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AIDS and Disability Employment Discrimination in and beyond the Classroom***

I. Introduction

Roughly a year ago, in *Chalk* v. *U.S. District Court Central California,*[1] a United States appellate court authorized a teacher to return to his teaching duties, after a California school department had barred him from his classroom upon learning he had Acquired Immune Deficiency Syndrome (AIDS). The case parallels the widely reported events of the Eric Smith story of Autumn 1987. Teacher Smith was initially removed from his Shelburne County, Nova Scotia classroom, and reassigned to non-teaching duties after a medical secretary disclosed that Smith had tested positive for the AIDS virus.[2] While Smith immediately refused the

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1. 840 F. 2d 701 (9th Cir. 1988).

2. *See: Globe & Mail,* March 27-28, 1988 at A4. Eric Smith's story has been recounted in several publications. *See* Erin Goodman, "The Trials of Eric Smith" *New Maritimes,* Sept./Oct. 1988, 15-24; *Globe & Mail,* Oct. 3, 1987, D2; Oct. 8, 1987 at A3; Oct. 17, 1987 at A4; Oct. 21, 1987 at A3; Parker Bauss Donham, "Eric Smith", *Chatelaine,* April 1988, 87; Halifax *Mail Star,* Aug. 29, 1987, at 1; Oct. 16, 1987 at 14; Oct. 21, 1987 at 1; Mar. 15, 1988 at 15; Halifax *Chronicle Herald,* Mar. 15, 1988 at 1, 2. On the basis of these publications and personal communications with Eric Smith, we have developed the following chronology:

Sept. 1986: Smith receives treatment for sexually transmitted disease in Shelburne. After a comment by Smith that he is gay, the doctor submits the collected blood samples to an AIDS test without Smith's knowledge or consent.

Sept. 1987: Shelburne County District School Board issues press release, stating that a teacher at Cape Sable Island school has the AIDS virus and will be transferred to an administrative position.

Sept. 1987: Smith seeks assistance from his Union, the Nova Scotia Teachers' Union (NSTU). NSTU issues a press release that it will not contest the reassignment, despite a policy that teachers infected with AIDS should have the right to continue employment. NSTU proposes a monetary settlement to the School Board between $160,000 to $200,000, which the School Board declines.

Oct. 6, 1987: School Board reverses its decision, and decides to reinstate Smith to the classroom effective October 19, 1987.

reassignment, he eventually accepted an educative position on the Nova Scotia Task Force on AIDS, which has recently completed its report.[3]

More recent events suggest that Smith's employment tribulations are not unique. A labour arbitration board in British Columbia has found the suspension of an AIDS-afflicted employee to be without cause.[4] Moreover, over half of the AIDS cases to be filed with human rights commissions across Canada have involved employment discrimination issues.[5] The statistics, the issue of legal discrimination against HIV-infected teachers or other workers, and the factual parallels between *Chalk* and the Eric Smith story, combine to suggest that *Chalk* may be of interest to those formulating Canadian AIDS discrimination law and policy. Accordingly, after summarizing the major medical facts and discussing the details of *Chalk,* we explore its relevance to Canada. We conclude with some observations on the emerging North American consensus on AIDS employment discrimination.

Oct. 9, 1987: Public meeting of "Concerned Parents of Cape Sable Island" opposes Smith's return to the classroom. They threaten a boycott of Smith's classroom.

Oct. 16, 1987: Education Minister, Tom McInnes, announces the creation of a Nova Scotia Task Force on AIDS with Eric Smith as an appointed member. Smith's acceptance of the appointment helps diffuse the immediate controversy on Cape Sable Island.

March 14, 1988: Councillors of the Municipality of Shelburne vote in favour of banning homosexuals, and AIDS-infected teachers, students and other workers from classrooms.

May 2, 1988: Smith accepts a 3-year position as AIDS consultant with Nova Scotia Department of Education, to commence after the completion of his work on the Nova Scotia Task Force on AIDS.

Sept. 1988: Report of the Nova Scotia Task Force on AIDS released.

Oct. 1988: The Nova Scotia Government rejects Task Force recommendations that the Nova Scotia *Human Rights Act* be amended (a) to include express protection for those who have, who are perceived to have, or who associate with those who have a communicable disease, provided they pose no significant health risk to others, and (b) to include sexual orientation as an express ground of discrimination. The N.S. Human Rights Commission has apparently proposed legislation that substantially adopts these recommendations.

3. Nova Scotia Task Force on AIDS, *The Challenge of AIDS: A Nova Scotian Response* (Sept. 1988) (hereinafter cited as NSTFA).

4. *Pacific Western Airlines* v. *Canadian Airline Flight Attendants Assoc.* (1987), 28 L.A.C. (3d) 291. *Accord: Walton* v. *Treasury Board* (1987), 16 C.C.E.L. 190, discussed in text accompanying note 82, *infra.*

5. Information received from human rights commissions across Canada between November 1988 and February 1989 indicated that 22 of 40 AIDS-related complaints involve employment matters. By contrast, of some 1650 AIDS discrimination complaints filed with the New York City Commission on Human Rights, 1983-88, some 30% were employment-related. Personal communication with AIDS Discrimination Unit of the N.Y.C.C.H.R., March 1989.

II. Medical Summary

AIDS was first discovered in North America in 1981. In 1983, the virus that causes AIDS was identified; it had accounted for 2492 reported cases in Canada as of March 1989.[6] A court has summarized the cause and spectrum of the disease in a recent school case:

> Acquired Immune Deficiency (AIDS) is a disease that disables the body from fighting infection. The cause of the disease is infection by the Human T-Lymphotropic Virus, Type III (HLTV-III), also known as Human Immunodeficiency Virus (HIV). Three categories of outcomes result from infection by HTLV-III. The first, AIDS, is the most severe form of the infection; and most victims of the disease die within two years. The second possible form of infection is AIDS-Related Complex (ARC), a milder degree of immunodeficiency. The third and most common form of infection is asymptomatic, resulting in no abnormal infections.[7]

The detection, treatment, and transmission of HIV-infection are relevant to understanding the employment and school controversies surrounding the disease.

1. Testing

In 1985, the enzyme-linked immunosorbent assay (ELISA) blood-screening test was licensed to detect the presence of antibodies to HIV-infection (seroconversion, seropositivity).[8] Antibodies usually develop within 12 weeks of infection, but may take up to six months. A falsely negative test result may register when a recently infected person has not had time to develop detectable antibodies; on the other hand, a falsely positive result may register because of the high sensitivity of the ELISA test.[9] In consequence, a standardized testing procedure has developed whereby if an initial ELISA test is positive, a second ELISA test is performed followed by a "Western blot" or like confirmatory tests.[10]

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6. Health and Welfare Canada, Federal Centre for AIDS, *Surveillance Update: AIDS in Canada* (6 Mar. 1989). Over 85% of the cases were reported from Ontario, Quebec and British Columbia.

7. *Board of Ed., Plainfield* v. *Cooperman*, 523 A.2d 655 at 656 (N.J. 1987) (upholding N.J. State Commission of Education AIDS policy & guidelines). Two years is apparently a considerable period of time in the rapidly moving field of AIDS epidemiological research. Medical authorities' technical redefinition of AIDS and its categories of illness may make some of the language and categories used in the court excerpt already dated. *See* CDC, *infra,* note 10.

8. *Kirkendale* v. *Harbour Ins. Co.,* 698 F.Supp. 768, 772 (W.D. Ark. 1988) *See also,* "Blood Test to Screen for AIDS Virus licensed" (1985), 132 C.M.A.J. 950.

9. Banks & McFadden, "Rush to Judgement: HIV Test Reliability & Screening" (1987), 23 Tulsa L.J. 1.

10. U.S. Public Health Service, Centers for Disease Control, "Revision of CDC Surveillance Case Definition for Acquired Immunodeficiency Syndrome," (14 Aug. 1987) 36(Supp.) *Morbidity Mortality Wkly Rpt.* at 10S.

Once it is confirmed that one is HIV-infected, the current medical consensus is that one may transmit the virus, even if that one remains asymptomatic. Yet it is still not known what percentage of HIV-infected individuals will have their immune systems compromised to the point of developing the pneumocystic pneumonia, skin cancer, and like clinical symptoms and opportunistic infections of "full-blown AIDS."[11]

2. Treatment

Medical science currently offers no medication for AIDS that parallels the curative impact that penicillin has had on common sexually transmitted diseases (STDs). Nor has a vaccine been developed that would immunize against HIV-infection.[12] Thus, from an historical perspective society finds itself in a position akin to the position it assumed prior to the development of a safe and effective treatment for STDs[13] and prior to the 1982 licensure of a vaccine for the similarly transmitted and potentially lethal Hepatitis B virus (HBV).[14] Several drugs are currently in different phases of development for treating various AIDS-related illnesses.[15] For example, AZT[16] is apparently effective in fighting viral reproduction, in arresting the development of AIDS-related diseases, and so in prolonging life.[17] Another drug called Aerosal Pentamidine has been more recently enlisted to fight the life threatening pneumonia that may afflict AIDS patients.[18]

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11. By recent World Health Organization estimates, 50% of those infected with HIV are likely to develop AIDS within 10 years of infection (Communication with Federal Centre for AIDS).
12. Mariner, "Why Clinical Trials of AIDS Vaccines are Premature" (1989), 79 Am. J. Pub. Hlth. 86.
13. A. Brandt, *No Magic Bullet: A Social History of Venereal Disease in the United States Since 1880* 12, 40, 123-4 (1985).
14. *See* U.S. Public Health Service Centers for Disease Control, "Update on Hepatitis Prevention" (19 June 1987), 36(23) Morbidity Mortality Weekly Rpt. 353. *See also* Baker & Brennan, "Keeping Health Care Workers Healthy: Legal Aspects of Hepatitis B Immunization Program" (1984), 311(10) N.E.J.M. 684.
15. Under regulations adopted pursuant to the *Food and Drug Act,* R.S.C., 1985, c.F-27, drugs become available in Canada (a) as an approved drug, as certified by a "notice of compliance" attesting to its safety and efficacy (b) as an experimental drug, in strictly controlled human clinical trials undertaken to test the safety and efficacy of new drugs, or (c) as an experimental drug, through "emergency drug releases" requested by physicians on compassionate grounds when standard therapy is not effective and a medical emergency exists. Health & Welfare Canada, Departmental Consolidation of the *Food & Drug Act* and of the *Food & Drug Regulations* (Amendments to March 1988) ss. c.08.002(1)(b); c.08.005; c.08.010.
16. "AZT", known technically as azidthymidine or zibovudine, is currently available through clinical trials in Canada.
17. *N.Y. Times,* 7 Feb. 1989, at B6.
18. *Id.*

3. Transmission

The Human Immunodeficiency Virus has been isolated in blood, semen, tears, saliva, vaginal secretions, urine and other body fluids.[19] This fact gives rise to a theoretical possibility that HIV may be transmitted by contact with such fluids. There has also been concern that HIV may be transmitted by sharing bathrooms and telephones, shaking hands, or otherwise having casual contact with HIV-infected individuals.

The evidence accumulated and studied by medical authorities reveals a different story, however. The medical evidence overwhelmingly indicates that HIV infection is transmitted (1) by intimate sexual contact, (2) by sharing needles contaminated with HIV-infected blood, (3) by an infected mother to her fetus or newborn child, (4) by transfusion of HIV-infected blood or blood products.[20] The blood, semen and vaginal secretions implicated in these activities are the primary modes of transmission.[21] Indeed, Canadian medical recommendations on universal AIDS precautions for health care workers recently advised that the precautions do not apply to tears, nasal secretions, vomit, sweat, urine, *etc.*, unless they contain visible blood.[22] Blood-letting, exchanging intimate sexual fluids, sharing intravenous needles are not the kinds of activities that characterize the typical job setting. Accordingly, the leading Canadian and U.S. public health authorities have unanimously concluded that the "contact that generally occurs among workers and clients or consumers in the workplace does not pose a risk of transmission for HTLV-III/LAV."[23] The conclusion also extends to the school.[24]

While such conclusions and medical evidence may reassure some, they provide slight assurance for others. Even if the risk of HIV infection is remote, theoretical, minimal, or dramatically less than the risk of catching

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19. Friedland & Klein, "Transmission of Human Immunodeficiency Virus" (1987), 317(18) N.E.J.M. 1125 at 1132.

20. U.S. Public Health Service, Centers for Disease Control, "Summary: Recommendations for Preventing Transmission of Infection with HTLV-III/LAV in the Workplace" (Part I) (6 Dec. 1985), 254(21) J.A.M.A. 3023.

21. Friedland, *supra,* note 19 at 1132.

22. Health & Welfare Canada, "Universal Precautions: Report of a Consensus Meeting" (4 Feb. 1989), 15-5 Canada Diseases Weekly Report 23.

23. CDC, *supra*, note 20 at 3023.

24. U.S. Public Health Service, Centers for Disease Control, "Recommendations for Preventing Transmission of Infection, Infection with HTLV-III/LAV in the Workplace" (Part II) (13 Dec. 1985), 254(22) J.A.M.A. 3162 at 3167. *See also* note 138, *infra.* The CDC recommendations on HIV infection in the workplace have been endorsed by the leading Canadian governmental analyst of public health disease, the Laboratory Centre for Disease Control/Federal Centre for AIDs, Health & Welfare Canada. *See: Pacific & Western, supra,* note 4 at 306. Many of the CDC recommendations have been collected in CDC, *Recommendations & Guidelines Concerning AIDS Published in the Morbidity & Mortality Weekly Report November 1982-1986* (1986).

such typical school diseases as the mumps, small pox or measles, it is argued that subjecting one's child or self to a fatal, incurable disease is a risk no sane parent should be asked to assume. Add to that the stigmatization of groups identified as being at higher risk of HIV infection — homosexuals and others regarded as engaging in unsafe sex, intravenous drug users, hemophiliacs and others who received multiple unit blood transfusions before 1985[25] — and it is predictable that infected and uninfected individuals perceived as belonging to these groups would become prime targets of discrimination. As *Chalk* and the Eric Smith story will show, it is this tension between reasonable and unreasonable fear of contagion, objective and subjective risk assessment, and individual and societal rights, which so drives the AIDS conflicts in the workplace and school house.

III. Chalk v. *U.S. District Court*

1. Factual Background

In the California case, an HIV-infected teacher of hearing-impaired students sought to enjoin a county education department from barring him from teaching. A teacher of some six years, Vincent Chalk was hospitalized in February 1987 for pneumonia and was diagnosed as having AIDS. Chalk underwent treatments and convalescence for two months before his personal physician discharged him from the hospital and pronounced him fit for duty. Chalk remained on administrative leave for another two months, through the end of the school year, during which time a county physician informed the Education Department that "nothing in his role as a teacher should place his students or others in the school at any risk of acquiring HIV infection."[26]

The medical opinion apparently had little effect on a subsequent decision by the Education Department. About a month before the start of the new school year, the Department offered to transfer Chalk from his classroom duties to a Department administrative position with the same pay and benefits. The offer strongly parallels the offer of the Shelburne County School Board to transfer Eric Smith from his classroom to an administrative position.[27]

At least one significant fact distinguishes Chalk's story from Smith's, however. A day after Chalk declined the offer, both he and the Department filed actions in court. Chalk claimed that the school action constituted unlawful discrimination on the basis of physical disability/

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25. CDC, *supra,* note 20 at 3023.
26. *Chalk, supra,* note 1 at 701.
27. *See,* note 2, *supra.*

handicap in violation of federal antidiscrimination law. Pending a trial on the merits, Chalk sought an injunction ordering the Department to return him to his classroom duties. After an adverse decision in U.S. district court, an appellate federal court one level below the U.S. Supreme Court reversed the lower court ruling and authorized Chalk to return to teaching.[28] Though the Court did not definitively decide the discrimination claim, the ruling is of major import because (a) the Court found Chalk likely to succeed on the merits of his claim, (b) it is the highest U.S. Court to hold that those who suffer AIDS likely enjoy the protection of federal handicapped antidiscrimination law and because (c) the Court adopted a "significant risk of transmission" standard to test a claim of alleged AIDS discrimination.

2. Federal Disability Discrimination Law

Chalk filed his claim under Section 504 of the *Federal Rehabilitation Act of 1973 (FRA).*[29] The Act provides disabled persons a statutory right to equal treatment, by prohibiting organizations, programs or activities receiving federal monies from discriminating against the "handicapped".[30] The prohibited employment discrimination is broad, and applies to recruitment, hiring, promotion, demotion, transfer, layoffs and termination.[31] The statute defines "handicapped" as a person either with a "physical or mental impairment" that substantially limits major life activities, or as a person regarded as having such impairment.[32] U.S.

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28. Chalk, supra, note 1.

29. Codified, as amended, 29 U.S.C. ss, 701-96.

30. 29 U.S.C. ss, 793, 794 ("No otherwise qualified individual with handicaps . . . shall, solely by reason of his handicap, be excluded from participation in . . . or be subjected to discrimination under any program or activity receiving Federal financial assistance. . .") *See also* note 32, *infra.*

31. 45 *Code Fed. Register* 84.11(b)(4) (1987).

32. The statutory definition provides, in pertinent part, as follows:

> . . . the term "individual with handicaps" means, for purposes of titles IV and V of this Act [29 USCS ss 789 et seq., 790 et seq.], any person who (i) *has a physical or mental impairment which substantially limits one or more of such person's major life activities,* (ii) has a record of such an impairment, or (iii) *is regarded as having such an impairment.* 29 U.S.C. 706(7)(b). (emphasis added.)

It is an open question whether a March 1988 amendment to the Federal Rehabilitative Act codified or amended the *Arline* ruling. The amendement provides that the term handicapped "does not include an individual who has a currently contagious disease or an infection and who, by reason of such disease or infection, would constitute a *direct threat* to the health and safety of individuals or who, by reason of currently contagious disease or infection, is unable to perform the duties of the job." *Civil Rights Restoration Act of 1987* s.9 (emphasis added), P.L. 100-259, 102 Stat. 31, amending 29 USC ss,706, 794. For purposes of our analysis, we find the codification view the more persuasive. Accordingly, our discussion of the significant risk analysis is developed on the assumption that "significant risk" is tantamount to or synonymous with "direct threat."

Department of Health and Human Services regulations further define "physical impairment" to include "any physiological disorder or condition" affecting the "hemic" (blood) or "lymphatic" system.[33] Hence, because HIV infection is a physiological disorder or condition in the blood that "impairs," in part, by attacking the lymphatic system, AIDS victims would seem likely to meet the threshold elements for qualifying as "handicapped individuals" under the FRA.[34]

Yet, before *Chalk,* no appellate federal court in the U.S. had so directly addressed the question, despite a recent U.S. Supreme Court opinion that broached the issue. For about the time that events in *Chalk* were moving towards court, the U.S. Supreme Court decided *School Board of Nassau Cnty., Fla.* v. *Arline.*[35] There, a public elementary school teacher sought reinstatement and back-pay under the *Federal Rehabilitation Act,* following her discharge from work after a relapse from the contagious disease of tuberculosis. Two general issues were before the Court: (1) whether one suffering from a contagious disease is "handicapped" within the meaning of the statute, and (2) how the risk and fears of infection from contagious diseases should be weighed and analyzed in determining whether one is "otherwise qualified" for employment despite one's handicap.

In *Arline,* the Court held 7-2 that one physically disabled by the contagious disease of tuberculosis is "handicapped" within the meaning of the *Federal Rehabilitation Act.*[36] The court construed the definition of a handicapped individual to include those who are physically impaired and those who are regarded as being impaired.[37] Writing for the majority, Justice Brennan addressed the role that the fear of contagion and medical evidence play in applying the anti-discrimination provisions to those with actual or perceived contagious diseases:

> *Few aspects of a handicap give rise to the level of public fear and misapprehension as contagiousness. Even those who suffer or have recovered from such non-infectious diseases as epilepsy or cancer have faced discrimination based on the irrational fear that they might be contagious. The Act is carefully structured to replace such reflexive reactions to actual or perceived handicaps with actions based on reasoned and medically sound judgments. . .*The fact that some persons who have contagious diseases may pose a serious health threat to others under

33. 45 *Code Federal Register* s.84(3)(j)(2)(i)(1987). HHS shares jurisdiction with the U.S. Department of Labor for implementing and enforcing the Act. *See* discussion in *Bentivegna, infra,* note 133.

34. *See generally,* Note, "Asymptomatic Infection with AIDS Virus as a Handicap Under the Rehabilitation Act of 1973" (1988), 88 Colum. L. Rev. 563.

35. 107 S. Ct. 1123 (1987).

36. *Id.,* at 1127.

37. *Id.,* at 1129. *See generally,* note 34, *supra.*

> certain circumstances does not justify excluding from the coverage of the Act all persons with actual or perceived contagious diseases. Such exclusion would mean that those accused of being contagious would never have the opportunity to have their condition evaluated in light of medical evidence and a determination made as to whether they were "otherwise qualified." Rather, they would be vulnerable to discrimination on the basis of mythology — precisely the type of injury Congress sought to prevent.[38]

Finally, in a passage of import to HIV-infected individuals who have not developed visible physical impairment, the Court addressed whether the contagiousness of a disease may be meaningfully distinguished from physical impairment in determining handicap discrimination:

> The United States argues that it is possible for a person to be simply a carrier of a disease, that is, to be capable of spreading a disease, without having a "physical impairment" or suffering from any other symptoms associated with the disease. The United States contends that this is true in the case of some carriers of the acquired immune deficiency syndrome (AIDS) virus. From this premise the United States concludes that discrimination solely on the basis of contagiousness is never discrimination on the basis of the handicap. *The argument is misplaced in this case, because the handicap here, tuberculosis, gave rise both to a physical impairment and to contagiousness. This case does not present, and we therefore do not reach, the questions whether a carrier of a contagious disease such as AIDS could be considered to have a physical impairment, or whether such a person could be considered, solely on the basis of contagiousness, a handicapped person as defined by the Act.*[39] [emphasis added]

Thus, though the court arguably left open the question whether all AIDS carriers are "handicapped," its analysis clearly indicates that individuals physically impaired by contagious diseases are protected by U.S. federal law prohibiting discrimination against the disabled or the handicapped. The *Arline* ruling may be expected to have precendential effect in areas beyond federal jurisdiction because more than 20 states in the U.S. have handicap anti-discrimination laws modeled on or paralleling the federal Act.[40]

3. Significant Risk Analysis

In the wake of *Arline,* Chalk sought a preliminary injunction against the Education Department initiatives to oust him from the classroom. In

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38. *Id.,* at 1129-30 (emphasis added).
39. *Id.,* at 1128, n. 7.
40. *See* Wasson, "AIDS Discrimination Under Federal, State, and Local Law After *Arline*" (1987), 15 Flor. St. Univ. L. Rev. 221 at 269 (discussing Colorado, Louisiana, Massachusetts, Minnesota, New Mexico, Oklahoma, Oregan, Rhode Island, Vermont, Alaska, Connecticut, District of Columbia, Illinois, Maryland, Montana, Nebraska, New Jersey laws).

doing so, he afforded a U.S. Court of Appeals the opportunity to address more fully the contagious disease and AIDS discrimination questions left open by the Supreme Court. The *Chalk* Court directly applied the principles of *Arline* to order the reinstatement of the AIDS-afflicted teacher pending trial. The Court issued its order on finding that Chalk had met the prerequisites for a preliminary injunction, namely; (1) that he demonstrated a likelihood of success on the merits,[41] (2) that if barred from teaching, he would suffer irreparable injury in the form of immediate emotional and psychological harms which could not be compensated by monetary awards after trial,[42] and (3) that the balance of hardship weighed in Chalk's favor.[43] The more instructive part of the analysis centered on the "likelihood of success on the merits."

Applying *Arline*, the Court found that Chalk would likely prove he had been discriminated against by the Education Department's refusal to permit him to teach given the overwhelming medical evidence that he posed "no significant risk" of communicating AIDS to others in the school environment. The Court first expressly found that the *Federal Rehabilitaton Act* fully applies to individuals suffering from contagious diseases.[44] Secondly, for purposes of its analysis, the Court assumed that one who suffers physical impairment from the contagious disease of AIDS is "handicapped" within the meaning of the Act.[45] It thus relied on and did not reject the express finding by the lower court that Chalk was "handicapped."[46]

Thirdly, the Court adopted a significant risk standard to test claims of AIDS discrimination. The Court asked when a "handicapped" individual, who may "perform the essential functions of the job", may be properly excluded from employment.[47] "The problem", the Court stated, "is in reconciling the needs for protection of other persons, continuation of the work mission and reasonable accommodation — if possible — of the afflicted individual."[48] To effect a balance, the Court concluded that the analysis should first focus on whether the AIDS-afflicted employee poses a "significant risk" of communicating the disease to others in the workplace:

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41. *Chalk, supra,* note 1 at 709.
42. *Id.,* at 709-710.
43. *Id.,* at 710-711.
44. *Id.,* at 704, citing *Arline.*
45. *Id.,* at 705, n. 6.
46. *Id.,* Though the lower court found Chalk to be a "handicapped" individual, it found he posed an unacceptable health risk. *See* text accompanying note 56, *infra.*
47. *Id.,* at 705, citing *Arline.*
48. *Id.,*

> *A person who poses a significant risk of communicating infectious disease to others in the workplace will not be otherwise qualified for his job or her job if reasonable accommodation will not eliminate the risk. . . .*
>
> The application of the standard requires, in most cases, an invidualized inquiry and appropriate findings of fact so that "s.504 may achieve its goal of protecting handicapped individuals from deprivations based on prejudice, stereotypes, or unfounded fear, while giving appropriate weight to such legitimate concerns . . . as avoiding exposure of others to significant health and safety risks."[49]

If the individualized inquiry reveals an employee poses a "significant risk" of infection, the court must next determine if the accommodation necessary to eliminate any significant risk is reasonable — that is, it imposes no undue financial or administrative burden or fundamental programmatic alterations on the employer.[50]

Applying the "significant risk" standard to the medical evidence on the transmission of AIDS in the workplace, the *Chalk* Court analyzed the risk criteria urged on, and adopted by, the *Arline* court in an *amicus* submission by the American Medical Association: namely, the nature, duraton, severity of risk, and probability of transmission and harm.[51] Given the known avenues of AIDS transmission (initmate sexual contact, mother to fetus, exposure to contaminated blood or other specific body fluids),[52] the court turned to the medical evidence accumulated by U.S. federal public health authorities to evaluate the specific risk of AIDS transmission in the classroom:

> None of the identified cases of AIDS in the United States are known or are suspected to have been transmitted from one child to another in school, day care or foster care settings. Transmission would necessitate exposure of open cuts to the blood or other body fluids of the infected child, a highly unlikely occurrence. Even then, routine safety procedures for handling blood or other body fluids . . . would be effective in preventing transmission from children with AIDS to other children in school . . . Casual social contact between children and persons affected with the AIDS virus is not dangerous.[53]

The Court found this view of the medical evidence to be shared by the U.S. Centers for Disease Control, the Nationl Academy of Science Institute of Medicine, and the American Medical Association (AMA).[54]

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49. *Id.*, at 705, citing *Arline* at 1131 (emphasis added).
50. *Id.*
51. *See Arline, supra*, note 35 at 1131, n. 16. *See: Chalk, supra*, note 1 at 705.
52. *See* note 20, *supra.*
53. *Chalk, supra*, note 1 at 706, citing U.S. Public Health Service, *Surgeon General's Report on Acquired Immune Deficiency Syndrome (1986).*
54. *Id.*, at 707.

It quoted the *amicus* brief of the AMA to conclude that there is no appreciable risk of HIV transmission "under the circumstances likely to occur in the ordinary school setting."[55]

Finally, the Court emphasized that evaluating a "significant risk" of transmission is not done on the basis of absolute certainty but on reasonable medical opinions based on current medical evidence:

> Nonetheless, the District Judge expressed skepticism about the current state of medical knowledge. He was troubled that there might be something yet unknown to science that might do harm. He said:
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> > "It seems to me the problem is that we simply do not know enough about AIDS to be completely certain. The plaintiff has submitted massive documentation tending to show a minimal risk . . . but in any event, the risk is small — the risk of infection through casual contact . . . I reiterate, I think the risk is small. The likelihood is that the medical profession knows exactly what it's talking about. But I think it's too early to draw a definite conclusion, as far as this case is concerned, about the extent of risk."
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> This language demonstrates that *the district court* failed to follow the legal standards set forth in Arline and *improperly placed an impossible burden of proof on the petitioner. Little in science can be proved with complete certainty,* and s. 504 does not require such a test. As authoritatively construed by the Supreme Court, *s. 504 allows the exclusion of an employee only if there is significant risk of communicating an infectious disease to others.*[56]

To buttress its conclusion that Chalk had likely been discriminated against, the Court cited analogous cass of discrimination against students, infected with HIV or Hepatitis B, who had been initially barred from the classroom.[57] Days after the decision, Chalk resumed his high school teaching responsibilities.[58]

IV. Relevance to Canada

The *Chalk* case is directly relevant to Canada for at least three reasons. First, it provides authority from the proposition that HIV-infected individuals are "disabled" within the meaning of applicable human rights law. Secondly, it announces a "significant risk" of transmission analysis to test claims that HIV-infected individuals should be barred or transferred from the classroom or other employment settings. Thirdly, the public law context in which *Chalk* arose suggests the strengths, limits and

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55. *Id.*
56. *Id.*, at 707-708 (emphasis added).
57. *Id.*, at 708, citing *Thomas, Ray* and *Carey,* discussed *infra,* note 118.
58. Personal communication with Chalk's lawyers.

complementary role adjudicative bodies may play in developing AIDS discrimination law and policy.

For example, had Eric Smith filed a complaint under the Nova Scoita *Human Rights Act* alleging discrimination on the basis of physical disability,[59] the claim would have presenteed questions (1) whether an HIV-infected (asymptomatic, seropositive) individual is "physically disabled," within the meaning of the Nova Scotia *Human Rights Act*,[60] (2) whether the nature and extent of disability "reasonably precludes performance"[61] of Smith's classroom teaching activities, and (3) whether any discrimination is legitimized by a *bona fide* qualification.[62] Should the reasoning in *Chalk* inform responses to these questions?

1. HIV Infection as a Disability

As to the first question, a narrow reading of *Chalk* may focus on the fact that because Vincent Chalk had suffered physical impairment, the *Chalk* Court did not directly reach the question of whether an asymptomatic HIV-infected individual is "disabled" under applicable human rights codes. A broader reading of *Chalk* may focus on the analytic approach and statutory basis of the decision to conclude that even those perceived as being HIV-infected are "disabled". As will be shown, courts have tended towards the broader reading.[63]

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59. Of course, employees who have suffered wrongful treatment by employers due to HIV-infection may have other avenues of legal recourse. *See, eg., Pacific Western, supra,* note 4 (arbitration grievance); *Saxton* v. *Vanzant,* No-86-civ-59 (Fayette Cnty Ohio, Court of Common Pleas, March 1986) (defamation); *Zabusky* v. *MBW Advertising Agency,* BNA *Aids Policy & Law,* June 29, 1988 at 7 (slander and mental distress); *Dr. Doe* v. *Primary Care Corporation,* CA No. 86-3777 (D.C. E. Va. 1986) (AIDS-related breach of contract). For AIDS-related constitutional claims, see notes 64, 136, *infra.* For commentary on Canadian slander *per se,* mental distress, and invasion of privacy causes of action, see A. Linden, *Canadian Tort Law* 50, 52, 363, 641 (4th ed. 1988).

60. R.S.N.S. c. H-24. Protection against discrimination in employment on the basis of physical disability is provided in s. 11B(1)(b) & (2) and 11C(1)(d). The circumstances of Eric Smith's transfer may raise the issue of discrimination on the basis of sexual orientation, though the Nova Scotia legislation provides no express protection against such discrimination. Moreover, there is Canadian authority to the effect that the protection against "sex discrimination" does not include discrimination based on sexual orientation., *See: Re Board of Governors of the University of Saskatchewan and Saskatchewan Human Rights Commission* (1976), 66 D.L.R. (3d) 561 (Sask. Q.B.). Accordingly, the Nova Scotia Task Force on AIDS recommended amending the *Human Rights Act* to prohibit, expressly, discrimination based on sexual orientation. *See* NTSFA recommendation excerpted, *infra,* note 71.

61. *Id.,* ss. 11B(1)(b) and 11C(2)(a).

62. *Id.,* s. 11C(2)(d). The Nova Scotia Act uses the term "*bona fide* qualification" because the defence is also relevant to discrimination in non-employment contexts. In most other jurisdictions the terms *bona fide* occupational qualification or *bona fide* occupational requirement are used. We use these terms interchangeably.

63. *See* text accompanying notes 68, 69, and 125. *See also* Note, *supra,* note 34 and *Centinela, infra,* note 115.

In the very least, *Chalk* may help in elaborating the principle of non-discrimination in the AIDS context, for the purpose, function, and definition of "handicap" in the *Federal Rehabilitation Act* (FRA) generally parallel the purpose, function, and definition of handicap or disability in Canadian human rights legislation.[64] The Nova Scotia, Ontario and federal acts, for example, define "physical disability" or "handicap" to include "infirmity . . . caused by . . . illness".[65] Still, as one Canadian commentator has noted, in contrast to the FRA, most Canadian human rights codes have no regulations defining a handicap or disability to include physiological conditions affecting the lymphatic system.[66] The inference is that such regulations would afford courts or commissions more authority for construing AIDS-related impairments under the statutory definitions of "disability" or "handicap".

The want of comparable regulations migh prove telling were it not for the broad and purposive approach generally urged in construing and applying human rights codes.[67] Indeed, this consideration recently proved dispositive in the first AIDS case to present squarely before a human rights tribunal in Canada the question of whether HIV-infection is a protected disability or handicap. In a case of alleged termination of a residential tenancy due to AIDS, a B.C. human rights tribunal adopted a purposive approach to hold that HIV-infection constitutes a physical disability within the meaning of the B.C. *Human Rights Act:*

> Any person who is seropositive by manifesting antibodies to HIV has a physical disability and, in the absence of a *bona fide* occupational

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64. *see, eg., Canadian Human Rights Act,* R.S.C. 1985, c. H-6, s. 65.1(3); *Ontario Human Rights Code,* R.S.O. 1980, c. 410 s. 9(b); *Nova Scotia Human Rights Act,* R.S.N.S. c. H-24 ss. 11B, 11C. The *Canadian Charter of Rights and Freedoms,* Part I of the *Constitution Act, 1982,* being Schedule B of the *Canada Act 1982* (U.K.), 1982, c. 11, s. 15, also provides explicit protection against discrimination on the basis of "physical disability". For a general discussion of the *Charter* and discrimination on the basis of physical disability, see David Lepofsky & Jerome Bickenbach, "Equality Rights and the Physically Handicapped" in Bayefsky & Eberts (eds.) *Equality Rights and the Canadian Charter of Rights and Freedoms* (Toronto: Carswell, 1985), c. 7, at 323-380. *Charter* protections against discrimination on the basis of disability might be relied on directly. *See: District 27 Comm. School* v. *Brd. of Education,* 502 N.Y.S. 2d (Sup. Ct. 1986). (Mandatory HIV testing of mentally disabled students, who pose theoretical risk of transmission, lacks rational basis and violates equal protection). In addition, human rights legislation might be challenged as failing to provide adequate protection against discrimination on the grounds of physical disability. For an example of the latter in the context of sex discrimination, see *Re Blainey and Ontario Hockey Ass'n* (1986), 54 O.R. 513 (Ont. C.A.) (leave to appeal denied) (athletic organizations exemption in Ontario *Human Rights Code* struck down as unconstitutional).

65. *Id.*

66. Kenney, "AIDS in the Workplace: Termination, Discrimination and the Right to Refuse" (1988), 11 Dalhousie L.J. 581, 601.

67. *See* discussion in *Action Travail des Femmes* v. *C.N.R. Co.* (1987), 40 D.L.R. (4th) 193 at 206-9 (S.C.C.) *per* Dickson C.J.

> requirement, if applicable, is entitled to the protection set out in sections 3, 4, 5, 6, 8, and 9 of the *Act.* This protection, by definition, would extend to those who have been disagnosed as having ARC or AIDS. In my view, there is nothing in the said decisons which would prohibit the said protection from being exended to those who are "perceived" as having ARC or AIDS.[68]

The tribunal relied, in part, on *Arline, Chalk* and other U.S. case law and medical evidence to frame its analysis.[69] Concluding that the B.C. Act may protect even those associating with persons perceived as having HIV-infection, the tribunal found the termination of the tenancy owed to violations of the lease rather than AIDS discrimination.[70] Still, the holding and principle survive the particular facts of *Biggs.* It would seem to confirm that *Chalk* provides U.S. authority for the proposition that HIV-infected individuals are handicapped or disabled. The reasoning in *Biggs* promises to be of national precedential value, moveover, because it is consistent with and supported by most Canadian authorities and commentators.[71]

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68. *Biggs & Cole* v. *Hudson* (1988), 9 C.H.R.R. D/5391 at D/5394, para. 40353. Compare one of the first State Human Rights Commission decisions to the same effect, *Shuttleworth* v. *Broward City,* FCHR No. 85-0624 (Fla. Dec. 11, 1985), explained in (1986), 9 Harv. J.L. & Public Pol'y 739; companion federal claims at 639 F. Supp. 654 (S.D. Fla. 1986).

69. *Id.,* at D/5395-96.

70. *Id.,* at D/5395, D/5402. *Cf.,* "AIDS Discrimination Costs Landlord $7000," *Globe & Mail,* 1 Dec. 1988, at A20. *See also: Harton* v. *N.Y.C. Comm'n on Human Rights,* 531 N.Y.S. 2d 979 (N.Y. Super. 1988).

71. *See: Pacific Western, supra,* note 4. Some commentators regard the definitions of handicap or disability as offering broad protection. *See* Stewart, Solfan & Thorne, "Acquired Immunodeficiency Syndrome — "AIDS", The Legal Issues are Also Frightening" (1988), 48 The Advocate 49 at 61. ("To date, there are no cases in British Columbia which fall within the definition of 'physical disability'. In our opinion, adjudicators will decide that AIDS falls within the defintion"); *see also* Bryden & Jarret, "AIDS, Employment Discrimination and the B.C. Human Rights Act" (July 1988), 9 C.H.R.R. C/88-7 at c/88-11 and 14 (. . . "The American case law does seem to support the view that it is not an unwarranted extension of the meaning of the term "disability" in the human rights context to interpret the Act as covering people actually suffering from AIDS. Since this is consistent with the Act's purpose, there is no reason for the Council to reject this interpretation . . . we think it is appropriate for people who are HIV sero-positive to be included in the class of individuals who are protected from employment discrimination on the grounds of their disability."); Kenny, *supra,* note 41 at 601. ("Thus, it can be safely stated that there is nothing in Canadian human rights legislation that would prevent a wide interpretation of handicap from being made, thereby offering a protection to persons with communicable diseases and AIDS.") Other commentators acknowledge the potentially broad coverage of the definitions, but query whether the language reaches asymptomatic seropositive individuals. *See* Ducharme, "Preparing for a Legal Epidemic: An AIDS Primer for Lawyers and Policy Makers" (1988), 26 Albta L. Rev. 471 at 487-488 ("It seems clear that complaints in AIDS-related cases will be dealt with as discrimination on the basis of 'handicap' and 'physical disability' . . . It seems clear that anyone suffering from any of the disabling effects of AIDS or an AIDS-related condition would be covered by these definitions. However, it might be argued that an asymptomatic seropositive individual is not caught by such language."); *see also,* The Canadian Bar Association —

2. Significant Risk Analysis

Chalk also proves instructive in addressing employer defenses that HIV-infected job applicants not be hired or that employees should be discharged or transferred due to HIV infection. Under the Nova Scotia legislation, an employer might argue that HIV infection "reasonably precludes performance" of a job or that freedom from HIV infection is a *bona fide* occupational qualification (bfoq).[72] Under the "significant risk" standard, adopted in *Chalk* and *Arline* and endorsed by the Nova Scotia Task Force on AIDS,[73] claims of discrimination are evaluated in light of the best medical evidence of whether one poses a "significant risk" of transmission in different contexts. The standard specifically requires court analysis of the (1) nature of the risk, (2) duration of risk, (3) severity of harm to third parties, and (4) nature and likelihood of transmission.[74] If one assumes on the basis of current medical evidence that HIV carriers are "perpetually" infected and that the ultimate risk of harm to third parties is "fatality," the inquiry reduces to an analysis of the nature and likelihood of transmission.[75] *Biggs* and *Chalk* indicate that courts tend to regard the evaluations and recommendations of such federal public health authorities as the U.S. Centers for Disease Control or the Canadian Federal Centre for AIDS as cogent medical evidence on the nature and likelihood of HIV transmission in different settings.[76] If the evidence suggests an employee poses a significant risk of transmission, the inquiry turns to whether the employee may be accommodated without undue financial or administrative burdens.[77]

Ontario, *Report of the AIDS Committee* 65 (1985) (". . . there appears to be no doubt that either AIDS or ARC would fall within these definitions, but is less obvious that persons who test antibody positive, who are otherwise asymptomatic, would fall within the terms of these definitions.") Because of such potential ambiguity, other commentators have called for amending human rights law to provide for explicit protection of all HIV-infected individuals. *See* NSTFA, *supra,* note 3 at 67 ("The Nova Scotia *Human Rights Act* should be amended to include protection expressly for persons who have, who are perceived to have, or who associate with those who have a communicable disease and who pose no significant health risk as determined by public health officers."); *see also,* Royal Society of Canada, *A Perspective for Canadians: AIDS Background Papers* at 381 (1988) ("To make the legislation more certain and humane, we recommend that all human rights legislation be amended to prohibit discrimination based on evidence of HIV infection, perceived HIV-infection, sexual orientation or perceived sexual orientation.").

72. *See* notes 61, 62, *supra.*

73. *See* NSTFA, *supra,* note 3 at 67.

74. *See* text accompanying note 51, *supra.*

75. This approach was generally outlined in *Martinez* v. *School Brd. of Hillsborough,* 692 F. Supp. 1293 at 1304 (M.D. Fla. 1988), vacated and remanded for other reasons, 861 F. 2d 1502. *See* text accompanying note 119, *infra.*

76. See *Biggs, supra,* note 68 at D/5392: *Chalk, supra,* note 1 at 707. *See also: Pacific Western, supra,* note 4 at 306.

77. *See* text accompanying note 50, *supra.*

This framework of analysis may be applied to help test Nova Scotia employer arguments that because of health risks to others an employee's HIV-infected status "reasonably precludes performance of the particular employment"[78]. This statutory language parallels the purpose and function of the FRA provision protecting only those who are "otherwise qualified" to perform the particular job.[79] It would seem instructive, therefore, to apply the *Chalk* approach to inquire whether an individual poses a significant health risk to others. Application of the *Chalk* approach to current medical evidence would seem to indicate that the health risks posed by an HIV-infected employee do not "reasonably preclude" employment in most job settings.

To buttress its position, however, an employer might argue that the duty to provide a safe workplace further justifies the conclusion that the HIV-infected individual is reasonably precluded from employment. Indeed, employers under Nova Scotian and federal jurisdiction, for example, do respectively have statutory duties to provide a workplace "not likely to endanger"[80] or one free from "imminent danger."[81] Current epidemiological evidence that HIV-infected employees in most settings pose no significant risk of HIV transmission, however, should satisfy reasonable minds that such employees pose neither an "imminent danger" to nor are "likely to endanger" the workplace. A labour relations board recently adopted this view in concluding that, within the meaning of the *Canada Labour Code*, a federal prison corrections officer was not in "danger" of HIV infection in the workplace.[82] Such reasoning also extends to employers' common law duties. AIDS employment policies structured on a significant risk standard, which itself comports with the preponderance of medical evidence, should satisfy employers' general common law duties to undertake prudent and objectively reasonable precautionary measures.[83]

Similarly, the "significant risk" analysis helps test employer arguments that the absense of HIV infection is a bfoq. In jurisdictions that follow or

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78. *See* note 61, *supra.*
79. *See* note 30, *supra.*
80. *Occupational Health & Safety Act,* S.N.S. 1985 c. 3, s. 22(1).
81. *Canada Labour Code,* R.S.C. 1985, c. L-2 ss. 124-28.
82. *Walton* v. *Treasury Board* (1987), 16 C.C.E.L. 190 at 197 ("The danger of infection from such contacts [with body fluids] has not, I believe, been ruled out definitively . . . However, 'danger', as defined only exists if it could 'reasonably be expeced' that a condition would cause illness. A speculative possibility of illness being caused is not enough to constitute a 'danger'. I have no alternative but to conclude . . . that there can be no reasonable expectation of the contact of the kind feared by Mr. Walton resulting in AIDS, and therefore that there was no 'danger' within the meaning of the Code".)
83. *Cf. Doe* v. *American Airlines,* No. 86-L-19638, (Cook Cnty., Ill. 1986).

adopt a significant risk standard for HIV infection, the fact that HIV-infected employees in most workplaces pose no significant risk to co-employees or the public should render the bfoq defence generally unavailing. In Canada the bfoq defense includes a subjective and objective element.[84] The subjective element requires that the qualification be "imposed honestly, in good faith, and in the sincerely held belief that such limitation is imposed in the interests of the adequate performance of the work involved."[85] Even assuming subjective good faith, application of a significant risk standard of analysis suggests that the defense would likely fail the objective prong of the test in most employment settings. The objective element requires the employer to prove that the bfoq relates "in an *objective sense* to the performance of the employment concerned, in that it is *reasonably necessary* to assure the efficient and economical performance of the job *without endangering the employee, his fellow employees and the general public."* [86] Again, the overwhelming medical evidence that HIV-infected individuals in most employment settings pose no known risk to fellow employees or the public[87] indicates that freedom from HIV infection is not "reasonably necessary"; in consequence, most employers' proffered defences would fail the objective test. For the reasons outlined above, most employer attempts to justify the bfoq defense on the basis of occupational health and safety duties would also likely fail.

Whether the significant risk standard for evaluating bfoq defenses will be adopted in Canada remains an open question. While the significant risk terminology *per se* has yet to be employed, the significant risk analytic process for risk assessment has been endorsed. In *Ontario Human Rights Commission* v. *Etobicoke,* the Supreme Court of Canada employed the term "sufficient risk" in a case in which a mandatory retirement policy for 60 year-old firefighters was found not to be a bfoq:

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84. The test was outlined by McIntrye J. in *Ontario Human Rights Commission* v. *The Borough of Etobicoke* (1982), 3 C.H.R.R. D/781 at D/783 (S.C.C.). It has been recently refined in *Commission des droits de la personne du Québec* v. *Ville de Brossard* (1988), 2 S.C.R. 279 *per* Beetz J. at 311-12.

85. *Id.,* (emphasis added). For a discussion of the bfoq defence, see Beatrice Vizkelety, *Proving Discrimination in Canada* (Toronto: Carswell, 1987) at 201-224; Tarnopolsky & Pentney, *Discrimination in Canada* (2d ed.) (Toronto: Richard de Boo, 1987). Some commentators (*e.g.,* Vizkelety) draw a distinction between the bfoq defence and the business necessity defence, the latter applying to cases involving "adverse effect" discrimination (as defined in the *Ontario Human Rights Commission and O'Malley* v. *Simpsons-Sears Ltd.* (1986), 7 C.H.R.R. D/3102 (S.C.C.)). In light of *Bhinder* v. *CN Rail* (1986), 7 C.H.R.R. D/3093 (S.C.C.), however, the Canadian Supreme Court appears to have collapsed the two together with the business necessity inquiry paralleling, in substance, the second prong of the bfoq defense.

86. *Id.*

87. *See* CDC, *supra,* note 20.

> In an occupation where, as in the case at bar, the employer seeks to justify the retirement in the interest of public safety, the Court must consider whether the evidence adduced justifies the conclusion that there is *sufficient risk* of employee failure in those over mandatory retirement age to warrant the early retirement in the interests of safety of the employee, his fellow employees and the public at large.[88]

In deciding whether "sufficient risk" exists, the Court concluded "that in cases such as this statistical and medical evidence based upon observation and research" as opposed to "impressionistic" evidence is warranted.[89]. This mirrors the analytic approach adopted in the *Chalk* and *Arline* courts enunciation of the significant risk analysis.[90]

Even so, there is apparent Canadian authority for the proposition that even a small or minimal risk suffices to establish a bfoq. In a case of alleged discrimination against a diabetic, the Federal Court of Appeal held that neither co-employees nor the public should be required to accept any additional health risks to provide employment opportunities for individuals with disabilities:

> The [human rights tribunal] decision under attack, it seems to me, is based on the generous idea that the employers and the public have the duty to accept and assume some risks of damage in order to enable disabled persons to find work. In my view, the law does not impose such a duty on anyone.[91]

Such language would appear to be troubling for HIV-infected employees. In fact, it echoes the language and analysis which the *Chalk* Court flatly rejected.[92]

But such language may, and arguably should, not prove binding on HIV-infected or like employees for several reasons. First, human rights provisions are to be broadly construed, while exceptions thereto are to be narrowly construed.[93] Secondly, the Federal Court of Appeal case involved assessment of the likelihood of injury, not medical evidence on the risk of transmission of a contagious disease.[94] Thirdly, while the Court referred to small risks, it nonetheless grounded its decision on the Supreme Court of Canada standard of whether a bfoq is "reasonably necessary in order to eliminate a sufficient risk."[95] "Sufficient" is an

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88. *Ontario Human Rights Commission* v. *The Borough of Etobicoke, supra,* note 84, *per* McIntyre J. at D/784.
89. *Id.*
90. *See* text accompanying notes 38, 52, 53 *supra.*
91. *Canadian Pacific Ltd.* v. *Canadian Human Rights Commission* (1987), 8 C.H.R.R. D/4263 at D4268. (Fed. C.A.); leave to S.C.C. denied.
92. *See* text accompanying note 56, *supra.*
93. *Etobicoke, supra,* note 88 at D/783; *see also* Vizkelety, *supra,* note 85 at 196.
94. *See: Canadian Pacific, supra* note 91 at D/4264-65.
95. *Id.,* at D/4267, para. 33490.

adjective of degree. "Reasonably necessary" connotes an objective standard and "sufficient risk", as the Supreme Court has held, is a determination arrived at by an analysis of objective, medical evidence.[96] "Sufficient risk," then, would seem to suggest more than small or minimal risk. Indeed, to simply or reflexively equate the two, arguably, subverts the reasoning of the Supreme Court.[97] Finally, applying the small or minimal risk approach to an employee afflicted with HIV infection, Hepatitis B, tuberculosis or like contagion would foster the very stereotypes, unfounded fears, stigmatization, ostracism, and unemployment against which disability protections of human rights codes were enacted.[98] It would directly contravene the reasoning and holding of *Chalk,* most U.S. courts[99] that have addressed the issue, and persuasive Canadian jurisprudence and commentary.[100] Such considerations provide convincing grounds for rejecting the small or minimal risk approach in Canada.

If the "significant risk" analysis is accepted as a more principled approach to testing employer bfoq defenses, questions still remain regarding the extent to which an employer has a duty to accommodate an HIV-infected individual. Under *Chalk* and *Arline*, the employer must accommodate an individual to the extent it is reasonable or does not pose an "undue burden".[101] This approach is substantively the same as the "undue hardship" test applied by the Ontario Human Rights Commission to define the employer's duty to accommodate an HIV-infected employee.[102]

In contrast, in areas of federal jurisdiction, the Supreme Court of Canada has held that a bfoq need not encompass any employer duty to accommodate.[103] Such an absolutist approach seems comparatively harsh on employees when viewed in light of the more balanced approach in Ontario and *Chalk*. It has been criticized as inconsistent with, and would seem to defeat, the broad remedial purposes of human rights legislation.[104] To effect those remedial purposes an approach that imposes, in substance, no duty to accommodate should at least hold

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96. *See* text accompanying note 89.
97. *Id.*
98. *See* text accompanying note 38, *supra.*
99. *See* cases cited in note 118, *infra.*
100. For a review of Canadian jurisprudence on point, see *Mahon* v. *Canadian Pacific Ltd.* (1986), 7 C.H.R.R. D/3287-D/3287-D/3288 (reversed on appeal); *see also*, Tarnopolsky & Pentney, *supra*, note 85, (Cummulative Supplement) at 43-49.
101. *See* text accompanying note 50, *supra.*
102. *Human Rights Code,* S.O. 1981 c. 53, as amended by S.O. 1986 c. 64, s. 18(15).
103. *Bhinder* v. *CNR Co., supra,* note 85 at D/3096.
104. *Id., per* Dickson C.J. at D/3098-D/3099.

employers to a stringent test or burden of proof *(eg.,* clear and convincing evidence) for establishing a bfoq. Indeed, more recent jurisprudence of the Canadian Supreme Court suggests the Court may be moving in this direction.[105] Such developments and the alternative Ontario and *Chalk* approaches suggest that the absolutist approach and its underlying statutory basis merit serious reconsideration.

3. AIDS Discrimination Law and Policy

Beyond the doctrinal issues, *Chalk* is instructive on the broader public law context of developing AIDS discrimination law and policy. The case illustrates the critical but reactive role adjudicative bodies play in checking and defining discrimination under existing law. Indeed, courts may play an invaluable societal role in protecting fundamental liberties and balancing compelling public health interests in the face of dread diseases. Chalk suggests that in instances where the medical evidence is largely conclusive, where the alleged health risks involve conspicuous public employment, and where there is implacable community resistance to the continued employment of the individual, court pronouncements may serve to remove legal ambiguity, vindicate individual rights, and legitimate and compel unpopular institutional conduct.

The courts' roles notwithstanding, a more proactive approach might involve the enactment of specific legislation to remove legal uncertainty and define employment rights and duties in an AIDS era, as the Nova Scotia Task Force and other commentators have urged[106]. Discussions on expressly including AIDS as a protected disability under human rights codes have yet to yield provincial legislation, however.[107] Such silence from the legislators effectively leaves the development of AIDS discrimination law and policy to adjudicative bodies and government ministries. In consequence, Ministries of Health, Education, Justice and Human Rights Commissions might choose to complement the largely reactive roles of courts and tribunals by playing a proactive role. Mayoral or municipal employment policies in Toronto,[108] Boston, San Francisco, Ann Arbor, Los Angeles, Philadelphia address or specifically bar AIDS

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105. In *Brossard, supra,* note 84, Beetz J. elaborated the *Etobicoke* test for a bfoq requiring that "the rule [be] properly designed to ensure the aptitude or qualification is met without placing an undue burden on those to whom the rule applies" (at 312). The Supreme Court of Canada has also recently granted leave in a religious discrimination case that raises the issue of the duty to accommodate: *see: Alberta Human Rights Commission* v. *Central Alberta Dairy Pool,* [1989] 1 W.W.R. 78 (Alta C.A.); leave to appeal granted June 30, 1988.

106. NSTFA, *supra,* note 3. *See also* Royal Society of Canada *supra,* note 71.

107. *See* Bryden & Jarret, *supra,* note 71 at C/88-19, n. 21.

108. *Policy & Guidelines with Respect to AIDS for the Municipality of Metropolitan Toronto.* (Jan. 1988).

employment discrimination against city employees or job applicants, for example.[109]

Similarly, Human Rights Commissions may affirmatively guide AIDS discrimination law and policy. In considering whether HIV-infection is a protected disability under a human rights code, a commission may (a) remain silent until the issue squarely presents itself, (b) recommend that the human rights code be amended expressly to include HIV infection as a protected disability, (c) initially or presumptively process AIDS discrimination complaints as claimed disabilites, (d) adopt an official public policy, by regulation or public pronouncement, (i) that HIV-infected individuals are or are not considered protected, and (ii) that addresses employers' use of medical exams to identify HIV-infected individuals; (e) consult in the development of AIDS employment policies and provide AIDS employment education as part of its educative mandate.

In the absense of cases squarely presenting the issue, an official public policy illustrates a modest, affirmative approach. The argument against such an approach is that the Commission may be proceeding *ultra vires,* or be seen as prematurely pronouncing on a delicate issue whose resolution warrants further deliberation and a specific factual context. The argument for an official public policy approach rejects the *ultra vires* argument as a misconstruction of a human rights commission mandate, and argues that affirmative pronouncements further the mandate and likely pre-empt AIDS discrimination, by educating the public and by elucidating the legal rights and duties in the workplace. Accordingly, several North American jurisdictions have adopted a public policy approach. Some U.S. jurisdictions have done so by declaring AIDS a protected disability in human rights regulations.[110] In Canada, such jurisdictions as the Ontario,[111] Manitoba[112] and Canadian Human Rights Commission[113] have done so through formal policies and public pronouncement.[114]

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109. BNA, *Individual Employment Rights Manual* 509:211. *See also* Comihearst, "Educating Through the Law: The Los Angeles AIDS Discrimination Ordinance" (1986), 33 U.C.L.A. L. Rev. 1410.

110. *See, eg.,* note 135, *infra.*

111. *See* Ontario Human Rights Commission Policy on AIDS (adopted Nov. 20, 1985).

112. *Manitoba Human Rights Commission Policy & Procedures Manual: Policy 1-1-72 (H.I.V. Infection & Aids),* effective June 1988. *See also Background Notes to the Manitoba Human Rights Commission Policy on HIV Infection/AIDS.*

113. *Acquired Immunodeficiency Syndrome (AIDS): Policy Adopted by Canadian Human Rights Commission* (May 1988).

114. In contrast to the public pronouncement or formal public policy approach, the human rights commissions of Alberta and Nova Scotia report that they *process* AIDS complaints under the disability provisions of their Codes. (Personal communications with Commissions.)

V. The Emerging U.S. Consensus

Viewed a year in retrospect, it would apper that *Chalk* enunciated an emerging consensus in U.S. AIDS discrimination law and public policy. Like *Chalk*, most U.S. courts construing the Federal Rehabilitation Act (FRA) have concluded that HIV-infected individuals enjoy protection of the Act; they have as consistently accepted the heretofore uncontroverted medical evidence that HIV infection is not transmitted by the casual contact that characterizes most employment settings. The Act has been recently construed to protect even those *regarded* as having HIV infection.[115] In the employment context, while *Chalk* remains the leading reported case under the FRA, other FRA cases are pending in U.S. district courts;[116] moreover, state adjudicative bodies have interpreted analogous state law in reliance on or through reasoning that parallels *Chalk*.[117] In the school context, the Act has been invoked repeatedly to enjoin schools from prohibiting HIV-infected children from the classroom.[118] Indeed, a U.S. appellate court recently considered HIV

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115. *Doe* v. *Centinela,* 57 U.S.L.W. 2034 (C.D. Cal. 1988). (alledgedly discriminationary discharge of asymptomatic AIDS carrier from hospital alcohol and drug abuse program.) In early 1989, a settlement was reached whereby the hospital rescinded its policy of testing and excluding those perceived as HIV-infected. (Personal communication with plaintiff's lawyer.)

116. *See, eg., Leckelt* v. *Bd. of Commissioners of Hosp. Distr. 1, Terrebonne Parish,* No. 86-4235 (D.C. E. La, Filed Sept. 29, 1986) (nurse perceived at risk of HIV infection alleging unlawful discrimination and discharge for failure to submit to HIV testing).

117. *See: Raytheon* v. *Fair Employment & Housing Commission,* Superior Court of the State of California for the County of Santa Barbara, No. 167995 (27 Apr. 1988), 56 U.S.L.W. 2637. *See also: Cronan* v. *New England Telephone,* No. 80332, (D.C. Mass. 1986) 55 U.S.L.W. 2202 (actual or perceived affliction with AIDS or ARC a protected disability).

118. *Doe* v. *Dolton Elementary School District,* 694 F. Supp. 440 (N.D. Ill. 1988) (granting preliminary injunction prohibiting exclusion of 12-year old HIV-infected child from school); *Robertson* v. *Granite City Com. Unit School D9,* 684 F. Supp. 1002 at 1006 (S.D. Ill. 1988) (granting preliminary injunction prohibiting exclusion of seven-year old HIV-infected hemophiliac from classroom); *Thomas* v. *Atascadero Unified School Dist.,* 662 F. Supp. 376 (C.D. Cal. 1987) (granting preliminary injunction prohibiting exclusion of HIV-infected child from classroom, despite child's involvement in biting incident); *Ray* v. *School Dist. of Desoto County,* 666 F. Supp. 1524 (M.D. Fla. 1987) (granting preliminary injunction prohibiting exclusion of three hemophiliac seropositive brothers from classroom). Roughly a year after the Ray family home was firebombed which prompted the family to assume residence some 50 miles away, the school district which initially denied the Ray boys entry to school settled the case for $1.1 million. *N.Y. Times,* 2 Oct. 1988 at 20. *But see, Martinez* v. *Sch. Bd. Hillsborough County,* 675 F. Supp. 1574 (M.D. Fla. 1987) (denying preliminary injunction for incontinent, mentally disabled, HIV-infected child). For the sequels to this case, see footnote 75 and text accompanying note 119. *Compare: New York State Ass'n of Retarded Children* v. *Carey,* 612 F.2d 644, 650 (2d. Cir. 1979) (school segregation of children carriers of Hepatitis B, not shown to pose significant risk of transmission, constitutes unlawful handicap discrimination), and *Kohl* v. *Woodhaven Learning Cntr.,* 865 F.2d 930 (8th Cir. 1989) (reversing order that residential vocational skills school accommodate Hepatitis B carrier's entry by instituting Hepatitis B vaccine inoculation program), decision for *en banc* review pending, 4/89. *See*

infection a protected disability and relied on the "significant risk" standard to vacate a lower court order that a seven-year-old neurologically disabled HIV-infected child attend school in a 9 x 6 foot glass booth adjoining a classroom.[119]

Paralleling the judiciary, the U.S. executive branch has now adopted affirmative AIDS employment anti-discrimination policies. The Centers for Disease Control (CDC) has for years amassed AIDS epidemiological evidence and offered recommendations which has made the CDC a leading medical force in minimizing discrimination against AIDS carriers.[120] The personnel office for the U.S. government has adopted an AIDS employment policy based on CDC employment recommendations.[121] More recently, in July 1988, the Presidents Commission on AIDS also relied on CDC medical evidence to conclude that discrimination against HIV-infected individuals in the workplace, housing, schools, and public accommodations, is "unwarranted because it has no health basis. Nor is there any basis to discriminate against those who care for or associate with such individuals."[122] The Commission called for AIDS anti-discrimination legislation, and an interim Presidential Order declaring HIV infection a disability under the FRA.[123] Perhaps most revealing, the U.S. Justice Department recently reconsidered its *Arline*[124] view, and unabashedly reversed itself to conclude that symptomatic and asymptomatic HIV-infected persons enjoy FRA protection:

> We have further concluded that section 504 applies in substance in the same way in the employment context, . . . Subject to an employer making reasonable accommodation within the terms of his existing personnel policies, the symptomatic or asymptomatic HIV-infected individual is protected against discrimination if he or she is able to perform the duties

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generally, "Discrimination in the Public Schools: Dick & Jane Have AIDS" (1988), 29 Wm. & Mary L. Rev. 881.

119. *Martinez* v. *Sch. Bd. Hillsborough Cnty.,* 861 F. 2d. 1502 at 1506 (11th Cir. 1988). ("The trial court found a 'remote theoretical possibility' of transmission with respect to tears, saliva, urine. This does not rise to the significant risk level that is required for Eliana to be excluded from the regular TMH classroom. . . Accordingly, we remand with directions that the trial court make findings as to the overall risk of transmission. . .")

120. *See* Neslund, Mathews & Clernan, "The Role of the CDC in the Development of AIDS Recommendations & Guidelines" (1987), 15 L. Med. & Hlth. Care 73. *See also* text accompanying notes 52, 53, *supra.*

121. U.S. Office of Personnel Management, "AIDS Guidelines for Federal Employers," 56 U.S.L.W. 2537; BNA, *Individual Employment Rights Manual* 595:3431.

122. *Report of the Presidential Commission on the Human Immunodeficiency Virus Epidemic* at 119 (June 1988).

123. *Id.,* at 121.

124. *See* text accompanying note 39, *supra.*

of the job and does not constitute a direct threat to the health or safety of others.[125]

Legislatively, the U.S. Congress recently passed anonymous AIDS testing legislation; though it offers no express provisions on AIDS-specific employment discrimination,[126] state legislators have been more active. Some 30 U.S. jurisdictions have declared AIDS a disability for purposes of employment discrimination law.[127] Wisconsin has even adopted the "significant risk" standard as an exception to legislative prohibitions against HIV testing of employees.[128]

Indeed, the latter approach highlights the discriminatory potential of requiring job applicants or employees to submit to HIV-screening as a condition of employment. The World Health Organization[129] and International Labour Organization have jointly advised against general HIV screening for employment, as has the Health and Welfare Canada National Advisory Committee on AIDS.[130] Some U.S. jurisdictions have enacted laws to bar HIV-tests that disqualify, terminate or otherwise affect terms of employment.[131] Under both Canadian and U.S. laws, the lawfulness of medical screening depends on whether it is "job related[132], a business necessity[133], a *"bona fide"* occupational qualification"[134] or

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125. U.S. Justice Department, Office of Legal Counsel, *Application of Section 504 of the Rehabilitation Act to HIV-Infected Individuals* 29 (Sept. 1988). *See also: N.Y. Times,* 7 Oct. 1988, at A17. For our commentary on significant and direct threat, see note 32 *supra.*

126. *See* Titles II ("AIDS Amendments of 1988") & IX ("Prison Testing Act of 1988") of the "Health Omnibus Programs Extension of 1988," P.L. 100-607, 102 Stat. 3062, 3171, affecting 42 USC s. 201, 300ee. *See also: N.Y. Times,* 14 Oct. 1988, at A12. The legislation provides federal monies to the states for anonymous HIV-testing and counseling, save for the mandatory testing of those convicted of intravenous drug or sex offences. Arguably, the voluntary underpinnings of the general anonymous testing provisions support a general public policy against compulsory testing in most employment settings.

127. Comment, "Prohibiting the Use of Human Immunodeficiency Virus Antibody Test by Employers & Insurers" (1988), 25 Harv. J. Legis. 275 at 286. *See also,* Lewis, "Acquired Immunodeficiency Syndrome: State Legislation Activity" (6 Nov. 1987), 258(17) J.A.M.A. 2410; Gostin, "Public Health Strategies for Confronting AIDS — Legislative and Regulatory Policy in the United States" (1989), 261(11), J.A.M.A. 1621.

128. *See, eg., Wisc. Stat. Ann.* 103(15)(2) (West Supp. 1988). *Cf.: Me. Rev. Stat. Ann.,* tit. 5, s. 19203-C (West Supp. 1988) (judicially determined "significant risk" exception for mandatory testing of patients after health care workers accidental exposure to patient's blood.)

129. WHO/ILO Global Program on AIDS, "Statement from the Consultation on AIDS & the Workplace" (Geneva, June 1988). *See also, Medical Post,* 25 Oct. 1988, at 51.

130. Health & Welfare Canada, "Human Immunodeficiency Virus Antibody Testing in Canada: Recommendation of the National Advisory Committee on AIDS" (25 Feb. 1989), 15-8 Canada Diseases Wkly Rpt. 37 at 41.

131. *See* Lewis, *supra,* note 127 at 214.

132. *See* 45 CFR ss. 84.13, 84.14 (1987).

133. *See, eg., Bentivegna* v. *U.S. Dept. Labor,* 694 F.2d 619 (9th Cir. 1982) (holding termination/non-hiring of diabetic, after pre-employment screening test, unlawful in that employer failed to establish non-diabetic requirement as business necessity).

134. *See Sask. Police Comm'n* v. *Sask. Human Rights Comm'n* (1984), 5 C.H.R.R. D/2317.

used non-discriminatorily.[135] The Wisconsin approach suggests these formulations may be tested, and in some instances resolved, by whether the employment conduct and setting pose a significant risk of HIV transmission to fellow employees or to one's clientèle.[136] Current medical evidence that HIV-infected individuals do not pose a risk of transmission in most work settings suggests that HIV screening is seldom justified.[137]

VI. Conclusion: A North American Consensus?

Taken together, the *Chalk* and Smith stories illustrate how law and medicine should combine to educate the parties in and resolve a classic AIDS employment controversy. The discovery of an HIV-infected employee in one's workplace raises both acute anxiety about a lethal contagious disease and deep sympathy for the afflicted employee. Before *Arline*, the Eric Smith story, *Chalk* or *Biggs,* however, the law appeared to offer more uncertainty and speculation than assurance or authority.

Today, society has begun to give meaning to the mandate of fair, equal treatment of the working disabled in the context of AIDS. Courts, human rights commissions, and legislators, increasingly tend to regard HIV infection as a protected handicap or disability; U.S. courts increasingly

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See also, "Yukon Aims to End Discrimination Against Disabled in Hiring Process," *Medical Post,* Dec. 6, 1988, at 67; Ontario Human Rights Commission, *Policy on Employment Related Medical Examinations* (as amended, July 1986); Canadian Human Rights Commission, *supra,* note 113 (HIV-negative status may qualify as bfoq where employee performs invasive medical procedures, or performs duties impinging on public safety, or travels to countries barring HIV-infected individuals). *See also* text accompanying notes 88-104. Compare Florida bfoq defense that requires employers to show "substantial risk" of future injury or reasonable basis for risk assessment. *Shuttleworth, supra,* note 68.

135. *See, eg., Employment Regulations of the Maine Human Rights Commission,* s. 3.08(E) (May 1988). *See also, Policy Position of the Maine Human Rights Commission* (March 24, 1986) (construing AIDS as protected disability and elaborating standards, procedures and burdens of proof for non-discriminatory use of pre-employment medical exams); *Me. Rev. Stat. Ann.* tit. 5 s. 19204-B (West Supp. 1988 (barring health care facilities from HIV-testing of job applicants or employees, unless based on *bona fide* occupational qualification). As of January 1989, the Maine Human Rights Commission had accepted seven Aids related complaints, all of which involved employment.

136. *See* text accompanying note 53, *supra. Compare: Local 1812* v. *U.S. Dept. of State,* 662 F. Supp. 50, 52 (D.D.C. 1987) (upholding addition of HIV-testing to medical exam required of foreign services workers as rational and closely relatedly to fitness for duty) and *Glover* v. *E.N.C.O.R.,* 867 F.2d. 461 (8th Cir. 1989) (mandatory employee screening is constitutionally unreasonable search and seizure given minuscule risk of transmission). *Compare: R.* v. *Dyment* [1988] 2 S.C.R. 417 (unconsented blood test violates constitutional privacy interest) and *National Treasury Employees Union* v. *Von Raab,* 109 S.Ct. 1384 (1989) (mandatory drug urine test of drug enforcement officers does not violate constitutional right to privacy). *See generally* Note, "The Constitutional Implications of Mandatory Testing for Acquired Immunodeficiency Syndrome — AIDS" (1988), 37 Emery L.J. 217.

137. *Accord,* World Health Organization and Health & Welfare Canada National Advisory Committee on AIDS. *See* text accompanying notes 129-130, *supra.*

hold AIDS discrimination claims to a "significant risk" of transmission standard. As *Chalk* makes clear, the standard declines the temptation to test discrimination claims on the basis of absolute medical certainty. An absolute standard would render it nigh impossible for complainants of AIDS-based discrimination to succeed. Such a standard would cater to biases, foster unfounded fear of contagion, invite further stigmatization and ostracism of a particular class of disabled individuals, and so frustrate the major purposes of human rights disability protections. Instead, the significant risk standard suggests that, as a society, we accept reasonable levels of risk to accommodate fundamental interests and competing values.

Particularly as regards AIDS, the law properly depends on the medical community for expertise in resolving controversy. The medical and public health communities have concluded, on the basis of current epidemiological evidence, that HIV-infected students[138], teachers[139], food service workers, and most employees pose no significant risk of HIV transmission either to fellow employees or to their respective clientèles.[140] Of course, this general view may not extend to employment settings that involve regular exposure to blood products, as occurs in hospital emergency rooms, surgery, medical examiner offices — all of which involve conduct and risks that may make the nature and likelihood of HIV transmission more than theoretical or more than "minimal."[141]

The contrast in the risks of transmission in different settings suggests that adoption of a "significant risk" standard ensures a uniform analytical approach not uniform outcomes. The ambiguity inherent in the standard may be reduced by appreciating that "significant risk" refers to a range in

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138. American Academy of Pediatrics, "School Attendance of Children & Adolescents With HTLV/LAV Infection" (1986), 77(3) Pediatrics 430. *See also,* CDC, "Education & Foster Care of Children Infected with Human T-lymphotrophic Virus Type III/lymphodenopathy — Associated Virus" (30 Aug. 1985), 34 Morbidity, Mortality Weekly Rpts. 583.

139. CDC, *supra,* notes 20, 24.

140. *Id.*

141. *See* U.S. Dept. of Labor, "Occupational Exposure to Hepatitis B Virus & Human Immunodeficiency Virus," 52 Federal Register 45438 (proposed rule forthcoming). *See also* U.S. Public Health Service, Centers for Disease Control, "Guidelines for Prevention of Transmission of Human Immunodeficiency Virus and Hepatitis B Virus to Health Care and Public Safety Workers" (Feb. 1989), (forthcoming in Morbidity Mortality Wkly. Rpt.); Universal Precautions, *supra,* note 22; Centers for Disease Control, "Update: Universal Precautions for Prevention of Transmission of Human Immunodeficiency Virus, Hepatitis B Virus, and other Bloodborne Pathogens in Health Care Settings" (22/29 July 1988), 260(4) J.A.M.A. 462; Marus, "Surveillance of Health Care Workers Exposed to Blood from Patients Infected with Human Immunodeficiency Virus" (27 Oct. 1988) 319 (17) N.E.J.M. 1118. *But see* Gostin, "HIV-Infected Physicians & the Practice of Seriously Invasive Procedures," 19 *Hasting Cntr. Rpt.* 32 (Jan./Feb. 1989); Federal Centre for AIDS, "Occupational Exposure to the Human Immunodeficiency Virus Among Health Care Workers in Canada" (1 Mar. 1989), 140 C.M.A.J. 503 (no cases of seroconversion in 205 cases of potential exposure).

the spectrum of risks which is distinct from the polar extremes of theoretical or minuscule and imminent and unequivocal risk. *Chalk* and *Biggs* counsel educators, the courts and policy makers to defer to reasonable expert medical opinion in determining precisely where on the spectrum of risk a particular fact situation lies.

If these principles were lost in the events on Cape Sable Island, perhaps the Eric Smith story will not have been lived in vain. As one of the first blatant instances of potential public AIDS employment discrimination in Canada, it necessarily stirred local and national thought and paranoia, as it caught "society unprepared."[142] Today Eric Smith serves as an AIDS education curriculum consultant to the Nova Scotia Department of Education; he is no longer in the classroom.[143] Months after Vincent Chalk returned to the classroom his lawyers and the school department signed a consent decree wherein Chalk agreed to dismiss his complaint in exchange for attorney fees, an undisclosed amount of damages, and an agreement that he would continue to teach.[144] Due in part to the disabling effects of AIDS he has, of late, been teaching three of five days a week.[145]

Still, the legacy endures. Some employers have begun to adopt formal AIDS employment policies.[146] Others should do so. Such policies might at least (a) treat HIV-infection like other employee life-threatening illnesses; (b) affirm the employer's commitment to reasonable accommodation; (c) implement appropriate training, safe-work and hygiene procedures to minimize any risk of HIV transmission; (d) provide AIDS education and counselling for all employees; (e) guarantee strict confidentiality; (f) maintain HIV-infected employee eligibility for company benefits; (g) establish internal procedures to resolve AIDS conflicts. Educators have also begun to help pre-empt AIDS conflicts and dispel public health illiteracy, by adopting such policies[147] and by doing what they do best: educating, in this instance, pupils, teachers, and the public on AIDS.[148] Perhaps the lessons of the Eric Smith and Vincent Chalk stories have thus made society the wiser. For in the tradition of the best of their calling, these teachers have taught us as much about the subject matter as about ourselves.

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142. The Nova Scotia Task Force on Aids so describes the Eric Smith story. *See* NSTFA, *supra*, note 3 at 27.
143. Personal communication with Mr. Smith, February 22, 1989.
144. Personal communication with Chalk's lawyers.
145. *Id.*
146. *See, eg.*, text accompanying notes 108, 109, 121, *supra.*
147. *See: Cooperman, supra,* note 7.
148. *See, eg.*, "Dal's AIDS Policy a First for Atlantic Universities," *Medical Post,* 8 Nov. 1988, at 72. Sometimes developing "satisfactory" AIDS curricula has proven to be a formidable task. See *Globe & Mail,* 25 March 1988, at A7. *See generally* CDC, "Guidelines for Effective School Health Education to Prevent the Spread of AIDS" (29 Jan. 1988), 37(S-2) Morbidity & Mortality Weekly Rpt.