Calming AIDS Phobia: Legal Implications of the Low Risk of Transmitting HIV in the Health Care Setting

American Bar Association AIDS Coordinating Committee

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Scientists are concluding that the risk of becoming infected with the virus that causes AIDS based on transmission from an infected health care worker is infinitesimal: in fact, only one health care worker has ever been documented as the source of HIV transmission to a patient. This Article sets forth the medical evidence concerning this low risk and argues that legal decision making should incorporate these facts into its analysis of legal problems involving HIV-infected health care workers. The Article analyzes three areas of such legal decision making: (1) employment and related credentialling of HIV-infected health care workers; (2)
liability of such workers to their patients for fear of contracting AIDS, including liability under doctrines of informed consent; and (3) insurance issues involving health care workers and HIV-related risks. In all three areas, the Article concludes that the law lags behind science and has not yet incorporated the facts about the low risk of HIV transmission into its treatment of HIV-infected health care workers. Until courts and legislatures recognize the scientific facts about the low risk of HIV transmission and incorporate them into cases and statutes, HIV-infected health care workers are likely to suffer unnecessary discrimination and other mistreatment.

INTRODUCTION

Between July 1990 and May 1993, the United States Centers for Disease Control (CDC) disclosed that six patients likely had become infected with the human immunodeficiency virus (HIV) while receiving treatment at the offices of David Acer, a Florida dentist.¹ These reports propelled public concerns about contracting HIV in the health care setting to the very top of the AIDS agenda, generating both much-needed attention and potentially damaging public fear and hysteria.² The anomaly of the Acer cluster³ has puzzled medical scien-


2. See, e.g., Mike Clary, Florida's Dilemma with AIDS Stirs National Attention, L.A. TIMES, June 9, 1991, at A21 (stating that “in the midst of an epidemic that has now spread into every corner of American life, that one [Florida] case has made all the difference” in catapulting the state of Florida into the national health care spotlight); Phillip J. Hilts, Congress Urges That Doctors Be Tested for AIDS, N.Y. TIMES, Oct. 4, 1991, at A18 (describing a bill approved by Congress that “suggests but does not require that doctors and other health care workers be tested for the AIDS virus”); cf. Sanford F. Kuvin, A Proactive Public Health Policy for the Mandatory Testing of Health Care Workers and Patients Involved in Invasive Procedures, 2 CTS. HEALTH SCI. & L. 115 (1991) (advocating that “public health officials and the medical profession must be at the forefront of developing a proactive public health policy to prevent the spread of infections between health care providers and patients”).

3. The term “cluster” refers to a group of patients who were infected by exposure to one health care worker. See Centers for Disease Control, Recommendations for Preventing Transmissions of Human Immunodeficiency Virus and Hepatitis
tists since its first report. No one has ever documented any other case of HIV transmission from health care worker to patient, despite diligent searches including a host of "look-back" studies conducted with respect to surgeons who performed highly invasive procedures after they had become HIV-positive.

While the issue of health care workers with HIV has receded from the public consciousness somewhat since the discovery of the last case in the Acer cluster, recent events have renewed interest in the topic. In October 1995, the only remaining lawsuit brought by one of Dr. Acer's patients was settled without a trial, bringing to an end the legal battles that arose out of the infections traced to Dr. Acer's practice. But interest in the legal and policy issues illuminated by the Acer cluster remains strong. Most notably, proposals for mandatory HIV testing of pregnant women and their babies raise many of the same medical, legal, and policy issues as earlier proposals for mandatory testing of health care workers. As in the debate over mandatory testing of health care workers, policymakers considering mandatory testing of pregnant women must balance the benefits of knowledge of HIV status with the risks of driving people away from the health care system. Fear of HIV and discrimination against those who are—or are perceived to be—infectected increases

_B Virus to Patients During Exposure-Prone Invasive Procedures_, 40 _MORBIDITY & MORTALITY WKLY. REP_. 2, 2-3 (1991) [hereinafter _CDC Guidelines_].

4. _See_, e.g., Dennis L. Breo, _The Dental AIDS Cases—Murder or an Unsolvable Mystery?,_ 270 _JAMA_ 2732, 2732 (1993) (quoting an epidemiologist who described the Acer cluster, "I don't know what happened and we may never know what happened.").

5. "Look-back" studies are studies in which the researcher contacts former patients of a health care worker who has AIDS to determine whether these patients have been infected with the HIV virus.


7. _See_ CDC, _Investigations of Persons Treated_, supra note 1, at 331.


because of excessive focus on mandatory testing to the exclusion of accurate public education about the true risks of HIV infection. As a result, it now seems appropriate to renew the conversation about HIV and the health care worker in a dispassionate way, while also broadening the focus of that conversation.

This Article constitutes the American Bar Association (ABA) AIDS Coordinating Committee's contribution to that end. Since its first meeting in January 1988, the AIDS Coordinating Committee of the ABA has sought to contribute in a constructive and dispassionate way to the public conversation concerning the legal and public policy issues raised by the AIDS epidemic and to facilitate legal representation of persons affected by HIV. This Article represents the latest in that series of efforts and builds upon hearings held by the Committee in 1992 in both Washington, D.C. and Chicago on the issue of HIV testing of health care workers.


After providing some background information about the low risks of HIV transmission in the health care setting and the guidelines issued by the CDC in response to those risks, this Article addresses legal developments in three areas: employment of HIV-infected health care workers; the professional relationship between HIV-infected health care workers and their patients; and insurance issues for HIV-infected health care workers. The Article emphasizes the low risk that HIV would be transmitted to a patient from a health care worker who follows proper infection control procedures. As a result, this Article argues that it is unwise and unnecessary to restrict the job performance of such health care workers, to require disclosure of their HIV status, to discriminate against them in their employee benefits, or for the law otherwise to penalize them for their HIV infection. This Article concludes that to disadvantage by legal means HIV-positive health care workers only fosters irrational fears of HIV and AIDS while doing nothing to resolve the public health problems which the AIDS epidemic has produced. 13

I. BACKGROUND CONCERNING AIDS AND HEALTH CARE WORKERS

A. The Scope of the AIDS Epidemic and Infection of Health Care Workers.

As of July 1, 1995, a cumulative total of 1,169,811 cases of Acquired Immune Deficiency Syndrome (AIDS) had been reported worldwide to the World Health Organization (WHO). 14 This represents a nineteen percent increase over the number

13. Public ignorance of the true risks of HIV transmission often results in discrimination based on HIV status. At times, this discrimination can result in those with AIDS and HIV receiving poor or no medical care. Cf. D.B. v. Bloom, 1995 U.S. Dist. LEXIS 11867, at *15-*16 (D.N.J. Aug. 15, 1995) (involving an instance in which a patient was told by a dentist to leave and obtain care elsewhere due to the patient’s HIV condition).

14. Telephone Interview with Dr. Fernando Zacarias, Coordinator, Regional Program on HIV/AIDS Standards, Pan American Health Organization (Nov. 13, 1995).
of cases reported in July 1994.\textsuperscript{15} In addition, the WHO estimates that 19.5 million persons have been infected with the HIV virus since the start of the AIDS epidemic.\textsuperscript{16} By 1993, HIV had become the leading cause of death among people in the United States between twenty-five and forty-four years of age, surpassing all other diseases, automobile accidents, and gun violence.\textsuperscript{17} As of June 1995, 295,473 individuals had died of AIDS in the United States.\textsuperscript{18} By June 1995, 476,899 cumulative AIDS cases had been reported in the United States.\textsuperscript{19} Further, the incidence of HIV infection is significantly higher than the reported number of AIDS cases; CDC estimates that at least one million Americans, or one in every 250 persons, are currently infected.\textsuperscript{20}

Of this overwhelming total, only forty-six documented AIDS cases (0.03\% of the total) had resulted from transmission of the HIV virus \textit{from} patients \textit{to} health care workers as of June 1995.\textsuperscript{21} Of the persons with AIDS in the United States reported to the CDC through December 31, 1994, 14,591 had been employed in the health care industry.\textsuperscript{22} Health care workers represent almost five percent of the AIDS cases for which occupational information is known by CDC.\textsuperscript{23}

In November 1993, CDC reported the following information about the transmission and occurrence of HIV in the health care setting:

\begin{itemize}
  \item \textsuperscript{15} Id.
  \item \textsuperscript{16} Id. The AIDS epidemic began in the late 1970s, and its outbreak in the United States was first recognized in an announcement by the Centers for Disease Control (CDC) in June 1981. 42 CDC MONTHLY VITAL STAT. REP. 18–20 (Oct. 1994) (providing the Annual Summary of Births, Marriages, Divorces and Deaths: United States, 1993).
  \item \textsuperscript{17} 42 CDC MONTHLY VITAL STAT. REP. 18–20 (Oct. 1994).
  \item \textsuperscript{18} CENTERS FOR DISEASE CONTROL, U.S. DEP'T OF HEALTH AND HUMAN SERVS., 7 CDC HIV/AIDS SURVEILLANCE REP. 14 (mid-year ed. 1995) (tabulations by editors) [hereinafter HIV/AIDS SURVEILLANCE REPORT].
  \item \textsuperscript{19} Id. at 3, 5.
  \item \textsuperscript{21} Id. at 15. Only the six Acer cases involved transmission of HIV from a health care worker to a patient. See supra notes 1-6 and accompanying text.
  \item \textsuperscript{22} CENTERS FOR DISEASE CONTROL AND PREVENTION, FACTS ABOUT HIV/AIDS AND HEALTH CARE WORKERS 1 (1995) (on file with the University of Michigan Journal of Law Reform).
  \item \textsuperscript{23} Id. To the extent that the CDC knows the specific health care occupations of persons with AIDS, the numbers break down as follows: nurses (3256 cases), health aides (2831), technicians (2011), physicians (1287), therapists (719), dental workers (365), paramedics (283), and surgeons (90). Id.
\end{itemize}
CDC is aware of 42 health care workers in the United States who have been documented as having seroconverted to HIV following occupational exposures. Fifteen have developed AIDS. These individuals who seroconverted include 17 laboratory workers (15 of whom were clinical laboratory workers), 13 nurses, 6 physicians, 2 surgical technicians, 1 dialysis technician, 1 respiratory therapist, 1 health aide, and 1 housekeeper/maintenance worker. The exposures were as follows: 36 had percutaneous (puncture/cut injury exposure), 4 had mucocutaneous (mucous membrane and/or skin) exposure, 1 had both percutaneous and mucocutaneous exposure, and 1 had an unknown route of exposure. Thirty-eight exposures were to HIV-infected blood, 2 to concentrated virus in a laboratory, 1 to visibly bloody fluid, and 1 to an unspecified fluid.

CDC is also aware of 91 other cases of HIV infection or AIDS among health-care workers who have not reported other risk factors for HIV infection and who report a history of occupational exposure to blood, body fluids, or HIV-infected laboratory material, but for whom seroconversion after exposure was not documented. The number of these workers who acquired their infection through occupational exposures is unknown.\(^{24}\)

Since that time, even more health care workers likely have become infected.\(^{25}\)

**B. Risk of HIV Transmission in the Health Care Setting**

Experts on HIV transmission believe that a risk of HIV transmission from health care worker to patient could exist only in situations where there exists both: (1) a high degree of trauma to the patient that would provide a portal of entry for

\(^{24}\) *Id.* Seroconversion is the development of antibody response to a disease or vaccine. *TABER'S CYCLOPEDIC MEDICAL DICTIONARY* 1300 (4th ed. 1981). In the context of HIV, a patient has seroconverted when her blood tests HIV-positive, thus proving that she has been invaded by and has had an immunological experience with HIV. *See also infra* note 71 and accompanying text (describing the "window period" between infection and appearance of HIV antibodies).

\(^{25}\) *See* CDC HIV/AIDS SURVEILLANCE REPORT, *supra* note 18, at 15.
the virus (e.g., during invasive procedures); and (2) presence of blood or other bodily fluid from open tissue of the health care worker, as might occur if the health care worker sustained a needle stick or scalpel injury during an invasive procedure. 26

HIV transmission in the opposite direction, from patient to health care worker, has occurred when a health care worker was exposed to HIV-infected blood through percutaneous exposures (e.g., needle sticks, scalpel lacerations) or mucous membrane exposures. 27

The risk of transmission from health care worker to patient is far lower than the risk of HIV transmission from patient to health care worker. While there has been only one cluster of HIV infection apparently transmitted from a health care worker to a patient, 28 there have been more than forty published reports of HIV transmission from patients to health care

26. CENTERS FOR DISEASE CONTROL, U.S. DEP'T OF HEALTH AND HUMAN SERVS., Summary: Recommendations for Preventing Transmission of Infection with Human T-Lymphotropic Virus Type III/Lymphadenopathy-Associated Virus in the Workplace, 34 MORBIDITY & MORTALITY WKLY. REP. 681, 690 (1985). The CDC has defined the term "invasive procedure" as "surgical entry into tissues, cavities, or organs or repair of major traumatic injuries associated with any of the following:

(1) an operating or delivery room, emergency department or outpatient setting, including both physicians' and dentists' offices; (2) cardiac catheterization and angiographic procedures; (3) a vaginal or cesarean delivery or other invasive obstetric procedure during which bleeding may occur; or (4) the manipulation, cutting, or removal of any oral or perioral tissues, including tooth structure, during which bleeding occurs or the potential for bleeding exists.

CDC Guidelines, supra note 3, at 9. The CDC Guidelines also define the phrase "exposure-prone invasive procedures" as "certain invasive surgical and dental procedures . . . implicated in the transmission of [Hepatitis B] from infected [health care workers] to patients" and as percutaneous exposures of patients during surgery which are thought to present a greater risk of HIV transmission than other invasive procedures. Id. at 4. The CDC Guidelines further describe exposure-prone procedures as follows:

Characteristics of exposure-prone procedures include digital palpation of a needle tip in a body cavity or the simultaneous presence of the [health care worker's] fingers and a needle or other sharp instrument or object in a poorly visualized or highly confined anatomic site. Performance of exposure-prone procedures presents a recognized risk of percutaneous injury to the [health care worker], and—if such an injury occurs—the [health care worker's] blood is likely to contact the patient's body cavity, subcutaneous tissues and/or mucous membranes.

Id.


28. See supra notes 1–6 and accompanying text; infra Part I.C.
workers. A major study of occupational HIV exposure showed that approximately 0.32%, or 3 out of every 1000 health care workers exposed to HIV-infected blood by needle stick, will become infected.

Due to the small number of reported cases, it is difficult to quantify the risk of HIV transmission from health care workers to patients, but in any event, the risk is probably very small. For example, the 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. On January 30, 1991, the CDC released its own estimates of this risk based on: "The number of surgeons and dentists with the virus, the number of procedures they perform, the number of accidents in which protective barriers are breached, and the probabilities of such accidents resulting in an infection." Using this method, the CDC estimated that between 13 and 128 patients may have been infected with HIV by HIV-infected doctors and dentists during invasive surgical procedures since 1981. Based on the estimates of the CDC and others, the risk of HIV transmission to a patient from a seriously invasive procedure may be in the range of 1 in 40,000 to 1 in 400,000.

In a subsequent report, the CDC presented a preliminary estimate suggesting that up to twenty-eight surgical patients could have been infected by invasive procedures performed by

29. CDC, HIV/AIDS SURVEILLANCE REPORT, supra note 18, at 15.
33. Id. See also Michael Kinsley, Red Peril: Congress Wastes Time on Doctors with AIDS Issue, NEW REPUBLIC, Aug. 12, 1991, at 4 (citing the same CDC statistic, and indicating that CDC estimated that 10 to 100 people had been infected by dentists and that 3 to 28 people had been infected by surgeons).
infected surgeons since the AIDS epidemic began. Based on that estimate, a patient undergoing an invasive surgical procedure performed by an infected surgeon has a risk of infection of between 2.4 to 24 per million. Given the data currently available, the highest estimated probability of an HIV-infected dentist transmitting HIV to a patient is .038 per million.

To put these risks in proper perspective, one should compare them to other risks patients face in the health care system. For example, one hundred out of every million persons undergoing general anesthesia die and ten to twenty out of every million persons treated with penicillin have an adverse (anaphylactic) reaction resulting in death. Given this data concerning risks, the degree of risk of transmission from health care worker to patient, even in "invasive, exposure-prone" procedures, is so low as to be immeasurable, or infinitesimal:

C. The Acer Cluster

Notwithstanding the high level of public concern about contracting HIV from HIV-infected health care workers, there has been only one reported instance of a health care worker transmitting HIV to his patients. In a July 1990 report, the CDC described its investigation of the case of a young woman who apparently contracted HIV from her contact with David Acer, a Florida dentist who had the virus. Seventeen months after the dentist had extracted two of her teeth, Kimberley Bergalis, the patient, was diagnosed as having oral candidiasis. Two years after the extractions, she was diagnosed as having pneumonia and subsequent blood tests revealed traces of the HIV antibody in her blood. She had contracted HIV.

35. See Kinsley, supra note 33.
37. ABA, Chicago Hearing, supra note 12, at 121 (statement of Eugene Moats).
39. See CDC, Possible Transmission of HIV, supra note 1, at 489.
40. Id.
41. Id.
Based on its findings that the patient did not have any other documented behavioral or other risk factors for HIV infection and that the Florida State Department of Health's investigation demonstrated a striking similarity between the HIV DNA sequences from the patient and the dentist, the CDC concluded that Ms. Bergalis possibly had been infected with HIV during the dental procedure. The CDC conducted a follow-up investigation which identified four additional patients of the dentist who had become infected with HIV. Finally, on May 7, 1993, the CDC reported that a sixth patient had become infected with HIV while receiving care from Dr. Acer. These cases have come to be known as the Acer cluster.

The CDC stated that its "investigation strongly suggest[ed] that at least three patients of a dentist with AIDS were infected with HIV during their dental care." Although the precise mode of transmission was unclear, the CDC speculated that the HIV virus could have been transmitted through needle stick injuries sustained by the dentist or through use of instruments or other dental equipment previously contaminated with blood from either the dentist or another patient. The dentist reportedly had used barrier precautions, but these techniques were not always consistent or in compliance with the universal precautions commonly recommended by public health officials. In addition, the CDC found that such precautions often do not prevent punctures or cuts that would allow the dentist's blood to flow directly into an open wound or the mucous membranes of a patient. The CDC also found that the dentist's office did not have a written policy for reprocessing dental instruments and equipment, and that Dr. Acer did not consistently adhere to universal precautions.

Although numerous look-back studies have investigated whether patients other than Dr. Acer's have contracted HIV from infected health care workers, no such cases have been identified. In the over seventy look-back studies known to the CDC, 19,036 patients of HIV-infected health care workers were

42. AMERICAN ACADEMY OF ORTHOPAEDIC SURGEONS, supra note 27, at 2–3.
43. See CDC, Transmission of HIV Infection—Florida, supra note 1, at 21.
44. CDC, Investigations of Persons Treated, supra note 1, at 329.
46. Id. at 26–27.
47. Id. at 26.
48. Id. at 27.
49. Id.
50. E.g., Phillips et al., supra note 30, at 853 & nn.1, 2 & 43–47.
tested and none was reported to have been infected by a health care worker. 51

Recent data collected in three separate studies suggest that the risk of transmission of HIV from surgeons and dentists to patients is extremely low. In one study of the patients of an HIV-infected surgeon, experts found that there was no HIV transmission in 369 person-hours of surgical exposure, indicating that HIV transmission to patients is unlikely to occur more frequently than once per thousand person-hours of surgical exposure. 52 Another study concluded that "the risk of transmission from an HIV-infected surgeon to patients undergoing invasive procedures is extremely low." 53 A third study of the patients of an HIV-infected dentist found that "[a]mong 900 patients who were actually tested, there were 6,901 dentist-patient contacts without transmission, a rate of less than 0.0002 per contact." 54 Although a small number of HIV-infected patients who did not have other risk factors were identified in these look-back studies, DNA sequence testing satisfied the researchers that these patients had not contracted the virus from an infected health care worker. 55 Finally, the most recent estimates of the CDC suggest that the risk of a single patient contracting HIV from an infected surgeon ranges from one in 42,000 to one in 417,000. 56

Significantly, the only documented cases of apparent transmission from a health care worker to a patient occurred in Dr. Acer's office, where compliance with infection control procedures was lax. 57 Supporters of mandatory HIV testing for health care workers speculate that many more patients have been infected by HIV-infected health care workers but look-

51. CDC, Investigations of Persons Treated, supra note 1, at 329.
53. C. Fordham von Reyn et al., Absence of HIV Transmission from an Infected Orthopedic Surgeon: A 13-Year Look-Back Study, 269 JAMA 1807, 1810 (1993); see also ABA, Chicago Hearing, supra note 12, at 183–84 (containing testimony of Dr. Howard J. Hess, who suggested that the risk of HIV transmission in health care settings "is actually very small").
55. Id. at 1804.
57. See CDC, Transmission of HIV Infection—Florida, supra note 1, at 21, 25.
back studies have not identified these patients. They maintain that the Acer cluster presented the sole opportunity for DNA sequencing of both a health care worker's and a patient's strand of HIV, thereby resulting in the only finding that a health care worker infected his patients. It is not true, however, that other look-back studies did not perform DNA sequencing. Most look-back studies performed DNA sequencing on infected patients for whom other risk factors had been eliminated. To date, no cases of transmission of HIV from health care worker to patient, other than those in the Acer cluster, have been documented.

D. Universal Precautions and the CDC's Response to the Acer Cluster to Reduce Risk of Transmission in the Health Care Setting

On July 12, 1991, partly in response to the publicity surrounding the Acer incident, the CDC published guidelines for preventing the transmission of Hepatitis B virus (HBV) and HIV from health care workers to patients. The guidelines may be summarized as follows:

1. All health care workers should adhere to "universal precautions" in the use and disposal of needles and other sharp instruments, and comply with current guidelines for disinfection of reusable devices used in invasive procedures;

58. See supra notes 50–51 and accompanying text.
59. See supra note 55 and accompanying text.
60. See supra notes 3–6 and accompanying text.
61. CDC Guidelines, supra note 3. Another important set of guidelines on this topic are the guidelines of the Occupational Safety and Health Administration issued December 6, 1991. See Occupational Exposure to Bloodborne Pathogens, 29 C.F.R. § 1910 (1994). These guidelines have been upheld as a reasonable regulatory response. See American Dental Ass'n v. Martin, 984 F.2d 823 (7th Cir. 1993), cert. denied, 114 S. Ct. 172 (1993). This Article will focus on the CDC's guidelines because they are the most widely known.
62. "Universal precautions" refer to guidelines issued by the CDC to promote infection control. CDC Guidelines, supra note 3. The CDC's system treats all human blood and body fluids as if known to be infectious for HIV, HBV, or other blood-borne pathogens. Universal precautions involve the appropriate use of protective barriers, needles, disposal methods, handwashing, education, and record keeping employed in a routine system such that infections are controlled and transmission risks are minimized or eliminated. See CDC Guidelines, supra note 3, at 2.
2. There is no scientific basis to restrict the practice of an HIV-infected worker who performs invasive procedures that are not identified as “exposure-prone,” provided universal precautions are practiced, because there is no risk of infecting patients in non-invasive procedures;63

3. HIV-infected workers should not perform “exposure-prone” procedures unless they have sought authority from a medical review panel and have obtained the informed consent of the patient;

4. “Exposure-prone” procedures should be more specifically identified by medical, surgical, dental, and other professional organizations and institutions at which the procedures are performed;

5. Mandatory testing of health care workers is not recommended because the current assessment of the risk of transmission does not support the intrusion and costs attendant to testing;

6. Compliance with the CDC’s recommendations can be increased through education, training, and confidentiality safeguards. Notification to patients of a possible HIV exposure and follow-up studies should be done by public health officials on a case-by-case basis, after taking into account the specific risks.64

While only advisory, the CDC Guidelines have subsequently been adopted into law by many jurisdictions. Congress mandated in 1992 that states adopt the CDC Guidelines or equivalent protections before October 1992.65 Some states have adopted the CDC Guidelines, but other states have certified that they are developing their own equivalent guidelines.66 The response of medical organizations was also divided, with many organizations strongly supporting the CDC’s recommendations that all

63. Id. at 5.
64. Id. at 5–6.
66. See Phillips et al., supra note 30, at 857.
health care workers adhere to universal precautions, but with a few organizations opposing them. The National Commission on AIDS also opposed mandatory testing of health care workers and urged that any restrictions on the practice of health care workers should be based on an assessment of the individual health care worker's professional competence, ability to comply with universal precautions and any previous transmission of other blood-borne infections.

The CDC supported voluntary HIV tests of health care workers who perform exposure-prone procedures. Many health care organizations and experts, including the CDC, have rejected mandatory testing of health care workers as an appropriate response to concerns over HIV transmission in the health care setting. Testing a health care worker provides information about that worker's HIV status only at a time prior to the specific time of testing. Thus, test results may be inaccurate because of false positives or negatives. Test results may also be affected by the "window period" between infection and the time that the body develops HIV antibodies which would be reflected on an AIDS test. The reliability of a negative test

67. See generally ABA, Washington Hearing, supra note 12 (containing testimony of representatives of the American Association of Dental Schools, American Medical Association, and the Federation of State and Medical Boards); ABA, Chicago Hearing, supra note 12 (containing testimony of representatives of the American College of Emergency Physicians and the Federation of State Medical Boards). At least one group that opposed the CDC Guidelines did so because the guidelines were too restrictive of health care workers. See NATIONAL COMM’N ON AIDS, PREVENTING HIV TRANSMISSION IN HEALTH CARE SETTINGS 9 (1992) (stating that the Infectious Disease Society of America opposed any restriction on practice by HIV-infected health care workers).

68. See, e.g., AMERICAN COLLEGE OF SURGEONS, STATEMENT ON THE SURGEON AND HIV INFECTION 28, 30–31 (1991). Although this statement agrees with the CDC that health care workers should comply with "universal precautions," the statement's recommendations vary drastically in content from the CDC's. See id. For one perspective from abroad, see Lynn M. Peterson, Book Review, 328 NEW ENG. J. MED. 450–51 (1993) (reviewing THE IMPACT OF HIV ON SURGICAL PRACTICE (J.P.S. Cochrane & C. Wastell eds., 1992) and noting that England's Royal College of Surgeons believes that HIV-infected surgeons should never perform invasive procedures).


70. ABA, Chicago Hearing, supra note 12, at 62.

71. This Article uses the term "window period" to describe the period from six weeks to three months from the time of infection until the appearance of HIV antibodies. See JOSEPH T. PAINTER, AMERICAN MEDICAL ASS’N, REPORT OF THE BOARD OF TRUSTEES: HIV AND PHYSICIANS 6 (1991), reprinted in ABA, Chicago Briefing Book, supra note 12, pt. 5. During this "window period," an infected person would not produce HIV antibodies and an HIV test would be negative although the virus would
result also could be affected by subsequent opportunities for exposure. Finally, negative test results could lead to the unjustified relaxation of and decreased dependence on universal precautions.

E. Conclusions

In light of the infinitesimal risk\(^{72}\) that a health care worker will transmit HIV to a patient, the AIDS Coordinating Committee (the Committee) recommends that states adopt legislation which allows health care workers infected with HIV or HBV to continue their jobs unless unusual circumstances surrounding their medical practices or procedures demonstrably pose a significant risk to patients. For infected health care workers who perform exposure-prone procedures, an expert review panel should advise the worker on the circumstances under which they may continue to perform these invasive procedures. Based on our hearings and based on the reaction of medical groups to the CDC's guidelines, the Committee believes that voluntary HIV testing and voluntary use of expert review panels are most effective, particularly because a voluntary system more likely will encourage health care workers to have an HIV test and learn about their HIV status. Armed with that knowledge, the health care provider can take appropriate precautions to minimize even the tiny risk of HIV transmission in the health care setting.

II. HIV-INFECTED HEALTH CARE WORKERS AND EMPLOYMENT

Courts that have considered the issue have reached different results as to whether a hospital or other health care employer

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72. *See supra* Part I.B–C.
may terminate a health care worker’s employment on account of that worker’s HIV status.\textsuperscript{73} Not surprisingly, a court’s opinion about the likelihood that an infected health care worker would transmit HIV to a patient significantly influences the court’s decision on the merits of the health care worker’s employment dispute. Such variation is troubling because the facts about the low risk of HIV transmission from health care worker to patient do not change significantly from case to case. Rather, what varies is the court’s own measure of how “significant” the risk of HIV transmission is. The significance of the risk of transmitting a disease is an important factor in determining an employee’s protection from adverse employment decisions under current Supreme Court precedent. Accordingly, the legal system should incorporate more uniformly medical knowledge about the risks of HIV transmission from health care workers to patients and should protect the employment rights of health care professionals.\textsuperscript{74}

\textbf{A. Statutory Protections of HIV-Infected Employees}

Two federal statutes protect HIV-infected employees, including health care workers, from employment discrimination. The Rehabilitation Act of 1973\textsuperscript{75} prohibits entities that receive federal financial assistance, entities that have federal contracts, and the federal government itself, from discriminating against an “otherwise qualified individual with a disability . . . solely by reason of her or his disability.”\textsuperscript{76} Title I of the Americans with Disabilities Act (ADA)\textsuperscript{77} prohibits discrimination by private employers against a “qualified individual with a

\textsuperscript{73} Compare Scoles v. Mercy Health Corp., 887 F. Supp. 765 (E.D. Pa. 1994) (upholding the hospital’s decision to bar Dr. Scoles from performing surgery at any of its hospitals without proof that his patients knew of his HIV status, in part because the doctor had not established that he did not pose a “significant risk” to his patients) with Doe v. District of Columbia, 796 F. Supp. 559 (D.D.C. 1992) (striking down as discriminatory the defendant’s decision to withdraw an offer of employment as a fire fighter to an HIV positive individual, in spite of a medical determination that having HIV rendered plaintiff unfit for such work).


\textsuperscript{76} Id. § 794(a) (1988 & Supp. V 1993).

disability" who, with or without reasonable accommodation, can perform the essential functions of the desired employment position. 78 Title II of the ADA prohibits state and local governments from discriminating against qualified individuals with disabilities. 79 Title III of the ADA prohibits private businesses, including hospitals, from discriminating against individuals with disabilities in the provision of goods or services, including the provision of privileges. 80

Although the two statutes contain different terms, the elements necessary to establish a prima facie claim under each law are essentially identical. An HIV-infected individual alleging discriminatory treatment must demonstrate that she: (1) has a "handicap" or a "disability" within the applicable statute; 81 (2) was otherwise qualified for the position; 82 and (3) was discriminated against on the basis of the handicap or disability. 83 In 1992, Congress added a provision to section 501 of the Rehabilitation Act providing that the standards of the ADA would apply to all section 501 claims. 84

1. Definitions of Disability Under the ADA—HIV infection is a covered disability under the ADA. To receive protection from the federal statutes, a health care worker must have a "disability," as defined by the relevant statutes. The worker must fit into one of three general definitions: (1) have a physical or mental impairment that substantially limits one or more

78. Id. §§ 12111(8), 12112. The ADA covers private employers with 15 or more employees. Id. § 12111(5)(A).
79. Id. § 12131.
80. Id. § 12182.
major life activities; (2) be regarded as having such an impairment; or (3) have a record of such an impairment. 85

With respect to physical impairment that substantially limits a major life activity, regulations promulgated by the Equal Employment Opportunity Commission (EEOC) and other government agencies define a physical impairment as "[a]ny physiological disorder, or condition . . . affecting one or more of the . . . body systems . . . hemic and lymphatic." 86 Major life activities are defined in EEOC 87 and Department of Justice (DOJ) 88 regulations in a nonexhaustive list as including functions such as caring for oneself, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning, and working. The DOJ concluded that HIV infection substantially limits an infected individual's major life activities such as normal procreation, freedom from the fear of how the infection will affect a fetus, and forming intimate personal relationships. 89 The DOJ Guidance to the ADA regulations repeats this conclusion regarding HIV infection. 90 The EEOC also has concluded that HIV infection substantially limits a major life activity and thus falls within the first prong of the definition of a disability. 91

In claims brought under the Rehabilitation Act, courts have agreed with the premise that individuals with AIDS and asymptomatic HIV infection are individuals with a handicap. 92

85. 29 U.S.C. § 706(8)(B) (Supp. V 1993); 42 U.S.C. § 12102(2) (Supp. V 1993). These three statutory definitions are alternative definitions. Thus, an individual need satisfy only one of the three alternatives to meet the statutory definition. See 29 U.S.C. § 706(8)(B); 42 U.S.C. § 12102(2).

86. 29 C.F.R. § 1630.2(h) (1995) (Health and Human Services Regulations); 45 C.F.R. § 84.3(j)(2)(i)(A) (1994) (EEOC regulations).


88. 28 C.F.R. § 36.104(2) (1994).


90. See Department of Justice Guidance, 28 C.F.R. app. § 36.104 (1995). The Department of Justice inserted the phrase "symptomatic or asymptomatic" before the term "HIV disease" in order to clarify that both symptomatic and asymptomatic HIV infection are covered. See id.

91. See EEOC Interpretive Guidance on Title I of the Americans with Disabilities Act, 29 C.F.R. § 1630.2(j) (1995) ("Other impairments . . . such as HIV infection, are inherently substantially limiting.").

Individuals with AIDS and asymptomatic HIV infection have also been permitted to state claims as individuals with disabilities under the ADA. 93

The third category of disability under the statutes—having a record of an impairment—protects individuals who have been misclassified as HIV-positive in, for example, educational, medical, or employment files. 94 It very much resembles the second category—being regarded as having an impairment—in that it protects a person from discriminatory animus even if the discriminator makes a factual error about whether the person is HIV positive. 95 Also, individuals who do not have AIDS and are not HIV-infected are protected even if they merely fit an employer's stereotype of the type of health care worker who might be HIV-infected. For example, a gay man who is falsely believed to be HIV-infected is nonetheless covered by the ADA if discriminated against in employment because he is perceived to be HIV-infected. 96

2. The Direct Threat and Significant Risk Test—When Congress passed the Civil Rights Restoration Act of 1987, 97 it added a provision to section 504 of the Rehabilitation Act stating that persons with "contagious diseases or infections" are not covered under section 504 if they pose a "direct threat to the health or safety of other individuals." 98 The members of Congress who introduced this provision explained that it was designed to codify the standard set in School Board v. Arline. 99

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94. See 29 C.F.R. § 1630.2(k) (1995). Such individuals could also argue that they fall under the second prong of the definition of disability—protecting those "regarded as" having an impairment.
95. See 29 C.F.R. § 1630.2(g)(3) (1995).
96. State laws often have analogous definitions of "disability," which have been used to protect people perceived to be HIV-infected. See, e.g., Sanchez v. Lagoudakis, 486 N.W.2d 657 (Mich. 1992) (holding that a plaintiff without HIV could still bring suit under the Michigan Handicap Civil Rights Act where her employer's discrimination was motivated by the erroneous perception that plaintiff was HIV-positive).
99. 480 U.S. 273 (1987); see, e.g., 134 CONG. REC. S1739 (daily ed. Mar. 2, 1988) (colloquy statement of Sen. Harkin) ("A person who poses a significant risk of communicating an infectious disease to others in the workplace will not be otherwise qualified for his or her job if reasonable accommodation will not eliminate that risk.")
Arline held that, for individuals who pose a significant health risk to others in the workplace and who have contagious diseases, these individuals are not otherwise qualified for the jobs they seek to hold "if reasonable accommodation will not eliminate that risk." Several members of Congress also explained that the specific reference to contagious infections in the new provision was to reaffirm coverage of people with asymptomatic HIV infection under section 504, unless they posed a direct threat to others.

In Arline, the Supreme Court ruled that four factors must be analyzed to determine whether a person with a contagious disease posed a "significant risk" to others:

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

The risk assessment must also include findings on whether the employer could reasonably accommodate an individual who is infected with a contagious illness. The Supreme Court noted that "courts normally should defer to the reasonable medical judgments of public health officials" when determining whether an individual infected with a contagious illness poses a "significant risk" to others in the workplace.

100. Arline, 480 U.S. at 287 n.16.
102. Arline, 480 U.S. at 288.
104. Arline, 480 U.S. at 288.
105. See id. at 287 n.16. The Supreme Court also noted that "[t]his case does not present, and we do not address, the question whether courts should also defer to the reasonable medical judgments of private physicians on which an employer has relied." Id. at 288 n.18.
Unlike the Rehabilitation Act, which does not provide a statutory definition of "direct threat," the ADA explicitly defines a "direct threat" to mean "a significant risk to the health or safety of others that cannot be eliminated by reasonable accommodation." The legislative history to this section indicates congressional intent to adopt the Arline approach and to establish a strict showing of actual risk. As the House Education and Labor Committee Report explained:

"[F]or a person with a currently contagious disease or infection to constitute a direct threat to the health or safety or [sic] others, the person must pose a significant risk of transmitting the infection to others in the workplace which cannot be eliminated by reasonable accommodation."

The EEOC, following the legislative history, likewise explained that the significant risk test is intended to be substantial. The EEOC's ADA regulations require that the disability pose a significant risk of substantial harm.

**B. Judicial Decisions Restricting Employment of HIV-Infected Health Care Workers**

Courts and agencies deciding cases concerning continued employment of HIV-infected health care providers have assessed the significance of the risk that these workers pose to their patients in varying ways. This variation is, of itself, troubling because the scientific facts concerning the risk of transmission posed by an HIV-infected health care worker using proper infection control procedures do not change. As the following cases demonstrate, stereotype, misunderstanding, and fear dominate the decisions in which courts have restricted the employment of HIV-positive health care workers while adherence to the medical and scientific facts more often prevails in the decisions permitting HIV-positive health care workers to maintain their employment responsibilities.

This Article will address decisions concerning employment, credentialling, and students, with the relevant cases on each topic discussed in chronological order.

1. Employees—The first court case to address the issue of an HIV-infected health care worker upheld a hospital’s decision to fire a health care worker who failed to report his HIV test results to the hospital. In *Leckelt v. Board of Commissioners of Hospital District No. 1*, the United States Court of Appeals for the Fifth Circuit held that the nurse failed to prove he had been fired solely because of a perceived handicap. Rather, the court concluded, the nurse had been fired because he had failed to submit HIV test results in compliance with hospital policy. The court also concluded that the hospital was justified, based on the CDC guidelines in effect at the time, in requiring testing of all health care workers who might pose any risk of exposure to patients.

More recently, the Fifth Circuit held that a hospital did not violate the Rehabilitation Act of 1973 when it reassigned a surgical assistant who was HIV-positive to a purchasing department position with no patient contact. In *Bradley v. University of Texas M.D. Anderson Cancer Center*, the court defined the issue as whether the plaintiff was “otherwise qualified” to continue in his employment as a surgical technician despite his HIV status. The court stated that plaintiff Bradley’s position as a surgical assistant required him to handle sharp instruments and to come in direct contact with open wounds, and the court noted that Bradley had suffered five needle puncture wounds while on the job. The court concluded that while the CDC had characterized the risk of transmitting HIV from an infected health care worker to a

110. 909 F.2d 820 (5th Cir. 1990).
111. *Id.* at 826.
112. *Id.*; cf. Doe by Lavery v. United States Attorney Gen., 814 F. Supp. 844, 848 (N.D. Cal. 1992) (holding that the FBI did not violate the Rehabilitation Act by discontinuing its contract with a physician with AIDS because the physician would not provide information about transmission risks and prevention), rev’d, 62 F.3d 1424 (9th Cir. 1995).
113. *Leckelt*, 909 F.2d at 830. The most recent CDC guidelines, of course, do not call for mandatory testing of all health care workers. In addition, under the ADA, the statutory language that an individual must prove he or she was discriminated against “solely” on the basis of disability was deleted. See 42 U.S.C. § 12112 (Supp. V 1993); H.R. REP. NO. 485, supra note 108, at 85, reprinted in 1990 U.S.C.C.A.N. at 367–68.
114. 3 F.3d 922 (5th Cir. 1993), cert. denied, 114 S. Ct. 1071 (1994).
115. *Id.* at 924.
116. *Id.*
In December 1994, the United States District Court for the Eastern District of Pennsylvania ruled that a hospital's refusal to allow an HIV-positive surgeon to perform surgery did not violate either the Rehabilitation Act or the ADA. In *Scoles v. Mercy Health Corp.*, defendant Mercy Health refused to allow the plaintiff, Dr. Scoles, to perform invasive procedures at any of its hospitals without documentation stating that his patients were aware of his HIV status. In addition, each patient had to consent to having Dr. Scoles perform their procedure. In denying both the ADA and Rehabilitation Act claims, the court found that the plaintiff had failed to establish that he was not a "direct threat" or a "significant risk" to his patients. In so finding, the court dismissed plaintiff's argument that the risk of transmission of HIV was low, and instead held that "knowledge of the probability of HIV transmission from surgeon to patient is very limited." The court was heavily influenced by the fact that "the disease . . . is almost always fatal." Clearly, fear of HIV dominated the court's view of the case.

Finally, the Fourth Circuit recently held that a neurosurgical resident could be fired because he was HIV-positive, effectively dismissing the resident's claims under the Rehabilitation Act and the ADA. *Doe v. University of Maryland Medical System Corp.* involved a neurosurgical resident whose HIV status was discovered in the third year of a six-year residency training. After Dr. Doe refused to transfer to a non-surgical residency, the University of Maryland Medical System Corporation (UMMSC) terminated him from its residency program. In upholding his termination, the Fourth Circuit rejected Dr. Doe's argument that the risk of his transmitting HIV to one of his patients was "so infinitesimal that it cannot, regardless of the degree of harm involved, be considered a significant risk." While the court occasionally stated that it based its

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117. *Id.*
119. *Id.* at 767.
120. *Id.*
121. *Id.* at 772.
122. *Id.*
123. *Id.*
124. 50 F.3d 1261 (4th Cir. 1995).
125. *Id.* at 1262-63.
126. *Id.* at 1266.
holding on a risk of transmission from “exposure-prone procedures,” further analysis of the case makes it clear that the court concluded that Dr. Doe posed a significant health and safety risk because the “risk of percutaneous injury can never be eliminated.” The court never identified a single case of surgeon to patient transmission, however, even in exposure-prone procedures. The Fourth Circuit even went so far as to state that “extra precautions,” over and above the universal precautions already required by the hospital’s medical review board, were inadequate because “some measure of risk will always exist.” Clearly, the court was not evaluating significant risk as required by School Board v. Arline, but rather allowed the hospital to terminate Dr. Doe unless he presented an absolute guarantee against the possibility that he would transmit HIV.

The University Medical System case is particularly disturbing because the hospital rejected a recommendation of its own panel of experts on blood-borne pathogens that Dr. Doe could safely continue a neurosurgical practice as long as he strictly followed proper infection-control procedures. The panel suggested minimal restrictions on Dr. Doe’s ability to perform surgical procedures and did not recommend that he notify his patients of his HIV status prior to performing surgery on them. Such is precisely the type of informed medical judgment which the CDC Guidelines recommend that an employer obtain. The fact that the hospital rejected the expert medical panel’s judgment is disturbing, perhaps dwarfed only by the fact that the court upheld the hospital’s opinion. In effect, the court placed its own judgment ahead of that of medical professionals—in contravention of the Supreme Court’s admonition

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127. Id. at 1267.
128. Id. at 1266 (citing Bradley v. University M.D. Anderson Cancer Ctr., 3 F.3d 922 (5th Cir. 1993), cert. denied, 114 S. Ct. 1071 (1994)).
129. Id. (“Although there may presently be no documented case of surgeon-to-patient transmission, such transmission clearly is possible.”).
130. Id.
131. See supra Part II.A.2.
132. Id. at 1262.
133. Id.
134. CDC Guidelines, supra note 3, at 142.
135. The Fourth Circuit noted that it deferred to the medical judgment of the hospital as a whole, not to that of the medical review panel. When the hospital rejected the medical review panel’s findings, the court then disregarded those findings as well. University Medical Sys., 50 F.3d at 1266.
in *Arline* to defer to reasonable medical judgment. In fact, the court seems to conclude that, as long as the hospital demonstrated no intent to hurt Dr. Doe, the hospital's actions are justified regardless of whether Dr. Doe has a protected disability.

The courts in *Leckelt, Bradley, Scoles,* and *University Medical System* relied heavily on the presumption that, although the risk of transmission of HIV from a health care worker to a patient is quite low, an infected health care worker could still be considered "not qualified" because the potential *outcome* of the risk, *if* it occurred, would be catastrophic. This analysis, however, contradicts the legislative history of the ADA and the EEOC Interpretive Guidance to the ADA which specifically require that an employer prove that an individual's disability will pose a "significant risk of substantial harm." Under the ADA approach, therefore, it would not suffice for one part of the equation, such as the substantial nature of the harm, to be high. Rather, there must be some showing to demonstrate that the first part of the equation, the significance of the risk, is also high.

In addition, these courts have improperly placed the burden of demonstrating an absence of risk on the infected health care worker. In *Scoles,* for example, the court found that Dr. Scoles had failed to establish that he did not pose a significant risk to his patients. Under the ADA, the presumption should be reversed and rest in favor of the health care worker, because a worker will not transmit HIV in most cases. The ADA provides that a person should be protected from adverse employment decisions, unless the employer can demonstrate that the worker presents a significant risk of substantial harm.

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136. School Bd. v. Arline, 480 U.S. 273, 288 (1987). We believe that the Fourth Circuit's conclusion is erroneous because the CDC and *Arline* recommend deference to medical expertise—not to the business-based decisions of administrators and lawyers who may be motivated by fear, among other factors, of lawsuits by patients. *Id.*

137. *University Medical Sys.*, 50 F.3d at 1266 ("[T]here is nothing in the record to indicate that UMMSC acted with anything other than the best interests of its patients and Dr. Doe at heart."). Of course, discriminatory animus is not an element of an ADA or Rehabilitation Act case. *Id.* at 1264–65.


139. 29 C.F.R. app. § 1630.2(r).


141. See 42 U.S.C. § 12113(a) (Supp. V 1993); 29 C.F.R. app. § 1630.2(r).
Other cases under the Rehabilitation Act have resulted in findings in favor of the HIV-infected person. In these cases, the courts have focused on the low probability of HIV transmission to a patient. For example, in 1992, the Department of Health and Human Services (HHS) ordered the termination of federal financial assistance to the Westchester County Medical Center because of the center's continuing discrimination against a pharmacist infected with HIV. The HHS Appeals Board held that the risk of the pharmacist transmitting HIV through the preparation of the pharmaceutical product at issue was "so small as not to be measurable." The agency relied on those studies which found that non-invasive procedures, such as the preparation of pharmaceutical products, pose no risk for the transmission of HIV. The agency carefully examined the pharmacist's job to determine whether he performed any "exposure-prone invasive procedures" as identified by the CDC and found that the tasks performed by the pharmacist fell outside those exposure-prone procedures.

The same type of analysis was used by the court in John Doe v. District of Columbia. The District of Columbia's Fire Department withdrew an offer of employment to the plaintiff because of a medical determination that his HIV-positive status rendered him unfit to work as a fire fighter. The district court found the fire department's conduct discriminatory and ordered the reinstatement of Doe in a fire fighting position, back pay with interest, compensatory damages of $25,000, and attorney fees and court costs.

To reach its decision, the court scrutinized the protective gear and equipment used on the job by fire fighters. Based on expert testimony that the risk of blood-to-blood transmission by a fire fighter on the job was "remote," the court concluded there was "no measurable risk" that Doe would transmit the
virus to other fire fighters or the public during the performance of fire fighting duties. The court gave great deference to the medical judgments of public health officials on the identifiable risk of transmitting the HIV virus while employed in the health care industry. For example, the court relied on CDC statistics which estimate that the risk of a health care worker communicating the HIV virus on the job ranged between 0.3% and 0.5%. The court stated that it was “jointly other courts that have refused to regard the theoretical or remote possibility of transmission of HIV as a basis of excluding HIV-infected persons from employment or educational opportunities.” The same court also held in a subsequent case that a fire fighter infected with Hepatitis B virus (HBV) would not be a “direct threat” when performing mouth-to-mouth resuscitation. For this reason, the employer’s conduct in restricting the fire fighter violated the Rehabilitation Act.

Under the Rehabilitation Act, most courts have appropriately recognized that the severity of the consequences of transmitting HIV is, as a matter of law, insufficient to find an HIV-infected individual unqualified for a job if the risk of transmission through occupational contact is incredibly small. Courts that overemphasize the consequences of transmission of HIV derogate from their statutory duty. As noted in the legislative history of the ADA and the EEOC’s regulations, Congress and the Executive did not expect that “any” risk of a catastrophic outcome sufficed to justify employment discrimination. Accordingly, they provided a test for significant risk. A risk which is considered extremely unlikely to occur should not be termed a “significant risk,” even if the consequences are catastrophic.

2. Credentialing—Hospitals’ credentialing decisions are also subject to antidiscrimination statutes. Two types of credentials are often essential to a physician’s ability to practice medicine: (1) medical staff membership and associated clinical privileges at one or more hospitals, and (2) membership on one

150. Id. at 564.
151. Id. at 569.
153. Id.
or more managed care panels, such as the provider directory of a health maintenance organization (HMO).

Coverage of credentialling decisions exists in a variety of provisions within the Rehabilitation Act and the ADA. Section 504 of the Rehabilitation Act, for example, has been interpreted by courts to apply to all actions taken by a hospital that receives Medicare or Medicaid funding. In addition, Title III of the ADA explicitly prohibits hospitals from discriminating on the basis of disability in granting hospital privileges. Title I of the ADA applies to medical staff members who call themselves independent contractors if such personnel are considered "employees" under Title VI of the Civil Rights Act of 1964.

In Estate of Behringer v. Medical Center at Princeton, a case brought under New Jersey's disability antidiscrimination law, the court upheld a hospital policy prohibiting HIV-infected health care providers from performing "any activity," including surgical procedures, "that creates a risk of transmission of the disease to others." The hospital restricted Dr. Behringer's surgical privileges after it learned that he was diagnosed with AIDS. The court upheld the restrictions based on its findings that patients faced two possible risks if Dr. Behringer operated on them—the risk of becoming infected with HIV and the risk of simple exposure to Dr. Behringer's blood, which may then subject a patient to "months or even years of continued HIV testing." The court's analysis did not consider whether the minimal possibility of actual transmission of HIV to a patient sufficed to cause Dr. Behringer's HIV status to rise to the level of "significant risk" required by the ADA.


160. Id. at 1275 (quoting the hospital's policy). The court decided that "the physician must make reasonable disclosure of the information and those risks which a reasonably prudent patient would consider material." Id. at 1278.

161. Id. at 1257-60.

162. Id. at 1279.

In addition to the antidiscrimination legislation, tort liability exists for the hospital or managed care plan that negligently credentials a physician who is truly hazardous to a patient.\textsuperscript{164} It is unclear whether the risk of tort liability should allow a hospital or managed care panel to require a physician to present evidence of HIV negativity. In contrast to most private sector employment decisions, credentialling decisions generally are made under an explicit set of procedures and criteria, which the credentialling body by contract must follow. Credentialling procedures are designed to ensure that the practitioner furnishes high quality care and has good clinical judgment and technical skills.\textsuperscript{165} According to these standards, the credentialling institution, the hospital in Behringer, is entitled to information about a practitioner's health status before granting or renewing credentials.\textsuperscript{166} This requirement is consistent with hospital infection control procedures that generally require affirmative disclosure of diseases that may be communicable.\textsuperscript{167}

In the context of HIV and AIDS, such disclosure requirements do not seem to bear any rational relationship to the harm which a hospital attempts to avoid. A medical staff seeks to avoid the risk of transmission of HIV—mere status as an HIV-positive practitioner does not necessarily do any damage. A better credentialling standard would focus on the individual's competence, and in particular on the individual's ability to satisfy the technical infection control procedures of the institution or medical plan. As noted above, adherence to infection control procedures is most relevant to the risk of transmission. Exclusion of a practitioner merely based on HIV-status is overprotective because many experts believe that an HIV-positive doctor who adheres to universal precautions and does not perform invasive procedures poses an infinitesimal risk of HIV transmission to their patients. It is also dangerous to ignore the quality of infection control procedures because a

\begin{itemize}
  \item \textsuperscript{164} For a related discussion of tort liability in risk determination and mandatory testing of health care workers, see Mark D. Johnson, \textit{HIV Testing of Health Care Workers: Conflict Between the Common Law and the Centers for Disease Control}, 42 Am. U. L. Rev. 479 (1993).
  \item \textsuperscript{165} See, e.g., Joint Comm'n on Accreditation of Healthcare Organizations, AMH: Accreditation Manual for Hospitals 54 (1993) ("The criteria are designed to assure the medical staff and governing body that patients will receive quality care.").
  \item \textsuperscript{166} \textit{Id.}
  \item \textsuperscript{167} \textit{Id.} at 37–38.
\end{itemize}
health care worker who is infected with HIV, but who has not yet seroconverted, could receive credentials and still pose a risk of infection if he fails to adhere to uniform precautions. The ABA AIDS Coordinating Committee believes that a health care worker should be denied credentials based on HIV-positive status only if the person fails to adhere to appropriate infection controls and universal precautions.

3. Students—In at least one instance, a court limited an HIV-infected student's entry into work in a health care setting. In Doe v. Washington University, the court upheld the university's decision to expel a third-year dental student who was HIV-positive. The court found the decision to be "academic" and not "medical" and thus used a less restrictive standard of review to determine if the university's expulsion of the student was discriminatory. In reviewing the "academic" decision to disenroll the plaintiff, the court stated it would not overturn the university's decision unless it constituted "such a substantial departure from accepted academic norms as to demonstrate that the person or committee responsible did not actually exercise professional judgment." 

The court deferred to the university's decision, in large part because that decision was made after conferring with more than forty professionals, considering medical information, and balancing the individual rights at stake. The court observed: "To permit even an occasional death to occur because of a failure to scrupulously guard the safety of patients would appear to be morally unacceptable and contrary to the fiduciary responsibilities of the medical profession." Although the court declined to address the broader question of whether HIV-positive health care workers should perform invasive procedures, it reached the narrower question of whether the university properly made this "academic" decision. Within this narrower issue, the court upheld the university's conclusion that the student posed a significant risk to patients whom

168. For a definition of "seroconversion," see supra note 24. See also supra note 71 and accompanying text (describing the "window period" between infection and appearance of HIV antibodies).
170. Id. at 630.
171. Id. at 631.
172. Id. (citation omitted).
173. Id. at 634.
174. Id. at 633-34.
175. Id. at 634.
he treated while completing the university’s requirement of 1021 clinical procedure hours.\textsuperscript{176}

The analysis of the \textit{Washington University} court is flawed because it focuses on the severity of harm caused by AIDS, rather than on the insignificant risk of transmission in a medical setting. HIV-positive dentists can safely practice dentistry if they follow proper infection control practices. All dental students should adhere to those same infection control standards because many dental students who are not known to carry a blood disease may nonetheless carry HIV or HBV. Moreover, it appears highly questionable whether the university and the court applied the proper standard of review because the decision to expel the student based on his HIV-positive status could be considered as much medical as academic.

Educational decisions do, however, present distinct issues from most employment contexts because issues of academic standards are present. It may, for example, have been appropriate for the university to refuse enrollment on the grounds that a student cannot adhere to proper infection control procedures in the early periods of her patient care because of her lack of experience. However, no scientific justification exists for automatically barring HIV-infected students from professional schools. Such exclusions violate the antidiscrimination provisions of the Rehabilitation Act and the ADA, as discussed above.

\textbf{C. Mandatory HIV-Testing of Health Care Workers}

No restriction has caused more concern or response within the health care industry than that of mandatory testing of health care workers to determine their HIV status. Courts have upheld mandatory HIV testing for fire fighters, paramedics, and personnel working overseas for the United States Department of State.\textsuperscript{177} In \textit{Anonymous Fireman v. City of Willoughby}, 779 F. Supp. 402 (N.D. Ohio 1991) (upholding a city’s mandatory HIV blood testing policy for fire fighters and paramedics because they are “high-risk government employees”); \textit{Local 1812, American Fed’n of Gov’t Employees v. United States Dep’t of State}, 662 F. Supp. 50, 53-54 (D.D.C. 1987) (holding that the likelihood that the plaintiff union would

\textsuperscript{176} Id. at 633-34.

\textsuperscript{177} E.g., \textit{Anonymous Fireman v. City of Willoughby}, 779 F. Supp. 402 (N.D. Ohio 1991) (upholding a city's mandatory HIV blood testing policy for fire fighters and paramedics because they are “high-risk government employees”); \textit{Local 1812, American Fed’n of Gov’t Employees v. United States Dep’t of State}, 662 F. Supp. 50, 53-54 (D.D.C. 1987) (holding that the likelihood that the plaintiff union would
Willoughby,\textsuperscript{178} for example, the United States District Court for the Northern District of Ohio applied a strict scrutiny standard of review and found that protecting the public from the contraction and transmission of AIDS constituted a compelling governmental interest which justified the intrusion into workers' privacy caused by mandatory testing.\textsuperscript{179}

In *Anonymous Fireman*, the court upheld a city's policy of requiring mandatory HIV testing of fire fighters and paramedics as part of their annual physical examination to determine each worker's "fitness to serve."\textsuperscript{180} The court found mandatory testing reasonable based on the compelling governmental interests in: (1) maintaining a safe work force, (2) protecting "the public from the contraction and transmission of AIDS by fire fighters and paramedics," and (3) "[s]topping the spread of the deadly AIDS epidemic."\textsuperscript{181} Mandatory testing "for the sole purpose of obtaining a baseline to determine whether an employee contracted AIDS on the job and thereby determine the validity of any future worker's compensation claims" was found not to constitute a valid governmental interest.\textsuperscript{182} The court also held that "[m]andatory AIDS testing of employees can be valid only if the group of employees involved is at a high risk of contracting and/or transmitting AIDS to the public."\textsuperscript{183} Accordingly, the court found that the risk of HIV transmission in the performance of duties as a fire fighter or paramedic was "high,"\textsuperscript{184} and upheld the mandatory testing requirement.\textsuperscript{185}

\textsuperscript{179} Id. at 402.
\textsuperscript{180} Id. at 404.
\textsuperscript{181} Id. at 416.
\textsuperscript{182} Id.
\textsuperscript{183} Id.
\textsuperscript{184} Id. at 417.
\textsuperscript{185} The *Anonymous Fireman* court's risk assessment gave great weight to its finding that "universal precautions for fire fighters ... are not very practical because it is difficult to function wearing all of these garments; it is too much paraphernalia [sic] to work efficiently." Id. at 407. Fire fighters and paramedics are, thus, in a higher risk occupation than hospital workers because they work in a noncontrolled environment that renders universal precautions less practical. The court also noted that the dangerous "line of work" performed by fire fighters created an increased risk of transmission of HIV and of being exposed to blood, bodily secretions, and bodily fluids of rescue victims. Id. at 412. The public's interest in preventing, detecting, and treating HIV as soon as possible rendered the testing requirement reasonable in the eyes of the court. Id. at 418.
In *Glover v. Eastern Nebraska Community Office of Retardation*,\(^{186}\) however, the United States Court of Appeals for the Eighth Circuit struck down a policy requiring employees to be tested for HBV and HIV because the policy had "'little, if any, effect on preventing the spread of [AIDS] or in protecting the clients.'"\(^{187}\) The court found that employees working with mentally retarded clients who sometimes bite and scratch did not pose a significant risk of transmitting HIV or HBV.\(^{188}\) The court concluded that such a "'minuscule'" risk of occupational transmission did not justify mandatory testing.\(^{189}\)

We believe the court's approach in *Glover* is correct, while the analysis in *Anonymous Fireman* is mistaken. The ABA's policy provides that "'[e]mployers should not test employees for HIV except in those extraordinarily rare instances in which an employee's HIV status is relevant to his or her job performance,"\(^{190}\) but we are not aware of any occupation, even surgery, for which HIV status is relevant to job performance. HIV simply is not transmitted casually or through occupational contact, even in such circumstances as fire rescue. While fire fighters and other emergency medical workers may practice in circumstances in which they find it impossible to protect themselves using universal precautions, such a situation does not create a significant risk to the public—even if the worker is HIV-positive—because the worker unlikely performs one of the handful of invasive procedures conveying any risk of transmission. Therefore, as no justification exists for mandatory testing of health care workers, no justification exists for such testing of fire fighters or other emergency medical technicians.

### D. Conclusions

A well-reasoned analysis of employment restrictions on HIV-positive health care workers should start by considering whether

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188. *Id.*
189. *Id.* at 463–64.
the techniques and practices of the individual worker create a significant risk to patients. The best evidence to date indicates that one can practice in every health care occupation without posing a risk of HIV transmission to the patient. In settings such as surgery or dentistry, in which the transmission of the virus to a patient is physically possible, following industry-standard infection control techniques such as “universal precautions” eliminates all significant risk of transmission from HIV-positive workers. Moreover, applying industry standards to all workers, whether or not they are known to be HIV-positive, increases safety to patients. Health care providers should impose employment restrictions only on workers unwilling or unable to adhere to industry-standard precautions, and regulations should focus on adherence to proper infection control techniques and practices.

III. HIV-INFECTED HEALTH CARE WORKERS AND THEIR PATIENTS

A. Informed Consent

It is well-established in every jurisdiction that administration of health care, except in emergencies, requires the informed consent of the patient. Some authorities have extended this informed consent doctrine to require that HIV-positive practitioners notify their patients of their status. Some authorities have extended this informed consent doctrine to require that HIV-positive practitioners notify their patients of their status.191 Some authorities have extended this informed consent doctrine to require that HIV-positive practitioners notify their patients of their status.192

192. For the most recent of these articles, see Theodore R. LeBlang, Obligations of HIV-Infected Health Professionals to Inform Patients of Their Serological Status: Evolving Theories of Liability, 27 J. Marshall L. Rev. 317 (1994), which appears as part of a symposium on AIDS law and discusses the rapidly emerging legal area of mandatory HIV status disclosure by health professionals. LeBlang concluded that “[i]t will be particularly important to carefully examine all new developments in state courts, legislatures, and regulatory agencies in an effort to seek additional guidance regarding evolving disclosure obligations in this complex and rapidly changing environment.” Id. at 330. See also Johnson, supra note 164, at 508–34, 541 (reviewing the differences between the CDC Guidelines and “the tort theory of the ‘special relationship’ among [health care workers], medical institutions, and patients,” and arguing that the latter “provides a more efficacious framework for hospitals and [health care workers] to use in resolving” the problems raised by the transmission of HIV in the health care setting); Karen C. Lieberman & Arthur R. Derse, HIV-Positive Health Care Workers and the Obligation to Disclose: Do Patients Have a Right to Know?, 13 J. Legal Med. 333, 355–56 (1992) (arguing that the “doctrines of informed
Several courts have allowed patients to sue their doctors (especially surgeons) for failure to notify them of the doctor’s HIV-positive status based on an informed consent theory. In *Estate of Behringer v. Medical Center at Princeton*, the court observed that a reasonably prudent patient would find the risk of exposure to the HIV virus from his physician “material” to the decision of whether to have the invasive procedure performed. After weighing the rights of the patient to know the risks associated with the invasive procedure against the surgeon’s “individual right to perform an invasive procedure as a part of the practice of his profession,” the court held that the risks created a “reasonable probability of substantial harm” to warrant the informed consent of the patient.

Although the court held in favor of the patient’s right to informed consent, it also found the hospital and the laboratory director negligent for failing to take reasonable measures to protect the confidentiality of an employee/patient who has been diagnosed with AIDS. The hospital’s policies for maintaining the privacy of medical records included placing HIV test results on the chart while simultaneously allowing the entire medical center to have access to the chart. The court noted that acceptable precautions could include securing the chart by limiting access to designated people with a “bona-fide need to know” or by excising portions of the record that contain HIV-related factors. It is difficult to understand how these confidentiality considerations could be reconciled with the informed consent requirement that the *Behringer* court imposed.

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195. *Id.* at 1283.

196. *Id.*

197. *Id.* at 1273–74.

198. *Id.* at 1271.

199. *Id.* at 1273.
In January 1992, a panel of judges in Pennsylvania allowed a lawsuit against two hospitals. One of the claims in that case charged the hospitals with failing to inform patients of the HIV-positive status of an obstetrician-gynecologist resident who had performed or assisted in invasive operative procedures on 442 patients. The claimants alleged that the hospitals' duty to provide patients with information that a reasonable patient would require to make an informed decision includes information concerning the HIV-positive status of the providers. Likewise, in *Scoles v. Mercy Health Corp.*, Dr. Scoles' hospital initially required that he produce documentation indicating that each patient had given her informed consent with full knowledge of Dr. Scoles' HIV status. The hospital later reduced that requirement slightly to require that Dr. Scoles "inform his patients of his HIV status prior to any invasive procedure." When Dr. Scoles sued the hospital under both the ADA and the Rehabilitation Act for restricting his staff privileges, the court denied the doctor's claim and found for the hospital.

More recently, two Maryland patients sued their surgeon's estate and his hospital more than one year after their operations. The patients learned, after the surgeon's death, that the doctor had been HIV-positive and knew as much at the time of their operations. Ruling for the plaintiffs, the Maryland Court of Appeals held that a physician's duty of care could encompass disclosure of his HIV infection, even though the probability of HIV transmission is extremely low. In different contexts, courts have imposed a duty of disclosure on health care workers, particularly surgeons, who know they are HIV-positive and yet continue to operate.

201. *Id.* at 17.
202. *Id.* at 3–4.
203. *Id.*
205. *Id.* at 767.
206. *Id.*
207. *Id.* at 772.
209. *Id.* at 339.
210. See also Doe v. United States Attorney Gen., 34 F.3d 781 (9th Cir. 1994), rev'd, 62 F.3d 1424 (9th Cir. 1995). This case involved a contract between the United States government and a health facility for performing physical examinations on FBI agents. *Id.* at 782. The FBI stopped sending agents to this hospital after the hospital
On the issue of patient notification, the CDC has taken a middle position between mandating notification and leaving the matter to the discretion of the health care provider. The CDC Guidelines do not generally require notifying patients, but they recommend that health care workers performing exposure-prone procedures notify patients of their HIV status. The CDC Guidelines provide that HIV-infected physicians should not perform "exposure-prone invasive procedures" without the authority of a medical review panel and the informed consent of the patient. Similarly, the American Medical Association (AMA) maintains that HIV-infected practitioners have an ethical obligation to warn their patients of the risks of transmission, and requires doctors to obtain the patient’s informed consent before performing invasive procedures. Although the great majority of state health department guidelines have rejected routine notification of prospective patients, a few have required notification prior to "exposure-prone procedures."

After analyzing these competing perspectives, we believe that using the "informed consent" doctrine to require disclosure of a surgeon's HIV status is mistaken. Requiring practitioners with HIV to disclose their status to patients goes beyond the ordinary requirements of informed consent in several respects. First, informed consent has never required an affirmative disclosure by the physician of all factors in her background that might involve risk to the patient. Indeed, the common

refused to give it information about a rumor that one of the hospital's doctors was HIV-positive. Id. at 783. While the court enjoined the FBI from breaking its contract with the facility, the court held that the facility's refusal to provide adequate information about the risk of HIV transmission precluded Dr. Doe from recovering damages. Id. at 786. Specifically, the court held that, under § 501 of the Rehabilitation Act, the question whether a person with an infectious disease is "otherwise qualified" requires an "individualized inquiry into the nature, duration, and severity of the risk [of HIV transmission], as well as the probabilities" of transmitting the disease. Id. at 784 (citing School Bd. v. Arline, 480 U.S. 273, 287–88 (1987)) (internal quotation marks omitted). By refusing to provide information, Dr. Doe blocked this inquiry and thus could not recover damages for his claim of discrimination. Id. at 786.

211. CDC Guidelines, supra note 3, at 5.
212. Gostin, supra note 71, at 304.
214. Under the common law, informed consent has been read to require disclosure of either: all information a reasonable practitioner would disclose under the circumstances, see, e.g., Mitchell v. Robinson, 334 S.W.2d 11, 19 (Mo. 1960) (holding that doctors owed a duty to inform the patient of possible, serious collateral hazards of a treatment where there existed a rather high incidence of such hazards), Natanson v.
law notions of informed consent do not require disclosure of facts about how well-rested the practitioner is, his history of alcohol intake, his emotional health, or his medical school grades. Such factors probably pose a more statistically significant risk to the patient's health than a surgeon's HIV status. Also, informed consent has never served as a vehicle to pry into the physician's otherwise private affairs.

Rather than requiring disclosure about the practitioner, informed consent requires disclosure about the proposed procedure and its significant risks. Medical negligence provides the legal redress if the practitioner negligently performs a procedure that the patient chose after informed consent. A negligence standard is more appropriate in this area than one of informed consent because it allows recovery when a legal wrong occurs independent of the fact that a health care worker was HIV-positive, such as when the practitioner has fraudulently misrepresented his health status.

Kline, 350 P.2d 1093, 1105 (Kan. 1960) (holding that a physician must disclose information that a reasonable medical practitioner would disclose under the same or similar circumstances in order to determine whether a patient has given "intelligent consent" to a proposed form of treatment); or all information a reasonable person in the patient's circumstances would find relevant to deciding whether to undergo treatment, see, e.g., Cobbs v. Grant, 502 P.2d 1, 9–10 (Cal. 1972) (holding that the physician's overall duty to the patient includes a "duty of reasonable disclosure of the available choices with respect to proposed therapy and of the dangers inherently and potentially involved"). While the informed consent doctrine recently was extended to require disclosure of a doctor's economic interest in his patient's organs or tissues, see, e.g., Moore v. Regents of Univ. of California, 793 P.2d 479, 483 (concluding that "a physician must disclose personal interests unrelated to the patient's health, whether research or economic, that may affect the physician's judgment"), cert. denied, 499 U.S. 936 (1991), it has never been extended to include a doctor's personal qualifications to perform the procedure at issue.

215. Id.

216. Id; see also Mary K. Logan, Who's Afraid of Whom? Courts Require HIV-Infected Doctors to Obtain Informed Consent of Patients, 44 DEPAUL L. REV. 483, 504–05 (noting that, given the recent judicial expansion of informed consent doctrine, "[d]isclosure also may be required of those with histories of alcoholism, drug abuse, and schizophrenic episodes, or those with cataracts or heart disease").

217. See, e.g., New York County Jury Awards Man $500,000 in Precedent-Setting Case Over 'AIDS-Phobia', AIDS POL'Y & L., Mar. 4, 1994, at 1, 7–8 (describing a case in which a Jehovah's Witness received damages for an HIV-positive blood transfusion because of the hospital's violation of the patient's religious beliefs and because of the patient's fear of getting AIDS).

218. In some cases courts have allowed patients to proceed with lawsuits against surgeons who allegedly gave misleading answers to direct questions about their health. See Kerins v. Hartley, 21 Cal. Rptr. 2d 621 (Cal. Ct. App.) (reversing summary judgment for defendant physician, allowing patient to try to prove that the physician's failure to reveal that he suffered symptoms related to HIV when asked about his health resulted in compensable damages), transferred with directions to vacate and reconsider, 868 P.2d
In addition, the consequences of requiring patient notification can be devastating for an employee. Patient notification would breach the confidential nature of the employee's HIV status. Once disclosed, knowledge of the HIV status often spreads quickly, ruining the worker's career. Moreover, studies suggest that the majority of patients do not want to be treated by HIV-infected providers. Further, those infected with HIV may face discrimination for nonoccupationally related reasons. Thus, any balancing that considers the health care professional's personal rights should be resolved in favor of voluntary disclosure, rather than mandatory patient notification.

Finally, notification of patients is unnecessary in light of the CDC's findings that the risk of HIV transmission in the health care setting is infinitesimal. Testimony before the ABA AIDS Coordinating Committee suggests that if a review panel has authorized an infected health care worker's performance of "exposure-prone invasive procedures," there is no public health need to disclose the fact of HIV infection to the worker's patients. Proper infection control procedures should allow HIV-positive health care workers to continue to perform their jobs safely and make mandatory disclosure unnecessary.

B. Post-Treatment Disclosure

In situations where informed consent is not possible because the practitioner did not know she was HIV-positive at the time, it has been suggested that health care providers have a duty to inform patients of their HIV status after the treatment is

906 (Cal. 1994). This decision was ultimately reversed. Kerins v. Hartley, 868 P.2d 906 (Cal. 1994). See also K.A.C. v. Benson, 527 N.W.2d 553, 564 (Minn. 1995) (holding that the question as to whether consent to a medical examination was induced by the doctor's misrepresentation about his health should go to the jury).

219. Barbara Gerbert et al., Physicians and Acquired Immunodeficiency Syndrome: What Patients Think About Acquired Immunodeficiency Virus in Medical Practice, 262 JAMA 1962, 1971 (1989) (citing research results which indicate that 60% of those surveyed do not believe that HIV-infected surgeons should continue to work).

220. See generally Sullivan, AIDS Law, supra note 11, at 276 (citing a report by the National Commission on AIDS which suggests that HIV cannot be understood "outside the context of racism, homophobia, poverty, and unemployment").

221. See supra notes 32-34 and accompanying text.

222. ABA, Chicago Hearing, supra note 12, at 18.
Access to one dentist’s records was granted under the “inherent authority [of public health officials] to protect the public health and study the epidemiological nature of an epidemic of HIV.” No informed consent rationale applied, but the court found a need for disclosure for public health reasons. In granting access, the court decided that the confidentiality rules which govern public health officials would protect the patient’s and the dentist’s privacy.

But some courts have found that the need for post-treatment disclosure supersedes any confidentiality interest that the doctor or prior patients may have in concealing their HIV status. In *Doe v. Hershey Medical Center*, the Pennsylvania Superior Court allowed two hospitals to disclose to affected patients and certain colleagues that a resident physician who participated in their surgical procedures was HIV-positive. The patients were offered the opportunity for counseling and testing by the hospitals. Viewing the risk of HIV transmission to be “high,” the court concluded that the affected patients’ right to know the risks attendant to the physician’s HIV status outweighed the physician’s right to confidentiality with respect to their medical records.

In addition to post-treatment disclosure, some states have enacted statutes allowing access to HIV information, and even mandatory testing of an exposing individual, following occupational exposure to blood or other bodily fluids that may transmit HIV. Such occupational exposures commonly take the form of exposure to the blood of a patient, although the rarer situation of a patient’s exposure to the blood of a health care worker may also be regulated. Of the state laws on this topic, a few states require that a “significant exposure” occur.

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223. See, e.g., infra notes 227–30.
225. Id. at 905.
226. Id.
228. Id. at 1302.
229. Although the court allowed disclosure of the possible transmission, it never permitted Dr. Doe’s name to be revealed to the public. Id. at 1301.
230. Id. at 1302.
232. CAL. HEALTH & SAFETY CODE § 199.65 (requiring notification of patient’s HIV infection status when there is significant exposure); CONN. GEN. STAT. ANN. § 19a-
to trigger the state mandate of testing or disclosure.\textsuperscript{233}

We believe that post-notification to patients about possible exposure to HIV from a health care provider is warranted only in certain limited circumstances.\textsuperscript{234} Such circumstances would arise where transmission from the provider to at least one other patient has occurred, where the patient to be notified has had a substantial exposure to the provider's blood or body fluids, or where the medical care was accompanied by a significant violation of infection control practices such as those in the CDC's universal precautions, which thus created a significant risk of a substantial exposure.

Similarly, we believe that state laws mandating testing of an exposing person or requiring disclosure of that person's HIV status go too far. Especially where no significant exposure has occurred and HIV transmission is consequently unlikely, revealing an individual's HIV information or testing the blood of an individual without consent outweighs any benefit to the potentially infected person. A voluntary HIV test of the exposed individual would yield most of the information gained from testing or disclosing HIV information from the exposing individual. Moreover, medicine cannot do anything to prevent HIV infection even if one knows whether the fluid came from someone who was HIV-positive.

Finally, voluntary educational mechanisms have proven highly effective for encouraging the exposing person to consent to testing and for informing the exposed individual of the attendant risks. For these reasons, we do not believe that

\textsuperscript{233} For example, it is possible that spilling blood on intact skin would not be a significant exposure, whereas a massive spray of blood into mucous membranes or cut skin could be biologically significant (i.e., an exposure to bodily fluids in which transmission of HIV is at least biologically possible).

\textsuperscript{234} Where a patient was infected with HIV from a source other than a health care provider, no privacy or confidentiality issues are raised and the provider is then clearly under a duty to inform the patient of the risk that the patient was infected with HIV. See Reisner v. Regents of Univ. of California, 37 Cal. Rptr. 2d 518 (Cal. Ct. App. 1995) (holding that a doctor had a duty to warn a girl that her blood transfusion contained HIV-positive blood in a suit raised by a later boyfriend of the girl who had contracted HIV from her through sexual contact); DiMarco v. Lynch Homes-Chester County, 583 A.2d. 422 (Pa. 1990) (holding that a physician owes a duty of care to third parties where the physician fails properly to advise the patient and the patient, relying on the advice, spreads a communicable disease to the third party).
mandatory testing or forced disclosure of the exposing individual is justified.

C. AIDS Phobia Cases in the Health Care Setting.

The so-called "AIDS phobia" litigation also raises the issues of informed consent and disclosure by health care workers with HIV. "AIDS phobia" litigation is conducted within the framework of a body of tort law in most jurisdictions relating to the recoverability of emotional distress damages for risk of future disease. Such cases have allowed plaintiffs to recover damages for either the plaintiff's present risk of contracting the disease in the future or for the plaintiff's mental distress and anxiety about the possibility of the future ailment. The rules for deciding such cases are not uniform among all jurisdictions, with some requiring an actual exposure to a disease agent, while others allow a recovery for a statistically significant degree of risk.

In "AIDS phobia" litigation, individuals who may have been exposed to HIV have sued based on their fear of exposure or their risk of contracting the disease. Courts have rejected such claims in a majority of these cases, requiring that plaintiffs show actual exposure or transmission of HIV for recovery. In


236. See Logan, supra note 216, at 494–96. See also supra note 235 and infra note 241

237. See, e.g., Jones v. United R.R., 202 P. 919 (Cal. Dist. Ct. App. 1921) (allowing jury instructions on damages for a reasonable apprehension of future disability or deformity resulting from injuries sustained by plaintiff in cable car accident). But see Doe v. Johnson, 817 F. Supp. 1382, 1393–94 (W.D. Mich. 1993) (holding that allowing an AIDS phobia tort without demonstration of actual exposure or significant risk is impractical and would result in an additional cause of action in every case of adultery because the spread of AIDS provides a risk, however small, of contracting the disease any time one "deviate[s] from the marital nest").

238. See infra notes 240–43.

239. E.g., Marchica, 31 F.3d at 1202–04.

some cases, courts have required a showing of actual exposure plus a likelihood of developing AIDS before allowing recovery for emotional distress damages.\textsuperscript{241} However, a few cases have allowed emotional distress recoveries where the risk of HIV transmission was significant, for example where sexual partners had unprotected sex with multiple partners.\textsuperscript{242}

In the health care environment, a number of courts have allowed recovery in instances where plaintiffs have not tested positive for HIV but where they also had alleged negligent and significant exposure to HIV\textsuperscript{243} or negligent breach of industry

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\item Kerins v. Hartley, 33 Cal. Rptr. 2d 172, 178 (Cal. Ct. App.) (holding on remand that a statistically insignificant chance that plaintiff contracted AIDS from surgeon precluded recovery of emotional distress damages for fear of AIDS), transferred with directions to vacate and reconsider, 868 P.2d 906 (Cal. 1994); Barrett v. Danbury Hosp., 654 A.2d 748, 749 (Conn. 1995) (involving a patient exposed to blood during rectal examination); Brzoska v. Olson, No. 284, 1995 Del. LEXIS 339, at *20 (Del. Sept. 8, 1995) (denying recovery for fear of contracting AIDS from a dentist who later died of AIDS absent a showing of any physical harm); Griffin v. American Red Cross, Civil Action No. 93-5924, 1994 U.S. Dist. LEXIS 16,838, at *4 (E.D. Pa. 1994) (denying recovery to plaintiff for "fear of AIDS" were plaintiff’s fear only lasted 24 hours); Hare v. State, 570 N.Y.S.2d 125, 126 (N.Y. App. Div. 1991) (providing no recovery for hospital employee bitten by inmate where there was no proof that inmate was HIV-infected and employee was HIV-negative); Doe v. Doe, 519 N.Y.S.2d 595, 598 (N.Y. Sup. Ct. 1987) (denying recovery to the wife in a divorce action where she made no allegation that her husband was HIV-positive and that she had contracted HIV); Lubowitz v. Albert Einstein Medical Ctr., 623 A.2d 3, 5 (Pa. 1993) (denying recovery where plaintiff-wife in an in vitro program was told that the blood she received was HIV-positive, although the blood proved to be HIV-negative after additional testing); Carroll v. Sisters of St. Francis Health Servs., Inc., 868 S.W.2d 585, 594 (Tenn. 1993) (holding that a plaintiff could have no recovery for fear of exposure to AIDS because she was unable to show actual exposure to HIV and tested HIV-negative after suffering a needle-stick in hospital); Funeral Servs. by Gregory, Inc. v. Bluefield Community Hosp., 413 S.E.2d 79, 85 (W. Va. 1991) (rejecting a mortician’s claim of fear of HIV transmission where exposure to HIV was not alleged).

\textsuperscript{241} See Marchica v. Long Island R.R., 31 F.3d 1197, 1204–06 (2d Cir. 1994) (surveying the "fear-of-developing-AIDS cases"), cert. denied, 115 S. Ct. 727 (1995); Harper v. Illinois Cent. Gulf R.R., 808 F.2d 1139 (5th Cir. 1987) (per curiam) (holding that the law does not recognize recovery for emotional distress resulting from fear of an unproven event); Petri v. Bank of N.Y., 582 N.Y.S.2d 608 (N.Y. Sup. Ct. 1992) (holding that recovery for exposure to HIV without transmission would be based on uncertainty as the specter of becoming infected and developing AIDS is too remote).

\textsuperscript{242} Cf. Doe v. Johnson, 817 F. Supp. 1382 (W.D. Mich. 1993) (holding that evidence of high-risk sexual activity may be relevant to a cause of action for wrongful transmission); Neal v. Neal, 873 P.2d 881 (Idaho Ct. App. 1993) (involving a wife's claim against adulterous husband and holding that there exists no actionable right to exclusive sexual intercourse with a spouse and that wife's fear of contracting sexually transmitted diseases was not actionable absent showing that she was actually exposed to these diseases).

\textsuperscript{243} See, e.g., Mariott v. Sedco Forex Int'l Resources, Ltd., 827 F. Supp. 59 (D. Mass. 1993) (involving a claim by oil rig worker who was inoculated with a vaccine
standard precautions regarding HIV transmission. For example, a New York court has held that the risk of infection was significant where there existed circumstantial evidence, such as a discarded hypodermic needle, of exposure to HIV infection. Cases such as this one, which involve a significant and unnecessary exposure to an HIV source, contrast sharply with situations in which HIV-positive providers use industry standard precautions which create no significant risk to the patient. These cases appear to follow the majority rule outside the health care setting, requiring some negligence or significant exposure before holding a health care provider liable for emotional distress caused by a patient's fear of contracting AIDS.

A few cases, however, have allowed patients to recover damages for emotional distress where the patient learned after surgery that the surgeon was HIV-positive, even though there had been no actual exposure to the blood of the surgeon and standard industry precautions had been followed. The most notable example is *Faya v. Almaraz*, a Maryland decision in which the court allowed plaintiffs to sue for their fear of contracting HIV even though they "did not identify any actual channel of transmission of the AIDS virus." In allowing the case to proceed, the court mentioned the Acer situation as a factor establishing that it was objectively reasonable for the plaintiffs to fear HIV contaminated by HIV and holding that the worker "exhibited compensable emotional damage under the Jones Act and the general maritime law for his fear of contracting AIDS"; Johnson v. West Virginia Univ. Hosps., Inc., 413 S.E.2d 889 (W. Va. 1991) (allowing a police officer who was bitten by an HIV-infected patient to recover for emotional distress even though police officer subsequently tested HIV-negative); *Corrections Officer Can Sue Hospital Over AIDS Exposure, Lower Court Rules*, 3 Health L. Rep. (BNA) 365 (Mar. 4, 1994) (describing a case from the New York Supreme Court in Warren County in which the court allowed a corrections officer to file suit against a hospital where he was sprayed with blood from an AIDS patient).

244. *See*, e.g., K.A.C. v. Benson, Nos. C6-93-1203, C5-93-1306, C4-93-1328, 1993 WL 515825 (Minn. Ct. App. Dec. 14, 1993) (involving a situation in which a surgeon allegedly operated on patients while having open sores on his hands and not using proper barrier techniques, even after a warning from the State Board of Medical Examiners), rev’d, 527 N.W.2d 553 (Minn. 1995).


248. 620 A.2d 327 (Md. 1993).

249. *Id.* at 336–37.
transmission in a health care setting. However, the Maryland court overlooked a crucial distinction from the Acer case; Dr. Acer had used infection control procedures that had been manifestly below the industry standard. By contrast, the surgeon in Faya followed normal industry precautions which make the risk of HIV transmission from an HIV-infected surgeon to his patient immeasurably low.

We believe that the Maryland court erred in upholding the reasonableness of emotional distress damages in circumstances where the risk of transmission is as low as that which exists in the case of a properly practicing surgeon. Emotional distress damages should be recoverable based upon a showing that infection control procedures were substandard. Courts agree that a patient's fear must be reasonable before allowing recovery on an AIDS phobia tort. Given the low risk of contracting HIV from a medical professional who follows proper infection control procedures, a person's fear that she has contracted AIDS from an HIV-positive doctor is not objectively reasonable unless she identifies a specific route of infection or offers evidence that the health care provider did not follow proper infection control procedures.

In contrast to the opinion in Faya, we believe that the Delaware Supreme Court recently suggested a better approach in Brzoska v. Olson. It held that a patient cannot recover for fear of contracting AIDS from a dentist who later died of AIDS,

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250. Id.
251. CDC, Transmission of HIV Infection—Florida, supra note 1, at 27.
252. Faya, 620 A.2d at 336.
253. See, e.g., Burk v. Sage Prods., Inc., 747 F. Supp. 285, 287 (E.D. Pa. 1990) (stating that "Pennsylvania case law supports the position that plaintiff must show exposure to the AIDS virus before he can recover"); Hare v. State, 570 N.Y.S.2d 125 (N.Y. App. Div. 1991) (denying a claim of an x-ray technician who was bitten by a prison inmate though there existed no evidence that the inmate had AIDS); Ordway v. County of Suffolk, 583 N.Y.S.2d 1014, 1016–17 (N.Y. Sup. Ct. 1992) (denying recovery against surgeon, with "no broken glove, pierced skin, patient bite, etc., which distinguishes the operations in question from any other"); McBarnette v. Feldman, 582 N.Y.S.2d 900, 907–08 (N.Y. Sup. Ct. 1992) (declining certification of a class action by patients against the estate of an HIV-infected dentist because of differences among the patients, including possible differences in practice of infection control procedures); Doe v. Doe, 519 N.Y.S.2d 595 (N.Y. Sup. Ct. 1987) (denying claim of wife against adulterous husband where she could not establish exposure to AIDS); Funeral Servs. by Gregory, Inc. v. Bluefield Community Hosp., 413 S.E.2d 79, 84 (W. Va. 1991) (concluding that if "a suit for damages is based solely on the plaintiff's fear of contracting AIDS, but there is no evidence of an actual exposure to the virus, the fear is unreasonable and this [c]ourt will not recognize a legally compensable injury").
absent a reasonable fear of exposure to AIDS.\textsuperscript{255} However, the court specifically held that a fear of AIDS is reasonable only if the patient has had an actual exposure to HIV.

It is unreasonable for a person to fear infection when that person has not been exposed to a disease. . . .

AIDS is a disease that spawns widespread public misperception based upon the dearth of knowledge concerning HIV transmission. Indeed, plaintiffs rely upon the degree of public misperception about AIDS to support their claim that their fear was reasonable. To accept this argument is to contribute to the phobia. Were we to recognize a claim for the fear of contracting AIDS based upon a mere allegation that one may have been exposed to HIV, totally unsupported by any medical evidence or factual proof, we would open a Pandora's Box of "AIDS-phobia" claims by individuals whose ignorance, unreasonable suspicion or general paranoia cause them apprehension over the slightest of contact with HIV-infected individuals or objects. . . .

In sum, we find that, without actual exposure to HIV, the risk of its transmission is so minute that any fear of contracting AIDS is per se unreasonable.\textsuperscript{256}

Accordingly, a surgeon or dentist with HIV should face the risk of damages for emotional distress only when that medical professional did something professionally negligent, such as performing a medical procedure without following proper infection control procedures, and should not face the risk of such damages merely as a result of his status of being HIV-positive.

\textbf{D. Advertising of Negative HIV Test Results}

Some health care workers, particularly dentists, advertise the fact that they have tested HIV-negative.\textsuperscript{257} Such advertisements

\textsuperscript{255} Id.
\textsuperscript{256} Id.
\textsuperscript{257} See, e.g., AIDS Tests for Health Caregivers?, BOSTON GLOBE, Aug. 10, 1992, at 27 (describing a telephone listing service called "AIDS Negative Professionals Inc.," that charges health care workers up to $99 a year to be listed as HIV-negative).
fuel public fear and misunderstanding with respect to HIV and the possibility of its transmission in the health care setting; they also lead to further discrimination against persons with HIV. Even if an advertisement refers more precisely to “negative HIV test results,” rather than to “negative HIV status,” the object of the advertisement seems to remain the same: to convince prospective patients that the health care worker is free of HIV infection.

Although an advertisement may be accurate as of the time of the HIV test, the fact may later prove false because the test only provides information regarding an earlier moment in time, due to the “window period” and subsequent risks of exposure. In 1991, the Council on Ethics, Bylaws and Judicial Affairs of the American Medical Association adopted a code of ethics provision stating that advertisement to the public of HIV-negative test results without conveying additional information which clarified the scientific significance of this fact is a misleading omission.

The ABA AIDS Coordinating Committee does not believe that these advertisements provide a significant service to patients and, for that reason, opposes the practice of advertising negative HIV status.

E. Refusal to Treat Patients Who Refuse to Disclose Their HIV Status to Health Care Professionals

Some physicians and facilities have declined to treat patients who would not disclose their HIV status. This has resulted in several recoveries by patients against facilities for discriminatory refusal to treat patients with HIV. In addition, a statute that would have allowed a physician to test a “high-risk” patient for HIV without the patient’s consent has been declared unconstitutional.

258. See supra note 71 (discussing definition of “window period”).
259. ABA, Chicago Hearing, supra note 12, at 125.
Questions about a patient’s HIV status are an appropriate part of a medical history work-up, but any patient should be entitled to refuse to disclose this information in the interests of personal privacy and because of the risk of discrimination including the risk of a discriminatory refusal to receive medical treatment. Practitioners should take the same “universal precautions” whether or not the patient is known to be HIV-positive because many patients who are HIV-positive are not aware of their infection.263

The ABA has adopted a policy that health care providers should not refuse to treat or limit treatment because of an individual’s actual or perceived HIV status, and an HIV test should not be routinely required as a condition for health care treatment.264 Several other authorities support the ABA’s policy statement on this point. A federal court recently issued the first decision in a suit brought by the United States Department of Justice (DOJ) under the Americans With Disabilities Act (ADA).265 The court granted summary judgment against a Louisiana dentist who refused to treat patients with AIDS and found that such a refusal to treat violated the ADA.266 Since it is unlawful to refuse to treat an HIV-positive person under the ADA, it should also be unlawful to require disclosure of HIV status prior to treatment because the fact of HIV infection does not lead necessarily to a risk of transmission. In addition, the ABA has taken the position that HIV testing should be conducted only after informed consent.267 We believe that consent procured under the veiled threat that health care treatment will be withheld constitutes coerced consent and,

263. *But see Court Rejects Discrimination in Use of Safety Precautions with HIV Patient, 2 Health L. Rep. (BNA) 47 (Dec. 9, 1993) (describing a case from New York in which the court “ruled” that an “employer whose workers took universal precautions to protect themselves while performing dental work on an HIV-positive patient did not unlawfully discriminate against the patient”).*


266. *Id. at *33; see also D.B. v. Bloom, 896 F. Supp. 166 (D.N.J. 1995) (entering a default judgment against a defendant dentist and finding the dentist in violation of the ADA for failing to treat a plaintiff solely because of the plaintiff’s HIV-positive status); Woolfolk v. Duncan, 872 F. Supp. 1381 (E.D. Pa. 1995) (denying summary judgment to defendant dentist who refused to treat HIV-positive patient, and allowing plaintiff to proceed with claim of violation of both the ADA and the Rehabilitation Act); cf. Mary A. Crossley, *Of Diagnosis and Discrimination,* 93 COLUM. L. REV. 1581, 1602 (1993) (noting that the prohibition on discriminatory refusal to provide medical treatment to people because of HIV infection includes such refusals to treat infants).*

therefore, is not consistent with the requirement of voluntary, informed consent.\textsuperscript{268}

\textbf{F. Conclusions}

Informed consent is a legal concept which requires health care workers to disclose to patients medically relevant information concerning the risks of any procedure that the patient may undertake. Personal facts about a health care provider have never been included among the types of information which the law requires a health care worker to disclose—even where those facts, such as lack of sleep or personal trauma, may indeed affect the patient’s care. Given the infinitesimal risk of HIV transmission in the health care setting, the HIV status of a health care worker does not constitute the type of information that a health care worker should be required to disclose to a patient either before or after performing a noninvasive medical procedure.

\textbf{IV. INSURANCE}

As the foregoing cases illustrate, statutes provide and courts recognize that discrimination against HIV-infected health care workers in their employment is unlawful.\textsuperscript{269} However, health care workers (and workers generally) continue to face discrimination in their ability to obtain and enjoy some fringe benefits of employment—specifically, medical and other insurance coverage—as a result of HIV infection. In late 1994, the Chicago director of the EEOC noted that one-fourth of the suits filed by the EEOC in federal courts under the ADA were filed on behalf of AIDS patients fighting caps on their health insurance.\textsuperscript{270}

\begin{footnotesize}
\begin{enumerate}
\item \textsuperscript{268} \textit{See supra} Part III.A.
\item \textsuperscript{269} \textit{See supra} Part II.
\item \textsuperscript{270} \textit{See EEOC Attorney Says Many ADA Charges Filed with Agency Are Reasonable Claims}, 1994 Daily Lab. Rep. (BNA) 232 (Dec. 6, 1994) (stating that the EEOC has filed 41 ADA suits in federal courts, 25\% of which have involved AIDS patients fighting health insurance caps, and that the EEOC has not yet lost an ADA case).
\end{enumerate}
\end{footnotesize}
Interestingly, the insurance industry generally has recognized the low risk of HIV transmission in the health care workplace and has not significantly altered professional malpractice standards because of the AIDS epidemic. Avoiding a fear-driven approach, as these insurers have done, is wise. In the future, an approach not driven by fear also should be legally required, because recent court decisions have extended the ADA’s antidiscrimination mandate to include insurance companies and other providers of benefit plans. The final Part of this Article will review these developments in the insurance industry and the governing law.

A. Insurance Against Contracting HIV Infection on the Job

In the early 1990s, some insurers began selling policies that provide benefits to workers who become infected with HIV in the course of their occupation. At least one commentator viewed this development as an indication that insurers believe that the risk of insuring health care workers is relatively low. Some policies were designed to pay only if the infection was determined to have resulted from a job-related injury, such as an accidental needle-stick injury. Other policies were designed to provide coverage even without proof that the insured became infected on the job. In either case, the advantage these policies offered was that the insured would be entitled to benefits before incurring reimbursable medical expenses, as required by a medical expense policy, or before becoming disabled, as required by a disability policy.

Many of these policies provided for a lump-sum benefit. For example, Harvard University obtained a policy that paid health care workers $100,000 if they became infected with HIV at the workplace. The American Medical Association offered a similar plan, offering up to $500,000 for practicing doctors and 

272. See Russell, supra note 271, at A16.
273. Id.
274. See id.
lower amounts for residents and medical students. This type of coverage met with both praise and resistance. One commentator noted that the availability of such coverage would enable infected health care workers to forego conducting certain procedures that may be perceived as presenting a higher risk of transmission, and also may encourage noninfected workers to seek routine testing. Other commentators worried that offering insurance against HIV was not economically sound. For example, Connecticut Insurance Commissioner Robert F. Googins warned insurance companies that he would not approve such policies. He said that insurance which is not based on economic loss is “fraught with abuse.”

At least one group of health care workers collectively bargained for special disability insurance for HIV infection. Coverage in that case was limited to infection from workplace incidents, but the policy provided $100,000 in disability insurance. The attention that HIV insurance coverage received a year or two ago seems to have decreased. Perhaps this decline can be attributed to a public perception that this type of insurance coverage is no longer newsworthy or that the coverage never captured its intended market. It is also possible that the perceived risk of contracting HIV at the workplace is so low that acquiring these insurance policies is not a priority for health care workers.

B. Professional Malpractice

While public reaction to the Acer cluster might suggest that professional liability insurance carriers would restrict the availability of such insurers in the health care field (perhaps

277. If the risk is negligible, however, the value of this incentive is questionable. It may be more realistic to assume that the benefit of this type of coverage is to protect the health care worker who is prevented unjustly from practicing in the health care field because of fear and prejudice. See supra notes 221–22 and accompanying text.
279. Id.
281. Id.
282. See supra Part I.C.
requiring HIV testing before issuing or renewing policies), such has not been the case. Concerns that state adoption of the CDC guidelines on HIV-infected health care workers also might affect the availability of professional liability insurance appear not to have been well-founded. Insurers apparently have been influenced more by the low risk of HIV transmission from provider to patient than by the publicity or state regulation. A report in the American Medical News in late 1992 indicated that professional liability insurers had not increased their rates at all because of HIV-infected physicians.

The report discusses HIV-related claims filed with three malpractice insurers. The insurers reported that physicians were being sued for transmission of HIV even though federal health officials stated that there was no substantiated case of a physician transmitting the virus to a patient. Under most policies, insurers would be required to pay to defend a negligence claim for HIV infection. That rates have not increased due to HIV infection suggests that the relative infrequency and low likelihood of success of these lawsuits mitigate the possible adverse effects of paying defense costs on the professional liability market as a whole.

At least one carrier is considering defending, but not indemnifying, infected physicians for claims arising from their failure to follow CDC recommendations. Other insurance companies are considering providing disability insurance for physicians who become HIV infected, provided that they refrain from performing exposure-prone procedures, in accordance with the CDC guidelines.

There is no indication that professional liability insurers are either inquiring about the HIV status of physician applicants or refusing to issue coverage to HIV-infected health care


284. Ragan, supra note 283.


286. Id.

287. Id.

288. Id.

289. See PAINTER, supra note 71, at 10.

290. Id. (citing as examples physician-owned companies in Michigan and New Jersey offering a $100,000 insurance benefit).
workers. If certain health care workers actually presented a higher professional liability risk (e.g., those who perform certain types of invasive procedures), the insurer would be cost-justified in charging higher premiums for those individuals. Similarly, if the risk were so high that the worker would be uninsurable, the insurer could decline to issue the coverage. One commentator has observed that the insurer could lawfully exclude the applicant, so long as the insurer had a "legitimate interest in protecting the health, safety and welfare of its potential insureds' patients, which includes protecting the society from the harm of an individual."

For now, however, insurers apparently have concluded that HIV infection is not a significant risk to be taken into account when underwriting professional liability coverage.

C. Extension of the Americans with Disabilities Act to Cover Employee Benefits

Recently, one federal court concluded that the ADA's antidiscrimination mandate on employers also applies to a trade union that provides insurance to employees and other individuals. In *Carparts Distribution Center, Inc. v. Automotive Wholesaler's Association of New England*, the First Circuit held that a trade association, which provided health insurance coverage for its members, could be treated as an employer under Title I of the ADA because it exercised control over the individual members' benefits. The court ruled that the insurer must prove that any cap it placed on benefits paid to AIDS patients was nondiscriminatory. While *Carparts* involved a

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291. Malpractice carriers, including St. Paul, Cigna, and CNA and physician-owned insurance companies such as Illinois State Medical Insurance Exchange and MAG Mutual, do not require HIV testing of physicians as a condition of coverage. *Id.* at 9. *See also GOUTIER, supra* note 213, at 44 (discussing whether malpractice insurers can require applicants to take an HIV test).


293. *Id.*


295. 37 F.3d 12, 17 (1st Cir. 1994).

296. *Id.*
self-insured company rather than a traditional insurer, this ruling appears to confirm an earlier holding by a federal district judge in New York that insurers are considered employers under the ADA. 297

Treating providers of health insurance as employers subjects them to the ADA's broad antidiscrimination mandate. The ADA prohibits an employer from: (1) limiting the access of disabled persons to benefits, 298 (2) using pre-existing conditions to limit access of disabled persons to benefits, 299 (3) reducing benefits for disabled persons, 300 or (4) reducing benefits based on a classification that has no sound actuarial basis. 301 These ADA protections are tempered by a broad exception for bona fide benefit plans. The ADA states that it does not prohibit or restrict:

(1) an insurer, hospital or medical service company, health maintenance organizations, or any agent, or entity that administers benefit plans, or similar organization from underwriting risks, classifying risks, or administering such risks that are based on or not inconsistent with State law; or

(2) a person or organization covered by this chapter from establishing, sponsoring, observing or administering the terms of a bona fide benefit plan that are based on underwriting risks, classifying risks, or administering such risks that are based on or not inconsistent with State law; or

(3) a person or organization covered by this chapter from establishing, sponsoring, observing or administering the terms of a bona fide benefit plan that is not subject to State laws that regulate insurance.

297. See Mason Tenders Dist. Council Welfare Fund v. Donaghey, 63 Empl. Prac. Dec. (CCH) ¶ 42,846, at 78,649, 78,654 (S.D.N.Y. Nov. 19, 1993) ("In making these payments, [the insurers] are administering funds which are being distributed on behalf of the multi-employer pension plans. In that sense I think it is clear that Congress intended to cover them.").

298. 29 C.F.R. app. § 1630.5 (1994).


300. 29 C.F.R. app. § 1630.5 (1994).

Paragraphs (1), (2), and (3) shall not be used as a subterfuge to evade the purposes of [the Act].

In June 1993, the EEOC approved an interim enforcement guidance (EEOC Guidance) on disability-based limitations in employer-provided health insurance. The EEOC Guidance directs EEOC investigators to make an initial determination of whether a challenged insurance term or provision is a "disability-based distinction." A disability-based distinction is one that singles out a particular disability or a procedure or treatment used exclusively for treatment of a particular disability, such as exclusion of a drug used only to treat AIDS.

If the EEOC determines that an employer's insurance plan contains a disability-based distinction, the EEOC considers the burden of proof to have shifted to the employer to show that (1) the health insurance plan is either a bona fide insurance plan that is consistent with either the applicable state law or a bona fide self-insured plan; and (2) the disability-based distinction is not being used as a subterfuge to evade the purposes of the ADA.

To gain the protection of the ADA bona fide benefit plan exception, according to the EEOC Guidance, employers must first show that a bona fide insured plan exists and pays benefits, that its terms have been accurately communicated to eligible employees, and that its terms are not inconsistent with applicable state law. If the plan is a self-insured plan, the

302. Id. § 12201(c).
304. EEOC Guidance, supra note 303, at 6422.
305. Id.
306. Cf. McDonnell Douglas Corp. v. Green, 411 U.S. 792, 802 (1973) (declaring that the complainant in a Title VII action must carry the initial burden under the statute of establishing a prima facie case of racial discrimination; the burden then shifts to the employer to articulate a legitimate, nondiscriminatory reason for its treatment of the complainant), aff'd, 528 F.2d 1102 (8th Cir. 1976).
307. EEOC Guidance, supra note 303, at 6418. The EEOC places the burden of proving a bona fide benefit plan exception on the employer because employers have the greatest access to facts and such a standard is consistent with the imposition of the burden of proof on employers in Title VII policies. See EEOC Official Defends Guidance on ADA and Health Plans, supra note 303, at 4.
308. EEOC Guidance, supra note 303, at 6420–21.
employer need only show that the plan exists and pays benefits and that its terms have been accurately communicated to covered employees. 309

Once the employer has proven that a bona fide plan exists, the employer must then show that the challenged disability-based distinction is not a subterfuge to evade the purposes of the ADA. The EEOC defines "subterfuge" as an exclusion of disability-based treatment that is not justified by the risks or costs associated with a disability. 310

The EEOC Guidance offers no single formula for determining what constitutes "subterfuge" and instead gives a nonexclusive list of possible business justifications. For example, an employer may show that it has not engaged in the disability-based disparate treatment alleged. 311 An employer can also establish that legitimate actuarial data, or actual or reasonably anticipated experience, justify the disparate treatment, and that conditions with comparable actuarial data and/or experience are treated in the same manner. 312

The EEOC Guidance list of acceptable justifications also includes the justification that disparate treatment is necessary to ensure the fiscal soundness of the challenged insurance plan so long as no feasible alternative to the disability-based distinction exists. 313 An employer may prove that the insurance practice is necessary to prevent an "unacceptable change" in the plan or the premiums, such as a drastic increase in premiums or a drastic alteration to the scope of the coverage. 314 Finally, the employer may defend the denial of disability-specific treatment by proving through reliable scientific evidence that the treatment does not provide any benefit or medical value. 315

A recent ruling suggests that the EEOC will not tolerate many asserted business justifications for disability-based distinctions. In Mason Tenders District Council Trust Fund, 316

309. Id.
310. Id. at 6421.
311. Id. That is, if a charging party alleges that a benefit cap of a particular catastrophic disability is discriminatory, the respondent may show that its health insurance plan actually treats all similarly catastrophic conditions in the same way. Id.
312. Id.
313. Id.
314. Id. at 6422.
315. Id.
the EEOC regional office in New York held that a union could not eliminate from its health insurance plan a benefit that provided for payment of expenses arising from HIV-related conditions. In that case, the Mason Tenders District Council Trust Fund (Fund) amended its health insurance coverage on July 1, 1991 to exclude payment for expenses related to HIV infection, AIDS, and/or AIDS-related complex (ARC). Later that year, a union member with HIV sued the union, the Fund, and related parties, claiming that the benefit plan violated the ADA. The New York district director of the EEOC ruled that the Fund's plan violated the ADA because it discriminated against individuals based on their disability, rather than on any sound actuarial justification.

The Fund subsequently filed a declaratory judgment action in federal district court seeking to establish that it was not obligated to reinstate insurance coverage for expenses related to HIV, AIDS, or ARC. In response, the EEOC filed its own suit against the Fund on June 9, 1993, the day after it had issued the Interim Guidance, charging the Fund with violating the ADA. This suit signaled the EEOC's determination to define the scope of the bona fide benefit plan exception and to enforce the provisions set forth in the guidance.

The issue to be decided in Mason Tenders is whether the Fund denied benefits on the basis of bona fide actuarial assumptions or subterfuge. In an order denying the Fund's motion for summary judgment, the trial judge stated that, in order to establish a violation of the ADA, the Fund's beneficiaries will have to prove that the Fund significantly affected a person's ability to gain benefits because of the person's disability. The beneficiaries will not have to prove that the

318. Id.
319. Id.
322. See Mason Tenders Dist. Council Welfare Fund v. Donaghey, 63 Empl. Prac. Dec. (CCH) at 78,649, 78,650 (S.D.N.Y. Nov. 19, 1993) ("The statute specifically contains language that says you can't use the subterfuge of a fund to evade the ADA.").
Fund had specific intent to discriminate. The Fund will have the burden of proving that the benefits were denied on the basis of bona fide actuarial assumptions rather than subterfuge.

Since the EEOC issued its Guidance, one-fourth of the ADA cases that the EEOC has filed in federal courts charge insurance plans which incorporate AIDS-based distinctions with violating the ADA. In Philadelphia, the EEOC District Director ruled that a $10,000 lifetime cap on payment for HIV-related medical treatment in a union health plan violated the ADA. The director concluded that the union’s action constituted subterfuge because the union trustees did not consider capping the health care plan, which originally provided lifetime benefits up to $100,000 for any disease or condition, until a few months after an employee made claims for AIDS-related treatment. The EEOC ultimately filed suit against the union health plan under the ADA, but in early 1995, the plan agreed to drop its cap on AIDS-related treatment and settled the case.

In a similar matter, the EEOC brought a suit in California against an insurance fund which placed a $5000 cap on AIDS-related benefits while maintaining a lifetime cap of $300,000 on other catastrophic illnesses. In the settlement, the insurance fund agreed to remove the cap. In March 1994, a self-insured company in Connecticut also agreed to remove a $10,000 cap on treatments for HIV and AIDS after the New York office of the EEOC ruled that the cap violated the ADA.

Recently, at least one federal case has been brought to challenge a cap on insurance for AIDS patients under the ADA. In *Carparts*, discussed above, the First Circuit held that this

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324. Id.
325. Id.
326. See supra note 270.
328. Id. at 6.
331. See id.
self-insured trade association must prove that any cap it placed on benefits paid to AIDS patients was non-discriminatory. 334 Few, if any, employers offering health benefit programs can meet such a burden or the burden imposed by the EEOC Guidance. 335 A national task force report released by the District of Columbia Bar argues that the ADA provision on subterfuge will continue to pose practical problems for insurers and employers and will be an ongoing point of contention. 336 The final outcome is difficult to predict, especially because the Carparts and McGann v. H & H Music Co. 337 decisions may signal the beginning of a significant conflict among the circuits concerning what insurers can proffer as viable business justifications. 338

The EEOC Guidance gives further clarity to the ADA's application to pre-existing condition clauses. The Guidance confirms that blanket pre-existing condition clauses that exclude from coverage the treatment of conditions that predate an employee's eligibility for benefits do not violate the ADA. 339 Universal exclusions from coverage of all experimental drugs or treatments also are not considered disability-based distinctions. 340 Even coverage limits on certain medical procedures for pre-existing conditions do not violate the ADA. 341 The EEOC Guidance notes that the ADA has retroactive application to health insurance plans that were adopted prior to the ADA's

336. See id.
337. 946 F.2d 401 (5th Cir. 1991) (holding that reduction of lifetime medical benefits for AIDS-related claims under self-insured plan did not unlawfully discriminate against employee and was permissive under the Employee Retirement Income Security Act (ERISA)), cert. denied, 113 S. Ct. 482 (1992) .
338. See infra notes 347-51 and accompanying text.
340. See EEOC Guidance, supra note 303.
341. See id. The EEOC Guidance suggests, however, that overly restrictive pre-existing condition clauses, which exclude treatments utilized only for a discrete group of related disabilities, may violate the ADA if the plan is not bona fide or the provisions are found to be subterfuge. Id. Employers may continue to use such clauses "so long as [they] are not used as a subterfuge to evade the purposes" of the Americans with Disabilities Act. Id. The EEOC Guidance gives an example in which a hemophiliac employee sues a hypothetical company because its insurance excludes from coverage treatment for any pre-existing blood disorders for a period of 18 months. Id. at 6420. In this situation, the Guidance asserts, the company must prove that its disability-specific pre-existing condition clause is not a subterfuge to avoid violating the ADA. Id. (Example 3).
July 26, 1990 enactment. Therefore, disability-based provisions of pre-ADA health insurance plans will be scrutinized under the same subterfuge standard as post-ADA health insurance plans.

Even if employers' health insurance plans do fall under the ADA bona fide benefit plan exception, new employees who are HIV-infected will still have access to benefit plan coverage in many situations. Large group health plans typically do not inquire into the health status of plan beneficiaries as a condition of coverage, except for special circumstances, such as late entry into the plan. Small groups often underwrite the medical condition of individual employees, but states increasingly restrict the insurers' ability to do so. Even without the protection of the ADA, therefore, many employers that offer health benefit plans to their employees are likely to include HIV-infected employees in the covered group.

Employers or their benefit plan insurers, however, may decline coverage to an employee altogether because nothing in either the ADA's provisions or the EEOC Guidance mandates that an employer even offer health or life insurance benefits. As long as the denial of coverage is based on an actuarial risk classification, an employer may choose to decline to offer insurance to a high-risk group.

The Employee Retirement Income Security Act of 1974 (ERISA) also contains an antidiscrimination clause which has been used to challenge reduction claim benefits stemming from HIV-related illnesses in two recent cases involving self-funded plans. In both cases, the courts held that placing

342. Id.

343. Id.

344. Underwriting late entrants is intended to avoid adverse selection by preventing healthy individuals from opting out of the plan until they become ill. Healthy individuals must participate so that the plan can spread the risk of covering those who are sick.

345. See NATIONAL ASS'N OF INS. COMPANIES, 1 OFFICIAL N.A.I.C. MODEL INSURANCE LAWS, REGULATIONS AND GUIDELINES 115-1, 115-7 (1995).


349. See McGann v. H & H Music Co., 946 F.2d 401 (5th Cir. 1991) (holding that a reduction of lifetime medical benefits for AIDS-related claims under a self-insured plan did not unlawfully discriminate against employee and was permissible under ERISA), cert. denied, 113 S. Ct. 482 (1992); Owens v. Storehouse, Inc., 773 F. Supp. 416 (N.D. Ga. 1991) (holding that modification of an employer-based self-insured plan to include a cap of $25,000 for AIDS-related claims did not violate the provision prohibiting discriminatory conduct under ERISA where the health benefits were
caps on AIDS benefits in employee benefit plans did not con-stitute illegal discrimination with respect to benefits under ERISA. 350 This approach clearly contrasts with that discussed above under the ADA, which was most recently affirmed in the First Circuit's decision in Carparts, which suggested that it may be unlawful to cap the amount of benefits to be re­ceived by an insured suffering an HIV-related illness. 351

C. Conclusion

The impact of HIV on health care workers' access to insur­ance appears to be about the same as that for most other professions. Nothing suggests that HIV-infected health care professionals have poorer access to insurance coverage than their noninfected colleagues as a result of HIV. Such is as it should be, because the ADA's antidiscrimination mandate applies to insurers. Courts and the EEOC should continue to apply the ADA to insurers, and interpret the exception for bona fide benefit plans narrowly, not only on behalf of patients, but also on behalf of health care workers.

If the courts do so, the myth that insurers have a special business justification for discriminating against HIV-positive patients will be debunked and insurers will be treated more like employers. Employees with HIV or other terminal conditions may require expensive medical treatment which will affect the cost of health benefit plans, but employers should not be permitted to contain costs by limiting coverage for HIV-infected health care workers and other employees. The Carparts and Mason Tenders cases suggest that, in attempting to contain costs, employers and insurers alike must be careful not to discriminate based on HIV status.

V. CONCLUSIONS AND RECOMMENDATIONS

Fear of HIV infection has caused some policymakers to respond to isolated events like the Acer cluster with calls for

350. McGann, 946 F.2d at 408; Owens, 984 F.2d at 400.
351. Carparts Distribution Ctr., Inc. v. Automotive Wholesaler's Ass'n of New England, 37 F.3d 12, 16 (1st Cir. 1994).
sweeping solutions such as mandatory HIV testing of all health care workers. Based on its research, extensive hearings, and consistent with the judgment of medical professionals and on current medical knowledge, the ABA AIDS Coordinating Committee does not believe that mandatory testing or forced disclosure of the HIV status of health care workers is the proper solution to the problem of preventing HIV transmission in the health care system. While such solutions respond to the well-publicized fear of becoming infected with HIV from health care workers, they are not responsive to the scientific facts about the tiny risk of HIV transmission from health care worker to patient. It bears repeating that since the discovery of the Acer cluster, no additional cases of transmission of HIV from health care worker to patient have been identified or even seriously alleged, despite significant effort to find such cases. It is clear that health care workers with HIV present an immeasurably small risk of transmission in most health care settings. It is also clear that even when "exposure-prone invasive procedures" are at issue, any risk posed by an HIV-infected health care worker can be controlled by adherence to proper infection control procedures. Legislative and regulatory concern about HIV transmission in the health care setting is better placed on encouraging adherence to proper infection control procedures, including implementation standards and peer review panels that would monitor such adherence.

Accordingly, the ABA AIDS Coordinating Committee recommends the following public policy actions to address the problems faced by HIV-infected health care workers and to combat public fear of HIV transmission in the health care setting. First, mandatory HIV testing of health care workers is not warranted, and should not be a requirement of employment, credentialing, licensure, professional liability insurance, training, or education. As the scientific literature and the ABA's hearings demonstrated, many medical professionals agree that the scientific data does not support mandatory testing of health care professionals. Monetary costs, the potential adverse effects on the health care system, and the rights of individual workers far outweigh the value of identifying infected health

352. Gostin, supra note 34, at 141 ("The current assessment of the risk that infected [health care workers] will transmit HIV or HBV to patients during exposure-prone procedures does not support the diversion of resources that would be required to implement mandatory testing programs.").
care workers through mandatory testing because no cost beneficial decrease in the risk of HIV transmission is likely to be achieved.\(^{353}\)

Second, with respect to informed consent, health care workers should not be required to disclose their HIV status to patients under this doctrine. Since the risk of HIV transmission from health care worker to patient is immeasurably small if universal precautions are employed, the fact that a procedure is being performed by an HIV-positive individual—where the patient would give consent to an HIV-negative individual to perform the same procedure—should not be material to a reasonable patient’s evaluation of the risks of a medical procedure. In the case of the few procedures that are so invasive as to involve a documented risk of HIV transmission, peer advisory panels should be put in place to discuss HIV-related health care practice matters and proper infection control procedures. HIV-positive health care workers should be encouraged to consult voluntarily on a confidential basis with such peer advisory panels. Hospitals, health plans, and other institutions should respect the informed medical judgments of such peer review panels.

Third, antidiscrimination mandates, such as those set forth by the Americans with Disabilities Act, should be uniformly upheld. Health care workers should not face discrimination based on their HIV status in employment or with respect to receipt of benefits such as medical insurance. Similarly, patients should not be denied treatment based on their HIV status, but may be required to disclose their HIV status solely for medical reasons. Confidentiality of the HIV status of

\(^{353}\) See id. The CDC did not recommend mandatory testing of health care workers for HIV and HBV on the grounds that the current assessment of risk does not justify the cost of such testing programs. CDC Guidelines, supra note 3, at 6; see also ABA, Chicago Hearing, supra note 12, at 87 (containing testimony of a surgeon who declined to recommend mandatory testing of all elective surgery patients just to catch the small number of open heart surgery patients who might benefit from such testing). A July 1991 report by the Pennsylvania Health Department estimated that it would cost $54 million annually to conduct quarterly HIV testing of the state’s health care workers, an amount more than twice the total Pennsylvania AIDS-prevention program budget. Mandatory HIV Testing Intensifies Across America, ADVOCATE, Sept. 10, 1991, at 40. Another 1991 study found that the cost of even one-time testing with pre- and post-test counseling for health care workers at San Francisco General Hospital would be approximately $886,000 per year, twice the entire infection control annual budget for that hospital. Id. at 42. A 1991 study by the AIDS Policy Center found that HIV and HBV testing for the seven million health care workers in the United States would cost between $350 and $525 million. Id.
patients and health care workers should be maintained to encourage HIV-infected individuals to become tested, learn their status, and adhere to appropriate infection control and other practices to avoid spread of the infection.

Fourth, increasing compliance with universal precautions should be the focus of government and private efforts to prevent HIV transmission in the health care setting. All health care workers should be trained in universal precautions and their adherence to these practices should be monitored by their institutions. Regular continuing education programs should be instituted to assist in compliance with infection control procedures.

Finally, the legal system should attempt to ensure that its decisions uniformly recognize the truly low risk that an HIV-infected health care workers will transmit HIV to her patients. Under the Supreme Court precedent set forth in Arline, all individuals, including health care professionals, should not face discrimination in employment or insurance actions based on their HIV-positive status unless their behavior constitutes a significant risk. While the consequences of HIV infection are horrible, courts and legislators must not forget the risk of HIV transmission from a health care worker can hardly be considered significant. In the history of HIV and AIDS, only one medical practice has been documented as the source of HIV transmission to patients—the office of Dr. David Acer. Given the extremely low risk of HIV transmission in a health care environment where proper infection control procedures are followed, courts and legislators must not allow health care workers to suffer because of public fear of HIV transmission that is not grounded in medical or scientific fact.

The AIDS Coordinating Committee does not mean for its analysis to trivialize public fear about HIV transmission in the health care setting. Public fear engendered by the Acer cluster has been real. Unfortunately, that fear often has been exacerbated to unreasonable proportions by sensationalized media reports or failures of public education about the methods and risks of HIV transmission. Public fear of HIV transmission from an infected health care worker to a patient simply is unrelated to the actual risk of such transmission. From both a public health and a legal perspective, the appropriate responses to such public concern are decisions based on scientific evidence. Courts and legislatures have the responsibility to ensure that the facts about the low risk of HIV transmission
prevail over public hysteria. As was aptly stated in the Committee's hearings, "public hysteria should never be the engine that drives the policy process."\textsuperscript{354} In the "battle between emotion, ethics and ... public perception"\textsuperscript{355} triggered by AIDS phobia in the health care setting, the only thing the public has to fear from HIV infected health care workers is fear itself.

\textsuperscript{354} ABA, Chicago Hearing, \textit{supra} note 12, at 96.
\textsuperscript{355} \textit{Id}. 