune deficiency syndrome. AIDSINFO, Service of U.S. Department of Health and Human Services.[1] People who have been infected with HIV have HIV disease. Once the HIV disease reaches a late stage, these people are said to have AIDS.

Medical researchers first discovered the late stage of the disease in 1981 and called it AIDS. They did not discover HIV, and that HIV causes AIDS, until 1983, which explains why the late stage of the disease has its own name. National Institute of Allergy and Infectious Diseases, National Institute of Health, Report, *The Relationship Between the Human Immunodeficiency Virus and the Acquired Immunodeficiency Syndrome* (1995);[2] National Institute of Allergy and Infectious Diseases, National Institute of Health, Fact Sheet, *The Evidence that HIV Causes AIDS* (2003).[3] Unlike other diseases,[4] AIDS was not renamed as HIV once the viral connection was proved, but was kept as the designation for the last stages of the health condition resulting from the progression of the HIV virus. The two terms are, however, often used interchangeably and are sometimes referred to as "HIV/AIDS."

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[1] *Available at http://aidsinfo.nih.gov* (follow "HIV/AIDS Glossary" hyperlink; then search "human immunodeficiency virus").
[2] *Available at http://www.niaid.nih.gov/Publications/hivaids/hivaids.htm*.
[3] *Available at http://www.niaid.nih.gov/factsheets/evidhiv.htm*. In 1986, the International Committee of Viral Taxonomy renamed the virus that causes AIDS "HIV." *Id.*
[4] For example, tuberculosis had been known as "phthisis," the "white plague," and "consumption" prior to the discovery in 1882 of the bacteria responsible for it, *mycobacterium tuberculosis*, from which the name "tuberculosis" was derived. *TB Notes No. 1, 2000*, U.S. Department of Health and Human Services, Center for Disease Control and Prevention, *available at* http://www.cdc.gov/nchstp/tb/notes/TBN_1_00/tbn1_00.pdf.

Medical literature has recognized that the distinction between these two terms is somewhat artificial. It now defines "HIV disease" or "HIV infection" as one disease with three[5] stages: acute, chronic, and AIDS. Bernd S. Kamps & Christian Hoffmann, Introduction, in HIV MEDICINE 2006 23, 25 (Christian Hoffmann, et al. eds. 2006).[6] As a chronic disease, HIV is progressive. As explained in one article:

> "There is, in fact, a single, continuous disease process beginning with the initial exposure to the infection and terminating in the advanced forms of immune deficiency, with death resulting from the complex interactions between the HIV infection itself and the secondary opportunistic infections and malignancies."

Mayer, *supra* n. 5, at 182 (*citing* Margaret Fischl, *Introduction to the Clinical Spectrum of AIDS*, in TEXTBOOK OF AIDS MEDICINE 139). The disease progresses as the virus replicates using certain white blood cells, the CD4+ cells (helper T-lymphocytes, or "T-cells"). T-cells are essential to the immune system, so their loss to HIV signals the progress of the disease and their number reliably marks the stage of a patient's disease. *Id.* at 181-83.

Until 1993, a diagnosis of AIDS was made solely upon the presentation of one of a group of "AIDS-defining illnesses," also known as "Category C" illnesses, based on their classification by the Centers for Disease Control (CDC). These twenty-six illnesses are rare in the general population, since they are mostly opportunistic infections ("OIs"), or illnesses caused by viruses and bacteria that take advantage of the weakened immune systems of certain people, such as people with HIV. The illnesses include Kaposi's Sarcoma, encephalopathy, a variety of lymphomas, and pneumocystis pneumonia. Department of Health and Human Services Centers

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[5] Others have broken down the progression of HIV disease into five stages, rather than three. Connie Mayer, *Is HIV a Disability Under the Americans with Disabilities Act: Unanswered Questions After Bragdon v. Abbott*, 14 J.L. & HEALTH 179, 182-83 (2000) (*citing* Margaret Fischl, *Introduction to the Clinical Spectrum of AIDS*, in TEXTBOOK OF AIDS MEDICINE 53-57 (Merigan, Bartlett & Bolognesi, eds. 1999).

[6] *Available at www.hivmedicine.com/hivmedicine2006.pdf*. Subsequent pages of HIV MEDICINE 2006 cited below are available at this same web address.

for Disease Control and Prevention, *1993 Revised Classification System for HIV Infection and Expanded Surveillance Case Definition for AIDS Among Adolescents and Adults***,** MMWR 41 (RR-17), Appendix B, Publication date: 12/18/1992, ("*CDC 1993 Revised Classification System*")[7]; Kamps & Hoffmann, *supra*, at 27; Dennis H. Osmond, *Epidemiology of Disease Progression in HIV, in* HIV INSITE KNOWLEDGE BASE (1998).[8] In 1993, the CDC broadened the definition of AIDS because many individuals were entering the final stages of HIV disease without presenting one of the Category C illnesses. It began to label persons with a CD4+ lymphocyte count of less than 200/µl as persons with AIDS. *See* Osmond, *supra*, at 27. The appearance of any of the AIDS-defining illnesses, or a CD4+ count below 200/µl, marks entry into the final stage of HIV disease, Mayer, *supra* n. 5, at 183 (*citing* J. Kilby & M. Saag. *Natural History of HIV-1 Disease,* TEXTBOOK OF AIDS MEDICINE 55), not an independent "new" disease.

The AIDS diagnosis can also be arbitrary in some respects. Once a patient is diagnosed with AIDS, the diagnosis never goes away, even if he is "cured" of the AIDS-defining illness or his CD4+ count returns to above 200/µl. *CDC 1993 Revised Classification*; Kamps & Hoffmann, *supra* at 27. The efficacy of anti-retroviral therapy (ART) and especially highly-active antiretroviral therapy (HAART), first used in 1995,[9] at slowing the progress of the disease has put a surprising number of people in the situation of having an AIDS diagnosis without any current markers for AIDS. Some people are not aware they have HIV until they are diagnosed with AIDS itself. CDC, *Late Versus Early Testing of HIV-16 Sites, United States, 2000-03*,

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[7] *Available at http://wonder.cdc.gov/wonder/help/AIDS/MMWR-12-18-1992.html*.
[8] *Available at http://hivinsite.ucsf.edu/InSite?page=kb-00&doc=kb-03-01-04*.
[9] Protease inhibitors and non-nucleotide reverse transcriptase inhibitors were added to antiretroviral treatment regimens in 1995 and the resulting therapy was labeled highly active antiretroviral therapy (HAART). Andrea Rubbert, Georg Behrens and Mario Ostrowski, *Pathogenesis of HIV-1 Infection,* HIV MEDICINE 2006 61.

MMWR WEEKLY REPORT 52(25), 581-86 (June 27, 2003).[10] These individuals typically initiate ART and achieve an increase in their T-cell count and a possible cure of any Category C illness on which their AIDS diagnosis was based. Christian Hoffman & Fiona Mulcahy, *ART* 2006, HIV MEDICINE 2006 89, 92. For that portion of the HIV/AIDS population, the AIDS diagnosis is a result of the progression of the disease prior to receiving any medical care, rather than being a true marker of an end-stage illness. For them and others who experience a radical health improvement due to starting ART or changing their therapy, the "last stage" of the disease may last for many, many years. Bruce R. Schackman, *et al*., *The Lifetime Cost of Current Human Immunodeficiency Virus Care in the United States*, 44 MED. CARE 990, 994 (2006).

HIV disease can be disabling in each of its stages. While HIV disease varies from patient to patient, there are many symptoms associated with pre-AIDS HIV disease that also occur after an individual obtains a formal AIDS diagnosis.[11] The first symptoms usually occur during the "acute" stage of HIV disease, which often happens two to three weeks after viral transmission but even before the patient tests positive for the antibodies to HIV ("seroconversion"). In that period, 50-90% of patients show symptoms that may include fever, adenopathy, pharyngitis, rash, diarrhea, headache, nausea/vomiting, and neurologic symptoms. This period is followed by seroconversion and eventually the middle stage of HIV disease, chronic HIV infection, the median length of which has been estimated at anywhere from 8 to 24 years. *See* Schackman, *supra*, at 994; John G. Bartlett, THE 2002 ABBREVIATED GUIDE TO MEDICAL MANAGEMENT OF HIV INFECTION 3 (2002).[12]

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[10] *Available at http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5225a2.htm* .

[11] This section discusses symptoms of HIV infection generally, and most studies cited refer to patients who are not undergoing ART. However, all of the symptoms and co-morbidities have also appeared in patients currently on ART.

[12] A*vailable at http://www.hopkins-aids.edu/publications/abbrevgd/abbrevgd.html*.

HIV infection, in the acute, chronic, as well as the AIDS stage, is associated with significant physical symptoms and conditions in nearly every organ system. Many of the conditions that begin during the chronic stage result from the increased susceptibility to infection by OIs caused by the virus's attack on the immune system. These conditions are caused by OIs that do not fall on the AIDS-defining Category C list. In addition to devastating impacts on the organ or body part they infect, OIs also have a tendency to affect sensory systems, such as vision. *See* Irma Ahmed, et al., *Ophthalmic Manifestations of HIV, in* HIV INSITE KNOWLEDGE BASE (2005).[13] Patients with HIV are likely to develop a variety of skin diseases and are at high risk of contracting human papilloma virus (HPV), shingles, fungal and yeast infections. *See* Helmut Schoefer, *et al.*, *HIV-associated Skin and Mucocutaneous Diseases*, *in* HIV MEDICINE 2006 585, 586.

The HIV virus itself also causes a number of symptoms that may be present both before and after an AIDS diagnosis. One such symptom is lipodystrophy syndrome, noted in 30-50% of HIV patients, which is marked by metabolic difficulties and abnormal distribution of fat throughout the body. This condition can cause gastrointestinal symptoms and creates a significant risk of developing cardiovascular disease, including heart attack. *See* Georg Behrens & Reinhold E. Schmidt, *Lipodystrophy Syndrome*, HIV MEDICINE 2006 301, 301-302. Additionally, many patients also present "idiopathic HIV fatigue." Patients with this condition wake refreshed and alert, only to become exhausted from performing a minor task. One researcher notes that, "[i]n addition to affecting quality of life, idiopathic HIV fatigue is usually disabling: patients with extremely unpredictable energy reserves may be unable to handle job

[13] *Available at* http://hivinsite.ucsf.edu/InSite?page=kb-00&doc=kb-04-01-12.

commutes, standard work hours, or work deadlines." Lisa Capaldini, *Symptom Management Guidelines*, *in* HIV INSITE KNOWLEDGE BASE (2004). [14]

Patients with both chronic HIV disease and AIDS are at a markedly higher risk for a number of circulatory ailments, including premature atherosclerosis and other coronary artery disease. *See* Peter Krings & Till Neumann, *HIV and Cardiac Diseases*, *in* HIV MEDICINE 2006 619, 619-27. There is also a "well-documented connection" between HIV infection and the development of pulmonary hypertension, a severe life-limiting disease. Georg Friese, *et al*., *HIV-associated Pulmonary Hypertension*, *IN* HIV MEDICINE 2006 629, 629. HIV infection is also associated with a number of serious blood-related conditions. *See* Donald W. Northfelt, *Hematologic Manifestations of HIV, in* HIV INSITE KNOWLEDGE BASE (1998).[15]

The psychiatric and mental health of individuals with all stages of HIV disease is often greatly impaired, even though it is difficult to identify whether these impairments are caused by the many neurological effects of the disease or have psychosocial origins, such as stigma, isolation and discrimination. Major depression is the most common symptom reported, with rates of up to 40%. *See* Susanne Tabrizian & Oliver Mittermeier, *HIV and Psychiatric Disorders*, *in* HIV MEDICINE 2006 667, 667. Even at the earliest stages of HIV, many patients report related depression, anxiety, adjustment disorder, and panic disorders. Dementia and delirium tend to occur only in later stages. *See* Mayer, *supra* note 5, at 184.

HIV disease, including AIDS, can also be significantly disabling because of side effects from the treatment for the disease. While the medications taken by most individuals with HIV and AIDS, anti-retroviral therapy ("ART"), have proven highly effective at slowing the course of

[14] *Available at* http://hivinsite.ucsf.edu/InSite?page=kb-00&doc=kb-03-01-06.
[15] *Available at* http://hivinsite.ucsf.edu/InSite?page=kb-00&doc=kb-04-01-09.

the illness,[16] ART itself causes a number of side effects which may have to be controlled with other medications. Common side effects include problems with gastrointestinal function, such as severe diarrhea and stomach upset, *see* Christiane Schieferstein & Thomas Buhk, *Management of Side Effects*, *in* HIV MEDICINE 2006 279, 280, as well as "drug eruptions," which are any of a number of skin lesions, rashes, or other marks that appear as a severe allergic reaction to ART. *See* Schoefer, *supra* As with many other strong drugs, ART causes elevated liver function levels in many patients, as well as disruption of kidney functions, osteoporosis, a variety of neurological troubles, blood defects, and vascular necrosis. *See* Schieferstein & Buhk, *supra*, at 281, 284-92.

Contrary to the District Court's conclusion, HIV and AIDS are not separate diseases, but different stages of one disease. That disease creates many disabling symptoms that appear both in patients with AIDS and in patients with pre-AIDS HIV.

II. The Courts Have Treated HIV/AIDS As One Illness Whose Symptoms And Treatment Impairs Major Life Activities In Similar Ways, Whether Or Not There Is A Formal AIDS Diagnosis.

The District Court's distinction between HIV and AIDS also makes no sense under the ADA. As demonstrated above, HIV disease disables at all stages of the disease, including AIDS. As a result many courts have found that both HIV and AIDS are by definition disabling. At a minimum, HIV disease – whatever its stage – substantially limits at least one major life activity: reproduction. HIV disease often substantially limits other major life activities as well, such as the ability to walk or to engage in intimate sexual relationships. As a result, the terms "HIV disease" and "AIDS" – which

[16] ART does not completely eliminate the impairment caused by HIV, since HIV remains in the bloodstream and its progress and many of its symptoms continue.

have a particular meaning to the medical community – should be largely interchangeable for purposes of alleging and analyzing a disability case under the ADA. Neither the medical understanding of the disease nor the legal analysis of its disabling symptoms by other courts support the District Court's formalistic treatment of the EEOC's case. The District Court's refusal here to consider the EEOC's evidence of limitations due to AIDS because it treated the complaint as one asserting only HIV discrimination completely disregards the course, progression and symptoms of the disease that other courts have overwhelmingly recognized.

Many of the courts that have evaluated HIV disability claims have recognized the fact that HIV is one disease with a different name, AIDS, given to those persons who meet the clinical definition for what is supposed to be its last stage. In *Bragdon v. Abbott*, 524 U.S. 624, 635-36 (1998), the Court outlined the three stages of the disease, first, the "acute or primary" stage, second, the "asymptomatic phase" (the chronic stage), and finally, the last stage, AIDS. It noted that the name for the middle stage, the "asymptomatic phase" "is a misnomer, in some respects, for clinical features persist throughout, including lymphadenopathy, dermatological disorders, oral lesions and bacterial infections." *Id.* at 635. The Court described the same development of HIV disease outlined above. For example, in describing the symptoms of AIDS, the Court wrote, "[d]uring this stage, the clinical conditions *most often associated with HIV*, such as *pneumocystis carninii* pneumonia, Kaposi's sarcoma, and non-Hodgkins lymphoma, tend to appear." *Id.* at 636 (emphasis added). It noted that during the course of the disease, "the general systemic disorders *present during all stages of the disease*, such as fever, weight loss, fatigue, lesions, nausea, and diarrhea, tend to worsen." *Id.*

In *Hernandez v. Prudential Ins. Co. of America*, 977 F. Supp. 1160 (M.D. Fla. 1997), the court noted that the "term AIDS . . . is considered obsolete in the sense that it describes only a later, end-stage of an epidemic disease more appropriately labeled 'HIV infection.' . . . It is thought that virtually everyone infected with HIV will progress at some point to active disease." *See also Doe v. Mutual of Omaha Ins. Co.*, 179 F.3d 557, 561 (7th Cir. 1999) ("'opportunistic' diseases [OIs] that HIV allows … to ravage the body" are referred to as "'complications' of *HIV or AIDS*") (emphasis supplied); *United States v. Happy Time Day Care Center*, 6 F. Supp. 2d 1073, 1075-76 (W.D. Wis. 1998) ("debilitating effects of HIV" experienced by plaintiff, L.W., even though he does not have AIDS, and "[i]t is statistically certain that L.W.'s HIV infection will progress to AIDS," which will lead to "fatal opportunistic infections and complications"). Once someone receives a formal AIDS diagnosis, he still has HIV, so one who is disabled by AIDS can be said to suffer impairments from both HIV and AIDS. *Doe v. County of Centre, PA.*, 242 F.3d 437, 442 (3d Cir. 2001) ("HIV and AIDS severely threatened Adam's health").

Whether someone is disabled due to HIV/AIDS under the ADA, 42 U.S.C. § 12102(2)(A), depends not on what name attaches to the disease he has, but on whether he suffers from a physical or mental impairment, and then on "whether the impairment substantially limit[s] the major life activity" asserted by the plaintiff. *Bragdon*, 524 U.S. at 631. *See also Sutton v. United Airlines*, *Inc.*, 527 U.S. 471, 483 ("The determination of whether an individual has a disability is not necessarily based on the name or diagnosis of the impairment the person has, but rather on the effect of that impairment on the life of the individual.") (*quoting* 29 CFR pt. 163, App. § 1630.2(j)). The District Court's analysis ignores this basic ADA law, which many courts have already applied to both HIV disease and AIDS.

The *Bragdon* Court decided that HIV disease, including AIDS, is a physical impairment under the ADA. 524 U.S at 637 ("HIV infection satisfies the statutory and regulatory definition of a physical impairment during every stage of the disease"). However, the *Bragdon* Court did not decide whether HIV disease is always disabling,[17] but left it to the lower courts to decide that question, or alternatively, whether a particular plaintiff with HIV is disabled by it. The Court found, however, that the *Bragdon* respondent was disabled by her asymptomatic HIV infection because it impaired the major life activity of reproduction. *Id.* at 637.[18] Additionally, the Court recognized that there were many other impairments of significant life activities that could qualify HIV as disabling under the ADA. *Id.* ("We have little doubt that had different parties brought the suit they would have maintained that an HIV infection imposes substantial limitations on other major life activities").

Although courts are instructed to evaluate whether a plaintiff is disabled on an individualized basis, *Sutton*, 527 U.S. at 483, some impairments, such as paraplegia, "may invariably cause a substantial limitation of a major life activity." *Albertson's, Inc. v. Kirkingburg*, 527 U.S. 555, 566 (1999). This Court has written that "[s]ince the

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[17] In her concurrence, Justice Ginsburg went even further, saying that she believes HIV *always* is an impairment that substantially limits major life activities. She noted:

> "The disease inevitably pervades life's choices: education, employment, family and financial undertakings. It affects the need for and, as this case shows, the ability to obtain health care because of the reaction of others to the impairment…. I am therefore satisfied that the statutory and regulatory definitions are well met. HIV infection is "a physical . . . impairment that substantially limits . . . major life activities," or is so perceived… including the afflicted individual's family relations, employment potential, and ability to care for herself.

524 U.S. at 568-569 (Ginsburg, J., concurring)(internal citations omitted).

[18] For further discussion of the impairment of reproduction, *see* Ulrike Sonnenberg-Schwan, et al. *HIV and Wish for Parenthood*, *in* HIV MEDICINE 2006 687.

Supreme Court held in *Bragdon* that infection with the AIDS virus (HIV) is a disabling condition from the onset of the infection, . . . before any symptoms appear, it is apparent that both ARC [AIDS-related conditions, that is, the symptoms of pre-AIDS HIV] and AIDS are disabilities." *Doe v. Mut. of Omaha Ins. Co.*, 179 F.3d 557, 558 (7th Cir. 1999); *see also Buie v. Quad/Graphics, Inc.*, 366 F.3d 496, 503 n.2 (7th Cir. 2004) ("Buie had AIDS when he was suspended and fired, which means that he was disabled for purposes of the ADA."). A number of courts have agreed that HIV/AIDS is by definition disabling, with and without an AIDS diagnosis. *See, e.g., Doe v. Dekalb County Sch. Dist.*, 145 F.3d 1441, 1445 n.5 (11th Cir. 1998) (HIV); *Doe v. Div. of Youth & Family Servs.*, 148 F. Supp. 2d 462, 490 (D.N.J. 2001) (HIV); *D.B. v. Bloom*, 896 F. Supp. 166, 170 & n.4 (D.N.J. 1995) (HIV); *Sharrow v. Bailey*, 910 F. Supp. 187, 191 (M.D. Pa. 1995); *Hoepfl v. Barlow*, 906 F. Supp. 317, 319 n. 7 (E.D. Va. 1995) (HIV); *Howe v. Hull*, 873 F. Supp. 72, 78 (N.D. Ohio 1994) (HIV and AIDS); *see also* 29 CFR pt. 1630, App., Section 1630.2(j) ("impairments . . . such as HIV infection, are inherently substantially limiting").

Like the *Bragdon* Court, many courts have found that particular plaintiffs who have HIV disease are disabled because the major life activity of reproduction[19] is substantially limited for such plaintiffs, including those who do not yet have an AIDS

[19] The EEOC defines "substantially limit[ed]" to mean that an individual is "[u]nable to perform a major life activity that the average person in the general population can perform"; or "[s]ignificantly restricted as to the condition, manner or duration under which an individual can perform a particular major life activity as compared to the condition, manner, or duration under which the average person in the general population can perform that same major life activity." 29 CFR § 1630.2(j) (2001). To determine whether an individual is substantially limited in a major life activity, the EEOC regulations suggest that the following factors should be considered: "[t]he nature and severity of the impairment; [t]he duration or expected duration of the impairment; and [t]he permanent or long-term impact, or the expected permanent or long-term impact of or resulting from the impairment." *Id.* at §§ 1630.2(j)(2)(i)-(iii).

diagnosis, *Birch v. Jennico 2*, 2006 WL 1049477 (W.D. Wis. 2006); *Rodriguez v. Manpower*, 2006 WL 2726871 (D. Puerto Rico, 2006); *Teachout v. New York City Dept. of Educ*., 2006 WL 452022 (S.D.N.Y. 2006); *Rivera v. Heyman*, 982 F. Supp. 932 (S.D.N.Y. 1997), *aff'd in relevant part*, 157 F.3d 101 (2d Cir. 1998); *Doe v. Montgomery Hosp.*, 1996 WL 745524 (E.D. Pa. 1996); *Doe v. Kohn, Nast & Graf, P.C.*, 862 F. Supp. 1310 (E.D. Pa 1994), those who do have AIDS, *May v. Sheahan*, 1999 WL 543187 (N.D. Ill. 1999); *Anderson v. Gus Mayer Boston Store of Delaware*, 924 F. Supp. 763 (E.D.Tex.1996); *Doe v. Dolton Elementary Sch. Dist. No. 148*, 694 F. Supp. 440 (N.D.Ill.1988), and those with HIV who may or may not have a formal AIDS diagnosis. *Hernandez v. Prudential Ins. Co. of America*, 977 F. Supp. at 1160.

In addition to reproduction, courts have recognized several other major life activities that are substantially limited by HIV and AIDS, including walking, *County of Centre, PA*, 242 F.3d. at 437 (HIV and AIDS); *May v. Sheahan*, 1999 WL 543187 (AIDS); working, *Giebeler v. M & B Assocs.*, 343 F.3d 1143 (9th Cir. 2003) (HIV, under FHAA), *Wallengren v. Samuel French, Inc.*, 39 F. Supp. 2d 343 (S.D.N.Y 1999) (AIDS); the ability to care for oneself, *Happy Time Day Care Center*, 6 F. Supp. 2d 1073 (HIV); *Hernandez*, 977 F. Supp. at 1160 (HIV/AIDS); the ability to interact with others, *Baxter v. City of Belleville, Ill.*, 720 F. Supp. 720 (S.D. Ill. 1989) (AIDS, under FHAA); *Doe v. Dolton Elem.*, 694 F. Supp. 440 (N.D. Ill. 1988) (AIDS, under Rehabilitation Act), the ability to engage in intimate sexual relationships,[20] *Rivera v. Heyman,* 982 F. Supp. at

[20] Sexual activity is impaired by the disease, since HIV infection can lead to sexual dysfunction (including loss of libido and erectile dysfunction) as a result of the infection itself, of co-morbidities, or of the side effects of ART. Christoph Mayr & U. Fritz Bredeek, *Sexual Dysfunction in HIV/AIDS*, *in* HIV Medicine 2006 679 (Christian Hoffmann, et al. eds. 2006).

932, *aff'd in relevant part*, 157 F.3d 101 (HIV); *Anderson v. Gus Mayer*, 924 F. Supp. at 763 (AIDS), talking, eating and digesting, *County of Centre*, 242 F.3d at 447 (AIDS).

In sum, the ADA asks not what stage of a disease a plaintiff has, but whether that disease substantially limits the plaintiff's major life activities. Because the District Court focused on the nomenclature rather than the consequences of the disease in question, its analysis was flawed and its judgment should be reversed.

III. The Stigma And Discrimination Against Persons With HIV Is The Same As That Directed At Individuals With AIDS.

Treating HIV and AIDS as separate diseases ignores the reality that those who have a fear of people with one stage of the disease fear people with the other as well. The ADA was aimed at redressing irrational fears about people with disabilities, and the District Court's decision diminishes the Act's efficacy at combating the discrimination engendered by such fears.

When it passed the ADA, "Congress acknowledged that society's accumulated myths and fears about disability and disease are as handicapping as are the physical limitations that flow from actual impairment." *Sutton*, 527 U.S. at 489 (*quoting School Bd. of Nassau Cty. v. Arline*, 480 U.S. 273, 284 (1987)). The *Arline* Court reasoned that "[f]ew aspects of a [disability] give rise to the same level of public fear and misapprehension as contagiousness. Even those who suffer or have recovered from such noninfectious diseases as epilepsy or cancer have faced discrimination based on the irrational fear that they might be contagious." 480 U.S. 273, 284 (1987). The Court wrote of the persistent history of stigmatizing and isolating the disabled: "The isolation of the chronically ill and of those perceived to be ill or contagious appears across cultures and centuries, as does the development of complex and often pernicious mythologies about the nature, cause, and transmission of illness." *Id.* at 284 n. 12. "The ADA … serves to 'prohibit employers from making adverse employment decisions based on stereotypes and

generalizations associated with the individual's disability rather than on the individual's actual characteristics.'" *Holiday v. City of Chattanooga*, 206 F.3d 637, 643 (6th Cir. 2000) (internal citation omitted).

The prejudicial attitudes behind stigmatizing someone because of her HIV status appear no different from those behind AIDS discrimination. *See, e.g.*, *Holiday*, 206 F.3d at 641, 648 (City's Personnel Director's withdrawal of offer to employ HIV-positive plaintiff as a police officer, because Director could not "put other employees and the public at risk by hiring [plaintiff]," and City's other unsupported assertions of risk were "sufficient evidence from which a jury could conclude that the City refused to hire him as a police officer because of its unsubstantiated fears of HIV transmission …."); *Doe v. S.E. Pa. Transp. Auth.*, 72 F.3d 1133, 1140 (3d Cir. 1995) ("social stigma, harassment, and discrimination that can result from public knowledge of one's affliction with AIDS"); *United States v. Happy Time Day Care Center*, 6 F. Supp.2d 1073, 1077-78 (day care center refused to enroll an HIV-positive child because two staff members threatened to quit if child was admitted); *Support Ministries for Persons With AIDS, Inc. v. Village of Waterford*, 808 F. Supp. 120, 123 (N.D.N.Y. 1992) (town enacted ordinance to prevent residence for HIV-positive homeless persons because of fear of contagion); *Cain v. Hyatt*, 734 F. Supp. 671, 675, 684-85 (E.D. Pa. 1990) (law firm partners who felt "apprehensive about the communicability of AIDS" and "imputed similar fears to their employees" fired plaintiff law partner because he had AIDS); *Baxter v. City of Belleville*, 720 F. Supp. 720 (S.D. Ill. 1989) (zoning board denied use permit for AIDS hospice due to board members' fears that town residents would be infected with AIDS); *Doe v. Dolton Elementary Sch. Dist. No. 148*, 694 F. Supp. at 440 (student who had AIDS excluded from school and given homebound education because of fear of transmission to other children and teachers).

In *Support Ministries*, town residents expressed "moral opposition" to persons with AIDS at a public meeting to discuss the residence for homeless persons with HIV and "spent a great deal of time talking about the fact that HIV and AIDS was an illness that people brought on themselves and it was a punishment from God …." 808 F. Supp. at 123. A zoning board member wrote: "Persons with a contagious disease are being placed in the middle of a residential area. . . . [A]mong many of the Villagers there is fear -- for themselves, their children and their relatives because the inhabitants of 31 Sixth Street will have the run of the Village, parks, swimming pool, etc. They cannot be prohibited from any of these facilities." *Id.* at 127. In support of its finding that the Fair Housing Act (FHA) prohibits discrimination against persons who are HIV-positive, the *Support Ministries* court quoted the legislative history of the 1988 amendments to the FHA: "People with Acquired Immune Deficiency Syndrome (AIDS) and *people who test positive for the AIDS virus* have been evicted because of an erroneous belief that they pose a health risk to others." *Id.* at 130 (quoting 1988 U.S. Code Cong. & Admin. News 2173 at 2179) (emphasis in court opinion). The human tendency to discriminate against those society fears is the same for HIV and AIDS and is the very reason Congress enacted the ADA and the other anti-discrimination statutes.

Psychologists and health researchers confirm that discrimination related to both HIV and AIDS come from at least two different sources – fear of the disease itself and dislike for those who are associated with the disease -- that often interact to produce heightened stigma. *See generally* Richard Parker & Peter Aggleton, Report, Horizons Program, Population Council, *HIV/AIDS-Related Stigma & Discrimination: A Conceptual Framework & An Agenda For Action* (2002)[21]; Gregory M. Herek & John P. Capitanio, *Symbolic Prejudice or Fear of*

[21] *Available at* http://www.popcouncil.org/pdfs/horizons/sdcncptlfrmwrk.pdf .

Infection? A Functional Analysis of AIDS-Related Stigma Among Heterosexual Adults, 20 BASIC & APPLIED SOCIAL PSYCH. 230 (1998).

Stigma related to HIV disease itself can come from a fear of illness, fear of contagion, and fear of death, sometimes, but not always, based on an "inaccurate understanding of how HIV is transmitted." Lisanne Brown, *et al.*, *Interventions to Reduce HIV/AIDS Stigma: What Have We Learned?*, 15 AIDS EDUC. & PREVENTION 1, 3 (2003). The widespread misunderstanding of how HIV is transmitted has shown little, if any, improvement in the last 16 years. The 2006 Kaiser Family Foundation *Survey of Americans on HIV/AIDS*, at 25, found that, "[m]any people still harbor misconceptions about the HIV epidemic, and knowledge has not increased over time in some key areas. Since 1990, there has been no change in the share [of the public] who incorrectly think HIV might be transmitted through kissing, sharing a drinking glass, or touching a toilet seat."[22] For example, as of March 2006, thirty-seven percent of the public still believed that HIV might be transmitted through kissing. *Id.*, Chart 21.

In addition, HIV and AIDS discrimination builds off of other forms of discrimination. Discrimination based on HIV-status is used as "a vehicle for expressing disapproval of the communities [that HIV and AIDS] disproportionately affect[ ], especially gay people and [intravenous] drug users." Gregory M. Herek, *et al.*, *Stigma, Social Risk, and Health Policy: Public Attitudes Toward HIV Surveillance Policies and the Social Construction of Illness*, 22 HEALTH PSYCH. 533, 533 (2003). As one court recognized, the "particular associations AIDS shares with sexual fault, drug use, social disorder, and with racial minorities, the poor, and other historically disenfranchised groups accentuates the tendency to visit condemnation upon its

[22] *Available at http://www.kff.org/kaiserpolls/upload/Chartpack-2006-Survey-of-Americans-on-HIV-AIDS.pdf* .

victims." *Cain*, 734 F. Supp. at 680 (*citing* S. Sontag, AIDS and Its Metaphors 44-46, 54-59 (1989)).[23]

None of these "sources" of discrimination makes a distinction based on the stage of HIV illness. The communities associated with HIV and AIDS are identical, and the fears about the illness apply equally to all of the stages of the illness. Thus, nothing about the disease or the reasons why someone might discriminate based on HIV/AIDS offers any support for the District Court's sharp distinction between HIV and AIDS.

CONCLUSION

The District Court erred when it relied on a distinction between HIV and AIDS that is not supported by the medical research about HIV disease, the social science research about HIV/AIDS stigma, nor by the law regarding who is disabled under the ADA. The District Court emphasized a distinction between HIV and AIDS that medical science minimizes and ignored the reality that many people have the same irrational fears about HIV/AIDS at every stage of HIV disease. Because of the erroneous distinction, the District Court erred by refusing to consider the EEOC's evidence that Ms. Stewart was disabled due to AIDS. The District Court also erred when it concluded that refusing to hire someone because she has AIDS is materially different from doing so because she is HIV positive. This Court should reject the distinction between HIV and AIDS made by the District Court as legally irrelevant, reverse the judgment, and remand for further proceedings.

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[23] The *Cain* court summarized some of the punitive actions spawned by fear of HIV/AIDS: "AIDS mythology … has spawned calls for … forced quarantine of person with AIDS," "tattooing HIV-positive persons for ready identification," and "banishing HIV carriers from the workplace and school." 734 F. Supp. at 680. "Thus, to conclude that person with AIDS are stigmatized is an understatement; they are widely stereotyped as indelibly miasmic, untouchable, physically and morally polluted." *Id.*

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Respectfully submitted,

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Pursuant to Fed. R. App. Pro. 32(a)(7)(C), the undersigned certifies that the foregoing brief complies with the type-volume limitations.

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James D. Esseks

CERTIFICATE OF SERVICE

I, Adam Schwartz, hereby certify that on the 27th day of December, 2006 I served to the persons shown below the foregoing **BRIEF OF AMICI CURIAE AIDS RESOURCE CENTER OF WISCONSIN, AMERICAN ACADEMY OF HIV MEDICINE, ASSOCIATION OF NURSES IN AIDS CARE, HIV MEDICINE ASSOCIATION, and HOWARD BROWN HEALTH CENTER** , by U.S. Mail, postage prepaid, as set forth below:

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