

An American Way of Life: Prescription Drug Use in the Modern ADA Workplace

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The dramatic rise in prescription drug use in the United States over the past two decades, with its attendant risk of a myriad of side effects, has left employers struggling with ways to balance their interests in productivity and safety with potential liability for violating their employees' legal rights under the Americans with Disabilities Act. Under the ADA, an employer may claim a "direct threat" defense if it fired or refused to hire an employee based on a threat the employer determined the employee posed to safety and health in the workplace. In a recent case, several employees brought an ADA suit against their employer after they were fired from their safety-sensitive jobs for the mere legal use of certain prescription drugs their employer had decided posed a safety risk in its workplace. The district court denied the employer's motion for summary judgment on the ground that a reasonable juror could find that the employer's drug policy was broader than necessary because the employer automatically excluded all employees who took certain drugs from working at the company, without any regard for individualized circumstances as required by the ADA. However, the Sixth Circuit reversed the decision on the ground that the employees were not disabled and thus were not protected under the ADA. In light of the ADA Amendments Act of 2008 and other developments since the passage of the ADA in 1990 that call for expanded protection under the Act, this Note establishes the contours of the highly individualized inquiry employers and courts must perform in addressing the problem of prescription drug use in the workplace.

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I. INTRODUCTION

A little over two decades ago, the Supreme Court first ruled that employers may test employees for illegal drug use in the workplace, subject to certain requirements.¹ A year after that decision, Congress passed the Americans with Disabilities Act² (“ADA” or “the Act”), which expanded the scope of civil rights protections for individuals with disabilities³ and set parameters for the testing of alcohol and illegal drug use in the workplace.⁴ Since then, a dramatic rise in prescription drug use among Americans for “pain, anxiety and other maladies”⁵ has resulted in the presence of a significant, and continually growing, number of employees in the American workplace with powerful, albeit legal, drugs in their systems.⁶ With prescription drug testing, prompted by concern over the risk of a myriad of side effects such drugs pose, employers have struggled to balance their interests in productivity and safety⁷ with potential liability for violating their employees’ legal rights. These concerns are especially marked in industries that involve high risks of injury, such as manufacturing, transportation, construction, healthcare, and law enforcement.⁸

1. Nat’l Treasury Emps. Union v. Von Raab, 489 U.S. 656 (1989). This case involved the U.S. Customs Service’s suspicionless drug testing of employees applying for promotion to sensitive positions requiring the interdiction of controlled substances or the carrying of firearms. The Court held that the drug testing program was reasonable under the Fourth Amendment. The Court reasoned that the government’s “extraordinary” interest in national security and public safety outweighed the intrusion on privacy of the employees in question, especially because the urine testing program was carefully tailored to minimize the intrusion. *Id.* at 674.

2. 42 U.S.C.A. §§ 12101–12213 (West 2009).

3. *Id.* § 12101(a)–(b).

4. *Id.* § 12114.

5. Katie Zezima & Abby Goodnough, *Drug Testing Poses Quandary for Employers*, N.Y. TIMES, Oct. 25, 2010, at A1.

6. *See infra* Part II.

7. EEOC Interpretive Guidance, 29 C.F.R. pt. 1630 app. § 1630.2(l) (2011) (“As the [ADA] legislative history notes, sociologists have identified common attitudinal barriers that frequently result in employers excluding individuals with disabilities. These include concerns regarding productivity, safety, insurance, liability, attendance, cost of accommodation and accessibility, workers’ compensation costs, and acceptance by coworkers and customers.”).

8. Press Release, Occupational Injuries and Illnesses (Annual) News Release, Bureau of Labor Statistics (Oct. 20, 2011), available at http://www.bls.gov/news.release/archives/osh_10202011.htm; *Career Guide to Industries, 2010-11 Edition: Healthcare*, U.S. DEPT. OF LABOR, BUREAU OF LABOR STATISTICS (last modified Feb. 2, 2010),

In 2007, Dura Automotive Systems fired employees who tested positive for certain prescription drugs, including the painkiller Oxycodone, one of the most prescribed drugs in the United States,⁹ even though the employees were taking them pursuant to a prescription and under a doctor's supervision.¹⁰ The company acted on a presumption that certain prescription drugs create a safety risk in the workplace.¹¹ The employees had worked on the manufacturing floor assembling glass windows for cars, and the company claimed that their jobs were safety-sensitive.¹² Under the company's drug-testing program, all employees were tested for twelve drugs, including legally prescribed drugs such as Xanax and Oxycodone, which the company deemed unsafe because their labels included warnings against driving or operating machinery.¹³ Several of the fired employees sued Dura for discrimination under the ADA.¹⁴ One plaintiff, Sue Bates, who suffered from depression, bipolar disorder, back pain, and ADHD, lost her job of many years after testing positive for Oxycodone, even though she had never had a safety violation while on her prescribed medication.¹⁵ The company had changed its policy during her employment to test for certain prescription drugs as well as illegal ones, such that her medication, among many others, was suddenly and automatically considered unsafe.¹⁶ The district court denied Dura's motion for summary judgment on the ground that a reasonable juror could find that Dura's drug policy was broader and more intrusive than necessary because Dura automatically excluded all employees who took certain drugs from working at the company, without any regard for individualized

<http://www.bls.gov/oco/cg/cgs035.htm>; *Occupational Outlook Handbook, 2010-11 Edition: Police and Detectives*, U.S. DEPT. OF LABOR, BUREAU OF LABOR STATISTICS (last modified Dec. 17, 2009), <http://www.bls.gov/oco/ocos160.htm>.

9. THE USE OF MEDICINES IN THE UNITED STATES: REVIEW OF 2010, IMS INST. FOR HEALTHCARE INFORMATICS 33 (2011) [hereinafter USE OF MEDICINES], Appendix 4, available at http://www.imshealth.com/imshealth/Global/Content/IMS%20Institute/Documents/IHII_UseOfMed_report%20.pdf.

10. *Bates v. Dura Auto. Sys., Inc.*, 650 F. Supp. 2d 754 (M.D. Tenn. 2009), *rev'd*, 625 F.3d 283 (6th Cir. 2010).

11. *Id.* at 759.

12. *Id.*

13. *Id.* at 759–61.

14. *Id.* at 763.

15. *Id.* at 760.

16. *Id.* at 759–60.

circumstances.¹⁷ However, the Sixth Circuit reversed the district court on Dura's interlocutory appeal, determining that the employees were not "disabled" within the meaning of the ADA and thus failed to meet the threshold requirement for protection under the ADA.¹⁸

The ADA, passed by Congress in 1990, acknowledges that people with disabilities often face many barriers to employment, such as prejudice, stereotypes, and presumptions, including misconceptions held by employers about the potential job performance and safety risks of disabled individuals.¹⁹ Title I of the ADA empowers employees and job applicants to bring suit against private employers who discriminate against disabled individuals who are otherwise "qualified"²⁰ for a particular job.²¹ This includes employer actions that are based not only on the disabilities themselves but on symptoms of, or mitigating measures used for, a disability.²²

The ADA also provides employers with a defense to such challenges: the "direct threat" defense.²³ The direct threat defense allows employers to claim that their challenged actions, even if based on an employee's disability, were justified because the employee posed a risk to health and safety in the workplace. This defense has a catch, though: it requires a rigorous individualized assessment. This requirement of an individualized assessment has important implications in the prescription drug use context. As this Note demonstrates, because of the wide variability in individuals experiencing a particular drug's various side effects, use of a particular prescription drug is not a permissible proxy indicator of direct threat; thus, employers may not use blanket drug policies that allow them to fire employees based merely on the presence of a legally-used drug in their system.

17. *Id.* at 771–72.

18. *Bates v. Dura Auto. Sys., Inc.*, 625 F.3d 283, 285–86 (6th Cir. 2010).

19. 42 U.S.C. § 12112(a)–(b).

20. *See infra* Part III.A.

21. 42 U.S.C. § 12117(a) ("The powers, remedies, and procedures set forth in . . . this title shall be the powers, remedies, and procedures this subchapter provides to the Commission, to the Attorney General, or to any person alleging discrimination on the basis of disability in violation of any provision of this chapter, or regulations promulgated under section 12116 of this title, concerning employment.").

22. This was contested under the ADA but is now resolved under the 2008 Amendments to the ADA. *See infra* Part III.C.

23. *See infra* Part III.B.

The ADA Amendments Act of 2008 (“ADAAA”) expanded the protections of the ADA but failed to clarify the contours of the direct threat defense in light of those provisions of the ADAAA that clarify and expand the Act’s scope.²⁴ Courts have similarly failed to clarify the defense in the specific context of prescription drug use in the workplace, primarily because the ADAAA only took effect fairly recently — in January 2009 — and most courts in such cases have held that the ADAAA does not apply retroactively.²⁵ Those cases that *have* applied the ADAAA do not address the direct threat defense.²⁶

This Note examines the proper approach employers and courts should take in making employment decisions based on a job applicant or current employee’s prescription drug use. Part II presents an overview of prescription drug use in the United States and in the workplace, including data on the occurrence of side effects for some of the most commonly prescribed drugs. Part III discusses Title I of the Americans with Disabilities Act, with a focus on the direct threat defense, as well as the 2008 Amendments to the Act. Part IV, in light of the information on prescription drug use provided in Part II, demonstrates that blanket policies such as Dura’s are improper and incompatible with the ADA, and establishes the contours of the highly individualized inquiry the ADA demands in the prescription drug context.

24. *See infra* Part III.C.

25. *See, e.g.*, *Geohan v. Long Island R.R.*, No. 06-1435, 2009 WL 982451, at *9 (E.D.N.Y. Apr. 9, 2009) (involving a plaintiff’s claim of discrimination under the ADA on the basis of his ADHD, which he had mitigated with Adderall); *Moran v. Premier Educ. Grp.*, 599 F. Supp. 2d 263, 271–72 (D. Conn. 2009) (involving an asthmatic employee who had a prescription for Albuterol, an asthma medication); *see also infra* note 222 and accompanying text.

26. *See infra* note 224 and accompanying text.

II. PRESCRIPTION DRUG USE IN THE UNITED STATES AND IN THE WORKPLACE

A. PRESCRIPTION DRUG USE IN THE UNITED STATES

Prescription drug use in the United States has risen steadily in the past two decades.²⁷ The percentage of Americans who took at least one prescription drug rose from 39.1% in 1988–1994²⁸ to 43.5% in 1999–2000, and up again to 48.3 percent in 2007–2008.²⁹ Spending on prescription drugs more than doubled from 1999 to 2008, even after accounting for inflation.³⁰ In constant dollars, Americans spent more than \$234 billion on prescription drugs in 2008, up from \$104.7 billion in 1999.³¹ Further, from 1999 to 2008, the percentage of Americans who used more than one prescription drug increased from 25.4% to 31.2%; the percentage of those who used *five* or more jumped from 6.3% to 10.7%.³² This increase in the number of people taking multiple prescription drugs is significant particularly because side effects become a more serious risk with the use of multiple drugs at a time.³³

27. QUIPING GU ET AL., NAT'L CTR. FOR HEALTH STATISTICS, PRESCRIPTION DRUG USE CONTINUES TO INCREASE: U.S. PRESCRIPTION DRUG DATA FOR 2007–2008 1 (2010) [hereinafter PRESCRIPTION DRUG DATA], available at <http://www.cdc.gov/nchs/data/databriefs/db42.pdf>. The data from this report come from the government's National Health and Nutrition Examination Survey, *id.* at 7, which "examines a nationally representative sample of about 5000 persons each year," through interviews and physical examinations, in order "to assess the health and nutritional status of adults and children in the United States." *About the National Health and Nutrition Exam Survey*, CTRS. FOR DISEASE CONTROL & PREVENTION, http://www.cdc.gov/nchs/nhanes/about_nhanes.htm (last modified Nov. 14, 2011).

28. NAT'L CTR. FOR HEALTH STATISTICS, HEALTH, UNITED STATES, 2009, at 350 (2010) [hereinafter HEALTH 2009], available at <http://www.cdc.gov/nchs/data/hus/hus09.pdf>.

29. PRESCRIPTION DRUG DATA, *supra* note 27, at 1.

30. *Id.*

31. *Id.*; HEALTH 2009, *supra* note 28, at 401.

32. PRESCRIPTION DRUG DATA, *supra* note 27, at 1.

33. Nicholas Bakalar, *Prescription Drug Use Soared in Past Decade*, N.Y. TIMES, Oct. 19, 2010, at D7 (quoting Dr. Quiping Gu, an epidemiologist who contributed to the PRESCRIPTION DRUG DATA report, *supra* note 27, who notes that "[w]hen you see such a big percentage taking five or more drugs, side effects and safety become very serious issues").

B. THE MOST COMMON PRESCRIPTION DRUGS AND THEIR SIDE EFFECTS

The most commonly used prescription drugs are stimulants for youths ages twelve to nineteen, painkillers and antidepressants for adults ages twenty to fifty-nine, and cholesterol-lowering drugs for adults age sixty and older.³⁴ What follows is an overview of each of these classes of drugs, as well as the listed side effects and available data on the actual occurrence of the side effects for some of the most commonly prescribed drugs in each class. Unfortunately, there is no comprehensive collection of data on the actual occurrence of prescription drug side effects, but the clinical trial data for specific drugs as provided here give a rough sense of their rates of occurrence. The shortcomings of these data, of course, are numerous: the clinical trials are performed while the drug is still in a trial phase, and so the results do not account for changes that may have been made in the drug before release on the market; the data come from the drug companies, which is less ideal than data provided by a general, non-interested source of drug information comparing drugs as well as cross-checking data from various sources; and the data do not give further details on the specific characteristics and circumstances of the individuals who experienced adverse side effects during the trial, nor on the intensity and duration of the side effects experienced.³⁵

34. PRESCRIPTION DRUG DATA, *supra* note 27, at 5.

35. *Understanding Clinical Trials*, CLINICALTRIALS.GOV, U.S. NAT'L INSTS. OF HEALTH, <http://clinicaltrials.gov/ct2/info/understand> (last visited Oct. 16, 2011). Drug labels often include, when providing clinical trial data, a disclaimer stating: "Because clinical trials are conducted under widely varying conditions, adverse reaction rates observed in the clinical trials of a drug cannot be directly compared to rates in the clinical trials of another drug and may not reflect or predict the rates observed in practice." See, e.g., *Prozac Label*, § 6: Adverse Reactions, ELI LILLY & CO. (1987), http://www.accessdata.fda.gov/drugsatfda_docs/label/2011/018936s096,021235s018lbl.pdf [hereinafter *Prozac Label*] ("The cited figures, however, do provide the prescribing physician with some basis for estimating the relative contribution of drug and nondrug factors to the side effect incidence rate in the population studied."); see also *Zocor Label*, § 6: Adverse Reactions, MERCK & CO. (2011), http://www.accessdata.fda.gov/drugsatfda_docs/label/2011/019766s077s082lbl.pdf [hereinafter *Zocor Label*]; *Adderall XR Label*, § 6: Adverse Reactions, SHIRE US INC. (2010), http://www.accessdata.fda.gov/drugsatfda_docs/label/2010/021303s020s022lbl.pdf [hereinafter *Adderall XR Label*]. Post-market data (of adverse reactions identified after approval of the drug and release into the market) also commonly come with a disclaimer like Prozac's: "Because these reactions are reported

Although prescription drug labels may list a number of potential side effects, from common to rare in occurrence, and may include warnings against driving or operating machinery, many users function normally and do not experience serious side effects.³⁶ In general, prescription drugs, when used legally pursuant to a prescription and taken as directed under a doctor's orders and supervision, will not cause problems.³⁷ Further, such carefully prescribed and supervised drugs help workers protect their health and thus perform more productively in the workplace. Thus, throughout the discussion of various drugs and their side effects that follows, it is important to keep in mind that most of the myriad of troubling side effects listed for each drug rarely occur and the degree and frequency of occurrence differ from individual to individual; further, the data provided suffer from important deficiencies, as described above and addressed again later in Part IV.E.

1. *Stimulants*

Stimulants, which include methylphenidate and amphetamines, are often used to treat attention-deficit hyperactivity disorder ("ADHD").³⁸ These drugs increase levels in the brain of dopamine, "a brain chemical (or neurotransmitter) associated with pleasure, movement, and attention."³⁹ They can "increase blood pressure, heart rate, body temperature, and decrease sleep and appetite, which can lead to malnutrition and its consequences. . . . At high doses, they can lead to serious cardiovascular complications, including stroke."⁴⁰

voluntarily from a population of uncertain size, it is difficult to reliably estimate their frequency or evaluate a causal relationship to drug exposure." *Prozac Label, supra*, at § 6: Adverse Reactions; see also *Zocor Label, supra*, at § 6: Adverse Reactions.

36. See, e.g., *infra* Part II.B.1–4 (discussing the occurrence of serious side effects for particular drugs during clinical trial studies).

37. PRESCRIPTION DRUG ABUSE IN THE WORKPLACE, SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN. 1 (2010) [hereinafter PRESCRIPTION DRUG ABUSE IN THE WORKPLACE], available at [http://www.workplace.samhsa.gov/pdf/Prescription Drug Abuse Fact Sheet.pdf](http://www.workplace.samhsa.gov/pdf/Prescription%20Drug%20Abuse%20Fact%20Sheet.pdf).

38. NAT'L INST. ON DRUG ABUSE, U.S. NAT'L INSTS. OF HEALTH, STIMULANT ADHD MEDICATIONS: METHYLPHENIDATE AND AMPHETAMINES 1 (2009) available at <http://www.drugabuse.gov/pdf/infofacts/ADHD09.pdf>.

39. *Id.*

40. *Id.* at 2.

Side effects for Adderall, a popular stimulant medication for treatment of ADHD,⁴¹ may include stomach pain, nausea, vomiting, dizziness, headache, nervousness, and trouble sleeping.⁴² Unlikely but serious side effects include mood and behavior changes (e.g., agitation, aggression, and abnormal thoughts), uncontrolled movements, and outbursts of words and sounds.⁴³ “[R]are but very serious side effects” include “shortness of breath, chest pain, fainting, severe headache, fast/pounding/irregular heartbeat,” seizures, extreme tiredness, blurred vision, weakness, and confusion.⁴⁴

A clinical trial study conducted by Shire Development, Inc., for eight months in 2004 found that 75% of subjects receiving Adderall XR experienced adverse side effects.⁴⁵ However, most adverse effects reported were mild or moderate, the most common of which were anorexia (50%) and weight decrease (25%).⁴⁶ Further, although three subjects reported severe adverse effects, only one such effect — insomnia — was reported by more than one subject.⁴⁷ No *serious*, as opposed to *severe*, adverse effects occurred.⁴⁸

41. *Id.* at 1.

42. *Adderall Oral: Side Effects*, WEBMD, <http://www.webmd.com/drugs/drug-63163-adderall+oral.aspx?drugid=63163&drugname=adderrall+oral&source=0> (last visited Oct. 16, 2011).

43. *Id.*

44. *Id.*

45. SHIRE DEV., INC., A PHASE IIIB STUDY TO EVALUATE THE EFFICACY AND TIME COURSE OF TREATMENT WITH ADDERALL XR AND STRATTERA COMPARED TO PLACEBO ON SIMULATED DRIVING SAFETY AND PERFORMANCE AND COGNITIVE FUNCTIONING IN ADULTS WITH ATTENTION DEFICIT HYPERACTIVITY DISORDER (ADHD) 4 (2005) [hereinafter SHIRE STUDY], available at http://www.clinicalstudyresults.org/documents/company-study_3563_0.pdf.

46. *Id.*

47. *Id.* Insomnia was reported by two subjects. *Id.*

48. *Id.* The U.S. Food and Drug Administration (FDA) clarifies the distinction between the terms “severe” and “serious” when applied to adverse events as follows:

The term “severe” is often used to describe the intensity (severity) of a specific event (as in mild, moderate, or severe myocardial infarction); the event itself, however, may be of relatively minor medical significance (such as severe headache). This is *not* the same as “serious,” which is based on patient/event *outcome* or *action* criteria usually associated with events that pose a threat to a patient’s life or functioning. Seriousness (not severity) serves as a guide for defining regulatory reporting obligations.

FED. DRUG ADMIN., GUIDELINE FOR INDUSTRY, CLINICAL SAFETY DATA MANAGEMENT: DEFINITIONS & STANDARDS FOR EXPEDITED REPORTING 4 (1995), available at <http://www.fda.gov/downloads/RegulatoryInformation/.../UCM129518.pdf>. The FDA defines a serious adverse event as one that is life-threatening; results in death, persistent or

Changes in vital signs in the subjects were small and not clinically significant, although one patient experienced blood in urine.⁴⁹

Results of clinical trials for Adderall XR, conducted by the same company, are also provided in the label for the drug.⁵⁰ In a four-week study involving adults with ADHD, twelve percent of the subjects stopped treatment due to adverse events (compared to less than two percent of subjects in a placebo group).⁵¹ The most common of these adverse events were insomnia (5.2%), anxiety (2.1%), nervousness (1.6%), dry mouth (1.6%), anorexia (1.6%), fast heartbeat (1.6%), headache (1.6%), and weakness (1.0%).⁵²

2. Painkillers (Opioids)

Pain medications are the single most prescribed type of medication in the United States.⁵³ Also known as opioids, these drugs include morphine, codeine, and oxycodone.⁵⁴ They

can cause feelings of euphoria or a high. . . . Since these drugs can depress respiration, even a large single dose can be dangerous. Mixing opioids with other substances that depress the central nervous system (such as alcohol or antihistamines) is equally risky since it increases the risk of respiratory depression.⁵⁵

The painkiller hydrocodone with acetaminophen was the most prescribed individual medication in 2010, with over 131 million prescriptions.⁵⁶ Hydrocodone, sold as a generic and under brand names such as Vicodin, works “by changing the way the brain

significant disability, or birth defect; requires hospitalization; or requires intervention to prevent one of these outcomes. *Id.* at 4–5.

49. SHIRE STUDY, *supra* note 45, at 4.

50. *Adderall XR Label*, *supra* note 35, at § 6: Adverse Reactions.

51. *Id.*

52. *Id.*

53. USE OF MEDICINES, *supra* note 9, at 33.

54. PRESCRIPTION DRUG ABUSE IN THE WORKPLACE, *supra* note 37, at 3.

55. *Id.* at 3.

56. USE OF MEDICINES, *supra* note 9, at 33.

and nervous system respond to pain.”⁵⁷ Side effects of hydrocodone may include nausea, vomiting, drowsiness, dizziness, and lightheadedness.⁵⁸ Unlikely but serious side effects include mood changes and severe abdominal pain.⁵⁹ Even rarer serious side effects include fainting, seizure, slow or shallow breathing, and unusual drowsiness.⁶⁰

In a clinical trial study of hydrocodone with acetaminophen conducted by Merck & Co., Inc., from 2002 to 2003, 24.8% of 145 patients experienced adverse side effects.⁶¹ However, 19.7% of individuals given a placebo as part of a control group also experienced adverse side effects.⁶² The study determined that there were “no significant differences with respect to the overall incidence” of adverse effects between the hydrocodone and placebo groups.⁶³ The most common adverse effects were nausea (10.3% for the hydrocodone group and 6.8% for the placebo group), headache (4.1% and 4.8%, respectively), and vomiting (3.4% for both groups).⁶⁴

3. Antidepressants

Antidepressants are used to treat depression.⁶⁵ The most common side effects, many of which go away after a few weeks, include daytime sleepiness, diarrhea, dizziness, headache, nau-

57. *Hydrocodone*, MEDLINEPLUS, U.S. NAT'L INSTS. OF HEALTH, <http://www.nlm.nih.gov/medlineplus/druginfo/meds/a601006.html#other-name> (last modified July 18, 2011).

58. *Hydrocodone-Acetaminophen: Oral Side Effects*, WEBMD, <http://www.webmd.com/drugs/drug-251-hydrocodone-acetaminophen+oral.aspx?drugid=251&drugname=hydrocodone-acetaminophen+oral> (last visited Oct. 16, 2011).

59. *Id.*

60. *Id.*

61. MERCK & CO., INC., STUDY SYNOPSIS, A RANDOMIZED, DOUBLE-BLIND, PLACEBO-CONTROLLED TRIAL OF THE EFFECT OF ROFECOXIB 50 MG AND HYDROCODONE 7.5 MG WITH ACETAMINOPHEN 750 MG IN PATIENTS WITH POSTOPERATIVE ARTHROSCOPIC PAIN [PROTOCOL 179], at 1–3, 6 (2005), available at http://www.clinicalstudyresults.org/documents/company-study_555_0.pdf.

62. *Id.* at 6.

63. *Id.*

64. *Id.*

65. Antidepressant Medicines — A Guide for Adults With Depression, Agency for Healthcare Research and Quality, U.S. Department of Health and Human Services, <http://effectivehealthcare.ahrq.gov/index.cfm/search-for-guides-reviews-and-reports/?pageaction=displayproduct&productID=10>.

sea, shakiness, and trouble sleeping.⁶⁶ *Scientific American* reported in 2008 that 11% of women and 5% of men currently take antidepressants.⁶⁷

Fluoxetine, sold under brand names Prozac and Sarafem, ranked twenty-fifth on a list of the top 200 generic drugs by total prescriptions in 2010.⁶⁸ It is prescribed for the treatment of depression, obsessive-compulsive disorder, panic attacks, bulimia, and a severe form of premenstrual syndrome.⁶⁹ As a selective serotonin reuptake inhibitor, or SSRI, it works by increasing serotonin levels in the brain.⁷⁰ Side effects may include nausea, drowsiness, dizziness, loss of appetite, and tiredness.⁷¹ Unlikely but serious side effects include unusual or severe mood changes (such as agitation, unusual high energy or excitement, and thoughts of suicide), easy bleeding, muscle weakness, and shakiness.⁷² Rare but serious side effects include seizures.⁷³ Fluoxetine may rarely cause a very serious condition called serotonin syndrome, especially when it is used with certain other drugs.⁷⁴ Symptoms of this condition include hallucinations, loss of coordination, fast heartbeat, severe dizziness, unexplained fever, severe nausea, and vomiting.⁷⁵

In a clinical trial study of fluoxetine conducted by Eli Lilly and Company from 2002 to 2003, 34% of patients reported at least

66. U.S. DEP'T OF HEALTH & HUMAN SERVS., AGENCY FOR HEALTHCARE RESEARCH & QUALITY, ANTIDEPRESSANT MEDICINES: A GUIDE FOR ADULTS WITH DEPRESSION 3 (2007) available at <http://effectivehealthcare.ahrq.gov/index.cfm/search-for-guides-reviews-and-reports/?pageaction=displayproduct&productID=10#92>.

67. Charles Barber, *The Medicated Americans: Antidepressant Prescriptions on the Rise*, SCI. AM. MIND, Feb. 27, 2008, at 44.

68. *2010 Top 200 Generic Drugs by Total Prescriptions*, DRUG TOPICS (June 2011), <http://drugtopics.modernmedicine.com/drugtopics/Chains+%26+Business/2010-Top-200-generic-drugs-by-total-prescriptions/ArticleStandard/Article/detail/727243?contextCategoryId=47443>.

69. *Fluoxetine: Oral Uses*, WEBMD, <http://www.webmd.com/drugs/-fluoxetine+-oral.aspx?drugid=1774&drugname=fluoxetine+oral> (last visited Oct. 16, 2011).

70. *Fluoxetine*, MEDLINEPLUS, U.S. NAT'L INSTS. OF HEALTH, <http://www.nlm.nih.gov/medlineplus/druginfo/meds/a689006.html> (last modified Aug. 15, 2011).

71. *Fluoxetine: Oral Side Effects*, WEBMD, <http://www.webmd.com/drugs/mono-95-fluoxetine+-oral.aspx?drugid=1774&drugname=fluoxetine+oral> (last visited Oct. 16, 2011).

72. *Id.*

73. *Id.*

74. *Id.*

75. *Id.*

one adverse event.⁷⁶ The most frequently reported adverse events were insomnia, tachycardia (disorder of the heart rate in which the heart beats too fast), gastrointestinal symptoms, and anticholinergic effect (the possible effects of which include loss of coordination, blurred vision, shaking, disorientation, respiratory depression, and hallucinations).⁷⁷ Additionally, one patient had an elevated alanine aminotransferase level, which is commonly measured to determine liver health.⁷⁸ However, although significantly elevated levels often suggest the existence of medical problems such as congestive heart failure, liver damage, or myopathy (a muscular disease in which the muscle fibers do not function), elevated levels do not necessarily mean that medical problems exist.⁷⁹

In another study conducted by the same company from 2001 to 2003, 76% of patients reported at least one adverse event.⁸⁰ The most frequent adverse events were “headache (41%), anxiety (37%), somnolence (21%), nausea (19%), and insomnia (17%).”⁸¹ Eleven percent experienced diarrhea, nervousness, weight gain, and dry mouth.⁸² One patient was removed from the study due to nausea and vomiting.⁸³ Despite these seemingly alarming data, however, neither study provides further detail on the intensity of these various reported side effects, nor on whether and how the side effects actually impaired the subjects in performing certain functions.⁸⁴

Further, the label for Prozac, which also includes results of clinical trials, notes that “[i]t is important to emphasize that reactions reported during [the trials] were not necessarily caused

76. ELI LILLY & CO., DEPRESSION WITH LACK OF MOTIVATION; COMPARISON BETWEEN FLUOXETINE AND TRAZODONE 2 (2006) [hereinafter ELI LILLY FLUOXETINE/TRAZODONE STUDY], available at http://www.clinicalstudyresults.org/documents/company-study_1677_0.pdf.

77. *Id.*

78. *Id.*

79. Paul T. Giboney, *Mildly Elevated Liver Transaminase Levels in the Asymptomatic Patient*, 71 AM. FAM. PHYSICIAN 1105, 1105–08 (2005).

80. ELI LILLY & CO., CLINICAL STUDY SUMMARY: STUDY B1Y-PU-S012, ENTERIC-COATED HYDROCHLORATE FLUOXETINE ADMINISTERED ONCE WEEKLY DURING THE MAINTENANCE TREATMENT OF MAJOR DEPRESSIVE DISORDER 7 (2006), available at http://www.clinicalstudyresults.org/documents/company-study_1963_0.pdf.

81. *Id.*

82. *Id.* at 8.

83. *Id.* at 2.

84. *Id.*; ELI LILLY FLUOXETINE/TRAZODONE STUDY, *supra* note 76.

by [the drug].”⁸⁵ In the trial results provided in the label, the most common adverse events were nausea (0.8%), headache (0.7%), insomnia (0.7%), nervousness (0.5%), weakness (0.4%), diarrhea (0.4%), anxiety (0.4%), and somnolence (0.4%).⁸⁶ Notably, the percentage was even higher in the placebo group for some of these events.⁸⁷

4. Cholesterol-Lowering Drugs

Almost 45% of people over age sixty take cholesterol-lowering prescription medication.⁸⁸ Simvastatin is by far the most prescribed cholesterol drug, with 94.1 million prescriptions in 2010.⁸⁹ The drug “may infrequently cause muscle problems,” which may manifest in muscle pain and weakness, and can be accompanied by fever or unusual tiredness.⁹⁰ However, in a clinical trial study conducted by Merck from 2002 to 2003, only one patient out of 202 experienced an adverse side effect, and it was not serious.⁹¹ Further, in clinical trials for Zocor, a brand name simvastatin drug, the most commonly reported adverse reactions were “upper respiratory infections (9.0%), headache (7.4%), abdominal pain (7.3%), constipation (6.6%), and nausea (5.4%).”⁹² 1.4% of subjects, who were followed for a median duration of approximately 18 months, stopped taking the drug due to adverse reactions. The most common of these adverse reactions that led to discontinuation were gastrointestinal disorders (0.5%), muscle pain (0.1%), and joint pain (0.1%).⁹³

85. *Prozac Label*, *supra* note 35, at § 6: Adverse Reactions.

86. *Id.* at § 6.1.

87. *Id.*

88. PRESCRIPTION DRUG DATA, *supra* note 27, at 5.

89. USE OF MEDICINES, *supra* note 9, at 33.

90. *Simvastatin Oral: Side Effects*, WEBMD, <http://www.webmd.com/drugs/drug-6105-simvastatin+oral.aspx?drugid=6105&drugname=simvastatin+oral> (last visited Oct. 16, 2011).

91. MERCK & CO., INC., A MULTICENTER, RANDOMIZED, DOUBLE-BLIND, PARALLEL GROUP STUDY TO EVALUATE THE TOLERABILITY AND EFFICACY OF THE CO-ADMINISTRATION OF SIMVASTATIN 20 MG/DAY AND FENOFIBRATE 160 MG/DAY COMPARED TO SIMVASTATIN 20 MG/DAY ALONE FOR 12 WEEKS OF TREATMENT IN PATIENTS WITH COMBINED HYPERLIPIDEMIA 1, 5 (2008), available at http://www.clinicalstudyresults.org/documents/study_307_0.pdf.

92. *Zocor Label*, *supra* note 35, at § 6: Adverse Reactions.

93. *Id.*

C. PRESCRIPTION DRUGS AND WORKPLACE ACCIDENTS

Unfortunately, there are limited data regarding the impact of prescription drug use in the workplace. The Bureau of Labor Statistics (BLS), which compiles the largest comprehensive and national set of data on workplace injuries,⁹⁴ documents workplace injuries caused by drug use, but does not provide further details as to which particular drugs were being used, and whether they were being taken legally or illegally.⁹⁵ This information is so limited because the BLS data are culled from surveys and other sources that do not necessarily provide such detail.⁹⁶ In any case, the number of documented injuries caused by “medicines” of any sort is very small compared to the overall number of documented workplace injuries — for example, of 4,340 workplace fatalities reported in 2009, only eighteen were caused by “medicines.”⁹⁷ Of over 1.2 million injuries reported in 2009, only 130 were categorized by “medicines” as the source of the injury.⁹⁸

One study by Quest Diagnostics, the nation’s leading provider of diagnostic testing and a leading provider of workplace drug tests,⁹⁹ does provide some detail on prescription drug use in the

94. *Injuries, Illnesses, and Fatalities: Frequently Asked Questions (FAQs)*, BUREAU OF LABOR STATISTICS, <http://www.bls.gov/iif/.htm#q01> (last modified Aug. 25, 2011).

95. *Injuries, Illnesses, and Fatalities: Case and Demographic Characteristics for Work-related Injuries and Illnesses Involving Days Away From Work*, BUREAU OF LABOR STATISTICS, <http://www.bls.gov/iif/oshcdnew.htm> (last modified Nov. 9, 2010); *Injuries, Illnesses, and Fatalities: Census of Fatal Occupational Injuries (CFOI) — Current and Revised Data*, BUREAU OF LABOR STATISTICS, <http://www.bls.gov/iif/oshcfoi1.htm> (last modified Aug. 25, 2011).

96. Employers are subject to more reporting requirements for workplace fatalities, as opposed to non-fatal injuries or illnesses, but even for those the provided data are limited in their detail. See BUREAU OF LABOR STATISTICS, BLS HANDBOOK OF METHODS, CHAPTER 9, OCCUPATIONAL SAFETY AND HEALTH STATISTICS, PART III: CENSUS OF FATAL OCCUPATIONAL INJURIES, *available at* http://www.bls.gov/opub/hom/homch9.htm#census_fatal (last modified Aug. 19, 2010); *id.* at PART II: SURVEY OF OCCUPATIONAL ILLNESSES AND INJURIES, *available at* http://www.bls.gov/opub/hom/homch9.htm#background_part2.

97. *Occupational Injuries/Illnesses and Fatal Injuries Profiles*, BUREAU OF LABOR STATISTICS, <http://data.bls.gov/gqt/InitialPage> (select “Fatal Injuries Numbers” → “2009” → “All U.S.,” “Single Year” → Characteristic Type: “Primary source” → Subcharacteristic: “Medicines 0743 XX,” Ownership: “All ownerships”).

98. *Id.* (select “Case and Demographic Numbers” → “2009” → “All U.S.,” “Single Year” → Characteristic Type: “Source of injury/illness” → Subcharacteristic: “Medicines 0743 XX,” Ownership: “Private industry”).

99. *Our Businesses*, QUEST DIAGNOSTICS, http://www.questdiagnostics.com/brand/business/b_bus_index.html (last visited Oct. 16, 2011).

workplace. The study found that the number of employees testing positive for prescription painkillers increased by more than 40% from 2005 to 2009, and by 18% from 2008 to 2009 alone, according to more than 5.5 million urine samples tested.¹⁰⁰ Out of 500,000 tests in 2009, 1.3% tested positive for hydrocodone, 1% tested positive for oxycodone, and 0.82% tested positive for hydromorphone.¹⁰¹ This represented a 20.5% increase in positive tests for oxycodone from 2008, and a 12.3% increase for hydromorphone.¹⁰² Of 20,000 tests performed following a workplace accident in 2009, 3.7% tested positive for hydrocodone, and 2.1% tested positive for oxycodone.¹⁰³ The study does not specify, however, whether the drugs were being taken illegally or pursuant to a prescription.¹⁰⁴ More importantly, there are no data establishing a causal link between the prescription drug use and the workplace accident. Thus, it is important not to assume from this kind of data that presence of a drug in an employee's system is necessarily related to a workplace accident involving the employee,¹⁰⁵ or that the drug was being used pursuant to a doctor's orders and supervision, without further information.¹⁰⁶

100. *U.S. Worker Use of Prescription Opiates Climbing, Shows Quest Diagnostics Drug Testing Index*, QUEST DIAGNOSTICS (Sept. 16, 2010), http://www.questdiagnostics.com/employersolutions/dti/2010_09/dti_index.html.

101. *Id.*

102. *Id.*

103. *Id.*

104. *Id.*

105. See PAUL ROUNTREE, DRUG TESTING AND WORKPLACE ACCIDENTS 1 (2004) [hereinafter ROUNTREE], available at <http://www.aiha.org/aihce04/handouts/rt227routree1.pdf> ("Unlike a blood alcohol test, correlations between a positive urine test, a drug's pharmacologic effect, and related levels of impairment are generally unknown.")

106. Further, a RAND study concluded that

[t]he proportion of injuries *caused* by substance use . . . is relatively small. Instead, there is mounting evidence that harmful substance use is one of a constellation of behaviors exhibited by certain individuals who may avoid work-related safety precautions and take greater work-related risks. Thus, we suspect that it is more likely that risk-taking dispositions . . . and other omitted factors can explain most empirical associations between substance use and injuries at work.

RAJEEV RAMCHAND ET AL., RAND CTR. FOR HEALTH & SAFETY IN THE WORKPLACE, THE EFFECTS OF SUBSTANCE USE ON WORKPLACE INJURIES 31 (2009), available at http://www.rand.org/pubs/occasional_papers/2009/RAND_OP247.pdf. The study does not refer to prescription drug use specifically, but the connection made between "harmful substance use" and "risk-taking dispositions" indicates that the study is referring to illegal drug use and/or prescription drug *abuse*, as such uses are generally associated with "risk-taking dispositions," while legally using a prescription drug to treat, for example, one's back pain, is generally not so associated. *Id.*

Under federal laws, there are almost no limits on the right of private employers to adopt workplace drug and alcohol testing policies.¹⁰⁷ However, employers must comply with the ADA, which provides civil rights protections to individuals with disabilities in such areas as employment, housing, public accommodations, education, and transportation.¹⁰⁸ The ADA, although it explicitly addresses alcohol and illegal drug use by employees,¹⁰⁹ does not explicitly address legal prescription drug use,¹¹⁰ leaving it unclear to both employers and employees alike how exactly the ADA applies in such a case.

III. THE AMERICANS WITH DISABILITIES ACT AND THE DIRECT THREAT DEFENSE

Congress enacted the Americans with Disabilities Act (ADA) in 1990, prompted in part by the

continuing existence of unfair and unnecessary discrimination and prejudice [which] denies people with disabilities the opportunity to compete on an equal basis and to pursue those opportunities for which our free society is justifiably famous, and costs the United States billions of dollars in unnecessary expenses resulting from dependency and non-productivity.¹¹¹

Additionally, “despite some improvements . . . discrimination against individuals with disabilities continue[d] to be a serious

107. *Workplace Drug Testing*, U.S. DEPT OF LABOR, <http://www.dol.gov/elaws/asp/drugfree/drugs/dt/asp> (“[M]ost private employers are not limited in the number of substances they can test for and may include drugs that individuals legitimately and/or therapeutically take based on a physician’s prescription.”).

108. 42 U.S.C.A. § 12101(a)–(b) (West 2009).

109. 42 U.S.C.A. § 12114.

110. However, the Equal Employment Opportunity Commission (“EEOC”), which is responsible for promulgating regulations and guidelines for the enforcement of Title I, *see infra* note 113, has clarified that “[t]he illegal use of drugs does not include drugs taken under supervision of a licensed health care professional, including experimental drugs for people with AIDS, epilepsy, or mental illness.” U.S. EQUAL EMP’T OPPORTUNITY COMM’N, TECHNICAL ASSISTANCE MANUAL, CHAPTER VIII: DRUG AND ALCOHOL ABUSE, § 8.3: ILLEGAL USE OF DRUGS (1992) [hereinafter TECHNICAL ASSISTANCE MANUAL], *available at* http://adaportal.org/Employment/TAM_I_Chapter_VIII_8_3.html.

111. 42 U.S.C.A. § 12101(a)(8).

and pervasive social problem,”¹¹² and thus Congress wanted “to provide a clear and comprehensive national mandate for the elimination of discrimination against individuals with disabilities.”¹¹³

The ADA acknowledges that people with disabilities are often “restricted in employment opportunities by many different kinds of barriers,”¹¹⁴ such as prejudice, stereotypes, and presumptions — including, for example, misconceptions held by employers about the potential job performance of, and safety risks associated with, disabled individuals.¹¹⁵ Title I of the ADA empowers employees and job applicants to bring suit¹¹⁶ against private employers¹¹⁷ who discriminate against disabled individuals who are otherwise “qualified” for a particular job.¹¹⁸ The Equal Employment Opportunity Commission (“EEOC”) is responsible for promulgating regulations and guidelines for the enforcement of Title I.¹¹⁹

To establish a *prima facie* case of disability discrimination under the ADA,¹²⁰ a plaintiff must show that he “(1) is disabled within the meaning of the ADA,¹²¹ (2) is qualified (with or without rea-

112. *Id.* § 12101(a)(2).

113. *Id.* § 12101(b)(1).

114. TECHNICAL ASSISTANCE MANUAL, *supra* note 110, at CHAPTER III: THE REASONABLE ACCOMMODATION OBLIGATION, § 3.2: WHY IS A REASONABLE ACCOMMODATION NECESSARY? (1992), available at http://adaportal.org/Employment/TAM_I_Chapter_III_3_2.html.

115. 42 U.S.C.A. § 12112(a)–(b).

116. 42 U.S.C. § 12117(a) (2006) (“The powers, remedies, and procedures set forth in . . . this title shall be the powers, remedies, and procedures this subchapter provides to the Commission, to the Attorney General, or to any person alleging discrimination on the basis of disability in violation of any provision of this chapter, or regulations promulgated under section 12116 of this title, concerning employment.”).

117. Title I of the ADA covers the actions of private employers, employment agencies, labor organizations, and joint labor-management committees with fifteen or more employees, in industries affecting commerce. 42 U.S.C.A. §§ 12111(2), (5)(A) (West 2009).

118. *Id.* § 12112(a).

119. See 42 U.S.C. §§ 12116, 12205a; 42 U.S.C. § 12111(1) (“The term ‘Commission’ means the Equal Employment Opportunity Commission . . .”). The regulations for the ADA are found at 29 C.F.R. §§ 1630.1–1630.16 (2011).

120. This follows the method of proof established for Title VII actions in *McDonnell Douglas Corp. v. Green*, 411 U.S. 792, 802 (1973). See *Daigle v. Liberty Life Ins. Co.*, 70 F.3d 394, 396 (5th Cir. 1995) (holding that the Title VII burden-shifting framework from *McDonnell Douglas* applies in ADA cases).

121. “Disability” is defined under the ADA as: “(A) a physical or mental impairment that substantially limits one or more major life activities of [an] individual; (B) a record of such an impairment; or (C) being regarded as having such an impairment . . .” 42 U.S.C.A. § 12102(1) (West 2009).

sonable accommodation)¹²² to perform the essential functions of the job at issue, and (3) has suffered an adverse employment decision because of the disability.”¹²³

For employees who are drug-tested by employers and suffer an adverse employment decision based on their prescription drug use, this Note assumes that the employee in question would be considered disabled under the ADA for the underlying condition being treated by the prescription drug.¹²⁴ Although counting as disabled under the ADA has been the primary obstacle for Title I ADA plaintiffs, the 2008 Amendments present a clear mandate for a broad reading of the definition of disability under the ADA,

122. An employer is not required to provide reasonable accommodation if it would “impose an undue hardship on the operation of the business” 42 U.S.C.A. § 12112(b)(5)(A).

123. *Cravens v. Blue Cross & Blue Shield of Kan. City*, 214 F.3d 1011, 1016 (8th Cir. 2000); *see also* *Macy v. Hopkins Cnty. Sch. Bd. of Educ.*, 484 F.3d 357, 363–64 (6th Cir. 2007); *Graves v. Finch Pruyn & Co.*, 457 F.3d 181, 183–4 (2d Cir. 2006); *EEOC v. Sears, Roebuck & Co.*, 417 F.3d 789, 797 (7th Cir. 2005); *Estades-Negroni v. Assocs. Corp. of N. Am.*, 377 F.3d 58, 63 (1st Cir. 2004); *Bartee v. Michelin N. Am., Inc.*, 374 F.3d 906, 912 & n.4 (10th Cir. 2004); *Morisky v. Broward Cnty.*, 80 F.3d 445, 447 (11th Cir. 1996); *Tyndall v. Nat’l Educ. Ctrs., Inc.*, 31 F.3d 209, 212 (4th Cir. 1994).

124. This assumption is warranted because this Note contemplates primarily those employees who are taking a drug out of necessity and thus cannot resolve the risk problem posed by potential side effects by simply discontinuing medication or changing to another medication. Changing medications is unlikely to resolve the problem because different drugs used to treat the same condition often contain similar side effect warnings. For example, compare the side effects of popular painkiller hydrocodone, *Hydrocodone-Acetaminophen Oral: Common & Rare Side Effects*, WEBMD.COM, <http://www.webmd.com/drugs/drug-251-hydrocodone-acetaminophen+oral.aspx?drugid=251&drugname=hydrocodone-acetaminophen+oral&source=0&pagenumber=6> (last visited Nov. 20, 2011), with those of another popular painkiller, oxycodone, *Oxycodone Oral: Common and Rare Side Effects*, WEBMD.COM, <http://www.webmd.com/drugs/mono-5278-OXYCODONE++ORAL.aspx?drugid=1025&drugname=oxycodone+oral&source=0&pagenumber=6> (last visited Nov. 20, 2011). Similarly, while Ritalin is a methylphenidate and Adderall is an amphetamine, both are popular drugs used to treat ADHD with similar side effects. *Ritalin Oral: Common and Rare Side Effects*, WEBMD.COM, <http://www.webmd.com/drugs/drug-9475-Ritalin+Oral.aspx?drugid=9475&drugname=Ritalin+Oral&source=0&pagenumber=6> (last visited Nov. 20, 2011); *Adderall Oral: Common and Rare Side Effects*, WEBMD.COM, <http://www.webmd.com/drugs/drug-63163-Adderall+Oral.aspx?drugid=63163&drugname=Adderall+Oral&source=0&pagenumber=6> (last visited Nov. 20, 2011). These employees, because they need medication in order to control their conditions so that they may function normally, or as normally as possible, would likely be considered disabled based on their underlying condition. *See infra* Part III.C (discussing how the ADAAA has loosened the requirements for qualifying as disabled under the ADA and requires individuals to be assessed in their unmitigated, or unmedicated, state; and that, if a drug is prescribed to treat, for example, severe pain, and the unmedicated pain itself substantially interferes with a major life activity, the employee would be considered disabled under the ADAAA).

so it is expected that more plaintiffs will now be able to reach the second prong of the prima facie case.¹²⁵

This Note therefore focuses on that second prong, which is the prong most relevant to prescription drug use challenges under the ADA. This is because the main defense an employer can make in response to an employee claiming discrimination based on prescription drug use is that the employee was not otherwise — as in, despite his or her disability — qualified for the position in question, particularly because the employee posed a “direct threat” to the health or safety of others in the workplace.¹²⁶

A. OTHERWISE “QUALIFIED” TO PERFORM THE “ESSENTIAL FUNCTIONS” OF THE JOB

An employee must prove two things in order to be considered an otherwise “qualified” individual under the ADA. First, the employee must demonstrate that he has the “requisite skill, experience, education and other job-related requirements” needed to perform the job.¹²⁷ This is usually not difficult to demonstrate because the employee in the typical case will have already been performing the job when the adverse employment action occurs.¹²⁸ Second, the employee must show that he can perform the “essential functions” of the job, with or without reasonable accommodation.¹²⁹ The EEOC regulations provide a non-exhaustive list of factors to consider in determining the “essential functions” of a given job; these include the employer’s judgment as to which functions are essential, the amount of time spent performing the function on the job, and the consequences of not requiring the employee to perform the function.¹³⁰ Under the ADA, deference is

125. See *infra* Part III.C.

126. See *infra* Part III.B.

127. 29 C.F.R. § 1630.2(m) (2011).

128. For example, in *Bultemeyer v. Fort Wayne Cmty. Schs.*, 100 F.3d 1281 (7th Cir. 1996), the court noted that the defendant school district “[could] not dispute” that the plaintiff, a janitor with bipolar disorder and paranoid schizophrenia, satisfied the prerequisites for the position, because it had employed him for “many years.” *Id.* at 1284. In *Taylor v. Phoenixville Sch. Dist.*, 184 F.3d 296 (3d Cir. 1999), the court noted that, because the plaintiff had “held her position as secretary to [an elementary school] principal for many years, receiving high praise, there is no serious dispute that she satisfies the prerequisites for the position.” *Id.* at 302, 311.

129. 42 U.S.C.A. § 12111(8) (West 2009).

130. 29 C.F.R. § 1630.2(n)(3) (2011).

given to the employer's judgment as to what the essential job functions are, especially to any written job description prepared by the employer before hiring the employee.¹³¹ EEOC regulations further emphasize that a court's determination of essential functions is "not intended to second guess an employer's business judgment with regard to production standards, whether qualitative or quantitative, nor to require employers to lower such standards."¹³²

This deference to the employer's judgment can be problematic, however, because it gives the employer a "great leeway in not only relying on traditional work arrangements" that may present obstacles for the disabled, "but also in incorporating stereotypes and prejudices about persons" when making employment decisions.¹³³ Judges, because they are just as susceptible as employers and the general public to widespread risk misperceptions, may then support the employer's "largely unexamined safety decisions."¹³⁴ For example, in *F.F. v. City of Laredo*,¹³⁵ an employer determined that one of its city bus drivers was unable to perform the essential function of driving a bus as soon as the driver was diagnosed with bipolar disorder.¹³⁶ The driver's psychiatrist, who was treating him with lithium, had released him to perform his

131. 42 U.S.C.A. § 12111(8) ("[C]onsideration shall be given to the employer's judgment as to what functions of a job are essential, and if an employer has prepared a written job description before advertising or interviewing applicants for the job, this description shall be considered evidence of the essential functions of the job.")

132. 29 C.F.R. pt. 1630 app. § 1630.2(n). See, e.g., *Russell v. TG Mo. Corp.*, 340 F.3d 735, 746 (8th Cir. 2003) ("[W]e do not sit as a super-personnel department with the power to second-guess employers' business decisions." (internal quotation marks omitted)).

133. Ramona L. Paetzold, *How Courts, Employers, and the ADA Disable Persons with Bipolar Disorder*, 9 EMP. RTS. & EMP. POL'Y J. 293, 341 (2005).

134. Ann Hubbard, *Understanding and Implementing the ADA's Direct Threat Defense*, 95 NW. L. REV. 1279, 1282 (2001).

135. 912 F. Supp. 248 (S.D. Tex. 1995). This case was brought under the Rehabilitation Act, not the ADA. *Id.* Congress patterned much of the ADA after the Rehabilitation Act. See, e.g., STAFF OF H. COMM. ON EDUC. AND LABOR, 101ST CONG., LEGISLATIVE HISTORY OF AMERICANS WITH DISABILITIES ACT OF 1990, 304-05 (Comm. Print 1990). The ADA's legislative history indicates that Congress incorporated the case law interpreting the Rehabilitation Act into the ADA with the intent that courts use Rehabilitation Act precedent to interpret the ADA. *Id.* Further, the ADA makes clear that no lesser standard than is required by the Rehabilitation Act be used in interpreting the ADA. 42 U.S.C. § 12201(a) (2009) ("Except as otherwise provided in this chapter, nothing in this chapter shall be construed to apply a lesser standard than the standards applied under title V of the Rehabilitation Act of 1973 or the regulations issued by Federal agencies pursuant to such title." (citation omitted)).

136. *City of Laredo*, 912 F. Supp. at 253.

regular duties as a bus driver.¹³⁷ However, the psychiatrist indicated that “the possibility of a relapse is always present,”¹³⁸ a statement which, despite the fact that the psychiatrist had deemed the plaintiff fit to return to bus-driving, prompted the company physician to determine that the plaintiff could not meet the physical standards required by the Department of Transportation to drive a bus.¹³⁹ The employer did not perform an individualized inquiry into the plaintiff’s particular condition and the risks it posed.¹⁴⁰

Despite the deference given to employers, the ADA requires that an employer’s qualification standards be “job-related” and “consistent with business necessity.”¹⁴¹ These standards may include “personal and professional attributes including the skill, experience, education, physical, medical, safety and other requirements established by a covered entity as requirements which an individual must meet in order to be eligible for the position held or desired.”¹⁴² The ADA also provides that “qualification standards’ may include a requirement that an individual shall not pose a direct threat to the health or safety of other individuals in the workplace.”¹⁴³ Thus, under the ADA, an employer may legally fire or refuse to hire an employee who poses a direct threat to others at the job.¹⁴⁴ This exception has been termed the “direct threat defense.”¹⁴⁵

B. THE DIRECT THREAT DEFENSE AND THE INDIVIDUALIZED ASSESSMENT REQUIREMENT

Courts have consistently recognized that a person cannot be considered a qualified individual with a disability under the ADA if the person poses a direct threat to the health or safety of others

137. *Id.* at 251.

138. *Id.* at 252.

139. *Id.*

140. *Id.* at 253–54.

141. 42 U.S.C.A. § 12113(a) (West 2009).

142. 29 C.F.R. § 1630.2(q) (2011).

143. 42 U.S.C.A. § 12113(b).

144. *Id.*

145. See, e.g., Sarah R. Christie, Note, *AIDS, Employment, and the Direct Threat Defense: The Burden of Proof and the Circuit Court Split*, 76 *FORDHAM L. REV.* 235 (2007); Hubbard, *supra* note 134.

in the workplace that cannot be eliminated by a reasonable accommodation.¹⁴⁶ However, courts disagree about how to properly analyze a direct threat defense. The defense has arisen most often in cases involving contagious diseases,¹⁴⁷ particularly AIDS,¹⁴⁸ violent employees,¹⁴⁹ diabetics and epileptics,¹⁵⁰ but has also been allowed in cases involving disabilities such as ADHD¹⁵¹ and depression.¹⁵²

The EEOC regulations define “direct threat” as a “significant risk of substantial harm to the health or safety of the individual or others that cannot be eliminated or reduced by reasonable accommodation.”¹⁵³ The regulations require that the determination of whether a person poses a direct threat “shall be based on an *individualized* assessment of the *individual’s* present ability to safely perform the essential functions of the job.”¹⁵⁴ The Supreme Court affirmed this individualized assessment requirement in

146. See, e.g., *Robertson v. Neuromedical Ctr.*, 161 F.3d 292, 296 (5th Cir. 1998). In that case, a neurologist whose ADHD caused “mistakes to be made in patients’ charts and in dispensing medicine,” and who himself stated that “it was only a matter of time before he seriously hurt someone,” was found to pose a direct threat to the health and safety of others at his job. *Id.*

147. See, e.g., *Sch. Bd. of Nassau Cnty., Fla. v. Arline*, 480 U.S. 273 (1987) (involving a teacher with tuberculosis).

148. See, e.g., *Holiday v. City of Chattanooga*, 206 F.3d 637, 648 (6th Cir. 1999) (refusing to allow a direct threat defense based on unsubstantiated “fear, ignorance or misconceptions” about HIV transmission).

149. See, e.g., *Borgialli v. Thunder Basin Coal Co.*, 235 F.3d 1284, 1295 (10th Cir. 2000); *Palmer v. Circuit Court of Cook Cnty., Ill.*, 117 F.3d 351, 353 (7th Cir. 1997) (“[W]e cannot believe that this duty [of reasonable accommodation] runs in favor of employees who commit or threaten to commit violent acts.”).

150. See, e.g., *Daugherty v. City of El Paso*, 56 F.3d 695, 698 (5th Cir. 1995) (holding as a matter of law that, under the ADA, “a [bus] driver with insulin-dependent diabetes is not otherwise qualified because his medical condition presents a genuine substantial risk that he could injure himself or others”); *but cf. Kapche v. City of San Antonio*, 176 F.3d 840, 845–47 (5th Cir. 1999) (reevaluating validity of *per se* holdings that insulin-dependent diabetic drivers pose a direct threat as a matter of law, given “significant changes in the federal highway safety regulations, as well as purported scientific advances in the control of diabetes”).

151. See, e.g., *Robertson v. Neuromedical Ctr.*, 161 F.3d 292, 296 (5th Cir. 1998).

152. See, e.g., *EEOC v. Amego, Inc.*, 110 F.3d 135, 145–46 (1st Cir. 1997) (holding that an employee responsible for administering medications to severely disabled patients posed a direct threat to the patients because her depression made her likely to mishandle medications).

153. 29 C.F.R. § 1630.2(r) (2011).

154. *Id.* (emphasis added).

*Chevron U.S.A. Inc. v. Echazabal*¹⁵⁵ and in *Albertson's, Inc. v. Kirkingburg*.¹⁵⁶ The Court, quoting the EEOC regulations, recognized that the direct threat defense “ordinarily requires ‘an individualized assessment of the individual’s present ability to safely perform the essential functions of the job.’”¹⁵⁷

The ADA’s legislative history reveals Congress’s concerns about the direct threat provision and emphasizes the requirement of an individualized assessment.¹⁵⁸ One House report states that a determination that an individual poses a safety threat to others should not come from “generalizations, misperceptions, ignorance, irrational fears, patronizing attitudes, or pernicious mythologies,” but from a careful, case-by-case assessment.¹⁵⁹ The same report states that safety criteria “must be based on actual risks and not on speculation, stereotypes, or generalizations about disability.”¹⁶⁰ By requiring an inquiry into the current specific abilities and limitations of each individual and how a mental or physical impairment actually affects the individual in relation to the particular job in question, the direct threat inquiry ensures “that employers are acting on fact rather than fear, information rather than ignorance, and medical evidence rather than mythology.”¹⁶¹

The EEOC regulations expressly adopt four factors which constitute what the Supreme Court called an “individualized inquiry” in *School Board of Nassau County v. Arline*,¹⁶² the case in which direct threat standards were first outlined: (1) the duration of the risk; (2) the nature and severity of the potential harm; (3) the likelihood that the potential harm will occur; and (4) the im-

155. 536 U.S. 73, 86 (2002) (“The direct threat defense must be . . . [based] upon an expressly ‘individualized assessment of the individual’s present ability to safely perform the essential functions of the job,’”) (quoting 29 CFR § 1630.2(r) (2001)).

156. 527 U.S. 555, 569 (1999).

157. *Id.* (quoting 29 C.F.R. § 1630.2(r) (1998)).

158. H.R. REP. NO. 101-485, pt. 2, at 33–34 (1990), *reprinted in* 1990 U.S.C.C.A.N. 303, 338–39 [hereinafter ADA HOUSE REPORT].

159. *Id.* at 33 (“[D]etermination that an individual with a disability will pose a safety threat to others must be made on a case-by-case basis and must not be based on generalizations, misperceptions, ignorance, irrational fears, patronizing attitudes, or pernicious mythologies.”).

160. *Id.* at 81; *see also* S. REP. NO. 101-116, at 27 (1990) [hereinafter ADA SENATE REPORT].

161. *EEOC v. Prevo’s Family Mkt., Inc.*, 135 F.3d 1089, 1101 n.3 (6th Cir. 1998) (Moore, J., dissenting).

162. 480 U.S. 273, 287 (1987).

minence of the potential harm.¹⁶³ The ADA's legislative history and EEOC guidelines further clarify that an employer cannot fire or refuse to hire a person with a disability simply based on a generalized fear of harm or speculation that the person will become unable to perform the job, cause increased health insurance or workers' compensation costs, or have excessive absences.¹⁶⁴ Rather, the employer must identify the specific risk posed by the individual.¹⁶⁵

The following sections delineate the contours of an "individualized inquiry" that sufficiently considers the factors outlined above. First, employers should evaluate an employee's potential threat based on objective, current, and thorough medical evidence. Second, assessments of future threat posed by an employee should involve evaluations of the employee's past work and medical history. Finally, a very narrow exception to the individualized assessment requirement should allow employers to apply blanket exclusions only in extreme cases.

1. *Objective, Current, and Thorough Medical Evidence*

The EEOC regulations call for a high level of objectivity in evaluating the individualized inquiry factors, requiring that findings of fact "be based on a reasonable medical judgment that relies on the most current medical knowledge and/or on the best available objective evidence."¹⁶⁶ Thus, a court must rely on the most up-to-date and reasonable scientific information about the symptoms, situations, and personal characteristics that could

163. 29 C.F.R. § 1630.2(r) (2011).

164. See ADA HOUSE REPORT, *supra* note 158, at 113 ("[A]n employer could not deny a qualified applicant a job . . . because of the increased costs of the insurance."); ADA SENATE REPORT, *supra* note 160, at 85 ("[A]n employer could not deny a qualified applicant a job because the employer's current insurance plan does not cover the person's disability or because of the increased costs of the insurance."); see also 29 C.F.R. pt. 1630 app. § 1630.2(m) (2011) ("The determination of whether an individual with a disability is qualified . . . should be based on the capabilities of the individual with a disability at the time of the employment decisions, and should not be based on speculation that the employee may become unable in the future or may cause increased health insurance premiums or workers compensation costs.").

165. ADA HOUSE REPORT, *supra* note 158, at 33 ("The determination that an individual with a disability will pose a safety threat to others must be made on a case-by-case basis and must not be based on generalizations, misperceptions, ignorance, irrational fears, patronizing attitudes, or pernicious mythologies.").

166. § 1630.2(r) (2011).

indicate an increased risk of harm, and “not on anecdotal or outdated information.”¹⁶⁷ According to the EEOC guidelines, proper evidence includes “input from the individual with the disability, the experience of the individual . . . in previous similar positions, and opinions of medical doctors, rehabilitation counselors or physical therapists who have expertise in the disability and/or have direct knowledge of the individual with the disability.”¹⁶⁸

Courts will not only look at the *types* of medical evidence gathered, but will also assess the level of specificity and thoroughness of the evidence.¹⁶⁹ The determination that a person poses a direct threat cannot be, as the Ninth Circuit put it,

based merely on an employer’s subjective evaluation or, except in cases of a most apparent nature, merely on medical reports. The question is whether, in light of the individual’s work history and medical history, employment of that individual would pose a reasonable probability of substantial harm. Such an evaluation necessarily requires the gathering of substantial information by the employer.¹⁷⁰

Courts have thus emphasized the importance of consulting not only the company physician, but also the individual’s own physician, the individual himself, and, if necessary, an expert on the particular disability in question.¹⁷¹ For example, in *Kelley v.*

167. Hubbard, *supra* note 134, at 1283; *Arline*, 480 U.S. 273, 284–85 (1987) (calling for replacing “reflexive reactions to actual or perceived handicaps with actions based on reasoned and medically sound judgments”); § 1630.2(r) (2011) (“The determination that an individual poses a ‘direct threat’ shall be based . . . on a reasonable medical judgment that relies on the most current medical knowledge and/or on the best available objective evidence.”).

168. 29 C.F.R. pt. 1630 app. § 1630.2(r) (2011).

169. See *Mantolete v. Bolger*, 767 F.2d 1416, 1422–23 (9th Cir. 1985).

170. *Id.* at 1422.

171. See, e.g., *EEOC v. Hussey Copper Ltd*, 696 F. Supp. 2d 505, 521 (W.D. Pa. 2010) (faulting the company doctor for failing to ask “[the employee] himself whether he had ever experienced methadone-related complications or inquire with his drug counselor . . . and treating doctor . . . about their opinions concerning the effects of his methadone use”); *E.E.O.C. v. Burlington N. & Santa Fe Ry. Co.*, 621 F.Supp.2d 587, 602 (W.D. Tenn. 2009) (refusing to conclude as a matter of law that the employer’s decision that the employee posed a direct threat was objectively reasonable because the employer failed to “examine [the employee] directly or consult those who had,” even though the employer had consulted medical specialists with knowledge of the condition in question); *Kelley v. Bechtel Power Corp.*, 633 F. Supp. 927 (S.D. Fla. 1986). See also 29 C.F.R. pt. 1630 app. § 1630.2(r) (2011) (clarifying that employers “must rely on objective, factual evidence,”

Bechtel Power Corp.,¹⁷² which involved an epileptic's claim under Florida's analogous non-discrimination law, the Florida Human Rights Act of 1977,¹⁷³ a district court concluded that the company physician lacked specific knowledge of whether the employee presented a substantial risk of having a seizure on the job because he had never examined the employee, requested his medical records, or ordered any neurological testing.¹⁷⁴ The court found fault with the company physician for not consulting with the employee's own physician as well as a neurologist with expertise in seizure disorders.¹⁷⁵ In the face of insufficient specificity and thoroughness, courts are more likely to find that the employer's decision was based on a "generalized fear," rather than an accurate "individualized assessment" of risk.¹⁷⁶

To further protect against careless risk assessments, the Supreme Court has recognized the importance of placing a high burden of proof on the employer in proving a direct threat defense. In *Bragdon v. Abbott*,¹⁷⁷ which involved a dentist who had

which may include "input from the individual with a disability, the experience of the individual with a disability in previous similar positions, and opinions of medical doctors, rehabilitation counselors, or physical therapists who have expertise in the disability involved and/or direct knowledge of the individual with the disability").

172. 633 F. Supp. 927.

173. The Florida Human Rights Act of 1977 is analogous to the ADA. To establish a prima facie case under the Florida Act, a plaintiff must prove: "(1) he is within the class to be protected; (2) he otherwise meets the qualifications for the position, and he was rejected for that position; and (3) after his rejection, the position remained open and the employer continued to seek applicants of like qualifications." *Kelley*, 633 F. Supp. at 935. "Once the plaintiff has made his prima facie case, the burden of persuasion shifts to the employer to show that the criteria used for making the employment decision were job-related and that the plaintiff could not safely and efficiently perform the job." *Id.* at 936. The employer is required to make an "individualized determination of the degree of risk presented" by the plaintiff. *Id.*

174. *Id.* at 933-34.

175. *Id.* at 933-35.

176. *Chalk v. U.S. Dist. Court Centr. Dist. of Cal.*, 840 F.2d 701, 708 (9th Cir. 1988) (criticizing the district court for, in finding that a school teacher with AIDS posed a direct threat under the Rehabilitation Act, "reject[ing] the overwhelming consensus of medical opinion and improperly rel[ying] on speculation for which there was no credible support in the record"). See also *EEOC v. Tex. Bus Lines*, 923 F. Supp. 965, 979 (S.D. Tex. 1996) (asserting that, in denying the plaintiff a bus-driving job because of her obesity, the employer's "blind reliance on a very limited medical examination . . . [could not] be used as a justification to circumvent the anti-discrimination mandate of the ADA").

177. 524 U.S. 624 (1998).

refused to fill a cavity for an asymptomatic AIDS patient,¹⁷⁸ the Court emphasized that the risk assessment must be based on “medical or other objective, scientific evidence” and “not simply on [a] good-faith belief that a significant risk exist[s].”¹⁷⁹ The Court clarified that, even if the dentist’s evidence, which attempted but failed to prove that seven dental workers had contracted HIV from patients, was accepted, it would provide only “some, albeit not necessarily sufficient, support for [the dentist’s] position. Standing alone, we doubt [this information] would meet the objective, scientific basis for finding a significant risk to the [dentist].”¹⁸⁰

2. *The Employee’s Past Work and Medical History*

In any employment decision, an employer will have to make some prediction of how the employee will perform, including the future risks associated with that anticipated job performance.¹⁸¹ The third and fourth *Arline* factors — the likelihood that the potential harm will occur, and the imminence of the potential harm — contemplate that such a prediction of future risk will factor into an employer’s decision.¹⁸² The *Arline* factors also acknowledge that the future risk must not be remote or speculative.¹⁸³ When it comes to individuals with disabilities, however, “[b]ecause of the commonly-known side effects and long-term health dangers of some illnesses,” employers have been particularly susceptible to “fears that even if the employee can perform the job at present, the illness or disability will at some future

178. Individuals with AIDS are “disabled” under the ADA, since it substantially limits the major life activity of reproduction due to the risk of infection either to the partner or to the child. 524 U.S. at 639–40.

179. *Id.* at 626–27.

180. *Id.*

181. Thomas O. McGarity & Elinor P. Schroeder, *Risk-Oriented Employment Screening*, 59 TEX. L. REV. 999, 1000–01 (1981).

182. 480 U.S. 273, 288 (1987).

183. See *Dairy Equip. Co. v. Dep’t of Indus., Labor & Human Relations*, 290 N.W.2d 330, 337 (Wis. 1980) (holding that the employer “failed to establish a reasonable probability that the [employee truck assembler] was unable to efficiently and safely perform [his] duties” because there was no evidence to support the employer’s fear that the employee was more likely to fall than others because he had only one kidney, nor any evidence that he had ever fallen or that any employee had ever been injured from a fall).

time cause a safety problem.”¹⁸⁴ The ADA addresses this by prohibiting employers from determining that an employee poses a “significant risk” based solely on the possibility that the currently qualified employee may become unqualified in the future.¹⁸⁵

The EEOC’s comment to its regulations cites a Ninth Circuit case, *Mantolete v. Bolger*,¹⁸⁶ to emphasize that the “assessment that there exists a high probability of substantial harm” “must be strictly based on valid medical analyses and/or on other objective evidence” applied to “individualized factual data.”¹⁸⁷ This suggests the importance of looking to the employee’s particular experience with the condition in question, as well as the employee’s previous work experience, especially in positions involving similar risk, in order to assess the future risk posed by the employee. In *Mantolete*, the court emphasized that the employer’s decision to not hire the plaintiff could not be based merely on “an elevated risk of injury” posed by the plaintiff’s epilepsy, even for a position involving dangerous machinery.¹⁸⁸ The employer was required to show a “reasonable probability of substantial harm”¹⁸⁹ and to “gather all relevant information regarding the applicant’s work history and medical history, and independently assess both the probability and severity of potential injury.”¹⁹⁰ The facts showed that the plaintiff had a very good work record, had only had three

184. Kathleen Amerkhanian, Note, *Direct Threat to Self: Who Gets to Decide?*, 34 U. TOL. L. REV. 847, 858 (2003). In one case, the court asserted that “[a]ny qualification based on the risk of future injury must be examined with special care if the Rehabilitation Act is not to be circumvented easily, since almost all handicapped persons are at greater risk from work-related injuries.” *Bentivegna v. U.S. Dep’t of Labor*, 694 F.2d 619, 622 (9th Cir. 1982). See *supra* note 135 and accompanying text for a discussion of the Rehabilitation Act and the ADA.

185. 29 C.F.R. § 1630.2(r) (2011). See also ADA SENATE REPORT, *supra* note 160, at 25 (“The term ‘qualified’ refers to whether the individual is qualified at the time of the job action in question; the mere possibility of future incapacity does not by itself render the person not qualified.”); 56 Fed.Reg. 35,745 (1991) (“Generalized fears about risks from the employment environment, such as exacerbation of the disability caused by stress, cannot be used by an employer to disqualify an individual with a disability. For example, a law firm could not reject an applicant with a history of disabling mental illness based on a generalized fear that the stress of trying to make partner might trigger a relapse of the individual’s mental illness. Nor can generalized fears about risks to individuals with disabilities in the event of an evacuation or other emergency be used by an employer to disqualify an individual with a disability.”).

186. 767 F.2d 1416 (9th Cir. 1985).

187. 56 Fed.Reg. 35,745 (1991).

188. *Mantolete*, 767 F.2d at 1424.

189. *Id.* at 1422.

190. *Id.* at 1423.

seizures while at her previous job, had never been injured as a result of her seizures, and, moreover, that her doctor had testified that “her medical condition was in complete control.”¹⁹¹ After asserting that “an ‘elevated risk’ standard does little to recognize the appropriate factors affecting the ability of an individual,” the court remanded “for a determination of whether, in light of [the plaintiff’s] work history and medical history, employment of her would pose a reasonable probability of substantial harm.”¹⁹²

3. *A Narrow Exception to the Individualized Assessment Requirement — Allowing Blanket Exclusions in Extreme Cases*

While the ADA seeks to protect disabled individuals from discrimination, it also acknowledges the interests and needs of employers. To that end, there may be extremely “limited circumstances in which an employer may categorically exclude persons with certain severe or advanced disabilities from specific jobs.”¹⁹³ This categorical exclusion would allow an employer to exclude disabled individuals without an individualized assessment on the ground that “in *all* cases [the] condition *by its very nature* would prevent the person with a disability from performing the essential functions of the job, even with reasonable accommodations.”¹⁹⁴ According to law professor Ann Hubbard, who has written and spoken extensively on disability law,¹⁹⁵ examples of such an extreme condition might include a lifeguard who is blind or a firefighter who cannot walk.¹⁹⁶ The ADA’s legislative history confirms this exception to the ADA’s core requirement of individualized assessment, but emphasizes that the exception is to be defined narrowly.¹⁹⁷

191. *Id.* at 1419–20.

192. *Id.* at 1424.

193. Hubbard, *supra* note 134, at 1313.

194. ADA SENATE REPORT, *supra* note 160, at 27 (emphasis added). In *Albertson’s, Inc. v. Kirkingburg*, 527 U.S. 555, 566 (1999), the Supreme Court acknowledged that some conditions may be considered per se disabilities. While holding that monocular vision (vision in only one eye) was not a per se disability, the Court stated that “some impairments may invariably cause a substantial limitation of a major life activity.” *Id.*

195. Ann Hubbard, *Professor of Law: Scholarship*, UNIV. OF CINCINNATI COLL. OF LAW, <http://www.law.uc.edu/faculty-staff/faculty/ann-hubbard>.

196. Hubbard, *supra* note 134, at 1313.

197. ADA SENATE REPORT, *supra* note 160, at 26 (“[T]his legislation prohibits use of a blanket rule excluding people with certain disabilities except in the very limited situation

C. THE ADA AMENDMENTS ACT OF 2008

By 2008, the ADA came to be viewed by many as “a huge disappointment, especially in the employment context.”¹⁹⁸ Plaintiffs had experienced extremely low success rates in Title I cases,¹⁹⁹ particularly because the definition of “disability” under the ADA was vague and courts interpreted the broad language narrowly, allowing few plaintiffs to pass the threshold.²⁰⁰ Courts also broadened the meaning of the direct threat defense, which was intended to be read narrowly and to require highly individualized assessments of risk;²⁰¹ for instance, courts allowed employers to fire employees with mental illnesses based on their threatening language alone, without any proof of likely harm.²⁰² Further, lower court judges in ADA cases often disregarded summary judgment standards, imposing excessively high burdens of proof on plaintiffs and deciding questions of fact that should have gone to a jury.²⁰³ As a result, employers won more than 90% of such cas-

where in all cases [the] physical condition by its very nature would prevent the person with a disability from performing the essential functions of the job, even with reasonable accommodations.”).

198. Alex B. Long, *Introducing the New and Improved Americans with Disabilities Act: Assessing the ADA Amendments Act of 2008*, 103 NW. U. L. REV. COLLOQUY 217, 217 (2008).

199. Sharona Hoffman, *Settling the Matter: Does Title I of the ADA Work?*, 59 ALA. L. REV. 305, 308 (2008).

200. Long, *supra* note 198, at 218. *See also* Hubbard, *supra* note 134, at 1308 n.165.

201. *See supra* Part III.B.

202. *See, e.g.*, Laysen v. Morrison, 935 F. Supp. 562 (E.D. Pa. 1995); Palmer v. Cir. Ct. of Cook Cnty., 905 F. Supp. 499 (N.D. Ill. 1995). In *Palmer*, the court held that the plaintiff did not demonstrate that she was “qualified” because her job as a caseworker required her to get along with her co-workers and supervisor. *Palmer*, 905 F. Supp. at 508–09. For a critique of such decisions by employers defining “the essential job functions as including, for example, not ‘offending customers,’ not ‘making others in the workplace feel threatened for their own safety,’ and ‘getting along’ with others,” see Elizabeth F. Emens, *The Sympathetic Discriminator: Mental Illness, Hedonic Costs, and the ADA*, 94 GEO. L. J. 399, 454 (2006) (internal citations omitted). Professor Emens urges courts to “view such decisions skeptically” because, given that “every employer might want all employees to contribute positive energy to the workplace,” almost every job involving human contact could in theory require these “functions.” *Id.* at 454. Because of the likelihood that people with mental illness may instead contribute negatively, “permitting such a broad requirement for most jobs would essentially allow employers to exempt themselves from the ADA’s grant of protection to people with mental illness.” *Id.* at 455.

203. *See* Ruth Colker, *The Americans with Disabilities Act: A Windfall for Defendants*, 34 HARV. C.R.-C.L. L. REV. 99, 101–02 (1999).

es.²⁰⁴ Although employers win most employment discrimination cases in general,²⁰⁵ for many this number represented a major failure on the part of the ADA.²⁰⁶

In response, Congress passed the ADA Amendments Act (“ADAAA”) in September 2008, clarifying “the broad scope of protection intended to be afforded by the ADA.”²⁰⁷ Concerned over the “inappropriately high level of limitation necessary to obtain coverage under the ADA,”²⁰⁸ Congress made explicit its intent that “the primary object of attention in cases brought under the ADA should be whether entities covered under the ADA have complied with their obligations, and . . . that the question of whether an individual's impairment is a disability under the ADA should not demand extensive analysis”²⁰⁹ Consistent with this, the ADAAA expands the definition of “disability” in a number of ways, “mak[ing] it easier for an individual . . . to establish that he or she has a disability within the meaning of the ADA.”²¹⁰

First, the ADAAA specifically rejects the holdings in certain Supreme Court cases that narrowed the definition of disability and imposed a high burden on the plaintiff under the ADA.²¹¹ Second, the ADAAA changes the “substantially limits” prong of the ADA’s definition of “disability” by expressly rejecting the holding of *Sutton v. United Air Lines*, a Supreme Court case which required that courts take into account measures used by an employee to mitigate his or her disability. The ADAAA makes clear that “determination of whether an impairment substantially limits a major life activity shall be made without regard to the ameliorative effects of mitigating measures,” with the exception

204. ABA Comm’n on Mental & Physical Disability, *Study Finds Employers Win Most ADA Title I Judicial and Administrative Complaints*, 22 Ment. & Phys. Dis. L. Rep. 403, 403 (1998).

205. See, e.g., Wendy Parker, *Lessons in Losing: Race Discrimination in Employment*, 81 NOTRE DAME L. REV. 889, 897 (2006); Colker, *supra* note 203, at 109 & n.45.

206. See *supra* note 198 and accompanying text; see also Colker, *supra* note 203, at 100.

207. ADA Amendments Act of 2008, Pub. L. No. 110-325, § 2(a)(4), 122 Stat. 3553, 3553–54 (2008) (codified in sections of 42 U.S.C.).

208. *Id.* § 2(b)(5).

209. *Id.*

210. *Notice Concerning the Americans with Disabilities Act (ADA) Amendments Act of 2008*, U.S. EQUAL EMP’T OPPORTUNITY COMM’N, http://www.eeoc.gov/laws/statutes/adaaa_notice.cfm (last visited Dec. 2, 2011).

211. Pub. L. No. 110-325, § 2(b)(2)–(5).

of ordinary eyeglasses or contact lenses.²¹² This particularly benefits employees who are treating their conditions with medication. Third, the ADAAA provides new protection for conditions that are episodic in nature, such as bipolar disorder, by adding that “[a]n impairment that is episodic or in remission is a disability if it would substantially limit a major life activity when active.”²¹³ Fourth, the ADAAA adds to the ADA a non-exhaustive list of “major life activities,”²¹⁴ further reaffirming the ADA’s intended broad scope of protection by making clear that “major life activities” encompasses more than just those activities of “central importance to daily life.”²¹⁵ Finally, the ADAAA changes the “regarded as” prong of the disability definition by making irrelevant whether or not the employer perceived the plaintiff’s impairment to be *substantially limiting*; all that is required after the ADAAA is that the employer’s perception that the plaintiff had an impairment motivated the employer’s adverse action.²¹⁶

Thus, while use of a prescription drug does not necessarily mean the underlying condition being treated is disabling, the ADAAA has loosened the requirements for qualifying as disabled under the ADA (or rather, clarified that the requirements were originally intended to be looser than they ended up being applied by courts), and requires individuals to be assessed in their unmitigated, or unmedicated, state.²¹⁷ For example, if a drug is prescribed to treat severe pain, and the unmedicated pain itself substantially interferes with a major life activity, the employee would be considered disabled under the ADAAA.²¹⁸ Further, if an

212. *Id.* § 3(4)(E).

213. *Id.* § 4(4)(D).

214. *Id.* § 4(a)(2)(A).

215. 29 C.F.R. § 1630.2(i) (2011). The EEOC regulations implementing the ADAAA acknowledge that the ADAAA rejected the holding of *Toyota Motor Mfg., Ky., Inc. v. Williams*, 534 U.S. 184, 187 (2002), that an activity must be of “central importance to most people’s daily lives” in order to be a “major life activity.”

216. Long, *supra* note 198, at 224 (“[I]f the plaintiff can show that the defendant, rightly or wrongly, perceived the plaintiff as having an impairment, and that this perception motivated the adverse action, the plaintiff is covered under the ‘regarded as’ prong, regardless of how limiting the defendant perceives the impairment to be.”).

217. While this may hurt plaintiffs where negative effects of mitigation might otherwise count in a plaintiff’s favor in terms of counting as disabled, the ameliorating effects of mitigation won’t count against the plaintiff.

218. § 3(4)(E) (“[D]etermination of whether an impairment substantially limits a major life activity shall be made without regard to the ameliorative effects of mitigating measures,” with the exception of “ordinary eyeglasses or contact lenses.”).

employer bases an adverse employment decision on its *perception* that an employee is impaired, the employee qualifies as “disabled” for purposes of the ADA.²¹⁹ The ADAAA, then, reaffirms the broad scope of protection intended under the ADA, and clarifies that the focus of an ADA inquiry should be on whether an employer has complied with its ADA obligations.²²⁰

However, the ADAAA’s effect in the prescription drug context remains uncertain because most courts have not found an opportunity to apply the ADAAA since its recent passage.²²¹ This is primarily because the ADAAA makes no mention of whether it is to be applied retroactively, and most courts that have addressed that question have concluded that it does not.²²² Those courts that *have* applied the ADAAA, either because they decided that it does apply retroactively²²³ or because the alleged discriminatory conduct occurred after the ADAAA went into effect, have not addressed the direct threat issue.²²⁴ Further, the ADAAA and subsequent EEOC regulations and guidelines do not clarify the direct threat defense as originally delineated.²²⁵ Thus, it remains unclear to both employers and employees what to expect from a

219. See *supra* note 216 and accompanying text.

220. 29 C.F.R. § 1630.1(c)(4) (2011) (“The primary object of attention in cases brought under the ADA should be whether covered entities have complied with their obligations and whether discrimination has occurred, not whether the individual meets the definition of disability.”).

221. Most courts, not just in prescription drug cases but also in general, have not found an opportunity to apply the ADAAA. Thus, there is little guidance to be found even from other, potentially analogous contexts.

222. See, e.g., *EEOC v. Agro Distrib., LLC*, 555 F.3d 462, 469 (5th Cir. 2009); *Geoghan v. Long Island R.R.*, No. 06-1435, 2009 WL 982451, at *9 (E.D.N.Y. Apr. 9, 2009); *Kravar v. Triangle Servs., Inc.*, No. 06-07858, 2009 WL 805807, at *4 n.3 (S.D.N.Y. Mar. 27, 2009); *Moran v. Premier Educ. Grp., LP*, 599 F. Supp. 2d 263, 271 (D. Conn. 2009); *Schmitz v La.*, No. 07-891, 2009 WL 210497, at *1 (M.D. La. Jan. 27, 2009); *Rudolph v. U.S. Enrichment Corp.*, No. 08-00046, 2009 WL 111737, at *4–6 (W.D. Ky. Jan. 15, 2009).

223. Courts that have found that the ADAAA applies retroactively have either done so erroneously or by implication, without providing any reasoning. One such case, *Menchaca v. Maricopa Cmty. Coll. Dist.*, 595 F. Supp. 2d 1063 (D. Ariz. 2009), applies the ADAAA to an alleged discriminatory action that took place before the ADAAA took effect. However, the opinion provides no discussion of the ADAAA’s retroactivity, apparently assuming that it applies. *Id.*

224. See *Gil v. Vortex, LLC*, 697 F. Supp. 2d 234, 236 (D. Mass. 2010) (applying the ADAAA where the alleged discriminatory action took place on January 2, 2009, one day after the ADAAA took effect); *Menchaca*, 595 F. Supp. 2d 1063, 1064–65 (D. Az. 2009) (applying the ADAAA, without any discussion of its retroactivity, where the alleged discriminatory action took place before the ADAAA took effect).

225. ADA Amendments Act of 2008, Pub. L. No. 110-325, 122 Stat. 3553 (2008) (codified in sections of 42 U.S.C.); 29 C.F.R. § 1630 (2011).

court in a challenge to an employer's adverse action based on a blanket policy regarding prescription drug use. The following Part, in light of the information on prescription drug use provided in Part II, argues that such blanket policies are improper and incompatible with the ADA, and establishes the contours of the highly individualized inquiry demanded by the ADA in the prescription drug context.

IV. INSTITUTING A HIGHLY INDIVIDUALIZED INQUIRY IN THE PRESCRIPTION DRUG CONTEXT

Because of the prevalence of prescription drug use in the United States, allowing employers to implement blanket policies regarding prescription drugs similar to that of Dura Automotive Systems²²⁶ would be unsustainable. It would effectively preclude a large portion of the population not only from safety-sensitive jobs but also from jobs for which an employer could muster a Dura-like justification that use of certain drugs poses a per se safety threat because of the risks indicated on their labels. Although erring on the side of safety has an understandable appeal to employers, it too frequently leads to unwarranted discrimination against individuals who may be just as capable of performing certain jobs as safely and effectively as other employees who are not disabled and are not using prescription drugs. Further, given the difficulty or cost of assessing the individual factors that make a person more or less susceptible to a drug's side effects, some employers will be drawn to the easy solution of categorically excluding persons who use certain drugs.

Such a categorical approach, however, goes against the ADA's core requirement of an individualized assessment of a person's abilities and limitations.²²⁷ Employers may claim that use of certain prescription drugs fits into the extremely narrow exception to the individualized assessment requirement, discussed above in Part III.B.3, because use of those drugs that, for example, include warning labels against operating machinery and driving would "by [their] very nature"²²⁸ always present a safety risk in a

226. See *supra* Part I.

227. 29 C.F.R. § 1630.2(r) (2011).

228. ADA SENATE REPORT, *supra* note 160, at 26.

workplace that required operating machinery or driving. However, the use of any particular prescription drug, despite its side-effect warnings, is generally a poor indicator of employee risk.²²⁹ Moreover, Congress made clear that employers may not exclude a person with a particular disability (or who is using a particular prescription drug) merely because some, or even many, persons with the same disability (or using the same drug) pose a health or safety risk in the workplace.²³⁰

Further, generalizations regarding a link between use of a drug and occurrence of its listed side effects can be very inaccurate given the wide variability in risk across individuals;²³¹ in other words, the risk of occurrence of a prescription drug's side effects may vary widely by person, in both severity and effect.²³² Further, occurrence of serious and severe side effects, particularly those types of side effects that may actually threaten health and safety in the workplace due to their suddenness and unmanageability (dizziness, for example, as opposed to mild headache) is rare in general.²³³ Thus, "[a]ny measure of the average . . . risks posed by" the group of all individuals using a particular drug "is likely to be an inaccurate measure of the actual [risks] of a given individual in that group."²³⁴ The employer must know not only the extent to which side effects generally occur, but also what symptoms, situations, and personal characteristics might indicate an increased or decreased risk in a particular individual.²³⁵ This requires that an employer carefully assess the individ-

229. See *supra* Part II.B–C.

230. See *supra* Part III.B.

231. See Ann Hubbard, *The ADA, The Workplace, and the Myth of the Dangerous Mentally Ill*, 34 U.C. DAVIS L. REV. 849 (2001) for a similar argument in the context of risk of violence associated with mental disorders.

232. See *supra* Part II.B.

233. See *supra* Part II.B–C (discussing the rate of occurrence of side effects in clinical trial studies of some of the most commonly prescribed drugs, as well as data on the impact of prescription drug use in the workplace).

234. Hubbard, *supra* note 134, at 1315 ("Any measure of the average abilities or risks posed by an entire group of persons with a given disability is likely to be an inaccurate measure of the actual abilities or limitations of a given individual in that group. So, for example, even if persons with mental disorders as a group are more likely to engage in violence, that information alone does not justify an employer's conclusion that all persons with mental disorders are likely to be violent, or that a particular individual with a mental disorder is likely to be violent." (citations omitted)).

235. For example, the label for Prozac warns that "[t]he prescriber should be aware that the [clinical trial data] cannot be used to predict the incidence of side effects in the course of usual medical practice where patient characteristics and other factors differ from

ual's recent conduct, current symptoms, prognosis, ability to sense and prepare for the impending occurrence of a side effect, and other factors that could increase or decrease the individual's risk of experiencing a particular drug's side effects in a way damaging to the health and safety of the workplace.²³⁶

As a result, it is essential that courts require a rigorous individualized assessment from employers asserting the direct threat defense. Although a rigorous individualized assessment is stricter, more costly, and more time-consuming for employers than a blanket policy, departing from the individualized assessment requirement goes against both the ADA and ADAAA by giving "employers a license to make preemptive and irrational risk assessments."²³⁷ This Part establishes the contours of such a rigorous individualized assessment in the prescription drug context.

A. OBJECTIVE, CURRENT, AND THOROUGH MEDICAL EVIDENCE

In prescription drug use challenges, judges and juries generally lack the expertise necessary to make highly objective decisions on the medical evidence presented. Professor Hubbard has explained: "Too often, employers' and judges' personal views of acceptable risks and medical probabilities replace the rigorous fact-specific inquiry demanded by the ADA. . . . [W]ell-meaning people perceive and assess risks based on factors that have nothing to do

those that prevailed in the clinical trials." *Prozac Label*, *supra* note 35, at § 6: Adverse Reactions. Many prescription drugs come with guidelines warning against using the drug with other substances, or suggesting that taking the drug be accompanied by certain lifestyle regimens (such as a particular diet). See, e.g., *Niaspin Side Effects: Treatment and Prevention*, PRESCRIPTIONDRUGS.COM, <http://www.prescriptiondrugs.com/articles/niaspan-side-effects-treatment-and-prevention-624> (last visited Nov. 20, 2011) ("The side effects of niaspan can be worsened by drinking alcohol or warm beverages directly after taking the medication. . . . Other drugs, including other cholesterol lowering medications can have adverse effects when mixed with niaspan. Also, this prescription is often accompanied by a low fat, low cholesterol diet and exercise. It is important to follow these guidelines as well in order to avoid side effects and get the most out of the medication."). Thus, different situations and personal characteristics may present different likelihoods that the side effects of a particular drug will occur.

236. See, e.g., *McCamish v. Douglas Cnty. Hosp.*, 466 N.W.2d 521, 525–26 (Neb. 1991) (finding hospital food service worker with epilepsy did not pose a risk of substantial harm because she did not have contact with patients while handling hot food items, had never experienced a seizure during her employment, and was "aware of the warning signs" of a possible seizure).

237. Jon L. Gillum, *Tort Law and the Americans with Disabilities Act: Assessing the Need for Realignment*, 39 IDAHO L. REV. 531, 567 (2003).

with actual, scientific probabilities.”²³⁸ For example, studies revealing a high rate of violence among alcoholics suggest that individuals with alcoholism pose much greater risks to others than those with schizophrenia,²³⁹ but we are generally “more fearful of the latter.”²⁴⁰

Because it requires analyzing scientific data, the determination of a “direct threat” should be made by qualified experts in the area under analysis. Some have suggested that this be effected through use of independent medical review boards, like those used in safety-sensitive industries such as the commercial motor vehicle industry.²⁴¹ This would solve the problem of courts

238. Hubbard, *supra* note 134, at 1281. Hubbard points out that “[r]esearch shows that we fear the potential harm that is unfamiliar, uncontrollable, and highly publicized more than the one that is known, actually or apparently within our control, or below the media’s radar screen.” *Id.*; see generally Timur Kuran & Cass R. Sunstein, *Availability Cascades and Risk Regulation*, 51 STAN. L. REV. 683, 691–703 (1999). For example, statistically, “[a] surgical patient has more to fear — including death — from a surgeon infected with hepatitis B than from one who has HIV, yet hospitals will transfer or fire health care workers infected with the well-publicized” and much more stigmatized HIV over those infected with hepatitis B. Hubbard, *supra* note 134, at 1281. See Sidney D. Watson, *Eliminating Fear Through Comparative Risk: Docs, AIDS and the Anti-Discrimination Ideal*, 40 BUFF. L. REV. 739, 799–802 (1992).

239. See Hubbard, *supra* note 134, at 1281 n.14 (citing Jeffrey W. Swanson et al., *Violence and Psychiatric Disorder in the Community: Evidence from the Epidemiologic Catchment Area Surveys*, 41 HOSP. & CMTY. PSYCHIATRY 761, 769 (1990)) (discussing a study that revealed a rate of violence of 25% for individuals with alcoholism, 12.7% for individuals with schizophrenia, including those with substance or alcohol abuse disorders, and 8% for individuals with schizophrenia only); see also James C. Beck, *Epidemiology of Mental Disorder and Violence: Beliefs and Research Findings*, 2 HARV. REV. PSYCHIATRY 1, 3 (1994) (referring to a study wherein “persons with alcohol diagnoses represented less than 8% of the sample, but accounted for 40.8% of the reported violence”). Further, the ADA’s legislative history makes clear that an employer seeking to exclude an individual on the basis of risk of violence associated with a mental disability must produce “objective evidence from the person’s behavior that the person has a recent history of committing overt acts or making threats which caused harm or which directly threatened harm.” H.R. REP. NO. 101-485, pt. 3, at 45–46 (1990), reprinted in 1990 U.S.C.A.N. 445, 468–69.

240. See Hubbard, *supra* note 134, at 1281.

241. Medical review boards “permit medical professionals to make an informed determination of whether an individual meets the medical qualifications for employment.” Jeffrey A. Van Detta, *“Typhoid Mary” Meets the ADA: A Case Study of the “Direct Threat” Standard Under the Americans with Disabilities Act*, 22 HARV. J.L. & PUB. POL’Y 849, 949 (1999). The Medical Review Board (MRB) established by the U.S. Department of Transportation’s Federal Motor Carrier Safety Administration (FMCSA), for example, is “composed of five of our Nation’s most distinguished and scholarly practicing physicians. . . [who] specialize in the areas most relevant to the bus and truck driver population” and provides “information, advice, and recommendations . . . on the development and implementation of science-based physical qualification standards.” *A Welcome Message from the Federal Motor Carrier Safety Administration*, MED. REVIEW BD., FED. MOTOR CARRIER SAFETY ADMIN., <http://www.mrb.fmcsa.dot.gov/> (last visited Oct. 16, 2011).

giving undue deference to the judgment of potentially biased or less than fully-informed company doctors, or of the court substituting its own untrained judgment.²⁴² In the prescription drug context, the medical review boards should have expertise on the particular drug in question, which would account for the specialized nature of various prescription drugs and their side effects.

The medical review board should take into account the prognosis, the data on the occurrence of side effects of the particular drug in question, the individual employee's medical and work history, the individual's personal experience with the condition, and the particular demands of the job and work environment conditions. The board should also refer to the employee's personal physician, who will generally have greater familiarity with the individual's health, and apply its expertise on the particular drug to the personal physician's own evidence and assessments relating to the particular individual in question. Evidence from the employer's company physician, if any, and any other relevant evidence, should also be reviewed. As much as possible, this evidence should include neurobehavioral and other types of testing that more accurately assess the risk of a particular individual experiencing side effects from drug use, rather than simply speculation based on the individual's history and general data on a particular drug.²⁴³

242. Van Detta, *supra* note 241, at 936–37.

243. In *EEOC v. Hussey Copper Ltd.*, 696 F. Supp. 2d 505 (W.D. Pa. 2010), an employer rescinded an employment offer upon receiving test results showing the employee was on methadone as part of a drug treatment program. *Id.* at 507–12. The court faulted the employer for not using a neurocognitive examination:

[The employer] does not dispute that a neurocognitive examination was available to assess [the employee's] ability to safely perform the job, that [the company doctor] had used such a test in the past, and that it was not utilized in this case. Instead, [the employer] speculates as to possible safety concerns which could have arisen if [the employee] were employed, without any indication that [the employee's] methadone use actually impeded his ability to safely perform as a production laborer.

Id. at 518 (internal citations omitted). The court concluded that “[t]hese circumstances alone raise material issues of fact,” even where the workplace “include[d] blast furnaces and casting areas, large pits containing open and exposed flames, moving molten metal, cranes, rolling mills, acid and lead baths, forklift trucks, coils of copper traveling above and knives used to cut copper.” *Id.* at 507, 518.

B. COMPARATIVE RISK ANALYSIS — DETERMINING THE
“SIGNIFICANCE” OF THE RISK

Even if an employer can prove that an individual employee poses a risk, or that it is impossible or impractical to individually assess each employee affected by its drug policy, the employer “must still satisfy the direct threat test by showing that the group affected by the policy constitutes a *significant risk* of substantial harm to themselves or others”²⁴⁴ Congress, in specifying that the risk supporting a direct threat defense be “significant,” must have meant a risk greater than that posed by employees with no disabilities who are not taking prescription drugs — otherwise, an employer would be free to exclude some employees but not others, ostensibly based on the risk they posed, even where all employees actually posed the same risk.²⁴⁵ As Part II.C established, employees using prescription drugs do not necessarily pose a risk greater than that posed by other employees. The Bureau of Labor Statistics data revealed that less than 0.5% of workplace fatalities, and less than .02% of workplace injuries, reported in 2009 were caused by “medicines.”²⁴⁶ Although it might be impossible or impractical to determine which employees are at risk for experiencing certain side effects, this is also true for employees who are not using prescription drugs — that is, it

244. *EEOC v. Exxon Corp.*, 967 F. Supp. 208 (N.D. Tx. 1997) (emphasis added). In that case, the EEOC brought an ADA action challenging an employer’s blanket exclusion of rehabilitated substance abusers from safety-sensitive positions. The court concluded that:

[A]n employer need not satisfy the direct threat test via individualized assessment if that employer can prove that it is impossible or impractical to individually assess each employee affected by the policy. However . . . [the employer] must still satisfy the direct threat test by showing that the group affected by the policy constitutes a significant risk of substantial harm to themselves or others that cannot be reduced by reasonable accommodation. See 42 U.S.C. § 12111(3); 42 U.S.C. § 12113(b).

Id. at 211.

245. Hubbard, *supra* note 231, at 891–92 (“When Congress specified that only a ‘significant’ risk would satisfy the direct threat defense, it must have intended a risk quantifiably greater than what even the most prudent employers assume every day without hesitation from employees with no disabilities. To permit an employer to exclude a person with a mental disability as presenting a ‘significant’ risk of violence, when it does not similarly guard against [other] greater risks . . . would only resurrect the ‘misperceptions, ignorance, irrational fears, . . . [and] pernicious mythologies’ that Congress banished from the direct threat determination.” (quoting ADA HOUSE REPORT, *supra* note 158, at 56)).

246. See *supra* Part II.C and notes 97–98.

might be impossible or impractical to determine which employees are at risk of, for example, falling asleep on the job.²⁴⁷ Drug testing thus focuses on a very narrow problem, while ignoring more widespread and common problems that affect performance in the workplace, such as the use of alcohol, stress, and untreated psychological and health problems.²⁴⁸

For example, data provided by the Bureau of Labor Statistics tend to show that alcohol, not drugs, is the biggest substance-use problem in the workplace.²⁴⁹ Yet testing for drugs has been more prevalent than for alcohol.²⁵⁰ Further, employees who test positive for alcohol are treated less harshly than those who test positive for drugs; this is because alcohol testing is more likely to involve a percentage limit below which an employee may not disqualify, while drug testing is more likely to disqualify an employee if *any* amount of illegal drugs, or legally-used prescription drugs

247. For similar reasoning, see *Bombrys v. City of Toledo*, 849 F. Supp. 1210, 1219–21 (N.D. Ohio 1993) (holding that “blanket disqualification of individuals with insulin-dependent diabetes as candidates for police officer violates the [ADA]” and noting that there was no blanket policy preventing epileptics or asthmatics from serving as police officers, even though “[a]sthmatics have been known to have such severe attacks that they lose consciousness or even die”).

248. Joan Hamilton, *A Video Game That Tells If Employees Are Fit For Work*, BUSINESSWEEK, June 3, 1991, available at <http://www.businessweek.com/archives/1991/b321624.arc.htm> (discussing how most failures of a particular job performance test did not appear to involve drug or alcohol use, and noting that “[c]ompanies report that it’s common for some employees [to] fail to admit that they are so distracted with personal problems they’re not fit to perform a sensitive job on a given day”); KEVIN ZEESE, DRUG TESTING LEGAL MANUAL § 2:43 (2d ed. 2011) [hereinafter ZEESE], available at Westlaw DRUGTSTMAN (“Companies which use [the performance test] are finding that drug and alcohol use are not the most common reasons for failure; rather, severe fatigue and illness are more common.”). For more discussion on performance tests, see *infra* Part IV.C.

249. See, e.g., William Weber & Cherron Cox, *Work-related Fatal Injuries in 1998*, COMPENSATION & WORKING CONDITIONS 27, 29 (Spring 2001) available at <http://www.bls.gov/opub/cwc/archive/spring2001art3.pdf> (reporting that, of 593 positive toxicology reports for work-related fatalities in 1998, 284 contained alcohol, 119 contained marijuana, 107 contained opiates, 93 contained cocaine, 48 contained benzodiazepines, and 28 contained amphetamine/methamphetamine). See also AM. PSYCHOLOGICAL ASS’N PRACTICE ORG., PSYCHOLOGICALLY HEALTH WORKPLACE PROGRAM, FACT SHEET: BY THE NUMBERS 6 (2010) [hereinafter FACT SHEET], available at http://www.phwa.org/dl/2010phwp_fact_sheet.pdf (reporting that “[a]n estimated 19.2 million U.S. workers (15.3%) reported using or being impaired by alcohol or hung over at work at least once in the past year [in 2006] — 19% reported doing so monthly and 11% weekly” (citation omitted)).

250. Tyler D. Hartwell et al., *Workplace Alcohol-Testing Programs: Prevalence and Trends*, MONTHLY LABOR REVIEW 27, 30 (June 1998), available at <http://www.bls.gov/mlr/1998/06/art4full.pdf>.

specified in an employer's drug policy, shows up.²⁵¹ Because prescription drugs are legal when used pursuant to a prescription, and because the amount of the dosage as well as the characteristics and history of the individual and the specific demands of the job and work environment are highly relevant in measuring risk posed, prescription drugs should, like alcohol, not be treated like illegal drugs and *entirely* prohibited by employers.

The determination of whether a risk posed is "significant" therefore requires a comparative risk analysis. What this process would involve is illustrated by the problems found in cases involving HIV-positive plaintiffs.²⁵² Courts in such cases have acknowledged that the significant risk standard does not "require[] the elimination of *all* risk posed by a person,"²⁵³ and that the focus of the analysis should be on the *probability* of the risk, and not merely on the *possibility* of the risk.²⁵⁴ Nevertheless, they have upheld the exclusion of individuals with HIV on the basis of much less than the showing of high probability demanded by the ADA,²⁵⁵ and in the process have "overlook[ed] individual characteristics, such as an individual's safety record or habits of extreme care, that might further reduce the risk."²⁵⁶

251. ZEESE, *supra* note 248, at § 1:2. Further, although the ADA does not protect illegal drug and current alcohol use, it does protect recovering alcoholics, even though they pose a risk of relapse. 42 U.S.C.A. § 12114 (2009). The difference in treatment between drugs and alcohol is further unjustified in light of the finding that, "[u]nlike a blood alcohol test, correlations between a positive urine test, a drug's pharmacologic effect, and related levels of impairment are generally unknown." ROUNTREE, *supra* note 105, at 1.

252. See, e.g., *Onishea v. Hopper*, 171 F.3d 1289 (11th Cir. 1999); *Montalvo v. Radcliffe*, 167 F.3d 873, 874 (4th Cir. 1999). For a discussion of these cases, see Brian S. Prestes, *Disciplining the Americans with Disabilities Act's Direct Threat Defense*, 22 BERKELEY J. EMP. & LAB. L. 409, 424–27 (2001).

253. *Estate of Mauro v. Borgess Med. Ctr.*, 137 F.3d 398, 402 (6th Cir. 1998).

254. *Id.* at 403.

255. 29 C.F.R. pt. 1630 app. § 1630.2(r) (2011) (requiring a "high probability"); see also *Mauro*, 137 F.3d at 412. In *Mauro*, the Sixth Circuit acknowledged that the ADA does not "require the elimination of *all* risk posed by a person with a contagious disease." *Mauro*, 137 F.3d at 402–03 (emphasis added). The court made clear that its direct threat analysis "must not consider the *possibility* of HIV transmission, but rather focus on the *probability* of transmission weighed with the other three factors of the *Arline* test." *Id.* at 403. However, the court seemed to consider "possibility" instead of "probability" in upholding a decision that a HIV-infected surgical technician posed a direct threat. The court, after referring to the CDC's estimate of "the risk of a patient being infected by an HIV-positive surgeon during a single operation as being somewhere between one in 42,000, and one in 420,000," relied on an infectious disease specialist's testimony that "any patient who comes in contact with the HIV-infected blood of a health care worker has *some* risk of the virus being transferred to that patient." *Id.* at 405, 407 (emphasis added).

256. Hubbard, *supra* note 134, at 1324.

Doe v. University of Maryland Medical Systems Corp. is illustrative of this problem. In this case, a hospital fired a HIV-positive surgical resident, even though its panel of experts on bloodborne pathogens had recommended that he be allowed, with certain restrictions, to continue working.²⁵⁷ The court simply asserted that he posed a significant risk to the health and safety of his patients that could not be eliminated by reasonable accommodation; in explaining its decision by stating that “transmission is clearly possible” and that “some measure of risk will always exist,” the court was clearly not applying the ADA-mandated significant risk standard.²⁵⁸ A more accurate assessment of the “significance” of the risk of transmitting HIV, which would take into account both the absolute risk and a comparative risk analysis, demonstrates the blatant error of the court’s decision. As to the absolute risk, the likelihood of HIV transmission during surgery is extremely low.²⁵⁹ There was only one documented case of HIV transmission from a health care worker to a patient in the United States at the time of *Doe*,²⁶⁰ and it involved a dentist who may have failed to use minimal precautions.²⁶¹ Nevertheless, health care workers were “routinely dismissed or transferred when their employers discover[ed] they ha[d] HIV.”²⁶² As to comparative risk, even though “patients face[d] a greater risk of infection and death from health care workers with active hepatitis B infections, and there ha[d] been hundreds of documented cases of hepatitis transmission from health care workers to patients,”²⁶³ workers infected with hepatitis B had “not been routinely excluded from

257. *Doe v. Univ. of Md. Med. Sys. Corp.*, 50 F.3d 1261, 1262 (4th Cir. 1995).

258. *Id.* at 1266.

259. Am. Bar Assoc. AIDS Coordinating Comm., Eric N. Richardson & Salvatore J. Russo eds., *Calming AIDS Phobia: Legal Implications of the Low Risk of Transmitting HIV in the Health Care Setting*, 28 U. MICH. J.L. REFORM 733, 741 (“[T]he New York State Department of Health reported that the probability of HIV transmission from an infected health care worker to a patient during an invasive procedure has been estimated to be between 1 per 100,000 and 1 per 1,000,000 procedures.” (citing N.Y. STATE DEP’T OF HEALTH, POLICY STATEMENT AND GUIDELINES: HEALTHCARE FACILITIES & HIV-INFECTED MEDICAL PERSONNEL 3 (Jan. 1991))).

260. Michael A. Gardam et al., *The HIV-Positive Dentist: Balancing the Rights of the Health Care Worker and the Patient*, 164 CAN. MED. ASS’N J. 1715, 1715–16 (2001).

261. See Hubbard, *supra* note 134, at 1324 & n.256.

262. *Id.* at 1325.

263. *Id.*

practice, because they [were] deemed to present a tolerable risk.”²⁶⁴

Determining whether a risk is “significant” in the prescription drug context thus requires a comparison between the statistical risk posed by a particular individual’s prescription drug use and the statistical risk posed by the most common causes of workplace accidents that are not subject to exclusion policies. This will prohibit employers from relying on the *source* of the risk to treat individuals posing equivalent risks differently.²⁶⁵ This protection is particularly crucial because courts are especially likely to uphold an employer’s actions without a rigorous individualized inquiry or considering probability (as opposed to *possibility*) if the disability in question is one that is feared or unfamiliar.²⁶⁶ With prescription drugs, many employers with little knowledge of the actual occurrence of side effects and variability among individuals will, erring on the side of safety, assume the worst and grossly overestimate the likelihood of any particular employee experiencing harmful side effects in the workplace.²⁶⁷ The requirement of a highly objective individualized assessment by medical review boards, coupled with the requirement of a comparative risk analysis, will serve to prevent such impermissible decisions by both courts and employers.

264. Hubbard, *supra* note 134, at 1325 (internal quotation marks omitted) (citing Centers for Disease Control, *Recommendations for Preventing Transmission of Human Immunodeficiency Virus and Hepatitis B Virus to Patients During Exposure-Prone Invasive Procedures*, 40 MORBIDITY & MORTALITY WKLY. REP. NO. RR-8, July 12, 1991, at 2–3, 5–6 [hereinafter CDC 1991 Recommendations]).

265. See Prestes, *supra* note 252, at 432.

266. See *supra* note 238.

267. Where no “cut-and-dried factual proof is available,” a court is more likely to defer to an employer’s overestimation of the risk posed. *Doe v. Region 13 Mental Health-Mental Retardation Comm’n*, 704 F.2d 1402, 1410 (5th Cir. 1983). In *Doe*, the Fifth Circuit upheld the termination of a therapist who was fired after being diagnosed with “depressive neurosis,” even though she was a “superior employee” who did “an outstanding job by all objective standards until her termination.” *Id.* at 1404. The court held that she posed a direct threat because of the mere *possibility* that “a therapist who accepts suicide as a reasonable alternative may pass along this bias to his or her patients,” *id.* at 1409, even though there was no evidence that she had ever done so and she had even been found to not be suicidal in a prior commitment proceeding. *Id.* at 1404, 1406. The court justified its deference to the employer’s decision on the ground that the plaintiff’s disability was mental, explaining that “[t]his is not a case involving whether an employee is able to screw nuts and bolts onto a widget with sufficient speed. No such cut-and-dried factual proof is available when dealing with the ‘soft science’ surrounding the health or affliction of an individual’s psyche.” *Id.* at 1410.

C. EMPLOYEE PERFORMANCE TESTS INSTEAD OF TESTING FOR
LEGAL PRESCRIPTION DRUGS

There are no data to support the effectiveness of drug testing, and many employers have come to see as excessive the high cost of testing all employees only to detect a few drug users.²⁶⁸ Drug testing has even caused problems for at least one industry required by law to drug-test its employees: in the trucking industry, many carriers have had “difficulty finding qualified drivers who meet safety requirements.”²⁶⁹

Further, other problems in the workplace may be more significant than drugs and even alcohol with respect to their effects on safety and productivity, calling for the prudence of using “performance” tests instead of only testing for substance use.²⁷⁰ Performance tests may test employees in mock situations simulating real work conditions to single out problem areas for individual employees; they may also take the less costly form of simply analyzing data taken from the employee’s actual work record in order to pinpoint these problem areas and their underlying causes.²⁷¹ Performance tests acknowledge that the risks posed by individuals who, for example, suffer from certain health problems but for one reason or another are not treating them with medication, would be undetectable in substance use tests, despite the fact that those individuals may pose a greater risk than those taking prescription drugs to treat their ailments.²⁷² Thus, focusing too much on drug tests may result in missing more serious risks.

268. One employer found only forty-nine positive results after testing 10,000 employees, resulting in a cost of roughly \$20,000 for each positive result. ZEESE, *supra* note 248, at § 1:2. The positive rate in government testing is even lower — only 0.5%, resulting in an estimated cost of \$77,000 for each positive. *Id.*

269. *Id.*

270. *Id.*

271. *See id.* at § 2:43; *Employment Tests and Selection Procedures*, EEOC, http://www.eeoc.gov/policy/docs/factemployment_procedures.html (last modified Sept. 23, 2010).

272. Similarly, the Genetic Information Nondiscrimination Act (“GINA”) of 2008, the first major American antidiscrimination statute since the ADA was passed over a decade before, prohibits employers from using an individual’s genetic information when making employment decisions. Genetic Information Nondiscrimination Act of 2008, Pub. L. No. 110-233, 122 Stat. 881 (codified in scattered sections of 26, 29, and 42 U.S.C.); Jessica L. Roberts, *The Genetic Information Nondiscrimination Act as an Antidiscrimination Law*, 86 NOTRE DAME L. REV. 597 (2011). This applies even to individuals who have been proven to be genetically predisposed to develop a disease or injury, no matter how serious and

A high focus on drug tests may also result in missing the more common causes of workplace accidents or even the underlying causes of drug use.²⁷³ Companies that use performance tests have found that fatigue, stress, and health problems — not drug and alcohol use — are the most common reasons why employees fail performance tests.²⁷⁴ Studies by sleep disorder experts have also blamed fatigue, brought on by disruptive scheduling and long work hours, for “a growing threat of ‘high consequence errors.’”²⁷⁵ Consistent with this, a 1990 National Transportation Safety Board (NTSB) study of 182 fatal truck driving accidents found that fatigue was “the most frequently cited accident probable cause.”²⁷⁶ Fatigue may even be an important factor in the use and abuse of drugs, as many employees self-medicate to deal with the fatigue of their jobs.²⁷⁷

D. EMPLOYER SAFETY MEASURES

The deference courts give to employers’ judgments on what constitutes the “essential functions” of a particular job, discussed in Part III.A, allows employers to rely on “traditional work arrangements” that incorporate their stereotypes and prejudices.²⁷⁸ This problematic deference calls for more judicial scrutiny into the measures employers are taking to make their workplaces safer; this increased scrutiny would in turn provide employers an incentive to take such measures, including considering new technologies and techniques. These measures should address safety

likely a risk the disease or injury poses. Genetic Information Nondiscrimination Act § 202. Thus, even those with potentially serious psychological and health problems may not be discriminated against under the Act, despite the likelihood and seriousness of the risks posed.

273. ZEESE, *supra* note 248, at § 1:2.

274. *Id.* See also FACT SHEET, *supra* note 249, at 1 (“In 2001, the median number of days away from work as a result of anxiety, stress, and related disorders was 25 — substantially greater than the median of 6 for all nonfatal injury and illness cases. . . . Job stress is estimated to cost U.S. industry more than \$300 billion a year in absenteeism, turnover, diminished productivity and medical, legal and insurance costs.” (internal citations omitted)).

275. ZEESE, *supra* note 248, at § 1:2.

276. *Safety Study: Fatigue, Alcohol, Other Drugs, and Medical Factors in Fatal-to-the-Driver Heavy Truck Crashes, Vol. 1*, NAT’L TRANSP. SAFETY BD, (Feb. 5, 1990), <http://www.nts.gov/safety/safetystudies/SS9001.htm>.

277. ZEESE, *supra* note 248, at § 1:2.

278. Paetzold, *supra* note 133, at 341.

risks posed by the setup of the workplace itself, particularly those that may compound the effects of what might only be simple mistakes made by employees, whether or not caused by prescription drug use. Such efforts to address overlooked safety issues that may have been long accepted, though treatable, as a fact of life of the workplace, would also account for the more common causes of workplace accidents, including fatigue and undetectable health problems.

In addition, employers are obligated under the ADA's reasonable accommodation requirement to take measures that accommodate the "known physical or mental limitations" of an employee, unless they impose an undue hardship on the employer.²⁷⁹ The employer should consider available technologies and tools that can enable persons with disabilities to perform jobs, as well as new ways to accomplish old tasks for employees with different limitations.²⁸⁰ An example of such technologies and tools in the HIV context is the safer needles that were developed to reduce the risk of exposure to bloodborne diseases. In that context, Congress even passed a law — the Needlestick Safety and Prevention Act — that in effect reinforced the requirement that employers use the safer needles.²⁸¹ Similarly, in the prescription drug context, employers should be required, even before they find themselves obligated to do so under the ADA's reasonable accommodation requirement, to consider and institute safer work environments above and beyond long-accepted traditional work arrangements.

279. 42 U.S.C.A. § 12112(b)(5)(A) (West 2009).

280. Hubbard, *supra* note 134, at 1294 ("At every step — formulating job descriptions, interviewing candidates, granting promotions, assessing health, safety and productivity issues — the employer is challenged to reexamine her assumptions, adjust her beliefs and revise her opinions. The employer must consider new information, including the prior job performance and safety records of applicants with disabilities; the latest medical and scientific information relevant to whether an employee can safely and effectively perform the essential functions of the job; information about available technologies and tools that can enable persons with disabilities to perform jobs that previously were out of their reach; and demonstrations of new ways to accomplish old tasks, ways that are better suited to employees with different physical or mental limitations.").

281. Pub. L. No. 106-430, 114 Stat. 1901 (2000). *See also* Occupational Exposure to Bloodborne Pathogens; Needlesticks and Other Sharps Injuries; Final Rule, 66 Fed. Reg. 5318 (Jan. 18, 2001).

E. THE NEED FOR MORE DATA

Although there remains a dearth of data on prescription drugs, as discussed in Part II, statistical data on the risks posed by various disabilities are becoming increasingly available, setting an example for what must be done in the prescription drug context: methodical collection and evaluation of detailed data on prescription drugs and the occurrence of side effects, particularly in the workplace.²⁸² Doctors, statisticians, and insurance companies, among others, have collected a wealth of data in other contexts. For example, in the early 1980s, at the beginning of the AIDS epidemic, the Centers for Disease Control and Prevention (CDC)²⁸³ began accumulating and analyzing data on HIV.²⁸⁴ Equipped with this information and expert input, the CDC established universal precautions that would further minimize the small risk of HIV transmission to patients and thus ensure that infected health care workers could safely perform invasive procedures, including most surgeries.²⁸⁵ Further, for certain procedures the CDC deemed to be “exposure-prone,” the CDC suggested an individualized assessment of whether the infected worker could safely perform the particular procedure.²⁸⁶

Similarly, in the diabetes context, medical and technological advances, as well as studies finding that safety concerns were exaggerated, undermined previous assumptions about the risks posed by diabetic individuals — even for safety-sensitive jobs.²⁸⁷

282. See, e.g., William L. Meadow & Cass R. Sunstein, *Statistics, Not Experts 2* (U. Chi. Law & Econ., Olin Working Paper No. 109, 2000), available at http://papers.ssrn.com/paper.taf?abstract_id=252824 (“For the first time, it is becoming possible for law to rely on [statistical data], precisely because such evidence is becoming increasingly available.”).

283. The CDC is a federal agency “dedicated to protecting health and promoting quality of life through the prevention and control of disease, injury, and disability.” *About CDC*, CTRS. FOR DISEASE CONTROL & PREVENTION, <http://www.cdc.gov/about/> (last modified Oct. 24, 2011). The CDC is a component of the Department of Health and Human Services. *About CDC Organization*, CTRS. FOR DISEASE CONTROL & PREVENTION, <http://www.cdc.gov/about/organization/cio.htm> (last modified May 2, 2011)

284. Verla S. Neslund et al., *The Role of CDC in the Development of AIDS Recommendations and Guidelines*, 15 L. MED. & HEALTH CARE 73, 73–76 (1987).

285. See CDC 1991 Recommendations, *supra* note 264, at 5.

286. *Id.* See also Watson, *supra* note 238, at 761 (“The CDC suggests that infected workers not perform exposure-prone procedures unless they have sought guidance from an expert review panel made up of the worker’s physician, an infectious disease specialist with expertise in HIV transmission, a health professional with expertise in the procedures performed by the worker, and state or local public health officials.”).

287. See Hubbard, *supra* note 134, at 1331.

As a result, federal transportation agencies adjusted their categorical prohibitions²⁸⁸ on licensing diabetic individuals for commercial driving, as well as other prohibitions.²⁸⁹ Although courts had upheld categorical prohibitions of diabetic individuals from various safety-sensitive jobs,²⁹⁰ some had simultaneously expressed hope, as early as 1988, that “medical science [would] soon progress to the point that ‘exclusions on a case by case basis will be the only permissible procedure; or, hopefully, methods of control may become so exact that insulin-dependent diabetics will present no risk of ever having a severe hypoglycemic episode.’”²⁹¹ By 1999, in light of the scientific advancements and changes in federal regulations, courts began reevaluating their prior approvals of such categorical prohibitions and requiring individualized assessments as well as evaluations of the new technologies.²⁹²

As noted above, however, data on workplace accidents caused by prescription drug use, and data on the actual occurrence of side effects from prescription drug use, are sparse.²⁹³ The rising prevalence of prescription drug use in American society, coupled

288. 49 C.F.R. § 391.41(b)(3) (2011) (“A person is physically qualified to drive a commercial motor vehicle if that person . . . [h]as no established medical history or clinical diagnosis of diabetes mellitus currently requiring insulin for control . . .”).

289. In the late 1990s, at the direction of Congress, the Department of Transportation found, after analyzing recent risk assessment studies, recommendations of an expert medical panel, and research on the treatment and management of insulin-treated diabetes, that it was feasible to screen and monitor insulin-treated diabetics who could safely drive commercial motor vehicles while “ensur[ing] a level of safety equal to or greater than that achieved with the current prohibition on individuals with insulin treated diabetes mellitus driving such vehicles.” Transportation Equity Act for the 21st Century, Pub. L. No. 105-178, 112 Stat. 107 (1998); U.S. DEP’T OF TRANSP., A REPORT TO CONGRESS ON THE FEASIBILITY OF A PROGRAM TO QUALIFY INDIVIDUALS WITH INSULIN TREATED DIABETES MELLITUS TO OPERATE COMMERCIAL MOTOR VEHICLES IN INTERSTATE COMMERCE AS DIRECTED BY THE TRANSPORTATION EQUITY ACT FOR THE 21ST CENTURY i, 61–64 (2000), available at <http://www.fmcsa.dot.gov/documents/diabetesrpt.pdf>.

290. See, e.g., *Davis v. Meese*, 692 F. Supp. 505, 520 (E.D. Pa. 1988) (holding that the FBI’s “preclusion of insulin-dependent diabetics from employment as special agents and investigative specialists does not violate the Rehabilitation Act”); *Kraft v. Bechtel Power Corp.*, 483 So. 2d 56, 56 (Fla. Dist. Ct. App. 1986) (upholding exclusion of plaintiff from “sensitive and dangerous duties” at nuclear power plant because his diabetes “rendered him unable to meet ‘bona fide occupational qualification reasonably necessary for the performance of the particular employment’”).

291. See, e.g., *Chandler v. City of Dallas*, 2 F.3d 1385, 1395 n.52 (5th Cir. 1993) (quoting *Meese*, 692 F. Supp. at 521 (E.D.Pa.1988)).

292. See, e.g., *Kapche v. City of San Antonio*, 176 F.3d 840, 841 (5th Cir. 1999) (vacating the district court’s grant of summary judgment for the employer and remanding for “a determination of the continued viability of this *per se* rule”).

293. See *supra* Part II.

with the requirement of a highly individualized inquiry in prescription drug cases, requires that employers, disinterested organizations, and the government participate in a concerted effort to collect and evaluate this important data.

V. CONCLUSION

Prescription drug use has become an American way of life, and employers, courts, and legislators must accommodate this new reality. The ADA prohibits employers from making employment decisions based on misconceptions and presumptions that are not truly indicative of a particular individual's abilities and limitations. In general, well-prescribed drugs at a stable dose that are well-supervised will not cause problems; further, when used legally pursuant to a prescription and taken as directed under a doctor's orders and supervision, prescription drugs help workers protect their health and thus perform more productively in the workplace. Therefore, prescription drug use, in many cases, may be in the best interests of not only employees but also employers, despite what warning labels say. Enforcing a highly individualized inquiry in the prescription drug context will ensure that these interests are protected and in line with the mandate of the ADA, particularly in light of the clarifications provided by the ADAAA and developments in other areas.