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"FIRST DO NO HARM . . .": CAN RESTRICTIONS ON HIV-INFECTED HEALTH CARE WORKERS BE JUSTIFIED?

This article is dedicated to the memory of Richard Kent Summers.

Barbara Matthews Anderson*

I. INTRODUCTION

On July 12, 1991, the Centers for Disease Control (CDC)¹ published guidelines for the prevention of HIV transmission in health care settings that sent shock waves through Congress, hospitals, and medical professional societies across the United States.² Federal legislators responded to increased public fear of health care worker to patient transmission of the virus by proposing a series of

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1. On October 27, 1992 the CDC changed its name to the Centers for Disease Control and Prevention with "CDC" still the official acronym. This change was enacted by Congress as part of the Preventative Health Amendments of 1992. The name change was made in recognition of the CDC's leadership role in the prevention of disease, injury, and disability. CDC: *The Nation's Prevention Agency*, 41 MORBIDITY & MORTALITY WKLY. RPT. (U.S. Dep't of Health & Hum. Serv., Wash., D.C.), Nov. 6, 1992, at No. 44, 1.)

2. *Recommendations for Preventing Transmission of Human Immunodeficiency Virus and Hepatitis B Virus to Patients During Exposure-Prone Invasive Procedures*, 40 MORBIDITY & MORTALITY WKLY. RPT. (U.S. Dep't of Health & Hum. Serv., Wash., D.C.), July 12, 1991, at No. RR-8, 1 [hereinafter *Recommendations for Preventing Transmission*].

The medical distinction between Acquired Immune Deficiency Syndrome (AIDS) and the Human Immunodeficiency Virus (HIV) which causes AIDS will be thoroughly outlined in part II, *infra*.

AIDS refers to those who are in the final stages of HIV infection who have specific illnesses and conditions. In general, current statutes, commentaries, and case law refer to HIV infection rather than AIDS; following this usage the author will use the terms "HIV infection," "HIV-positive," and "HIV transmission" except when quoting others or when the specific term "AIDS" is legally relevant. See generally AMERICAN BAR ASSOCIATION, COMMISSION ON THE MENTALLY DISABLED AND CENTER ON CHILDREN AND THE LAW, AIDS AND PERSONS WITH DEVELOPMENTAL DISABILITIES: THE LEGAL PERSPECTIVE (1989) [hereinafter A.B.A. COMMISSION ON THE MENTALLY DISABLED AND CENTER ON CHILDREN AND THE LAW]; AMERICAN BAR ASSOCIATION, AIDS COORDINATING COMMITTEE, AIDS THE LEGAL ISSUES, 4 (Discussion Draft 1988) [hereinafter A.B.A. AIDS COORDINATING COMMITTEE].

bills restricting HIV-infected health care workers' practices³; and similar laws have been proposed and enacted in state legislatures⁴. The CDC guidelines evoked criticism and conflicting scientific opinions from the medical community, speculation as to the constitutionality of restricting health care professionals' activities, and increased pressure from voters who demanded that their elected officials protect them against the risk of contracting HIV from their doctors and dentists.⁵ Six months after they were issued, the CDC guidelines were reported to have been under revision, and after a year of controversy and speculation the CDC decided not to modify them.⁶

This article will examine the issues raised by these recent guidelines and the subsequently proposed federal legislation regarding HIV-infected health care workers. It will illustrate the conflicting medical opinions and lack of scientific certainty regarding the actual risk of HIV transmission from health care worker to patient. In addition, the article will examine the few existing court opinions that have dealt with hospital restrictions of HIV-infected employees and will address whether the AIDS crisis is "over-politicized,"⁷ rendering it what some have called a "civil rights issue" rather than the

3. A major portion of this article analyzes the federal response to increased fear of HIV transmission from health care provider to patient. See *infra* notes 4, 7, 70. The topic is thoroughly discussed *infra* part VI.

4. The responses to increased fear of HIV transmission from health care provider to patient in the state legislatures have varied. See *infra* text accompanying notes 179-86.

5. Congressman William Dannemeyer, R-California, who has introduced numerous bills into Congress on HIV infection and whose most recent bill, Kimberly Bergalis Patient and Health Provider Protection Act of 1991, H.R. 2788, 102d Congress, 1st Sess. (1991), comprises a significant portion of discussion in this article, stated in a press release promoting the bill: "[W]hen Americans seek medical or dental care, they must be certain that their health care providers will not inadvertently transmit a deadly virus to them, whether that virus be the AIDS virus, hepatitis B, or something else." For further discussion of the bill, see *infra* part VI.

6. *CDC Not Publishing Revised Guidelines on Infected Workers*, 7 AIDS ALERT (Am. Health Consultants, Atlanta, Ga.), Aug. 1992, at 113. This topic is thoroughly discussed *infra* notes 138, 139, 174-176 and accompanying text.

7. See Linda Jill Anderson, *The AIDS Crisis and Directed Donations*, 37 MED. TRIAL TECH. Q. 451, 456-57 (1991). The author notes:

Other diseases such as mumps, tuberculosis, venereal disease, chickenpox, syphilis and gonorrhea are tested and reported routinely. In contrast, AIDS, although a medical disease, is afforded the privilege of choice regarding testing and reporting. Thus instead of the disease being targeted, it is the fear of discrimination that underlies existing reporting policy. The unusual treatment of AIDS has led to the conclusion that AIDS is politically protected.

Id.

For further discussion of the "politicization of AIDS," see ROBERT J. JARVIS ET AL., AIDS LAW IN A NUTSHELL 41-44 (1991); MICHAEL L. CLOSEN ET AL., AIDS CASES AND MATERIALS 177-262 (1989).

true "public health threat" that it is.⁸

II. MEDICAL OVERVIEW OF AIDS

Acquired Immune Deficiency (AIDS) is a disease caused by the Human Immunodeficiency Virus (HIV), a retrovirus belonging to the lentivirus group.⁹ Unlike most other viruses which have their basic genetic material coded in DNA, HIV is coded in RNA, and is part of a family of retroviruses whose existence in human beings was just recently established.¹⁰ The term "retrovirus" essentially means "backwards," in that the virus is capable of converting itself into DNA and incorporating itself into the genetic material of the infected person.¹¹ These retroviruses, which are widespread among many animals, are characterized by their integration into host cells facilitated by the enzyme reverse transcriptase which enables the process of viral infection to occur.¹²

HIV attacks CD4 lymphocytes, the white blood cells which help fight infection and are largely responsible for many functions of the human immune system.¹³ As a result of this viral attack, the invaded helper cells become crippled and die. As the total number of CD4 cells decline, the immune system slowly becomes weaker, and thus patients with HIV become susceptible to a wide range of opportunistic infections associated with "full-blown" AIDS.¹⁴

The actual disease of AIDS represents the final stage of HIV infection which has been clinically divided by the CDC into four stages.¹⁵ In the first, some, but not all, of those who contract the

8. Senator Jesse Helms, R-North Carolina, excerpted from his speech to the Senate in mid-July, 1991, in support of his amendment requiring AIDS testing of all health care workers performing invasive procedures. Sen. Jesse Helms, *The AIDS-infected Physician, Are Criminal Penalties Necessary to Protect the Public Health? Yes: Protect Innocent Victims*, A.B.A. J., Oct. 1991, at 46. The Helms amendment is thoroughly examined *infra* part VI.

9. Harold L. Hirsch, *A Visitation with AIDS, Part X: Medical Dilemma, Legal & Ethical Quagmire*, 37 MED. TRIAL TECH. Q. 417, 417 (1991). "Lentivirus" is a subfamily of the retrovirus group. *Id.*

10. DONALD H.J. HERMANN & WILLIAM P. SCHURGIN, LEGAL ASPECTS OF AIDS 7 (1991).

11. Anderson, *supra* note 7, at 451-52.

12. *Id.* at 452; see also HERMANN & SCHURGIN, *supra* note 10, at 7.

13. See Hirsch, *supra* note 9, at 417.

14. *Id.*; see also A. Alyce Werdell, *Mandatory AIDS Testing: The Legal, Ethical and Practical Issues*, 5 NOTRE DAME J. L., ETHICS & PUB. POL'Y 155, 158 (1990). The author defines "full-blown" AIDS as the final stage of HIV infection where the immune system is so weak that the body is unable to fight off opportunistic infections - those which do not ordinarily cause disease in human beings. Because the AIDS patient's immune system is so weakened, these infections often will cause the AIDS patient's death.

15. A.B.A. AIDS COORDINATING COMMITTEE, *supra* note 2, at 12.

virus initially suffer from flu-like symptoms which usually appear two to six weeks after HIV infection; symptoms may include headache, diarrhea, sore throat, swollen lymph nodes, or a rash.¹⁶ The second stage, termed asymptomatic HIV infection, is a period during which infected individuals remain healthy, gradually developing symptoms associated with HIV infection.¹⁷ This incubation stage can be characterized by a latency period in some of up to eight to ten years before the onset of AIDS.¹⁸ And, once infected, the HIV-positive person can pass the virus to another person until the day he or she dies.¹⁹ This asymptomatic "carrier state" can be detected by evidence of HIV infection upon laboratory testing.²⁰

In the third stage, persons infected with HIV develop symptomatic HIV infection, a phase in which individuals develop various clinical signs including swollen lymph nodes, weight loss, fever, diarrhea, skin tumors, and other conditions.²¹ The fourth phase, AIDS or "full-blown" AIDS, encompasses the clinical diagnosis representing the end stage of HIV infection.²² This stage is marked by specific symptoms and diseases identified by the CDC, such as Kaposi's sarcoma and pneumocystis carinii pneumonia.²³

HIV has been isolated in blood, semen, saliva, tears, vaginal secretions, urine, breast milk, cerebrospinal fluid, synovial fluid, and amniotic fluid; but isolation of the virus from a specific body fluid

16. Anderson, *supra* note 7, at 452.

17. A.B.A. COMMISSION ON THE MENTALLY DISABLED AND CENTER ON CHILDREN AND THE LAW, *supra* note 2, at 8.

18. *Id.*

19. Jerry Adler et al., *Living with the Virus*, NEWSWEEK, Nov. 18, 1991, at 63; *see also* Anderson, *supra* note 7, at 452.

20. HERMANN & SCHURGIN, *supra* note 10, at 9.

21. A.B.A. COMMISSION ON THE MENTALLY DISABLED AND CENTER ON CHILDREN AND THE LAW, *supra* note 2, at 8.

22. *Id.*; *see also* HERMANN & SCHURGIN, *supra* note 10, at 8.

23. A.B.A. COMMISSION ON THE MENTALLY DISABLED AND CENTER ON CHILDREN AND THE LAW, *supra* note 2, at 8.

The CDC has further subdivided this final stage of the disease, known as CDC IV into five specific subcategories.

Kaposi's sarcoma is a cancerous lesion, visually obvious on the skin, which is blue-purple in color. It can appear anywhere on the HIV-infected person. In addition, it can occur in the palate, gastrointestinal tract, and even on the inner surface of the eyelids. CLOSEN ET AL., *supra* note 7, at 178. Pneumocystis carinii pneumonia, a previously rare type of lung infection, is the most widely known opportunistic infection to afflict persons infected with HIV. A.B.A. AIDS COORDINATING COMMITTEE, *supra* note 2, at 12. On January 1, 1993, the CDC broadened its definition of "full-blown" AIDS to include cervical cancer, pulmonary tuberculosis, and recurrent pneumonia as indicator illnesses. *U.S. Broadens Definition of AIDS*, SAN JOSE MERCURY NEWS, Jan. 1, 1993, at 20A.

does not mean that the fluid is a viable source of transmission.²⁴ To date, only blood, semen, vaginal secretions and breast milk have been directly linked to HIV transmission.²⁵ Host sites best suited for transmission of infection after exposure appear to be the blood system, breaks in the skin, and the soft tissues of sexual organs.²⁶ Prior to 1990, only four methods of transmission had been documented: sexual contact; parenteral exposure to blood and blood products through needle-sharing and transfusions; transmission by infected mothers to their fetuses and infants in utero, during labor and delivery and through breastfeeding; and occupational exposure through needlestick injury or mucous membrane exposure.²⁷ The CDC emphasizes that HIV cannot be transmitted by nonsexual "casual" contact²⁸, and that people with AIDS can be cared for in the home without high risk of infection to caregivers or other family members.²⁹

On July 27, 1990 the CDC published a *Morbidity & Mortality Weekly Report* that contained an article entitled "Possible Transmission of Human Immunodeficiency Virus to Patient During an Invasive Dental Procedure."³⁰ A 22-year old woman with no other risk factors for HIV infection had been diagnosed with AIDS twenty-four months after being treated by her HIV-infected dentist.³¹ Until this case, authorities had asserted that transmission of HIV from a health care professional to a patient had a low, but not zero, probability.³² Six months later, the CDC published another *Morbidity & Mortality Weekly Report* on the case entitled "Update: Transmission of HIV Infection during an Invasive Dental Procedure—Florida."³³ The word "possible" had been dropped from the title of the CDC report, and an additional four patients of the dentist

24. HERMANN & SCHURGIN, *supra* note 10, at 23.

25. *Id.*

26. A.B.A. AIDS COORDINATING COMMITTEE, *supra* note 2, at 11.

27. HERMANN & SCHURGIN, *supra* note 10, at 23; *see also* A.B.A. AIDS COORDINATING COMMITTEE, *supra* note 2, at 11.

28. A.B.A. AIDS COORDINATING COMMITTEE, *supra* note 2, at 11.

29. *Id.*; *see also* Hirsch, *supra* note 9, at 438.

30. *Possible Transmission of HIV to Patient During an Invasive Dental Procedure*, 39 MORBIDITY & MORTALITY WKLY. RPT. (U.S. Dep't of Health & Hum. Serv., Wash., D.C.), July 27, 1990, at 489.

31. *Id.*

32. Barbara Gerbert et al., *Possible Health Care Professional-to-Patient HIV Transmission*, 265 JAMA 1845, 1845 (1991).

33. *CDC Update: Transmission of HIV Infection during an Invasive Dental Procedure*, 40 MORBIDITY & MORTALITY WEEKLY RPT. (Dep't of Health & Hum. Serv., Wash., D.C.), Jan. 18, 1991, at 21.

with no other risk factors for the virus were identified as infected with HIV.³⁴

The responses to the July, 1990 CDC report were immediate, and were covered in both the lay and professional press.³⁵ Whereas the mainstream press coverage reflected extreme public concern over the issue, the professional medical societies responded quietly to the first report and much more strongly to the second.³⁶ Shortly after publication of the January 1991 updated report the American Medical Association (AMA) and the American Dental Association (ADA) issued new recommendations for HIV-infected health care professionals, calling for these individuals to inform their patients of their HIV status or refrain from performing invasive procedures.³⁷ These recommendations were then followed by new CDC guidelines in July of 1991.³⁸ Thus a new mode of HIV transmission was officially documented, and a new medical and political controversy created.

III. A DECADE OF EPIDEMIC

On June 5, 1991, the nation passed the official decade mark of the AIDS epidemic. The date represented ten years since the CDC published a report of a cluster of mysterious and profound immune deficiency cases associated with pneumocystis pneumonia and other opportunistic infections in Los Angeles.³⁹ Within weeks of the MORBIDITY & MORTALITY WEEKLY findings, similar cases were being reported in other parts of the country—and even before the isolation of HIV in 1983 and the advent of serologic testing in 1985 it was clear that a major epidemic had begun.⁴⁰ As the initial cases of this mystery disease were reported, it became clear that its first victims were primarily male homosexuals, followed by intravenous drug users, and Haitian immigrants and refugees.⁴¹ Thus, certain “high

34. *Id.*

35. See Gerbert, *supra* note 32, at 1845. The authors cite the following headlines in response to the July, 1990 CDC report: “AIDS case puzzles, troubles experts: Could dentist have infected patient with HIV while extracting teeth?” (quoting from the SAN FRANCISCO EXAM., July 27, 1990, at A1); “Confusion about danger to patients.” (quoting from the SAN FRANCISCO SUNDAY EXAM. & CHRON., July 29, 1990, at A3); and “Many dental appointments canceled after HIV report” (quoting from the SAN FRANCISCO CHRON. July 28, 1990, at A3). *Id.*

36. *Id.*

37. *Id.* at 1848.

38. See *Recommendations for Preventing Transmission*, *supra* note 2.

39. Marcia Angell, *A Dual Approach to the AIDS Epidemic*, 324, NEW ENG. J. MED., 1498, 1498 (1991).

40. *Id.*

41. RANDY SHILTS, AND THE BAND PLAYED ON: POLITICS, PEOPLE, AND THE AIDS

risk groups" were identified, and unlike other major epidemics, AIDS was not initially seen as threatening the entire population.⁴² The disease was originally referred to by many as the "gay pneumonia" and later as the "gay plague."⁴³

Although the force and threat of the epidemic have been compared to those of other epidemics in the United States, many commentators note that the AIDS epidemic carries with it unique social issues which complicate the public's response to it:

Unlike the polio epidemic of the 1950's or the influenza pandemic of 1918, AIDS tends to afflict people who are for one reason or another the objects of discrimination. Although increasingly a disease of inner-city black and Hispanic intravenous drug abusers of both sexes and their sexual partners, AIDS was at first almost exclusively a disease of homosexual men. It therefore carried the stigma of any sexually transmitted disease, but unlike syphilis or gonorrhea, it also carried the stigma of homosexuality—a double burden.⁴⁴

Other commentators emphasize the "politicization" of this epidemic, noting that AIDS has become fuel for the moral majority:

As the spread of AIDS became linked in the public imagination to the very presence of homosexuals . . . the gay visibility and affirmation of the past decade allowed for some very nasty scapegoating. AIDS came along just when the old religious, moral and cultural arguments against homosexuality seemed to be collapsing . . . [R]ight-wing moralists sought to shore up traditional condemnations of homosexuality; AIDS provided a godsend to them.⁴⁵

Thus from the outset of the AIDS epidemic discrimination has

EPIDEMIC 123-135 (1988).

The author highly recommends Shilts' book to those interested in the political and medical development of AIDS. Shilts traces the discovery of the epidemic in 1981 including the various names initially given the disease such as "CAIDS," "ACIDS," and "GRID", while documenting CDC activity vis-a-vis tracking the initial "mystery diseases" and the exponential growth of the epidemic. *Id.* Of additional interest in Shilts' work is his reporting of the race between the French and Americans in isolating and naming the virus causing this tragic disease. *Id.*

42. CLOSEN ET AL., *supra* note 7, at 178.

43. *Id.* at 65; see also SHILTS, *supra* note 41, at 152. Shilts documents the early development of the epidemic: "By May 18 [1982], 355 biopsy-confirmed GRID cases had been counted in twenty states. . . . About 79 percent of all cases were among gay or bisexual men. Nearly 12 percent were among heterosexual men who were intravenous drug users, although the CDC still wasn't saying this for public consumption." *Id.*

44. Angell, *supra* note 39, at 1498.

45. CLOSEN ET AL., *supra* note 7, at 179.

characterized the disease. In addition, AIDS has other qualities that render it subject to extreme controversy: (1) it is always fatal;⁴⁶ (2) the epidemic is largely "invisible" because those with full-blown AIDS constitute only a fraction of those who are infected with HIV⁴⁷ (3) HIV has been found to have a median incubation period of almost ten years, during which time the infected person is a carrier of the virus, fully able to transmit it, but without any visible symptoms;⁴⁸ and (4) the activities that initially spread the HIV virus (sex and drugs) are private and fundamentally not amenable to the coercive power of the state.⁴⁹ These factors set the epidemic apart from other public health issues, creating what commentators refer to as "a paradox of epidemiological and medical facts,"⁵⁰ "a pandemic [that] has challenged some of our well-worn moral values . . . concern[ing] those with liberty, equality, and privacy,"⁵¹ and "the most difficult ethical question now at issue in medicine."⁵²

Since AIDS was first identified in 1981, its exponential growth has shocked the United States. In the first nine months after the disease was recognized and before any official reporting system had been established, 355 cases were identified in 20 states;⁵³ nineteen months into the epidemic the rate of AIDS cases reached 1,025 cases nationally—twenty-five percent of which had been reported in just the two months prior to the compilation of the reported figures.⁵⁴

46. Scott H. Isaacman, *The Other Side of the Coin: HIV-Infected Health Care Workers*, 9 ST. LOUIS U. PUB. L. REV. 439, 454 (1990) (quoting C. Everett Koop, former United States Surgeon General).

The author quotes the former Surgeon General, C. Everett Koop as follows:

When you look at all the reported cases of AIDS since 1981, and the reported deaths as well, the mortality rate is about 56%, which is bad enough. But when you look back at those persons who had AIDS in 1981, you discover that 92% of them have since died of the disease. And in my book, a mortality rate of 92% is as bad as a rate of 100%.

Id.

47. David C. Wyld & Sam D. Cappel, *The Big Easy? Legal and Managerial Perspectives on AIDS and Health Care Delivery in the 1990s*, 5 AIDS & PUB. POL'Y J., 99, 99 (1990).

48. *Id.*

49. Sheldon H. Landesman, *The HIV-Positive Health Professional: Policy Options for Individuals, Institutions and States*, 151 ARCHIVES OF INTERNAL MEDICINE 655, 655 (1991).

50. Wyld & Cappel, *supra* note 47, at 99.

51. John Kleinig, *The Ethical Challenge of AIDS to Traditional Liberal Values*, 5 AIDS & PUB. POL'Y J. 42, 42 (1989).

52. Wyld & Cappel, *supra* note 47, at 99, citing Edmund D. Pellegrino, *Medical Ethics: Entering the Post-Hippocratic Era*, 1 J. AM. BOARD. FAM. PRAC., 230 (1988).

53. SHILTS, *supra* note 41, at 152.

54. *Id.* at 233.

Today, of course, the numbers of diagnosed AIDS cases are staggering, and the CDC estimates that between 1 million and 1.5 million people in the United States are infected with HIV.⁵⁵ Whereas homosexual and bisexual men accounted for over 79% of those diagnosed with AIDS in 1982, and intravenous drug users 12%,⁵⁶ today's figures reveal that the spread of the disease in the homosexual community has slowed, with a substantial number of cases being reported in heterosexual non-drug users.⁵⁷ Homosexual and bisexual males are now estimated to account for approximately 65% of those infected, non-homosexual intravenous drug users 22%, heterosexuals 5.7%, and undetermined cases approximately 3.7%.⁵⁸ In March of 1990 reported cases of AIDS reached approximately 129,000;⁵⁹ in January of 1991, 165,000;⁶⁰ and in September of 1991, 195,000.⁶¹ And it is estimated that the number of cases in 1992 will reach over 300,000.⁶² While examining these figures, it is important to keep in mind the length of the average incubation period for HIV; the people listed with AIDS above were largely infected in the 1980s, and those who are HIV-positive today will become the AIDS patients of the next century. Because of the sheer magnitude of the epidemic and its tragic effects on its victims, over the past decade AIDS has changed its status from that of an obscure and mysterious disease known only to the medical and homosexual communities to that of a "household word" covered daily in the media, of concern to most Americans, and frightening to many others.⁶³

As discussed briefly above, on July 27, 1990, the CDC published a *Morbidity & Mortality Weekly* report that contained coverage of "possible" HIV transmission from a dentist to his patient;⁶⁴ this report was updated six months later with the addition of four other patients who were identified as infected with HIV.⁶⁵ At the time of the publications the patients were referred to as patients "A-E", anonymous and unfortunate persons who had tested HIV-posi-

55. *Living with the Virus*, NEWSWEEK, Nov. 18, 1991, at 63.

56. SHILTS, *supra* note 41, at 65.

57. *Magic's Message*, NEWSWEEK, Nov. 18, 1991, at 59.

58. *Id.*

59. *Update*, AIDS ALERT, June 1990, at 119.

60. *Update*, AIDS ALERT, Apr. 1991, at 78.

61. *Update*, AIDS ALERT, Dec. 1991, at 242.

62. Karen Markus, *Patients with HIV*, CAL. NURSING, Nov.-Dec. 1991, at 20 (citing U.S. Public Health Service predictions of approximately 365,000 persons diagnosed as having AIDS by the end of 1992).

63. Angell, *supra* note 39, at 1498.

64. *See supra* note 33.

65. *See supra* notes 33-38 and accompanying text.

tive, some of whom had already begun to show symptoms of AIDS.⁶⁶ Patient "A", the first person ever officially documented as contracting HIV from her dentist, Dr. David Acer, was later identified as Kimberly Bergalis, a twenty-three year old college student whose tragic struggle with AIDS became known across the nation.⁶⁷ As her case was covered in national media and on television, Americans were confronted with their greatest fears about AIDS. Whereas it had been believed that contracting HIV was somehow associated with voluntary lifestyle choices (i.e. sexual preference, drug use, and promiscuity) or the unfortunate early cases of blood transfusion and organ transplants, now proven safe after the advent of HIV blood screening,⁶⁸ it now appeared that the invisible killer could be transmitted by one's seemingly healthy dentist or physician. In the final months of her life, Ms. Bergalis joined forces with legislators who clamored for restrictions of HIV-infected health care workers and wrote an open letter to Florida public health officials in which she stated, "I blame every one of you bastards . . . [who] knew Dr. Acer was infected . . . and stood by not doing a damn thing about it If laws are not formed to provide protection, then my suffering and death was in vain."⁶⁹

Thus the summer of 1991 marked the close of the first decade of the AIDS epidemic, with staggering statistics, the growing spread of the disease into the heterosexual population, and the first documented cases of dentist to patient transmission of HIV. As soon as the CDC guidelines were released, legislation was introduced into Congress calling for restrictions of HIV-infected health care workers.⁷⁰ And public opinion polls revealed that over 90% of Americans favored requiring HIV-infected health care workers to reveal their HIV status to patients.⁷¹

66. *CDC Update: Transmission of HIV to a Patient during an Invasive Dental Procedure*, *supra* note 33, at 26.

67. *Doctors with AIDS*, *NEWSWEEK*, July 1, 1991, at 49.

68. A full discussion of blood screening and the early cases of AIDS transmitted by blood transfusion is beyond the scope of this article and involves an in-depth study of early CDC activities vis à vis the isolation and discovery of the virus, and the eventual realization by the CDC that the virus was being spread by blood transfusions. For a detailed report on these topics, see *SHILTS*, *supra* note 41, at 206-346.

69. *Doctors with Aids*, *supra* note 67, at 49, 52.

For a thorough discussion of the proposed bill bearing Ms. Bergalis' name, see *infra* part VI.

70. The bills introduced into Congress will be thoroughly examined in Part VI.

71. *Doctors with Aids*, *supra* note 67, at 49, 51. For this Newsweek Poll, the Gallup Organization interviewed a national sample of 618 adults by telephone on June 20, 1991. The exact breakdowns of the poll were as follows: "[Q]. Which of the following kinds of health-

The CDC guidelines, the Bergalis case, and the proposed legislation evoked controversy, conflicting medical opinions as to the genuine risk of physician to patient transmission, and criticism of both the federal government and the CDC because of their lack of decisiveness and uniformity in handling the AIDS epidemic.⁷² Thus the second decade of the epidemic started, with new groups claiming discrimination, factions being created within the medical community, and commentators stating that the medical profession was entering the "post-Hippocratic era," with HIV infection as the most difficult ethical question at issue in medicine.⁷³

IV. CDC GUIDELINES: JULY, 1991

Officially entitled "Recommendations for Preventing Transmission of Human Immunodeficiency Virus and Hepatitis B Virus to Patients During Exposure-Prone Invasive Procedures," the CDC guidelines, as they are better-known, were premised upon the fact that they were interim until further data on HIV transmission was available.⁷⁴ Prior to this publication, the CDC had recommended adherence to "universal precautions" to reduce the risk of occupational HIV transmission to health care workers.⁷⁵ The precautions recommended primarily that all patients be considered HIV/HBV carriers and required that health care workers routinely use appropriate barrier protection to prevent skin to mucous membrane exposure when contact with blood or body fluids is anticipated. Gloves were recommended for the touching of any body fluids, and eyewear, masks and gowns were recommended during procedures that were likely to generate droplets or splashes of blood.⁷⁶ In addition, the universal precautions required thorough handwashing, procedures promoting the prevention of injury caused by needles, scalpels and other sharp instruments, and proper disposal of such sharp instruments.⁷⁷ The recommendations also instructed that health care workers with exudative lesions or weeping dermatitis should refrain from all direct

care workers should be required to tell patients if they are infected with the AIDS virus? [A]. 95% surgeons, 94% all physicians, 94% dentists, 90% all health care workers." *Id.*

72. See *infra* parts V., VI.

73. Wyld & Cappel, *supra* note 47, at 99.

74. *Recommendations for Preventing Transmission*, *supra* note 1, at 2.

75. Larry Gostin, *Hospitals, Health Care Professionals, and AIDS: The "Right to Know" the Health Status of Professionals and Patients*, 48 M.D. L. REV. 12, 24 (1989). The official name of the precautions are the "universal blood and body fluid precautions" and blood and body fluids are abbreviated as "BBFs." *Id.*

76. Gostin, *supra* note 75, at 25.

77. *Id.*

patient care.⁷⁸ Under the subtopic of "occupational risk of acquisition" the precautions recommended counselling of HIV-infected workers as to their risks of acquiring infections from their patients and recommended that the health care worker's (HCW's) personal physician and the appropriate hospital personnel should determine on an individual basis whether the HCW can adequately and safely perform patient-care duties, indicating work assignment changes where necessary.⁷⁹

As to the question of possible health care worker to patient transmission of HIV, the 1985 precautions stated that "whether additional restrictions are indicated for HCWs who perform invasive procedures is currently being considered,"⁸⁰ and a 1987 update of these recommendations provided:

The question of whether workers infected with HIV—especially those who perform invasive procedures—can adequately and safely be allowed to perform patient care duties or whether their work assignments should be changed must be determined on an individual basis. These decisions should be made by the health care worker's personal physicians in conjunction with the medical director and personnel health service staff of the employing institution or hospital.⁸¹

The July 1991 guidelines emphasized adherence to universal precautions and still required that blood and other bodily fluids be handled as if HIV-and HBV-infected.⁸² In addition, the guidelines were premised upon the following considerations: HBV- or HIV-infected health care workers who adhere to universal precautions and do not perform invasive procedures posed no risk of HBV or HIV transmission to patients, and that HIV is transmitted much less readily than HBV.⁸³ The CDC used an HBV transmission model to outline "exposure prone" procedures and defined the characteristics of such procedures as follows:

Despite adherence to the principles of universal precautions, certain invasive surgical and dental procedures have been implicated in the transmission of HBV from infected HCWS to patients, and should be considered exposure-prone. Reported ex-

78. *Recommendations for Preventing Transmission*, *supra* note 1 at 2.

79. *Leckelt v. Board of Commissioners of Hospital Dist. No. 1*, 714 F. Supp. 1377, 1381-82 (E.D. La. 1980). This case will be discussed at length *infra* part VII.C.

80. *Id.* at 1381.

81. *HERMANN & SCHURGIN*, *supra* note 10, at 38, 47.

82. *Recommendations for Preventing Transmission*, *supra* note 1 at 2.

83. *Id.*

amples include certain oral, cardiothoracic, colorectal, and obstetric/gynecologic procedures.

Characteristics of exposure-prone procedures include digital palpation of a needle tip in a body cavity or the simultaneous presence of the HCW'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 HCW, and—if such injury occurs—the HCW's blood is likely to contact the patient's body cavity, subcutaneous tissues, and/or mucous membranes.⁸⁴

As published in July of 1991, the CDC guidelines left the identification of exposure-prone procedures to the "medical/surgical/dental organizations and institutions at which the procedures are performed."⁸⁵ And in June, 1992, the CDC notified each state that it would be for state health departments to decide on a case-by-case basis which procedures are exposure-prone, taking into consideration the specific procedure as well as the skill, technique, and possible impairment of the infected health care worker.⁸⁶ The 1991 guidelines also recommended that health care workers comply with current guidelines regarding disinfection and sterilization of reusable devices used in invasive procedures.⁸⁷ In an appendix to the report, the CDC defined "invasive procedure" as follows:

[S]urgical 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)vaginal or caesarean delivery or other invasive obstetric procedure . . . ; 4)the manipulation, cutting or removal or any oral or perioral tissues, including tooth structure, during which bleeding occurs or the potential for bleeding exists.⁸⁸

The CDC did not recommend mandatory testing of health care workers because the "current assessment of risk . . . [did] not support the diversion of resources that would be required to implement mandatory testing programs."⁸⁹ Of the greatest impact in the guide-

84. *Id.* at 4 (citations omitted).

85. *Id.* at 5.

86. *CDC Not Publishing Revised Guidelines on Infected Workers*, AIDS ALERT, August 1992, 113, 113.

87. *See supra* note 73, at 5.

88. *Id.* at 9.

89. *Id.* at 6.

lines were the following recommendations:

- [1] HCWs who perform exposure-prone procedures know their HIV status;
- [2] [Those] . . . infected should not perform exposure-prone procedures unless they have sought counsel from an expert review panel and have been advised under what circumstances, if any, they may continue these procedures.
- [3] Such circumstances would include notifying prospective patients of the HCW's seropositivity before they undergo exposure-prone invasive procedures.
- [4] The review panel should include experts . . . [who] might include a) the HCW's personal physician(s) b) an infectious disease specialist . . . c) a health professional with expertise in the procedures performed by the HCW, and d) state or local public health officials. If the HCW's practice is institutionally based, the expert review panel might also include a member of the infection-control committee, preferably a hospital epidemiologist.
- [5] HCWs whose practices are modified because of their . . . infection status should, whenever possible, be provided opportunities to continue appropriate patient-care activities. Career counseling and job retraining should be encouraged.⁹⁰

The CDC concluded its report by outlining "additional needs" regarding its research in this important area, including:

- [1] [A] clearer definition of . . . the circumstances of blood contact between patients and HCWs during invasive procedures.
- [2] Development . . . of new devices, protective barriers, and techniques that may prevent such blood contact.
- [3] More information on the potential for HIV and HBV transmission through contaminated instruments.
- [4] Improvements in sterilization and disinfection for certain reusable equipment and devices.
- [5] Identification of factors that may influence the likelihood of HIV or HBV transmission after exposure to HIV- or HBV-infected blood.⁹¹

The responses to the CDC guidelines were immediate. Within a week of their publication, two measures were passed in the Senate, one which required criminal penalties against HIV-infected health care workers who continued to perform invasive procedures without telling their patients of their status, and another that would require that states adopt the guidelines or risk non-receipt of federal public

90. *Id.* at 5-6.

91. *Id.* at 6.

health funds.⁹² AIDS newsletters for medical professionals predicted that "mandatory HIV testing of surgeons and dentists [was] 'inevitable',"⁹³ and that "four to five patients a year may be infected by surgery."⁹⁴ Sharp criticism of the guidelines was reflected in statements that "these new recommendations elevate prejudice, politics, and public relations over sound public policy."⁹⁵

The Bergalis case moved to the center of discussions in both lay and professional newspapers, magazines and journals—and the medical debate as to the actual risk of physician to patient transmission that had started with the January 1991 CDC update regarding Bergalis escalated.⁹⁶ The CDC came under increased criticism from both pro-restriction and anti-restriction factions and was plagued by adverse publicity,⁹⁷ epitomized by a chief officer's statement that "for years we've been expecting a case like this."⁹⁸

V. THE RISK OF HIV TRANSMISSION FROM HEALTH CARE PROFESSIONAL TO PATIENT

In March of 1991 the CDC reported from a compilation of documented cases that over 6,400 health care workers had contracted AIDS since the beginning of the epidemic.⁹⁹ In November of 1991,

92. *Id.*

93. 6 AIDS ALERT (Am. Health Consultants, Atlanta, Ga.), Sept., 1991, at 165.

94. *Four to Five Patients a Year May be Affected During Surgery*, 6 AIDS ALERT (Am. Health Consultants, Atlanta, Ga.), Aug. 1991, at 151.

95. *Hysteria Trumps Reason on Health Worker Policy*, 4 AIDS UPDATE (Lambda Legal Defense & Educ. Fund, Inc., New York, N.Y.), July 1991, at 3.

96. See *Doctors with AIDS*, *supra* note 67, at 49. This article noted that the cover story of Newsweek was entitled "Doctors with AIDS." The cover featured a photograph of an HIV-infected physician with a sub-topic to the title which stated: "Dr. Richard Duff retired last week, three and a half years after he got sick. Chances are none of his patients will contract the disease. But stories like his have Americans scared and arguing about the right of patients and doctors to know each other's HIV status." *Id.*; see also Frank S. Rhame, *The HIV-Infected Surgeon*, 264 JAMA 507 (1990). The author states, "[n]o surgeon-to-patient HIV transmission has been reported, but it is an example of the collective denial that has afflicted past HIV-related deliberations to avoid rigorous consideration of the issue. *Id.* The debate as to the risk of HIV transmission from health care worker to patient is thoroughly discussed *infra* part V.

97. Gerbert et al., *supra* note 32, at 1847.

98. *Id.* (quoting Harold Jaffe, MD, CDC deputy director for AIDS science).

99. *Doctors with Aids*, *supra* note 67, at 49-50. Newsweek broke down the CDC figures as follows:

Nurses	1,358
Health Aides	1,101
Technicians	941
Physicians	703
Paramedics	116

the New England Journal of Medicine stated that "more than 7,000 health care workers have AIDS . . . and an additional unknown number have HIV infection."¹⁰⁰ These figures do not take into account any underreporting, which is estimated at approximately 20%,¹⁰¹ it is further estimated that health care workers are less likely than other AIDS patients to report intravenous drug use.¹⁰² The above figures show an increase over the January 1989 reported cases of approximately 3,500 HIV-infected health care workers,¹⁰³ and although estimates are in conflict on this issue, it is reported that approximately 5.4% of all health care workers have AIDS, compared to 5.7% of the work force at large.¹⁰⁴

Calculation of the actual risk of HIV transmission from health care worker to patient involves the examination of several factors. The first factor is the rate of exposure of the health care workers' bodily fluids to those of the patient.¹⁰⁵ Although the statistics vary on this factor, studies indicate that surgeons and dentists will cut a glove in one of every four cases and will sustain a significant skin cut in one of every 40 cases.¹⁰⁶ More conservative estimates, as presented during the Seventh International Conference on AIDS in Florence in June of 1991, place the median risk of injury at 12 injuries per 1,000 operating room hours, or .012 per hour of surgery.¹⁰⁷ The second factor, also presented at the conference, is the risk that a surgeon is infected with HIV.¹⁰⁸ Although difficult to evaluate, the CDC estimates that five per 1,000 surgeons, or .005 are infected

Therapists	319
Dentists and Hygienists	171
Surgeons	47
Misc. (administrators, social workers, etc.)	<u>1,680</u>
TOTAL	6,436

100. Richard N. Danila et al., *A Look-Back Investigation of Patients of an HIV-Infected Physician* 1406 *NEW ENG. J. MED.* 1 (1991).

101. Isaacman, *supra* note 46, at 443 n.25.

102. *Id.* at 441 n.13.

103. *Id.*

104. Gostin, *supra* note 75, at 15. The authors of one casebook estimate health care worker infection percentages at .07%, challenging Gostin's estimate of 5.4%. CLOSEN ET AL., *supra* note 7, at 179 ("The claim that one-twentieth of the work force at large and HCWs are HIV-infected is incredulous. Indeed, in the calculations presented by Gostin, the numerator . . . may have been placed over the wrong denominator.").

105. Larry Gostin, *The HIV-Infected Health Care Professional*, 151 *ARCHIVES OF INTERNAL MEDICINE* 663, 663-64 (1991).

106. *Id.* at 664.

107. *Four to Five Patients A Year May be Infected During Surgery*, *supra* note 94, at 151.

108. *Id.*

with HIV.¹⁰⁹

The third factor, that of the risk of HIV transmission to the patient after exposure or injury in the operating room, is under great debate because researchers originally used rates of seroconversion based upon health care worker exposure to HIV-infected patients.¹¹⁰ These figures, it is argued, depict a greater rate of seroconversion because the nature of health care worker exposures pose a greater potential for a transfer of greater amounts of the virus (i.e. per hollow needle sticks).¹¹¹ Whereas some commentators use the range of .03 to 0.9 percent probability that a health care worker will contract HIV following a documented case of percutaneous or mucous membrane exposure,¹¹² others argue that the lower figure should be halved, resulting in a one in 11.1 million chance per hour of surgery that HIV transmission from *any given surgeon* to patient would occur.¹¹³ If the surgeon is HIV-infected, only two probability factors are used to determine the risk of infection, estimated at one in 48,000 per hour of surgery.¹¹⁴ In conclusion, it is estimated that four to five patients a year may be infected during surgery.¹¹⁵ These figures are similar to those estimated by the CDC, which concedes that additional data are still needed on the frequency of injuries among dentists as well as more details as to the risks associated with particular surgical procedures.¹¹⁶

Although these figures are the subject of debate among medical scholars, others are quick to emphasize that the *cumulative* risk that one patient of an HIV-infected surgeon will contract HIV is within a range that justifies public concern and public health policy precautions.¹¹⁷ In addition, as modeled upon documented HBV transmis-

109. *Id.*

110. *Id.*

111. *Id.*

112. Gostin, *supra* note 75, at 17.

113. *Four to Five Patients A Year May be Infected During Surgery*, *supra* note 94, at 151-52 (emphasis added). This figure is calculated by multiplying the risk of injury (.012) by the risk of physician infection (.005) by the risk of seroconversion after exposure (.0015). *Id.*

114. *Id.* at 152. This figure is calculated by multiplying the risk of injury (.012) by the risk of seroconversion after exposure (.0015). *Id.*

115. *Id.*

116. *Id.*

117. Gostin, *supra* note 105, at 664 (emphasis added).

In another journal, Professor Gostin outlines the figures involved in a surgeon's cumulative risk of infecting his patients: "Assuming that the surgical patient's risk [of contracting HIV from the surgeon] is exceedingly low (1/130,000), the risk that one of his patients will contract HIV becomes more realistic the more operations he performs—1/13,000 (assuming 100 operations) or 1/126 (assuming 500 operations)." Larry Gostin, *HIV-infected Physicians, and the Practice of Seriously Invasive Procedures*, HASTINGS CTR. RPT., Jan.-Feb. 1989, at

sion, it is argued that HIV-infected physicians and dentists will transmit in clusters, further increasing the probability of infecting their patients.¹¹⁸

Is the CDC being over-cautious regarding the risk of HIV transmission from health care worker to patient? This, too, is another area of controversy. Many professionals do not believe the CDC's attribution of Dr. Acer's patients' HIV to their dental care.¹¹⁹ Others allude to the fact that the CDC may be overcompensating for their past mistakes of being too slow and overly cautious in releasing potentially controversial data.¹²⁰ Still others point out that early in the history of the epidemic the CDC lost public trust by making bald assurances that there was no risk of transmission through transfusions or blood products.¹²¹

The CDC's DNA studies revealed that the viruses of the dentist and his HIV-infected patients were within a range difference of 3.4%,¹²² an extent of similarity expected for epidemiologically-linked individuals.¹²³ And as to patients "A," "B," and "C," Acer's viral sequence was closer to each of the three patients than their DNA sequences were to each other.¹²⁴ These findings suggest that cross contamination between patients was a less likely route of HIV transmission in Acer's office than direct blood-to-blood transfer from the

32, 33.

118. Gostin, *supra* note 105, at 664.

119. Gerbert, *supra*, note 32, at 1847; *see also* Hirsch, *supra* note 9, at 325. The author notes:

The danger of catching a disease at the dentist's office was first noticed in 1974, when it was discovered that a healthy-looking . . . dentist . . . had infected 55 patients with hepatitis B over a three-year period. Eight other local outbreaks of hepatitis B have been traced to dentists since then.

Id.

120. *Id.*

121. Isaacman, *supra* note 46, at 454.

122. Harold L. Hirsch, *A Visitation with AIDS, Part IX*, 37 MED. TRIAL TECH. Q. 110, 110 (1990).

123. Gerbert et al., *supra* note 32, at 1847.

Although a full discussion of genetic linking of viruses is beyond the scope of this article, the average difference between Acer and his five patients is reported between 2.5% and 4.6%. According to specialists in the Los Alamos National Laboratory, HIV viral sequences from mothers to babies have been shown to vary by 3% to 6%. When comparing viral sequences found in infected women and unrelated babies, sequences can vary from 12%-16%. In addition, the HIV sequence of the dentist and the five patients shared a signature pattern that has not been found in any other HIV sequence published in the National Laboratory's data base. For more information on this topic, see *Four to Five Patients a Year May be Infected During Surgery*, *supra* note 94, at 157.

124. *Unreported Findings Shed New Light on HIV Dental Case*, 6 AIDS ALERT (Am. Health Consultants, Atlanta, Ga.), July, 1991 at 128.

dentist to his patients.¹²⁵ This area, namely the route of HIV transmission, is another area of medical speculation and debate. Those doubting the possibility of health care worker to patient transmission insist that Acer must have transmitted HIV to his patients through the use of improperly sterilized equipment, and that the case is in effect one of patient to patient transmission.¹²⁶

The CDC is not certain of the mode of HIV transmission from Dr. Acer to his patients, but theories offered, given the closeness of his viral strain to that of the infected patients, include injury of Acer during an invasive procedure during which he bled into each patient's mouth;¹²⁷ treating his lover and not properly sterilizing the equipment afterward;¹²⁸ treating himself and not properly sterilizing his equipment afterward;¹²⁹ and, the most chilling of all, intentionally injecting his infected blood into each patient.¹³⁰

The CDC's guidelines are consistent with recent policy statements issued in January of 1991 by both the American Medical Association (AMA) and the American Dental Association (ADA). In acknowledging that the new policy was created in response to the CDC reports on dentist to patient transmission of HIV, the AMA policy stated:

HIV-positive [physicians] have an ethical obligation not to engage in any professional activity which has an identifiable risk of transmission . . . to the patient [R]ecent cases of possible dentist-to-patient transmission have caused some uncertainty about the risk of transmission . . . under certain circumstances. In cases of uncertainty about the risks to patient health, the

125. *Id.* at 122.

126. *Hysteria Trumps Reason on Health Worker Policy*, *supra* note 95, at 6.

127. *Unreported Findings Shed New Light on HIV Dental Case*, *supra* note 124, at 124-25.

128. *Id.* at 123.

129. Lawrence Kaltman, *An Aids Puzzle: What Went Wrong in the Dentist's Office*, N.Y. TIMES, July 30, 1991, at C3.

130. *Unreported Findings Shed New Light on HIV Dental Case*, *supra* note 124, at 137. This last theory, although appearing extreme, was offered by medical researchers believing that Acer was "a militant, meaning he wanted to make a statement . . . that he deliberately infected these people." *Id.*

An equally chilling theory is that Acer may have used "contaminated instruments some of which may have been used to cauterize his lesions." Sari Staver, *CDC Still Backing HIV Restrictions*, AMERICAN MEDICAL NEWS, Nov. 18, 1991, at 31 (quoting ADA Trustee Walter F. Lamacki).

Although a thorough discussion of the implications of AIDS "dementia" affecting a physician's practice is beyond the scope of this article, it is an area of growing concern among those who believe that physicians should be required to disclose their HIV status to patients and employers.

medical profession, as a matter of medical ethics, should err on the side of protecting patients

Consequently, until the uncertainty about transmission is resolved, the [AMA] believes that HIV-infected physicians should either abstain from performing invasive procedures that pose an identifiable risk of transmission, or disclose their seropositive status prior to performing a procedure and proceed only if there is informed consent.¹³¹

The ADA, stating that the risk of dentist to patient HIV transmission was "infinitesimal," nonetheless also recommended that HIV-infected dentists should refrain from performing invasive procedures or should disclose their seropositive status until the uncertainty regarding possible transmission is resolved.¹³² In response to the CDC's initial reports of the Acer case in July of 1990, the Surgical Infection Society, the Society of Thoracic Surgeons, the American College of Surgeons, and the American Academy of Orthopedic Surgeons recommended to the CDC that "the public would best be protected if infected surgeons no longer operated."¹³³

In July of 1991 when the Bergalis case, the new CDC guidelines, and proposed legislation were topics covered on a daily basis in newspapers across the country, the AMA reiterated its policy, stating that those members who flouted recommendations to refrain from invasive procedures or warn their patients could be accused of "unprofessional conduct, an offense punishable by every state licensing board in this country."¹³⁴

Four months later, in response to continued requests that medical professional associations assist the CDC in compiling the list of "exposure-prone invasive procedures" as the July guidelines required,¹³⁵ the majority of the country's leading medical and dental groups criticized the CDC for attempting to develop such a list without more scientific data.¹³⁶ These groups also insisted that factors such as a surgeon's individual technique must be considered in deter-

131. *AMA Statement on HIV-Infected Physicians*, 6 AIDS ALERT, Feb. 1991, at 24.

132. *ADA Statement on HIV-Infected Dentists*, 6 AIDS ALERT, Feb. 1991, at 24. *But see infra* note 315.

133. *Surgical Associations: Don't Operate if Infected with HIV*, 5 AIDS ALERT, Oct. 1990, at 181.

134. Martin Tolchin, *Stricter Action by Hospital Predicted After AIDS Votes*, N.Y. TIMES, July 20, 1991, at A13.

135. *See supra* text accompanying notes 84-90.

136. *CDC Revises Recommendations on HIV-Infected Providers*, 7 AIDS ALERT, Jan. 1992, at 1-3.

mining whether a procedure poses a significant risk to patients.¹³⁷ Only the AMA expressed continued support for the CDC's July guidelines and its plans to compile such a list, with a spokesperson stating that "it is simply unacceptable for the medical profession to stand by, wait, and watch for possible cases of health care workers infecting patients with HIV in order to bring more scientific confidence to our recommendations Ambiguity or uncertainty should be resolved in favor of our patients' interests."¹³⁸

On June 18, 1992, the CDC stated that it would *not* modify its July guidelines and that it would *not* develop a national list of exposure-prone procedures.¹³⁹ The CDC decided instead that state health departments should decide on a case-by-case basis which, if any, procedures are exposure-prone, taking into consideration factors such as the specific procedure, as well as the skill, technique, and possible impairment of the infected health care worker.¹⁴⁰

VI. PROPOSED FEDERAL LEGISLATION: "FIRST DO NO HARM"

"First, do no harm," the basic tenet of the Hippocratic oath, was used repeatedly in the discussions of proposed legislation in both houses of Congress in the summer and fall of 1991.¹⁴¹ On July 18,

137. *Id.* at 4.

138. *Id.* at 5 (quoting AMA trustee Nancy Dickey, M.D.).

139. *CDC Not Publishing Revised Guidelines on Infected Workers*, *supra* note 6 (emphasis added). This announcement was made in a letter dated June 18, 1992 which was sent from William L. Roper, M.D., M.P.H., the director of the CDC to each state health officer. The letter reflected the controversy surrounding the compilation of such a list and revision of the original guidelines, and state in part:

After careful review and consideration, we have decided not to modify the July 12, 1991 recommendations. Our review of state guidelines, with respect to their equivalency to the July 12 recommendations, will give appropriate consideration to those states that decide that exposure-prone invasive procedures are best determined on a case-by-case basis, taking into consideration the specific procedure as well as the skill, technique, and possible impairment of the infected health care worker.

Id. at 115. Commentators note that "[b]y not coming out with a national list of exposure-prone procedures, the CDC has essentially revised the July 1991 guidelines." And a spokesman, Kent Taylor, stated that the CDC decided not to publish revised guidelines because it didn't want to further confuse the issue and create more controversy. Taylor stated that the decision was based on the agency's inability to satisfy all of the medical groups commenting on the guidelines, and that although the letter sent to state health departments doesn't state specifically that the CDC is not planning to develop a national list of exposure-prone procedures, the agency has abandoned the idea. *Id.* at 114.

140. *Id.* at 113.

141. The Honorable Senator Edward Kennedy, D-Massachusetts, in opposition to the Helms amendment and in support of the "leadership amendment" stated: "The first requirement of the health profession and of any doctor is to 'Do no harm.' That should also be the

1991, Senator Jesse Helms (R-North Carolina) introduced onto the Senate floor an amendment to an appropriations measure for the Treasury Department and Postal Service which included language calling for prison terms for health care workers with AIDS who fail to notify their patients of their condition.¹⁴² The measure specifically made it a “[f]ederal crime for a doctor, dentist or other health care professional who has AIDS and knows it to perform invasive medical procedures without informing the patient,” and imposed maximum fines of \$10,000 and maximum prison terms of ten years.¹⁴³ In support of the amendment, Senator Helms emphasized that the measure did not require mandatory testing and noted that the inspiration for the amendment was Kimberly Bergalis, who “[f]or the last few months . . . has taken her struggle to the American people, demanding that HIV-infected doctors, dentists, and health care workers be required to disclose their condition to their patients.”¹⁴⁴

Helms criticized physicians who “recklessly expose thousands of innocent Americans to this deadly disease,” and stated that to do so “is a vile act which should be rooted out and punished.”¹⁴⁵ In conclusion, Helms admitted that the “vast majority [of physicians] have honorably abided by the opening sentence of the Hippocratic Oath: ‘I shall first do no harm.’ However,” he emphasized, “there are a few people in the medical establishment who have thrown away their oath and duty to others.”¹⁴⁶

In opposition to the Helms amendment, and in support of a bipartisan leadership amendment that would require States to adopt the July 1991 CDC guidelines or risk losing public health funds, Senator Edward Kennedy criticized the Helms measure as “purport[ing] to give peace of mind to patients by terrorizing physicians

requirement for any action by Congress on this critical and highly charged emotional issue: ‘Do no harm.’” 137 CONG. REC. S10332 (daily ed. July 18, 1991) (statement of Sen. Kennedy).

Dr. George Bohigian, a witness in the House of Representatives in support of the “Bergalis Bill” sponsored by the Honorable William E. Dannemeyer (R-California), testified on September 27, 1991, as follows: “Physicians should be the leaders in determining their HIV status. As a profession, we need to hold ourselves up to a high standard. Remember, Hippocrates said, ‘First, do no harm.’” Philip J. Hiltz, *AIDS Patient Urges Congress to Pass Testing Bill*, N.Y. TIMES, Sept. 27, 1991, at A12.

142. Kitty Dumas & Julie Rovner, *Helms Wins Big on AIDS Issue, But Victory May Not Last*, CONG. Q., July 20, 1991, at 1978.

143. 137 CONG. REC., S10322-31, S10333, S10363 (daily ed. July 18, 1991).

144. *Id.* at S10334.

145. *Id.*

146. *Id.*

and other health care workers."¹⁴⁷ "Our alternative," he stated, ". . . would enact the best recommendations of our public health experts by implementing the new guidelines issued by the CDC."¹⁴⁸ The Senator further criticized the Helms amendment as doing "nothing to protect the health of the American people,"¹⁴⁹ and because it punished HIV-infected health care workers who knowingly practiced, he noted its potential to "seriously undermine the willingness of health care workers to seek HIV testing when they know they have been placed at risk."¹⁵⁰ In closing, Senator Kennedy made the following statement:

The choice we face is clear. Either we will vote to instill fear and avoidance among physicians and other health care workers . . . or we will vote to strengthen our health care system and make it safer for everyone by adopting these guidelines To vote for penalties in the Helms amendment is a mockery of the CDC guidelines, and dashes any hope of their implementation in a sound and rational manner This is a public health problem, not a criminal law problem.¹⁵¹

Both measures were passed in the Senate, the Helms measure by a vote of 81 to 18, and the leadership measure by a unanimous vote of 99.¹⁵² Before their debate in the House, both measures were the target of criticism and speculation. Helms' critics accused the Senator of having as his primary aim "not to protect the public health but to demonize and scapegoat HIV-positive doctors, particularly those who are gay."¹⁵³ Others noted that "hospitals are going to have no choice but to become tougher,"¹⁵⁴ while officials predicted that "hospitals will take action whether or not the Senate bills become law."¹⁵⁵ The consensus was that "the Senate was responding to public opinion, to assure that they were on record as doing everything possible to reassure the public."¹⁵⁶

As the two appropriations amendments were introduced into the House for further debate and House approval, so too was the

147. *Id.* at S10332.

148. *Id.*

149. *Id.*

150. *Id.*

151. *Id.* at S10332.

152. *Id.* at S1022-48, S10363, D923.

153. *Hysteria Trumps Reason on Health Worker Policy*, *supra* note 95, at 6.

154. Tolchin, *supra* note 134, at 13 (quoting Fred Entin, General Counsel of the American Hospital Association).

155. *Id.*

156. *Id.* (quoting Dr. James S. Todd, Executive Vice President of the AMA).

"Kimberly Bergalis Patient and Health Providers' Protection Act of 1991," sponsored by Representative William Dannemeyer (R-California).¹⁵⁷ The bill was an amendment to the Public Health Service Act that was designed to protect patients from infected health care providers and to protect health care providers from infected patients.¹⁵⁸ For patient protection the bill required that the Secretary of Health and Human Services:

- 1) publish a list of communicable diseases that pose a risk to the public health (to include HIV and hepatitis B);
- 2) list invasive procedures that an infected health care worker would be prohibited from performing;
- 3) list the categories of health care providers that should be subject to the above provisions; and
- 4) specify the frequency of testing required for each disease and category of health care worker.¹⁵⁹

The bill also required for further patient protection that states accepting funds under the Ryan White law¹⁶⁰ must require:

- 1) testing of certain health care providers as determined by the Secretary of Health and Human Services;
- 2) that infected providers refrain from performing invasive procedures for the duration of the disease unless the provider informs the patient of his HIV status and obtains the patient's express written consent to perform the procedure;
- 3) require employers of infected providers to help such providers make the necessary professional adjustments to deliver health care in a capacity consistent with the protection of public health; and
- 4) guarantee that patients of infected providers be informed of their possible exposure to the disease and be offered counseling and testing for such disease.¹⁶¹

For the protection of the health care provider against infected patients, the secretary was to list relevant diseases and medical procedures that pose a risk to the provider.¹⁶² He was also to authorize nonconsensual testing of patients where (1) the provider has consent to perform the invasive procedure creating the risk; (2) the provider has a reasonable basis for believing that the patient has the disease;

157. H.R. 2788, 102d CONG., 1st Sess. (1991).

158. *Id.* at 2-15.

159. *Id.* § 2648A, at 2, 3.

160. Ryan White Law, Pub. L. No. 101-381.

161. H.R. 2788, *supra* note 157, § 2648A, at 4-7.

162. *Id.* § 2648B.

(3)the provider only test for such diseases as there is reasonable basis; and (4) the test results are subject to state confidentiality protection.¹⁶³

The hearings on the Bergalis' bill were extensively covered in the media and were the target of attack by those who believed that the Bergalis case was "being used by the right-wing forces to rekindle some of the fear . . . lurking . . . about AIDS."¹⁶⁴ Ms. Bergalis herself, weakened by the ravages of the disease, testified in Congress in support of the bill, stating: "I didn't do anything wrong Please enact legislation so other patients and health care providers don't have to go through the hell that I have."¹⁶⁵ By early October headlines stated: "AIDS Battle Reverting to 'Us Against Them,'" and news stories reported that the right-wing was using "innocent victims" to advance their agenda as opposed to "others" (homosexuals and drug addicts) who were somehow to blame for their plights.¹⁶⁶ The extremeness of this battle was revealed by those who referred to "Kimberly-mania",¹⁶⁷ or others who suggested that the question that the Bergalis case raises is "have we been lied to about the way we can get AIDS?"¹⁶⁸

The outcome of the Bergalis bill was that Representative Henry A. Waxman, (D-CA) chairman of the House Subcommittee on Health and the Environment, which oversees all health legislation in the House, would not allow a vote on it.¹⁶⁹ Congressman Dannemeyer believes that there is tremendous support for the bill and will reintroduce it when the proper legislative opportunity arises.¹⁷⁰

As to the two appropriations amendments, the Helms bill was defeated¹⁷¹ and the "leadership" bill was compromised to require states, within one year of the date President Bush signed the bill into law on October 28, 1991, to either adopt the CDC guidelines or

163. *Id.* § 2638B.

164. Hiltz, *supra* note 141, at A12.

165. *Id.*

166. Richard L. Berke, *AIDS Battle Reverting to 'Us Against Them,'* N.Y. TIMES, Oct. 6, 1991, § 4, at 1.

167. *Id.*

168. *Id.*

169. Telephone interview with Bret Barbre, Special Assistant to Congressman William E. Dannemeyer, 39th Dist. (Jan. 23,1991)

170. *Id.* In our discussion, Mr. Barbre outlined that the bill has to be attached to the proper "vehicle," i.e., another bill that is germane to the topic that Congressman Dannemeyer is presenting. *Id.*

171. Philip J. Hiltz, *Congress Urges that Doctors be Tested for AIDS,* N.Y. TIMES, Oct. 4, 1991, at A18.

their equivalent at the state level.¹⁷² The law requires that the states certify to the U.S. Department of Health and Human Services that they have instituted an appropriate policy on HIV-infected health care providers; and the director of the CDC is to judge whether states have adopted such equivalent guidelines should they choose not to adopt those of the CDC.¹⁷³ Although the equivalency criteria were originally undetermined when the guidelines were first released,¹⁷⁴ the CDC eventually decided that "[e]quivalency will be decided on a case-by-case basis."¹⁷⁵ States that fail to make this certification will risk losing money under the Public Health Service Act.¹⁷⁶ And commentators speculate that the states will be able to satisfy the new "equivalency" requirements even if their guidelines are more lenient or more restrictive than the CDC's.¹⁷⁷

Thus, at the conclusion of the 1991 legislative sessions of Congress, a uniform federal policy as to how to regulate HIV-infected health care providers was proposed and defeated. What remains is state regulation that should be the equivalent of the CDC guidelines. And after a year of controversy surrounding the July 1991 guidelines, during which it was reported that they were under revision,¹⁷⁸ the CDC announced that it would continue to follow the 1991 guidelines but not develop a national list of exposure-prone procedures as originally recommended.¹⁷⁹ Instead it is now up to state health departments to decide on a case-by-case basis which procedures are exposure-prone, taking into consideration the specific procedure, as well as the skill, technique, and possible impairment of

172. *CDC Questioned as State Responses to Guidelines Vary*, 7 AIDS ALERT, (Am. Health Consultants, Atlanta, Ga.), Jan. 1992, at 1, 7. The "leadership" bill was passed as a provision of the 1992 Treasury, Postal Services and General Government Appropriations Act, Section 663 of Public Law 102-141. AIDS ALERT, *supra* note 6, at 113-115.

173. *CDC Questioned as State Responses to Guidelines Vary*, 7 AIDS ALERT, *supra* note 6 at 1, 7, (Jan. 1992).

174. *Id.*

175. AIDS ALERT, *supra* note 6, at 117, quoting CDC spokesman Kent Taylor: "How the CDC will determine equivalency is somewhat unclear. "In the [June 18, 1992] letter sent to state health officers, those officers are asked simply to check a block next to a statement saying they have accepted the CDC guidelines or their equivalent." *Id.* at 117.

176. *Id.* Under the Public Health Service Act, states receive several million dollars in grants from the CDC, the National Institutes of Health, the Health Resources Services Administration, and other health agencies. *Id.*

177. *Id.* (quoting Professor Larry Gostin, executive director of the American Society of Law and Medicine and adjunct professor of Health Law, Harvard School of Public Health).

178. *Id.* at 1. AIDS Alert emphasized that these changes were in draft form and that they received a copy of the draft from a source not connected to the CDC. They also reported that the CDC has released a statement saying that it has revised its July 1991 guidelines.

179. See *supra* notes 139 and 140 and accompanying text.

the infected health care worker.¹⁸⁰ In addition, the worker's ability to continue to practice is to be evaluated upon factors such as individual technique, experience and infection control compliance.¹⁸¹

Critics accuse the CDC of "throw[ing] the issue of HIV-infected health care workers into the laps of the states" because the CDC did not develop their guidelines based on sound public health policy.¹⁸² Others, such as health officials in California, insist that "no scientific data exist to show that automatic restrictions are warranted or disclosure necessary."¹⁸³ And an advisory council to the National Institute of Allergy and Infectious Disease (NIAID) has asked the U.S. Department of Health and Human Services to appoint a non-government panel to review data on the risk of HIV transmission in health care settings, because they believe that the CDC "bowed to political pressure in making its recommendations" rather than basing them on available scientific evidence.¹⁸⁴

180. *Id.* In the summer of 1992, conflicting reports still existed regarding the CDC's position. In June, 1992, one commentator wrote:

The July 12 recommendations achieved the force of law in October 1991, when Congress required state public health officials to certify that the recommendations or equivalent guidelines would be instituted within one year. . . . Most likely, since the CDC appears to have backed away from the recommendations, the federal government will accept state certification without rigorous interpretation.

Frank S. Rhame, *Preventing HIV Transmission*, 91 *POSTGRADUATE MED.*, 15, 15 (June 1992).

In August, 1992, another commentator reported:

The Centers for Disease Control has abandoned its controversial attempt at national policymaking for employment of HIV-infected health care workers. State health departments were notified in June that they and local health authorities should make their own decisions. The agency is standing by its 1991 guidelines which recommended that professionals voluntarily seek testing if their work poses the possibility of their blood contacting a patient's tissues, cavities, or organs. Infected practitioners were urged to stop performing high-risk procedures unless they got clearance from a panel of local experts and written permission from patients. But health care groups rebelled when they were asked to help draw up a list of "exposure-prone procedures;" many flatly refused to comply, contending that the guidelines are too restrictive and that the risk of worker-to-patient transmission is minuscule. With no consensus in sight, "we thought it appropriate to take the middle ground and leave it up to the local review panels to decide on a case-by-case basis," a CDC spokesperson said.

NewsCaps, 92 *AM. J. NURSING* 65, 65 (1992).

181. *CDC Questioned as State Responses to Guidelines Vary*, *supra* note 172, at 1.

182. *Id.* at 6 (quoting Michael Carbine, director of the bureau of HIV/AIDS for the Pennsylvania Department of Health).

183. *Id.* at 8 (quoting Mark Madsen, California Medical Association's director for physician education).

184. *Id.* at 10 (quoting NIAID Council Member Janet Mitchell, MD, Chief of Perinatology for the Department of Obstetrics and Gynecology at Harlem Hospital in New

Today, existing state policy varies as to the regulation of HIV-infected health care providers. Illinois and Alabama have policies that go beyond the CDC guidelines by requiring public health officials to review the records of HIV-infected providers and to notify patients treated by them if deemed necessary.¹⁸⁵ Texas has turned the CDC guidelines into law by subjecting providers who fail to comply to disciplinary measures by licensing authorities.¹⁸⁶ A bill that was introduced into the Texas Legislature in 1990 that would have made it a crime for HIV-infected professionals to perform invasive procedures did not pass.¹⁸⁷ New York, on the other hand, rejected the CDC guidelines in early October 1991, when State Health Department officials released a policy proposal that required all health care workers to take a formal course in infection control.¹⁸⁸ In addition, New York officials proposed the development of review panels that would determine whether infected providers pose a significant risk to patients and should be restricted.¹⁸⁹ And infected workers who violate these recommendations could be cited for professional misconduct—but the system is voluntary and depends upon the willingness of infected providers to submit their cases to review panels; infected workers are under no obligation to inform their patients of their status.¹⁹⁰ Michigan's policy is also based upon following infection control procedures and emphasizes the need for medical devices that will reduce the risk of HIV transmission in health care settings.¹⁹¹ Other states, such as Pennsylvania, have yet to make final decisions on how they will respond to the guidelines.¹⁹²

Today the issue of restricting HIV-infected health care professionals is the subject of ongoing debate, with the ultimate responsibility as to how to resolve this difficult question left to the states themselves. The courts, in response to restrictive hospital policies, have relied upon common law principles and constitutional analysis in determining whether such policies will be upheld.

York).

185. *Id.*

186. *Id.*

187. *Id.* at 10.

188. Keven Sack, *Albany Plans to Allow Surgery by Doctors With the AIDS Virus*, N.Y. TIMES, Oct. 9, 1991, at A1.

189. *Id.*

190. *Id.*

191. *CDC Questioned as State Responses to Guidelines Vary*, *supra* note 172, at 8.

192. *Id.* at 6.

VII. RECENT CASE LAW REGARDING RESTRICTIONS UPON HIV-INFECTED HEALTH CARE PROFESSIONALS

The first issue addressed in the cases that have discussed restrictions of HIV-infected health care workers is whether such policies and practices are discriminatory.¹⁹³ Analysis of these cases therefore is discussed by examining federal and state antidiscrimination law. Section 504 of the Federal Rehabilitation Act of 1973, as amended in 1978 (the Act),¹⁹⁴ prohibits discrimination in employment, housing, and access to facilities on the basis of handicap and applies to the federal government, federal contractors and those entities receiving federal assistance.¹⁹⁵

A. *School Board of Nassau County v. Arline*

In the context of cases involving HIV-infected health care workers, the threshold question is whether AIDS or HIV infection constitutes a handicap under the Rehabilitation Act. This issue was indirectly addressed by the United States Supreme Court in *School Board v. Arline*,¹⁹⁶ in which the Court determined that contagious diseases were covered under the Act.¹⁹⁷ Ms. Arline, a schoolteacher, was fired after suffering a third relapse of tuberculosis, and the School Board admitted that it had fired her because they feared her contagiousness threatened her students.¹⁹⁸ The Court "held that an individual with a contagious disease . . . was a handicapped person protected under the . . . Act, and that discrimination based on fear of contagiousness of the disease was actionable . . ."¹⁹⁹ "In a footnote,

193. See the cases discussed *infra* in text accompanying notes 190, 220 and 258.

194. The Rehabilitation Act of 1973, 29 U.S.C. § 794(a), as amended by the Rehabilitation, Comprehensive Services, and Developmental Disabilities Amendments of 1978, Pub. L. No. 95-602, § 119, 92 Stat. 2955.

195. A.B.A. AIDS COORDINATING COMMITTEE, *supra* note 2, at 156. The language of the Act used by the courts in assessing a Section 504 claim is as follows:

No otherwise qualified individual with handicaps in the United States . . . shall, solely by reason of his or her handicap, be excluded from the participation in, be denied benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance.

196. *School Bd. v. Arline*, 480 U.S. 273 (1987).

197. *Id.* at 289.

198. *Id.* at 276, 281.

199. A.B.A. AIDS COORDINATING COMMITTEE, *supra* note 2, at 159. "In so holding, the Court explicitly rejected the reasoning of [a 1986 U.S. Department of Justice memo] which had argued . . . that discrimination based on fear of contagiousness. . . as [opposed] to discrimination based on the impairment itself was not actionable." *Id.* at 158-59 n.19.

For a full discussion of the Department of Justice's 1986 memo see Walter B. Connolly, Jr. & Alison B. Marshall, *An Employer's Legal Guide to AIDS in the Workplace*, 9 ST.

[however, the Court specifically] . . . noted that it was not deciding the issue of whether HIV-infected people [were] protected under the . . . Act because the facts before it did not" require such a ruling.²⁰⁰

The second issue addressed by the *Arline* Court was whether persons with infectious diseases are "otherwise qualified" for employment as required by the Rehabilitation Act.²⁰¹ The Court determined that such individuals would be otherwise qualified for their employment if they did not pose a "significant risk" of communicating the disease.²⁰² In determining a standard of significant risk the Court adopted guidelines formulated by the American Medical Association, including an assessment of the mode of transmission of infection, the duration of contagiousness, the severity of harm to third parties, and the probability that the disease would be transmitted.²⁰³ The Court further emphasized that whether "an individual is otherwise qualified will depend on the facts of the individual's particular case."²⁰⁴

The Court noted that the final step in the "otherwise-qualified" inquiry is to evaluate whether, in light of the medical findings listed above, the employer could reasonably accommodate the employee.²⁰⁵ The Court also specified that "[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."²⁰⁶ Because the Court lacked sufficient findings as to the severity of Arline's condition and the probability of whether she would transmit the disease, it concluded

LOUIS U. PUB. L. REV. 561, 564-65 (1990) (footnotes omitted) (first alteration in original)(quoting Memorandum from Charles J. Cooper to Robert E. Robertson (June 20, 1986) (available from the U.S. Dept. of Justice, Office of Legal Counsel, Wash., D.C.).

200. A.B.A. AIDS COORDINATING COMMITTEE, *supra* note 2, at 159.

201. *Arline*, 480 U.S. at 287.

202. *Id.*

203. *Id.* at 288.

204. Connolly & Marshall, *supra* note 199, at 566-67.

205. *Arline*, 480 U.S. at 288. The Court clarified pertinent terms, citing its prior decisions to do so:

"An otherwise qualified person is one who is able to meet all of a program's requirements in spite of his handicap." . . . When a handicapped person is not able to perform the essential functions of the job, the court must also consider whether any "reasonable accommodation" by the employer would enable the handicapped person to perform those functions. . . "[W]here reasonable accommodation does not overcome the effects of a person's handicap, or where reasonable accommodation causes undue hardship to the employer, failure to hire or promote the handicapped person will not be considered discrimination."

Id.

206. *Id.* at 287 n.16.

that it was unable to rule as to whether she was otherwise qualified, and remanded the case for further findings of fact.²⁰⁷

In March of 1988, Congress codified the *Arline* decision in the Civil Rights Restoration Act of 1987,²⁰⁸ amending the critical definition of a handicapped individual to include people with contagious diseases, while excluding those whose conditions would either endanger themselves and/or others or would render them unable to perform their jobs.²⁰⁹ The Act stated that section 504 of the Rehabilitation Act is "applicable to a person with a contagious disease if he or she does not pose a 'direct threat to the health or safety of other individuals.'"²¹⁰ And the congressional history of the Act shows that the language "direct threat" embodies the standard of "significant risk" of transmission articulated by the *Arline* Court.²¹¹

In the context of applying the Rehabilitation Act to the medical setting, recent decisions have interpreted the provisions pertaining to recipients of federal assistance to include hospitals and physicians receiving Medicare and Medicaid reimbursements.²¹² In addition, the Americans with Disabilities Act (ADA),²¹³ which was signed into law on July 26, 1990 and goes into effect in stages until January, 1993, prohibits discrimination on the basis of disability in the public and private sector in the areas of employment, public accommodations, transportation, and public services.²¹⁴ The Act specifically pertains to HIV-infected individuals and uses the basic legal framework of section 504 of the Rehabilitation Act in defining "handicaps" as well as incorporating the "otherwise qualified" anal-

207. *Id.* at 288-289. On remand, the district court held that Arline was an otherwise qualified person under the Act and ordered that she be reinstated to her position as a school teacher. *Arline v. School Board*, 692 F. Supp. 1286, 1290 (M.D. Fla. 1988).

208. Civil Rights Restoration Act of 1987, Pub. L. No. 100-259, § 9, 102 Stat. 28, 31-32 (1988); see Connolly & Marshall, *supra* note 199, at 567.

209. Civil Rights Restoration Act of 1987, § 9.

210. Lawrence Gostin, *HIV-Infected Physicians and the Practice of Seriously Invasive Procedures*, HASTINGS CENTER REP., Jan.-Feb. 1989, at 32, 37 (quoting Civil Rights Restoration Act of 1987, § 9).

211. *Id.*; *Arline*, 480 U.S. at 287 n.16.

212. Wyld & Cappel, *supra* note 47, at 102.

213. Americans with Disabilities Act, Pub. L. No. 101-336, 104 Stat. 327.

214. *Id.* Starting in January, 1992 (eighteen months after its enactment), customers and clients can use the ADA against discriminatory public accommodations. By July, 1992, any business that employs between 11 and 25 people cannot discriminate against individuals with disabilities; and by January, 1993, the ADA will apply to all businesses employing 10 or fewer people. *Id.*; see also *New Federal Law Protects People with HIV Disease*, 6 AIDS ALERT 50, 51 (1991); Lawrence O. Gostin, *The AIDS Litigation Project*, 263 JAMA 2086, 2087 (1990).

ysis articulated in *Arline*.²¹⁵

The ADA also uses the same standards as the Rehabilitation Act in determining that a person with a contagious disease will not be "otherwise qualified" if he or she poses a "direct threat to the health or safety of other individuals in the work place."²¹⁶ The ADA adopts the Arline standard as does the Rehabilitation Act by defining "direct threat" as a "significant risk to the health or safety of others that cannot be eliminated by reasonable accomodation."²¹⁷ The ADA, unlike the Rehabilitation Act, contains direct restrictions on pre-employment inquiries and HIV testing, specifically forbidding inquires of employees as to whether they are disabled or as to the nature or severity of a disability, unless such inquiries are "shown to be job-related and consistent with business necessity."²¹⁸

Many "state courts have ruled that AIDS is a protected handicap under [their] applicable handicap discrimination statutes, [and] unlike the Federal Rehabilitation Act, [most] state handicap statutes apply to all private employers within a state."²¹⁹ "Although there is no common definition of handicap under state discrimination statutes, many states follow the Rehabilitation Act's definition," while others have no definition whatsoever.²²⁰ To date, the case law regarding restrictions of HIV-infected health care workers have reached consistent decisions as to the violation or non-violation of both state and federal antidiscrimination law.²²¹ Prior to the passage of the Americans with Disabilities Act, state law would have had a broader application to the private sector, but this has been of little consequence in the health care setting where most hospitals and private physicians qualify for application of the Rehabilitation Act because they are recipients of federal funds.²²² In summarizing the application of antidiscrimination law to the issue of HIV-infected health care workers, a noted commentator has concluded:

215. Americans with Disabilities Act of 1990, § 101(8).

216. *Id.* § 103(b); see HERMANN & SCHURGIN, *supra* note 10, at §§ 10:05, :07.

217. Americans with Disabilities Act of 1990, at § 101(3).

218. HERMANN & SCHURGIN, *supra* note 212, § 10:06 (quoting Americans with Disabilities Act of 1990, § 102(c)(4)(A)).

219. *Id.* § 10:06.

220. *Id.* § 12:21.

221. See *Doe v. County of Cook*, No. 87 Civ. 888 (N.D. Ill. filed Aug. 5, 1990), reprinted in CLOSEN ET AL., *supra* note 7, at 668; *Estate of Behringer v. Medical Center*, 592 A.2d 1251 (N.J. Super. Ct. Law Div. 1991) (where the court left uncertain whether its standard under New Jersey Law was the same as that of the Rehabilitation Act and the ADA).

222. Wyld & Cappel, *supra* note 47, at 102; see also *supra* text accompanying note 212.

Physicians, then, have a right under federal and state handicap laws not to be denied the right to practice medicine or to be reassigned to an administrative position unless there is a significant risk of HIV transmission. Any limitation on the right of a physician to practice must be reasonably related to the achievement of greater patient safety. Narrow limitations on the practice of seriously invasive procedures may thus be found not to be discriminatory.²²³

B. *Doe v. County of Cook*

The first case involving an HIV-infected health care worker that was decided based upon the language of *Arline* was *Doe v. County of Cook*,²²⁴ in which U.S. District Court Judge John A. Nordberg required the signing of a consent decree to protect an HIV-infected neurologist from unreasonable limitations placed on his right to practice.²²⁵ The plaintiff, a physician at Cook County Hospital in Illinois, alleged in his complaint that because he had AIDS the hospital had restricted his clinical privileges in a manner which effectively prevented him from providing any direct care to patients.²²⁶ The plaintiff brought his action on the basis of handicap discrimination in violation of section 504 of the Rehabilitation Act and the Fourteenth Amendment to the United States Constitution.²²⁷

Prior to the plaintiff's filing of his action, the defendant hospital, in implementing the recommendations of a hearing committee appointed pursuant to their bylaws, prohibited Dr. Doe from performing certain invasive procedures.²²⁸ Two months later, the hospital partially restored the plaintiff's clinical privileges and required him to comply with CDC universal precautions; in addition, the hospital required him to "double-glove" for certain invasive procedures.²²⁹ The hospital stated that the restoration of partial privileges was due to "further individual evaluation of his condition."²³⁰

In the consent decree the physician agreed to be subject to special surveillance, to double glove before performing invasive procedures, and not to perform muscle biopsies, sural nerve biopsies or

223. Gostin, *supra* note 210, at 37.

224. *Doe v. County of Cook*, No. 87 Civ. 888 (N.D. Ill. filed Aug. 5, 1990).

225. Gostin, *supra* note 210, at 37.

226. *Doe v. County of Cook*, No. 87 Civ. 888 (N.D. Ill. filed Aug. 5, 1990).

227. *Id.*

228. *Id.*

229. *Id.*

230. *Id.*

cerebral arteriographies.²³¹ The judge held, in language similar to that in *Arline*, that future alterations regarding the physician's practices could be permitted only if the physician posed a "significant health or safety risk to himself or others."²³² In stating the criteria of a "significant risk" the court specified that it would be determined with "reference to the state of medical knowledge regarding: (1) the nature of the risk; (2) the duration of the risk; (3) the severity of the risk; and (4) the probabilities that AIDS or a related condition pertinent to plaintiff will be transmitted and will cause varying degrees of harm."²³³

C. *Leckelt v Board of Commissioners of Hospital District No. 1*²³⁴

In *Leckelt v. Board of Commissioners of Hospital District No. 1*, a federal district court in Louisiana, held that a hospital did not violate Section 504 of the Rehabilitation Act when it terminated a male nurse for refusing to reveal the results of an HIV test.²³⁵ In addition, the court held that the employer did not violate the employee's equal protection or privacy rights because the hospital's infection control policies were rationally related to the legitimate state interest of protecting patients, and the plaintiff did not have a reasonable expectation of privacy in his test results.²³⁶ The *Leckelt* case is perceived as extremely important by many commentators who believe that it could set precedent for restrictive HIV-infected health care worker policies.²³⁷

In *Leckelt*, the plaintiff was a licensed practical nurse whose duties included making rounds, performing assessments, giving medication (orally and by injection), starting I.V.'s, changing dressings, performing catheterizations and giving enemas.²³⁸ Prior to the com-

231. CLOSEN ET AL., *supra* note 7, at 669.

232. *Doe v. County of Cook*, No. 87 Civ. 888, at 669.

233. *Id.* at 670.

234. *Leckelt v. Board of Comm'rs. of Hosp. Dist. No. 1*, 714 F. Supp. 1377 (E.D. La. 1989).

235. *Id.* at 1378.

236. *Id.* at 1390-91.

237. See HERMANN & SCHURGIN, *supra* note 216, § 10:16 (stating that the case is "a possible sweeping decision"); see also Clozen, *A Call for Mandatory HIV Testing and Restriction of Certain Health Care Professionals*, 9 ST. LOUIS U. PUB. L. REV. 421, 433 (1990) (calling for mandatory testing and restriction of certain health care professionals). This article cites *Leckelt* as "caselaw support[ing] the view that an HCP [health care professional] with HIV might create a risk of transmission to patients during invasive procedures." *Id.* The author believes that the "logical extension" of the court's ruling is to urge HIV testing of HCPs who undertake invasive procedures.

238. *Leckelt*, 714 F.Supp. at 1382.

mencement of plaintiff's action against the hospital, his roommate and lover of eight years died of AIDS and plaintiff decided to have an HIV test performed.²³⁹ In the context of how the case was decided, it is important to note that the plaintiff never received his HIV test results.²⁴⁰

The medical center was informed of the plaintiff's lover's death by the acting chief of staff who reported that the medical staff believed that the plaintiff's health status should be determined.²⁴¹ This request was consistent with the hospital's infection control policy, which required that employees report any infectious or communicable disease to their employee health service.²⁴² Once such reports were made, testing of employees was conducted where indicated and employee test results were evaluated by the employee health nurse and the individual's physician.²⁴³ An individual who had a communicable disease was required to receive clearance from his physician prior to returning to active employment.²⁴⁴ If the employee was absent from work due to an infectious disease, he was paid sick benefits, and working restrictions were placed on employees as their disease indicated, including reassignment to areas not associated with direct patient care.²⁴⁵

In addition, those infectious employees who were allowed to work in direct patient care were required to closely follow universal precautions to decrease potential risk to others.²⁴⁶ The defendant's employee handbook outlined this policy and further stated that employees committing serious infractions of the hospital policy were subject to immediate termination, with insubordination being listed as a serious offense.²⁴⁷ When asked to submit his test results, the plaintiff did not do so, and the hospital later learned that for several years the plaintiff had been a carrier of hepatitis B, and had suffered a syphilis infection without informing the hospital as policy required.²⁴⁸ On these grounds, as well as plaintiff's failure to report to work, plaintiff was terminated for insubordination.²⁴⁹

239. *Id.* at 1383.

240. *Id.*

241. *Id.*

242. *Id.* at 1379.

243. *Id.*

244. *Id.*

245. *Id.* at 1379-80.

246. *Id.*

247. *Id.*

248. *Id.* at 1384.

249. *Id.* at 1384-85. The court also found that the plaintiff consistently failed to use

In rendering its decision, the court analyzed the 1985 CDC precautions regarding occupational risks and potential reassignments of HIV-infected employees.²⁵⁰ Although the precautions stated that testing of HCWs who perform invasive procedures was "under consideration," as was whether additional restrictions of them were warranted, the precautions did state that because of the increased risk of the HIV-positive HCW's susceptibility to other diseases, the HCW's personal physician and the hospital's appropriate staff should evaluate whether the HCW could adequately and safely perform patient-care duties or should be reassigned work duties.²⁵¹ The court also relied heavily upon medical experts who concluded that it would be impossible to follow CDC precautions regarding HIV-infected employees unless the health care facility knew the health care worker's status.²⁵²

In reaching its decision, the Court granted the defendant great deference in establishing its hospital policy:

Under nationally followed guidelines hospitals may have to modify the duties of employees with certain infectious diseases. . . . In order to implement these guidelines . . . a hospital may need to require medical testing for an employee whom it learns has a high medical risk of having such diseases. . . . Because a hospital has a right to require such testing in order to fulfill its obligation to its employees and to the public concerning infection control and health and safety in general, plaintiff's employer was justified in terminating him.²⁵³

In finding that the hospital had not violated the Rehabilitation Act, the court outlined the elements necessary for such a claim and ruled that the plaintiff did not prove the first element, that the defendants had perceived him as handicapped.²⁵⁴ The court found that "no evidence was produced . . . that anyone involved in the decision to discharge plaintiff had ever concluded that he was seropositive."²⁵⁵ Further, the hospital's intention if he tested positive was that "he should be placed on immediate leave with pay pending further review," thus providing evidence that the defendants did not intend to

barrier precautions when treating patients. *Id.* at 1383.

250. *Id.* at 1381-82.

251. *Id.*

252. *Id.*

253. *Id.* at 1379.

254. *Id.* at 1385-86.

255. *Id.* at 1386.

immediately terminate plaintiff based on his HIV status.²⁵⁶

In outlining the second element, the court concluded that the plaintiff did not prove that the hospital discharged him solely because of his handicap:

When an employer has a lawful motive for discharging an employee, the employer's coincidental consideration of the employee's handicap does not prevent the employer from acting on its lawful motive Defendants . . . testified that plaintiff was terminated for failure to follow hospital policy and not because he was perceived to be seropositive for HIV.²⁵⁷

Regarding the third element, that of whether the plaintiff was "otherwise qualified" to continue his duties, the court ruled that the plaintiff's refusal to comply with hospital infection control policies rendered him not "otherwise qualified" for the job:

Essential to the function and purpose of such a public safety sensitive institution as a hospital is the adherence by the hospital employees to infection control policies

[O]pportunities exist for the transmission of HIV from health care workers to patients such that hospitals must monitor employee's health status (especially those in high risk groups) and their use of barrier precautions.²⁵⁸

In addition, the court noted, the *Arline* decision "clearly endorsed an employer's right to inquire into the health status of its employees and to make reasonable accommodations for that employee's handicap;²⁵⁹ the defendant's request for the plaintiff's test results was nothing more than "the first step in this inquiry."²⁶⁰ In summation, the court stated that the defendants had a "legitimate and nondiscriminatory reason for discharging the plaintiff" and that his claim failed under Louisiana handicap law for the same reason that it failed under federal law.²⁶¹

D. *Estate of Behringer v. Medical Center at Princeton*²⁶²

In April of 1991, the New Jersey case of *Estate of Behringer v. Medical Center at Princeton* was decided. Although the plaintiff

256. *Id.*

257. *Id.*

258. *Id.* at 1387.

259. *Id.* at 1389.

260. *Id.* at 1388.

261. *Id.*

262. *In re Behringer v. Medical Ctr.*, 592 A.2d 1251 (N.J. Super. L. 1991).

brought his claim under state antidiscrimination law, the terms of the law are similar to those of the Americans with Disabilities Act, except that New Jersey limits claims to places of public accommodation.²⁶³ Here, the court ruled that the defendant hospital qualified as a place of "public accommodation" and thus was prohibited from discriminating.²⁶⁴ At issue in the case were the hospital's policies restricting the HIV-infected plaintiff's privileges to practice surgery and the requirement that he obtain informed consent from his patients before performing invasive procedures.²⁶⁵ In addition, the plaintiff sued the hospital for breach of confidentiality of his AIDS diagnosis.²⁶⁶

The plaintiff was an otolaryngologist and plastic surgeon who was also a member of the staff at the medical center.²⁶⁷ Upon learning of his diagnosis with AIDS, the president of the medical center immediately directed the cancellation of the plaintiff's surgical cases.²⁶⁸ This initial decision, the president admitted, was based upon a primary concern for the medical center's liability and was made with little knowledge or information on the potential transmission of the disease.²⁶⁹ When the chief of surgery reached a contrary result urging that the plaintiff resume his surgical practice, the matter was brought before the hospital's board of trustees.²⁷⁰

As an interim measure prior to establishing a new policy on HIV-infected health care workers, the board voted to require the use of a special "informed consent form" to be presented to all patients about to undergo surgery by HIV-positive surgeons.²⁷¹ The form in essence stated that the patient had been informed of the doctor's HIV-positive status and of the potential risk of transmission of the virus and under those terms consented to the procedure.²⁷²

Over the next year the board of trustees and the executive committee of the medical staff met to discuss the medical and ethical implications of the possible transmission of HIV during invasive procedures, as well as the questions raised by the informed consent

263. David Orentlicher, *HIV-Infected Surgeons: Behringer v. Medical Center*, 266 JAMA 1134, 1136 (1991).

264. *Behringer*, 592 A.2d at 1252.

265. Orentlicher, *supra* note 263, at 1134.

266. *Id.*

267. *Behringer*, 592 A.2d at 1254.

268. *Id.* at 1257.

269. *Id.*

270. *Id.* at 1257.

271. *Id.* at 1258.

272. *Id.*

issue.²⁷³ This series of meetings included presentations by representatives of the American Medical Association, and the hospital's epidemiologist, ethicists and legal counsel.²⁷⁴ In June of 1988, the hospital adopted a policy that stated that an HIV-positive health care worker "may continue to treat patients . . . but shall not perform any procedures that pose any risk of transmission to the patient."²⁷⁵ The policy specifically forbade certain surgical procedures and included a procedure for recredentialing of physicians:

A known HIV seropositive member of the Medical and Dental Staff may be permitted to continue to admit and care for his patients in the hospital, but shall immediately suspend the performance of all surgical procedures, including surgical assisting. In addition, he shall not perform any procedures that involve piercing the integument, including IVs and phlebotomy The staff member's Department Chairman may re-credential the member . . . with regard to allowing procedures in accordance with [this] policy.²⁷⁶

In addition, the interim requirement that HIV-infected surgeons disclose their status to their patients and obtain their informed consent remained.²⁷⁷

In deciding the case, the court addressed the "conflict between a doctor's rights under . . . [antidiscrimination] law and a patient's right to know under the doctrine of informed consent."²⁷⁸ The court summarized its holding as follows:

- [1] Plaintiff, as an AIDS-afflicted surgeon . . . was protected by the Law Against Discrimination.
- [2] The Medical Center met its burden of establishing that its policy . . . was substantially justified by a reasonable probability of harm to the patient.
- [3] The "risk of harm" to the patient includes not only the actual transmission of HIV . . . but the risk of surgical accident . . . which may subject the patient to post-surgery HIV testing.
- [4] Defendant . . . properly required plaintiff, as a physician with a positive diagnosis of AIDS, to secure informed consent from any surgical patients.²⁷⁹

273. *Id.* at 1259.

274. *Id.*

275. *Id.* at 1260.

276. *Id.*

277. *Id.*

278. *Id.* at 1254.

279. *Id.* at 1255.

As to whether the plaintiff's antidiscrimination claim would stand, the court acknowledged that "courts should allow hospitals, as long as they proceed fairly, to run their own businesses."²⁸⁰ And the court determined that the test to be applied in the context of restricting an HIV-infected surgeon was

whether the continuation of surgical privileges, which necessarily encompasses invasive procedures, poses a 'reasonable probability of substantial harm' to others, including co-employees and, more importantly, patients. [Citations omitted] There must be a 'materially enhanced risk of serious injury.' [Citations omitted]. And . . . there must be a distinction between the risk of an incident taking place and the risk of injury from such an incident.²⁸¹

In assessing these dual risks the court emphasized that (1) not enough adequate study had been done regarding the risk of HIV transmission,²⁸² (2) that the risk of transmission from the plaintiff to his patients would steadily increase as he performed more operations,²⁸³ and (3) much of the plaintiff's surgery involved contact with his patients' mucous membranes, tissues that are relatively susceptible to HIV transmission.²⁸⁴

Of particular interest in the case was the court's view that the risk of transmission of the HIV virus was not the sole risk threatening patients.²⁸⁵ The court reasoned that a surgical accident could "subject a previously uninfected patient to months or even years of continual HIV testing . . . with the attendant anxiety of waiting for test results, and the possible alterations to life style and child-bearing during the test period, even if those results ultimately are negative."²⁸⁶ In addition, the court emphasized that in spite of the inability to precisely quantify the probability of HIV transmission, the extent of harm once a patient becomes HIV positive is death.²⁸⁷ In further assessing this issue the court used a risk-benefit analysis, weighing the risk posed by the HIV-positive provider against the value of having these same providers performing invasive procedures.²⁸⁸ In citing a well-known commentator, the court concluded

280. *Id.* at 1276.

281. *Id.*

282. Orentlicher, *supra* note 263, at 1134.

283. *Id.*

284. *Id.*

285. *In re Behringer v. Medical Ctr.*, 592 A.2d 1251 (N.J. Super. L. 1991).

286. *Id.* at 1279-80.

287. *Id.* at 1282.

288. *Id.* at 1281.

that "restrictions due to HIV positivity will only interfere with the provision of a very small fraction of the total health care services. All of these services can be adequately provided by non-infected practitioners."²⁸⁹

In its closing analysis, the court pointed to the ethical aspects of the physician-patient relationship, stating that "a small but palpable risk of transmitting a lethal disease to the patient gives the doctor an ethical responsibility to perform only procedures that pose no risk of transmission."²⁹⁰ And, the court concluded, the only safeguard against "physician self-interest" lies in making patients the final decision makers:

If there is to be an ultimate arbiter of whether the patient is to be treated invasively by an AIDS-positive surgeon, the arbiter will be the fully-informed patient. The ultimate risk to the patient is so absolute—so devastating—that it is untenable to argue against informed consent combined with a restriction on procedures which present 'any risk' to the patient.²⁹¹

The Behringer decision has been noted for adhering to the ethical principle that patient welfare must be the primary concern of physicians.²⁹² But it has also been subject to criticism for establishing a "zero-tolerance risk standard that restricts health care workers from performing procedures that pose any risk of transmission."²⁹³ And it is uncertain if the Behringer court's finding of a reasonable probability of substantial harm under New Jersey antidiscrimination law would meet the "significant risk" of transmission standard under the Rehabilitation Act or the "direct threat" exception of the ADA.²⁹⁴ But the court's message seems clear: restrictions on HIV-infected health care workers can be implemented in the interests of patient welfare.

E. *Application of Hershey Medical Center v. Doe*²⁹⁵

The July, 1991 case of *Application of Hershey Medical Center v. Doe*, although decided on the basis of Pennsylvania's Confidential-

289. *Id.* at 1282 (citing Keyes, *Health Care Professionals with AIDS: The Risk of Transmission Balanced Against the Interests of Professionals and Institutions*, 16 J.C. & U.L. 589, 603 (1990)).

290. *Behringer*, 592 A.2d. at 1282.

291. *Id.* at 1283.

292. Orentlicher, *supra* note 263, at 1134.

293. *Id.* at 1135.

294. *See supra* notes 202-206, 216-218, and accompanying text.

295. *In re Milton S. Hershey Med. Ctr. v Doe*, 595 A.2d 1290 (Pa. Super. 1991).

ity of HIV-Related Information Act,²⁹⁶ is pertinent to this analysis because it acknowledged the current conflicting inquiries surrounding restriction of HIV-infected health care workers. Dr. Doe, a resident physician in obstetrics and gynecology, sustained a cut through his surgical glove during an invasive internal procedure, exposing a patient to his infected blood.²⁹⁷ The following day he submitted to a blood test for HIV and when he found out that his test results were positive, he voluntarily withdrew from participation in further surgical procedures.²⁹⁸

After extensive investigation, the medical center identified 279 patients who were treated by Dr. Doe; the issue before the court was thus whether the disclosure of Dr. Doe's identity in the follow-up contacts the hospital conducted to inform patients of their possible HIV exposure was in violation of the state's Confidentiality Act.²⁹⁹ In determining that disclosure of Dr. Doe's identity was necessary, the court ruled that the hospital had sustained its burden of demonstrating the "compelling need" standard required by the Act.³⁰⁰ In reaching its decision, the court reviewed recent decisions by other courts and concluded that the hospital had the duty to insure their patients' health to the best of their capabilities.³⁰¹ The court further stated that a hospital "impliedly assures its patients that they will receive safe and adequate medical care."³⁰²

The court reasoned that although it was "unfortunate that Dr. Doe will be made to suffer personally and/or professionally as a result of his illness . . . societal implications [must [be] consider[ed]."³⁰³ The court further found that Dr. Doe's decision to voluntarily withdraw from his residency program was admirable because he presented a health risk to others.³⁰⁴ But the court further stressed that "*Dr. Doe's medical problem was not merely his. It became a public concern the moment he picked up a surgical instrument and became a part of a team involved in invasive procedures.*"³⁰⁵

296. The Confidentiality of HIV-Related Information Act, 35 PA. CONS. STAT. §§ 7601-7612 (Supp. 1992).

297. *In re Hershey Med. Ctr.*, 595 A.2d. at 1291.

298. *Id.* at 1292.

299. *Id.*

300. *Id.* at 1294.

301. *Id.* at 1295.

302. *Id.*

303. *Id.* at 1297.

304. *Id.* at 1298.

305. *Id.*

The court limited its holding to the narrow issues on appeal and chose to make additional comments on the AIDS dilemma in its footnotes:

[W]e note the new Federal guidelines, recommended by the [CDC] on July 15, 1991 . . . [which] recommend that infected individuals not participate in invasive procedures absent permission from an expert panel and notification to the patient The task of resolving these most pressing inquiries rests with our Legislature and the appropriate medical committees, associations and boards.³⁰⁶

In closing, the court stated:

AIDS is not a disease that is, or that should be taken lightly by our society. Rather, many view it as a problem of epidemic proportion that knows no bounds and discriminates against no one. Although HIV has been extensively researched, the public, justifiably or not, is wary and frightened of its prevalence in our society.

[T]his court has put public opinion aside and has attempted to balance the competing interests in this case carefully and thoroughly [T]he public's right to be informed in this sort of potential health catastrophe is compelling and far outweighs a practicing surgeon's right to keep information regarding his disease confidential.³⁰⁷

VIII. CONCLUSION

As the above court decisions illustrate, the general trend in case law regarding restrictions placed on HIV-infected health care workers is to assess, on an individual basis, the procedure performed by the employee and the risk of HIV transmission to patients. But today, the actual risk of HIV transmission from health care worker to patient is a topic of scientific debate, and the statutory terms of "significant risk of transmission,"³⁰⁸ "direct threat to the health and safety of others,"³⁰⁹ and "reasonable probability of substantial harm"³¹⁰ place the burden of scientific uncertainty and debate upon the courts. The courts, as the Behringer and Hershey Medical Center decisions illustrate, assess the probability of HIV transmis-

306. *Id.* at 1298-99 nn.14, 18.

307. *Id.* at 1301-02.

308. *See supra* note 202 and accompanying text.

309. *See supra* notes 216-218 and accompanying text.

310. *See supra* notes 281-284 and accompanying text.

sion against the outcome of such transmission—death—and find even the lowest probabilities unacceptable. Here, the courts believe, such an apportionment of risk can only be justified by the patient's informed consent.³¹¹

Commentators point out that terms such as "significant risk" need further scientific clarification, and that cases on health care worker restrictions are frequently decided on the outcome of the "battle of the expert witnesses," whose opinions on HIV transmission reflect the current debate that is raging in the medical field.³¹² Many believe that case-by-case determinations of which medical procedures are sufficiently safe for HIV-infected health care workers to perform belong not with the courts, but with the medical community, and demand that clear professional guidelines be promulgated to determine how this controversy shall be resolved.³¹³ But, as this article has illustrated, professional guidelines and recommendations regarding HIV-infected health care workers are also the subject of controversy, and many medical associations have refused to assist the CDC in developing a list of invasive procedures from which HIV-infected health care workers should refrain.³¹⁴

As of October 28, 1991 states had one year to adopt the CDC guidelines or their equivalent,³¹⁵ and after a year of controversy and rumors regarding revision of the July 1991 guidelines, the CDC decided not to modify them and to place the responsibility on state health departments to determine which procedures are exposure-prone.³¹⁶ The federation's position was updated in an April 1992 policy statement which recommended that:

[a]ll physicians should comply with the guidelines established by the Centers for Disease Control (CDC) for preventing the transmission of human immunodeficiency virus (HIV) and of Hepatitis B virus (HBV) to patients, *and* physicians who are infected with HIV or with HBV . . . should not perform exposure-prone procedures as defined by the CDC except within

311. See *supra* notes 285-291 and accompanying text.

312. Gostin, *supra* note 210, at 37. In the *Behringer* case for example, the defendant hospital used Dr. Lorraine Day, a contemporary San Francisco orthopedic surgeon who prepares for surgery in a "space suit designed to prevent the migration of HIV from her patients to her in blood or in aerosols." Albert Jonsen, *Is Individual Responsibility a Sufficient Basis for Public Confidence?*, 151 ARCHIVES OF INTERNAL MEDICINE 660, 660 (1991).

313. Gostin, *supra* note 210, at 38.

314. See *supra* notes 131-138 and accompanying text.

315. See *supra* notes 172-177 and accompanying text; see also *supra* note 180 (conflicting reports on the status of the guidelines).

316. See *supra* notes 139, 140, 180, and 181 and accompanying text.

guidelines set by the state medical board.³¹⁷

Thus, hospitals are waiting to see what the outcome of the HIV-infected health care worker debate will be. And, as the Behringer case illustrates, hospital legal counsel are advising their clients to closely examine legal doctrines such as that of informed consent to limit their exposure to liability.

What is the standard of care that would determine liability should a patient acquire HIV from his or her physician? In general, the standard of care is set by the medical profession, administrative sources, and occasionally, by the courts.³¹⁸ As of January, 1992, the AMA has stood firm on its recommendations that physicians have an ethical obligation to either refrain from invasive procedures or obtain informed consent for such procedures if they are HIV-positive.³¹⁹ The ADA, which in January of 1991 endorsed similar recommendations, has reversed its position, recommending that HIV-infected dental health care workers who perform invasive procedures "should practice only under the evaluation and monitoring of their personal physician and/or under recommendations of public health officials, expert review panels, or in compliance with institutional policies."³²⁰ In October of 1991, the Federation of State Medical Boards of the United States recommended that states should require doctors who perform exposure-prone procedures to be tested for HIV, and those infected "should not be allowed to perform surgeries except in re-

317. THE FEDERATION OF STATE MEDICAL BOARDS, POLICY STATEMENT RELATED TO THE PREVENTION OF HIV/HBV TRANSMISSION TO PATIENTS (1992).

The Policy Statement further recommends that state medical boards should have the following powers and responsibilities:

1. to encourage that physicians doing exposure-prone procedures know their HIV and their HBV status;
2. to require reporting to the state medical board and/or the state public health department of HIV and HBV infected physicians;
3. to ensure confidentiality of those reports received by the state medical board and/or state health department under #2 above;
4. to establish practice guidelines for HIV and for HBV infected physicians;
5. to monitor, or the state public health department monitor, the practices and health of HIV and HBV infected physicians.

Id.

The Federation noted that the above recommendations should also apply to all other persons regulated by the state medical board. *Id.*

318. Hirsch, *supra* note 9, at 469.

319. CDC Revises Recommendations on HIV-Infected Providers, 7 AIDS ALERT (Am. Health Consultants, Atlanta, Ga.), Jan. 1992, at 1,5; *see also supra* notes 131-138 and accompanying text.

320. CDC Revises Recommendations on HIV-Infected Providers, *supra* note 318, at 1,

stricted circumstances."³²¹

The CDC guidelines are consistent with the AMA's recommendations and the American Hospital Association's recently released policy endorses all aspects of the CDC guidelines except the requirement of patient informed consent.³²² The position of the AHA is that if "it is determined by an expert panel that a health care worker can practice, there is no need to notify the patient of the health care worker's status and obtain the patient's consent for invasive procedures."³²³ This statement is consistent with those who argue that the doctrine of informed consent should not shield the medical profession from exposing patients to significant risk.³²⁴ These commentators argue that "if one believes that the risk *is* significant, then one ought not to subject one's patient to it *regardless of his/her consent*."³²⁵

Will hospitals over-compensate for the lack of scientific certainty regarding HIV-infected health care worker to patient transmission and impose greater and greater restrictions upon their HIV-infected employees? Although the answer to such a question involves speculation in the midst of political and medical controversy, hospitals will be restrained in doing so by their consciences, anti-discrimination law, and changes in scientific data. Their motivation for greater restrictions will be patient welfare and protection against liability, determined by the evolving standard of professional care. Case-by-case assessments by expert review panels as recommended by the CDC will require greater administrative responsibility, and it is arguable that the hospitals will not be fully protected by a patient's informed consent should the patient acquire HIV from an invasive procedure. In addition, any restrictions imposed by hospitals in compliance with the CDC guidelines would still be subject to review by the courts.³²⁶

Some commentators argue that the "evolving standard of professional care is for an HIV-infected physician to refrain from perform-

321. *Medical Group's AIDS Policy*, SAN FRANCISCO CHRON., Oct. 6, 1991, at A3. It should be noted that the federation's rules are not binding on any state, but carry considerable authority. In addition to calling for mandatory testing of physicians, the guidelines would also set up a program of collecting the names of HIV-infected doctors and monitoring their practices. *Id.*

322. Telephone Interview with Ms. Jeanna Pugliese, Director of Infection Control, American Hospital Association, Chicago Headquarters (Mar. 9, 1993).

323. *Id.* (quoting Ms. Pugliese).

324. David Price, *What Should We Do About the HIV-Positive Health Professionals?*, 151 ARCHIVES OF INTERNAL MEDICINE 658, 659 (1991).

325. *Id.*

326. See Orentlicher, *supra* note 263, at 1135.

ing seriously invasive procedures."³²⁷ Others speculate that "the courts will likely decide that hospitals following the CDC guidelines are not guilty of unlawful discrimination, [while] . . . any restrictions that go beyond the CDC guidelines would probably be prohibited."³²⁸

Is the question of whether an HIV-infected health care worker should be restricted from invasive procedures purely an ethical one? The AMA believes so, stating that "HIV-infected physicians have an ethical obligation not to engage in any professional activity that has an identifiable risk of transmission . . . to the patient."³²⁹ Dentists polled in August and September of 1990 believed that dentist-to-patient transmission of HIV is unlikely, but still thought HIV-positive dentists should refrain from practicing.³³⁰ And the American Nurses Association has taken the position that a nurse is ethically obligated to undergo HIV antibody testing when a patient has been exposed to the nurse's blood or bodily fluids.³³¹ As *Hershey Medical Center* revealed, physicians who voluntarily refrain from practicing are often considered "admirable."³³²

There are those who believe that individual responsibility in the face of this chilling dilemma is not a sufficient basis for public confidence and that the medical profession needs to assure the public that its self-interests will not conflict with the welfare of patients.³³³ There are physicians who, when questioned about their decisions not to inform patients of their HIV-positive status, reply, "[B]eing alive involves risk."³³⁴ Further, some leaders in associations of gay dentists advise their HIV-positive colleagues "not to answer" when asked

327. Gostin, *supra* note 210, at 34.

328. Orentlicher, *supra* note 263, at 1135.

329. *See supra* note 138 and accompanying text.

330. Gerbert et al., *supra* note 32, at 1848.

331. Karen Markus, *Patients with HIV*, CALIFORNIA NURSING, Nov.-Dec. 1991, at 20, 20.

332. *See supra* text accompanying note 304.

333. Albert Jonsen, *Is Individual Responsibility a Sufficient Basis for Public Confidence?*, 151 ARCHIVES OF INTERNAL MEDICINE 660, 660 (1991); *see also* Orentlicher, *supra* note 263, at 1134.

334. *Doctors with AIDS*, *supra* note 67, at 57. this article quotes an anonymous doctor who tested positive for HIV two years ago and is still healthy and not on medication. The doctor "follows universal precautions to the letter," including hand-washing, gloves and masks." *Id.* The following is an excerpt of his interview:

"Do I think there's no situation where HIV could be transmitted?" he asks. "No there must be. But living in 1991 America puts you at risk for lots of things. You could ride on a subway that catches on fire. You can be involved in a car accident. Being alive involves risk."

Id.

about their HIV status.³³⁵ Other physicians, however, state that if they learned that they were HIV-positive that they wouldn't ask their patients to take even a "minuscule" risk of infection.³³⁶ And an ophthalmologist, testifying before Congress in support of the Bergalis bill in September of 1991, stated: "[P]hysicians should be the leaders in determining their HIV status. As a profession we need to hold ourselves up to a high standard. Remember, Hippocrates said, 'First, do no harm.'"³³⁷

The first five cases of dentist to patient transmission of HIV have stirred controversy in medical and political arenas and speculation as to how many additional patients could be infected each year. As HIV continues to spread to the general population, the public is questioning the medical and dental professions while demanding that their political representatives protect them against the threats of such a lethal disease. Leading medical and ethical scholars are calling for an end to "HIV exceptionalism," noting that the efforts to sustain a set of policies treating HIV infection as fundamentally different from all other public health threats is becoming increasingly difficult.³³⁸

As the second decade of the AIDS epidemic begins, the controversial issues raised by this disease must be addressed swiftly and efficiently. Congress has taken the first steps toward this end by requiring states to adopt CDC guidelines or their equivalent - and the CDC must still shoulder the responsibility of determining equivalency on a case-by-case basis. The CDC, subject to criticism by medical associations, the public at large, and AIDS activists, will struggle with conflicting medical opinions and limited scientific data in implementing its guidelines. And the courts, in the series of cases expected after individual states take action on the guidelines, will balance competing interests in determining what risks to patients, if any, are acceptable, and whether restrictions on HIV-infected health care workers are fair, nondiscriminatory, and justifiable in light of conflicting medical opinions and scientific uncertainty.

335. Mireya Navarro, *Patients Grilling Health Care Workers on AIDS*, N.Y. TIMES, Aug. 2, 1991, at B1.

336. Elizabeth Rosenthal, *Angry Doctors Condemn Plans to Test Them for Aids*, N.Y. TIMES, Aug 20, 1991, at C1 (quoting Dr. William Schechter, trauma surgeon at San Francisco General Hospital).

337. Hiltz, *supra* note 141, at A12 (quoting Dr. George M. Bohigian, a doctor of ophthalmology in St. Louis who testified for the Bergalis legislation).

338. Bayer, *Public Health Policy and the AIDS Epidemic: An End to Exceptionalism?*, 324 JAMA 1500, 1503 (1991).