University of Richmond Law Review

Volume 23 | Issue 1 Article 6

1988

Aids, Health-Care Workers, and Workers' Compensation in Virginia

M. Grey Sweeney
University of Richmond

AIDS, HEALTH-CARE WORKERS, AND WORKERS' COMPENSATION IN VIRGINIA

I. INTRODUCTION

The recent explosion of medical malpractice litigation has heralded the era of defensive medicine.[1] Health-care professionals at all levels of the industry have been forced to evaluate both the lawsuit potential as well as the life sustaining potential of every act and treatment.[2] Since 1981,[3] however, the threat of Acquired Immunodeficiency Syndrome (AIDS) has added a third, more threatening, perspective to the way health-care workers must view their actions. The average doctor or nurse must balance not only the medical and legal significance of every action, but must also consider whether an action might result in exposure to AIDS.[4]

Although the Centers for Disease Control (CDC)[5] has advised that health-care workers' occupational risk of Human Immunodeficiency Virus (HIV)[6] infection is low,[7] workers can, and do, become infected.[8] As the

---

1. *See, e.g.*, Harris, *Defensive Medicine: It Costs, but Does It Work*? 257 J. A.M.A. 2801 (1987).

2. *See, e.g.*, DeAngelis, *Medical Malpractice Litigation: Does it Augment or Impede Quality Care*?, 110 J. PEDIATRICS 878 (1987).

3. According to the Centers for Disease Control (CDC), the first cases of Acquired Immunodeficiency Syndrome (AIDS) were reported in 1981. *See Human Immunodeficiency Virus Infection in the United States*, 36 MMWR 801 (1987) [hereinafter *1987 HIV Infection Report*]. The *Morbidity and Mortality Weekly Report* is cited within the health-care industry as MMWR, and will be cited in that fashion.

4. Such worries can and have produced frightening consequences in emergency situations. *See, e.g.*, Jonsen, Cooke & Koenig, *AIDS and Ethics*, 2 ISSUES IN SCIENCE & TECHNOLOGY 56, 59 (1986) (discussion of anxiety among nurses and medical technicians over the threat of having to do mouth-to-mouth resuscitation on AIDS patients), *cited in* Hermann, *Hospital Liability and AIDS Treatment: The Need for a National Standard of Care*, 20 U.C. DAVIS L. REV. 441, 442 n.3 (1987).

5. The CDC, established by the Department of Health, Education and Welfare as an agency within the Public Health Service, develops national guidelines for the diagnosis, vaccination and containment of contagious diseases. The CDC has been responsible for publishing the *Morbidity and Mortality Weekly Report* since 1973, a publication which reports weekly compilations of disease statistics, infection control guidelines, and case definitions of infectious diseases. For an overview of the role of the CDC in the AIDS crisis, see Neslund, Matthews & Curran, *The Role of CDC in the Development of AIDS Recommendations and Guidelines*, 15 LAW, MED. & HEALTH CARE 73 (1987).

6. Human Immunodeficiency Virus (HIV) causes the AIDS complex. For an explanation of the etiology of AIDS, see *infra* notes 25-39 and accompanying text.

7. *See, e.g., Update: Evaluation of Human T-Lymphotropic Virus Type III/Lymphadenopathy-Associated Virus Infection in Health-Care Personnel—United States*, 34 MMWR 575, 576 (1985). Note that the CDC reports that the risk to health-care workers is low only if CDC infection control guidelines are followed.

8. *See infra* notes 63-81 and accompanying text.

number of reported AIDS cases continues to double each year,[9] and as more identified—and unidentified—HIV carriers enter the nation's hospitals, the risk to health-care workers will continue to increase as exposure becomes more common.[10]

For the health-care worker in Virginia who is exposed to HIV on the job, the compensatory alternatives are limited.[11] While such occupational exposure should trigger workers' compensation[12] benefits, recovery may prove to be beyond the reach of many affected individuals. Proving a causal connection between the employment and the disease may be more difficult than most laymen, and many lawyers, can imagine. This Note explores some of the initial problems[13] a health-care worker may encounter in filing a workers' compensation claim for AIDS in Virginia, focusing on HIV infection as an injury,[14] AIDS as an occupational disease,[15] and AIDS as an accidental infectious disease,[16] under the existing language of the Virginia Workers' Compensation Act (the Act).[17] The first part of this Note is an AIDS primer which explains the epidemiology, transmission, testing, and risk group classifications associated with the AIDS virus, as well as the specific risks endemic to the health-care community.[18] The second part of this Note explores the legal problems which may arise when classifying AIDS under existing workers' compensation definitions, and analyzes in light of those problems, whether a health-care worker can receive workers' compensation benefits for an AIDS-related disability in Virginia.

---

9. *Compare Update: Acquired Immunodeficiency Syndrome—United States*, 35 MMWR 17 (1986) *with 1987 HIV Infection Report*, *supra* note 3. The 1986 report gives 16,458 as the number of AIDS cases reported to the CDC since 1981, while the 1987 report puts the number at over 46,000.

10. *Recommendations for Prevention of HIV Transmission in Health-Care Settings*, 36 MMWR 3S (1987) ("The increasing prevalence of HIV increases the risk that health-care workers will be exposed to blood from patients infected with HIV, especially when blood and body fluid precautions are not followed for all patients.") [hereinafter *1987 CDC Health-Care Recommendations*].

11. Liability for HIV transmission is currently being litigated in countless lawsuits, and is beyond the scope of this Note. *See* D. HERMANN, *Torts: Private Lawsuits About AIDS*, in AIDS AND THE LAW: A GUIDE FOR THE PUBLIC 153 (1987).

12. *See* VA. CODE ANN. §§ 65.1-1 to -163 (Repl. Vol. 1987).

13. This Note does not claim to cover every problem that may arise in this situation. Since this is a new area of law, and there are no cases in the United States on point. Thus, the problems anticipated in this area are highly theoretical in nature.

14. *See infra* notes 96-105 and accompanying text.

15. *See infra* notes 106-124 and accompanying text.

16. *See infra* notes 125-140 and accompanying text.

17. VA. CODE ANN. §§ 65.1-1 to -163 (Repl. Vol. 1987).

18. *See infra* notes 19-57 and accompanying text. Considerable space is devoted to the discussion of these topics, since a basic understanding of the medical concepts underlying the AIDS epidemic is crucial to understanding the legal issues later discussed.

II. An AIDS Primer

A. *General Concepts*

AIDS first came to the attention of physicians on the East and West Coasts in 1981, when a few normally rare diseases[19] began appearing in increasing numbers in the gay communities of San Francisco and New York.[20] Since its identification in 1981, over 46,000 cases of AIDS have been reported to the CDC.[21] The number of reported cases has doubled every six to thirteen months since 1981.[22] However, these figures represent only reported cases of full blown AIDS. In 1986, the Public Health Service estimated that at least 1.5 million Americans had been infected with the AIDS virus.[23]

Contrary to public belief, people do not "catch" AIDS. AIDS is but one of three conditions which may be caused by the Human Immunodeficiency Virus,[24] a virus which attacks the body's immune defense system.[25] HIV destroys the white blood cells known as T-helper cells[26] which prevent infectious diseases. This results in an immunodeficiency that exposes the body to a host of infections, common and uncommon, which people with fully functioning immune systems ward off every day.[27] For the immunocompromised person, however, these infections can represent serious illness and death. Thus, no one dies from AIDS—they die from the onslaught of opportunistic infections[28] which attack the body once the barrier of immunity is destroyed.

---

19. *See infra* note 38.

20. J. Osborn, *The AIDS Epidemic*, in AIDS and the Law: A Guide for the Public 17, 18 (1987).

21. *1987 HIV Report*, *supra* note 3, at 801. This report summarizes the current knowledge on HIV up to 1987, and was presented to the Domestic Policy Council as part of an AIDS symposium. Although the CDC publishes an annual AIDS update, the 1987 version had not been released as of February 22, 1987. For the most recent annual compilation of AIDS statistics, see *Update: Acquired Immunodeficiency Syndrome—United States*, 35 MMWR 17 (1986) [hereinafter *1986 AIDS Update*].

22. J. Osborn, *supra* note 20, at 19; *see supra* note 9; *see also 1986 AIDS Update*, *supra* note 21, at 17 (chart depicting incremental rise in reported AIDS cases since 1981).

23. *1987 HIV Infection Report*, *supra* note 3, at 804.

24. Human Immunodeficiency Virus, or HIV, is the name proposed by the International Committee on Taxonomy of Viruses for the virus that causes AIDS. J. Osborn, *supra* note 20, at 22. The CDC regularly employed the more technical label "Human T-Lymphotropic Virus Type III/Lymphadenopathy-Associated Virus," or HTLV III/LAV, until 1986, when its reports abandoned that name for the more workable HIV.

25. A person whose immune system has been damaged is referred to as "immunocomprised" or "immunodeficient."

26. R. Green, *The Transmission of AIDS*, in AIDS and the Law: A Guide for the Public 28, 29 (1987). T-cell lymphocytes which bear the helper/inducer phenotype are an integral part of the body's immune system, fighting fungi, bacteria and viruses. HIV, a retrovirus, destroys the T-helper cell by compromising the cell's protein coat, invading the cell and actually changing the cell's DNA makeup. *Id.*

27. *See id.*

28. The term "opportunistic infection" refers to an organism capable of causing disease

HIV can cause three distinct conditions after the initial infection: the seropositive state, Aids Related Complex (ARC), and AIDS.[29] The first, the seropositive state, is revealed when blood tests show the presence of HIV antibodies.[30] A majority of people test seropositive within two to three months of infection.[31] The seropositive individual does not have, and may never develop, symptoms of ARC or AIDS. He[32] is, however, an HIV carrier and can transmit the virus to others. It is estimated that over one million people are seropositive.[33]

HIV can also produce a non-fatal condition called AIDS Related Complex (ARC).[34] ARC causes only moderate damage to the immune system and produces non-specific signs of illness.[35] The ARC patient does not manifest the specific AIDS-indicative opportunistic infections, and people with ARC seldom develop AIDS.[36]

AIDS, the most serious (and most publicized) condition caused by HIV, causes a major collapse of the body's immune defense system.[37] This collapse allows opportunistic infections to invade the body of the immunocompromised individual.[38] The average interval between infection with HIV and the development of AIDS exceeds seven years, and death occurs, on the average, within two years of diagnosis.[39]

B. *Diagnosis of AIDS and HIV Antibody Testing*

Another popular misconception is that AIDS is diagnosed through blood testing. To the contrary, one thing that blood testing does *not* do is

---

only in an immunocompromised host. *See infra* notes 38-41 and accompanying text.

29. R. GREEN, *supra* note 26, at 29.

30. *Id.* For a discussion of AIDS blood testing, see *infra* notes 40-48 and accompanying text.

31. R. GREEN, *supra* note 26, at 29.

32. For the purposes of this Note, the male pronoun shall include the female gender.

33. R. GREEN, *supra* note 26, at 30 (citing *Epidemiology of AIDS: Current Status and Future Prospects*, 229 SCIENCE 1354 (1985)).

34. *Id.*

35. *Id.* Some of the symptoms associated with ARC are fever, weight loss, diarrhea, fatigue, night sweats and lymphadenopathy. To confirm an ARC diagnosis, the patient must exhibit two or more of these symptoms for at least three months. *Id.*

36. *Id.*

37. *Id.*

38. The most common AIDS-indicative opportunistic infections are *pneumocystis carinii* pneumonia (PCP), and Kaposi's sarcoma, a form of cancer, both very rare in people with fully functioning immune systems. *Revision of the CDC Surveillance Case Definition for Acquired Immunodeficiency Syndrome*, 36 MMWR 3S (1987) [hereinafter *1987 CDC AIDS Case Definition*]. Over one-half of all AIDS patients die from PCP. Green, *supra* note 26, at 30 (citing Peterman, *Epidemiology of the Acquired Immunodeficiency Syndrome (AIDS)*, 7 EPIDEMIOLOGICAL REVS. 1 (1985)).

39. R. GREEN, *supra* note 26, at 30; *see also 1987 HIV Infection Report*, *supra* note 3, at 801.

identify persons with AIDS.[40] The CDC defines AIDS by symptoms, using an array of AIDS-indicative diseases and conditions as diagnostic indicators.[41] The CDC also specifies a list of alternate causes of immunodeficiency, each of which must be excluded before AIDS can be diagnosed.[42] Blood testing, referred to by the CDC as "laboratory evidence,"[43] is a secondary tool used by physicians in tandem with signs of AIDS-indicative diseases to support an AIDS diagnosis. The presence or absence of HIV antibodies is never definitive, and under certain circumstances the CDC recognizes an affirmative AIDS diagnosis even with a negative HIV antibody test.[44]

The reluctance of the medical community to rely more heavily on AIDS antibody tests stems from the nature of the tests themselves. The Enzyme-Linked Immunosorbent Assay (ELISA) test is the currently accepted blood screening device for HIV antibodies. It detects the presence of antibodies in the blood, indicating exposure to HIV.[45] The extreme sensitivity of the ELISA test, however, frequently leads to a false positive result.[46] Thus, the test's usefulness as a diagnostic tool is limited. A positive ELISA test is always repeated, and a second positive result is then confirmed with the Western Blot test, which identifies antibodies to proteins of a specific molecular weight.[47] The Western Blot test, while less

---

40. M. ROTHSTEIN, *Screening Workers for AIDS*, in AIDS AND THE LAW: A GUIDE FOR THE PUBLIC 126, 130 (1987). The Rothstein article focuses on the constitutional rights of workers in relation to AIDS testing, which is beyond the scope of this Note.

For an in-depth, technical explanation of the types of AIDS antibody tests, see T. ROITT, J. BROSTOFF & D. MALE, IMMUNOLOGY 25.5 (1985). For a discussion of AIDS antibody testing as a privacy issue, see Closen, Cannor, Kaufman & Wojcik, *The Test: Is it Accurate? Is it Legal?*, 14 HUMAN RIGHTS 30 (1987).

41. *1987 CDC AIDS Case Definition*, *supra* note 38, at 4S-8S.

42. *Id.* at 4S.

43. *Id.*

44. *Id.* at 6S. According to CDC standards, if the patient has a negative AIDS antibody test, but all other causes of immunodeficiency are ruled out, *and* the patient has AIDS-indicative diseases and a low T-helper cell count, the patient may be diagnosed as having AIDS. *Id.*

45. The ELISA test uses a plastic square covered with a thin layer of virus proteins. Serum from the test subject, along with certain chemicals, are added to the sheet. A color reaction is produced, which is graded with a device called a spectrophotometer to indicate the test results. Hermann, *AIDS: Malpractice and Transmission Liability*, 58 U. COLO. L. REV. 63, 64 n.7 (1986).

46. Aside from sensitivity, other explanations for false positive results have been advanced, including "positivity produced by structurally similar but unrelated antibodies, differences in test kits, a weakly positive test, and statistical variation inherent in any test of this nature." Closen, Cannor, Kaufman & Wojcik, *supra* note 40, at 32.

47. M. ROTHSTEIN, *supra* note 40, at 130. The Western Blot is much more expensive than the ELISA ($100 compared to $4), and is technically more difficult and time consuming. *Id.* (citing Levine & Bayer, *Screening Blood: Public Health and Medical Uncertainty*, HASTINGS CENTER REP. 8, 9 (1985).

likely to produce false positives and thus more reliable than ELISA, also retains weaknesses as a diagnostic tool, since it tests only for antibodies to HIV, not for the virus itself.[48]

C. *Transmission of HIV and Recognized Risk Groups*

The CDC has reported that HIV has been isolated from blood, semen, vaginal secretions, breast milk, amniotic fluid, urine, saliva, tears and cerebrospinal fluid.[49] While the virus has been found in these body fluids and will probably be detected in others, only blood, semen, vaginal secretions and breast milk have been implicated in transmission.[50] HIV has been shown to be transmitted only through sexual contact, parenteral exposure[51] to contaminated blood or body fluids, and perinatal transmission from mother to child.[52]

The six risk groups identified by the CDC correspond closely to the proven modes of HIV transmission. Risk groups are comprised of individuals whose past behavior suggests a possible means of disease acquisition.[53] The risk groups recognized by the CDC are men with homosexual or bisexual orientation who use intravenous (IV) drugs, homosexual or bisexual men who do not use IV drugs, heterosexual IV drug users, hemophiliacs, transfusion recipients, and heterosexual partners of any risk group members.[54] Although the first five groups may seem limited in scope, the sixth group has the potential to broaden the base of seropositive individuals immeasurably. Since the average interval between the asymptomatic seropositive state and the development of AIDS is seven years,[55] a heterosexual who is unknowingly exposed to HIV through sexual contact with a risk group member could then unwittingly spread HIV throughout a pool of other heterosexual partners for a period of seven years or more.[56] Additionally, it is important to note that studies focusing

---

48. M. ROTHSTEIN, *supra* note 40, at 131. For instance, both the ELISA and Western Blot tests would fail to identify those persons in the developmental stages between exposure and seroconversion. *Id.*

Many experts suggest that the antibody tests should be followed by a T-helper cell test, which measures the ratio of T-cell lymphocytes in a person's blood. Since HIV destroys T-helper cells, a combination of low T-helper cell levels and positive antibody tests could indicate the presence of the virus. Hermann, *supra* note 45, at 65 (citing P. EBBESEN, AIDS: A BASIC GUIDE FOR CLINICIANS 140 (1984)).

49. *1987 CDC Health-Care Recommendations*, *supra* note 10, at 3S.

50. *Id.*

51. Parenteral exposure (exposure by means other than through the gastrointestinal track or lungs) includes contamination of the mucous membranes, open wounds, transfusions and percutaneous (needlestick) exposure.

52. *1987 CDC Health-Care Recommendations*, *supra* note 10, at 3S.

53. *See 1986 AIDS Update*, *supra* note 21, at 18.

54. *Id.*

55. *See* sources cited *supra* note 39.

56. *See, e.g.*, Redfield, *Heterosexually Acquired HTLV-III/LAV Disease: Epidemiologic*

on risk groups have been concerned not only with recent behavior, but also with risk-indicative behavior since 1978,[57] thus including many people who might have considered themselves risk-free.

III. AIDS AND HEALTH-CARE WORKERS

Health-care workers are defined by the CDC as "persons, including students and trainees, whose activities involve contact with patients or with blood or other body fluids from patients in a health care setting."[58] Health-care workers may be exposed to HIV in a multitude of ways, including needlesticks and cuts, blood splashed into eyes or mucous membranes, daily handling of infected blood and body fluids (in both patient care and lab settings), and through other percutaneous or parenteral exposures.[59] Since health-care workers encounter additional risks to which the public generally is not exposed, it seems odd that the media, and in particular the medical media, has stressed repeatedly that the risk to health-care workers from HIV exposure is very low.[60]

One possible explanation for the media's strident assertions could be the medical community's need to stem the rising concern over AIDS within its membership before that concern develops into panic.[61] Since every patient is a potential source of HIV infection, a panic about intra-hospital HIV contagion could inhibit a hospital's ability to help the sick.[62] Another possible explanation is that the comforting generalities advanced by the media are true. An examination of the methodology behind the

---

Evidence for Female to Male Transmission, 254 J. A.M.A. 2094 (1985). The seropositive state of the carrier could be exposed by HIV antibody tests, but an asymptomatic person may have no reason to seek AIDS testing.

57. *See, e.g.*, Lifson, Castro, McCray & Jaffe, *National Surveillance of AIDS in Health-Care Workers*, 256 J. A.M.A. 3231 (1986).

58. *1987 CDC Health-Care Recommendations, supra* note 10, at 3S.

59. *See supra* note 51. The CDC has compared HIV transmission to the Hepatitis B mode of transmission, although Hepatitis B is more infectious than HIV. *See Summary: Recommendations for Preventing Transmission of Infection with Human T-Lymphotropic Virus Type III/Lymphadenopathy-Associated Virus in the Workplace*, 34 MMWR 681 (1985).

60. *See, e.g., You're not Likely to get AIDS from Patients*, 48 RN 12 (1985).

61. Signs of rising concern within the medical community are also evidenced in the media, although not to the extent of the "low risk" assertions. *See, e.g., AIDS: A Time Bomb at Hospitals' Door*, 60 HOSPITALS 54, 60 (1986); *Attitudes that Shape the Fight Against AIDS: Even Among Doctors, an Epidemic of Fear*, NY Times, June 2, 1985, at 6E, col. 1.

An interesting aside on physician concern over AIDS is that "[h]istorically, physicians have tacitly accepted an occupational risk of exposure to fatal infectious diseases . . . . Only the current generation of physicians, trained after the development of effective antibiotics has never confronted this potential occupational risk." Abrans, *Clinical Care and Research in AIDS*, HASTINGS CENTER REP., Aug. 1985, Supp. at 16, *quoted in* T. BANKS, *The Right to Medical Treatment*, in AIDS AND THE LAW: A GUIDE FOR THE PUBLIC 175, 176 (1987).

62. *1987 CDC Health-Care Recommendations, supra* note 10, at 3S (warning that all patients should be treated as potential HIV carriers).

studies which lead to the "low risk" conclusions, however, shows that while the risk to health-care workers is low if CDC guidelines are followed, it is not as minuscule as the headlines lead the public to believe.

Several studies on health-care workers and AIDS have been conducted in the last five years. The methods of data collection vary widely. Some studies trace reported parenteral exposures to determine whether any of the reported exposures have resulted in seroconversion.[63] Other studies work from the opposite end, questioning workers who are already seropositive, or who have AIDS, to determine whether the infection resulted from occupational exposure. With both methods of study, the data is often incomplete. When complete data cannot be obtained, seropositive workers are often lumped into the non-occupational transmission group instead of being excluded from the overall subject pool.[64] It is even more alarming that all of the studies automatically exclude infected health-care workers with possible risk group status from the category of workers who contracted AIDS on the job, despite documented occupational exposures to HIV.[65]

The first CDC study of health-care workers with possible HIV exposure focused on 361 subjects with documented parenteral or mucous membrane exposure to potentially infectious body fluids.[66] The CDC report stated that none of the workers had developed signs or symptoms of AIDS. However, only forty percent of the 361 workers had been followed for twelve months or longer.[67] Thus, according to the CDC's own data, the workers had not been observed long enough for HIV infection to be ruled out.[68] Later that same year, the CDC updated its study on health-care workers, combining the results of several published studies with statistics from its own test groups.[69] This report identified twenty-six seropositive health-care workers, all with documented exposure to HIV, yet only two of those twenty-six were accepted as representing occupational transmis-

---

63. The subject pools for these studies are always deceptively small; it is estimated that between one-third and one-half of accidental needlesticks are not reported, and studies deal only with reported exposures. Hamory, *Underreporting of Needlestick Injuries in a University Hospital*, 11 AM. J. INFECT. CONTROL 174 (1983).

64. *See* Lifson, Castro, McCray & Jaffe, *supra* note 57, at 3232-33 (chart breaking down categories).

65. *See infra* note 75.

66. *Update: Prospective Evaluation of Health-Care Workers Exposed via the Parenteral or Mucous Membrane Route to Blood or Body Fluids from Patients with Acquired Immunodeficiency Syndrome-United States*, 34 MMWR 101 (1985).

67. *Id.* at 101.

68. *See 1987 HIV Infection Report*, *supra* note 3, at 801; *see supra* text accompanying notes 37-39.

69. *Update: Evaluation of Human T-Lymphotropic Virus Type III/Lymphadenopathy-Associated Virus Infection in Health-Care Personnel—United States*, *supra* note 7. This report integrated the results of a serosurvey conducted by Staneley H. Weiss which involved needlestick injuries, making this CDC study broader in scope than its predecessor.

sion. Twenty-three belonged to recognized risk groups, and a twenty-fourth was tested anonymously, resulting in incomplete epidemiologic information.[70] The assumption is obvious: a health-care worker who becomes infected with HIV, but belongs to a risk group based upon behavior that may have occurred as many as ten years ago,[71] did not become infected at work, despite documented evidence of parenteral exposure in most cases.

Not surprisingly, the conclusions of most "low risk" serosurveys of health-care workers are gleaned from this same type of pared-down subject pool. One survey reported 922 health-care workers with AIDS and found that only eighty-eight had no identified risk group status. After further interviews, the study reclassified fifty-two subjects into risk groups.[72] The study then concluded that ninety-five percent of health-care workers with AIDS belonged to identified risk groups, and therefore "the risk of human immunodeficiency virus transmission in the occupational setting is low."[73] To its credit, the survey did note that "the possibility of occupational transmission of HIV cannot be excluded" for workers in risk groups.[74] Thus, all 922 workers may have contracted HIV on the job, but because of risk group classifications, the survey summarily concluded that they did not have valid occupational transmissions.

The two most recent CDC reports on health-care workers have begun to recognize the increasing risk to health-care workers and have put more emphasis on universal precautions. The latest CDC update on health-care workers and AIDS[75] acknowledged nine confirmed instances of occupational transmission where the individuals had no known risk group status.[76] The report emphasizes that most of these workers were not follow-

70. The case histories of the two infected workers are presented in the update. One was a female health-care worker who sustained needlestick injuries while drawing blood from AIDS patients, and the other was a male laboratory worker who cut his hand while processing blood from a leukemia patient. *See id.* at 575.

71. *See supra* note 57 and accompanying text.

72. Lifson, Castro, McCray & Jaffe, *supra* note 57.

73. *Id.* at 3231. The most recent CDC estimates have used these figures grouped in this fashion as well. *See 1987 CDC Health-Care Recommendations*, *supra* note 10, at 45.

74. Lifson, Castro, McCray & Jaffe, *supra* note 57, at 3233.

75. *Update: Human Immunodeficiency Virus Infections in Health-Care Workers Exposed to Blood of Infected Patients*, 36 MMWR 285 (1987) [hereinafter *1987 Study Update*]. The study did not provide the numbers of health-care workers who were seropositive and had a risk group classification; the only figures offered were those representing workers with no known risk status. *Id.*

76. *Id.* at 285; *see Needlestick Transmission of HTLV-III from a Patient Infected in Africa*, 2 LANCET 1376 (1984); Neisson-Vernant, Arfi, Mathez, Leibowitch & Monplasir, *Needlestick HIV Seroconversion in a Nurse*, 2 LANCET 814 (1986); Oksenhendler, Harzic, Le Roux, Rabian & Clauvel, *HIV Infection with Seroconversion after a Superficial Needlestick Injury to the Finger*, 315 N. ENG. J. MED. 582 (1986); Stricof & Morse, *HTLV-III/LAV Seroconversion Following a Deep Intramuscular Needlestick Injury*, 314 N. ENG. J. MED. 1115 (1986).

ing CDC infection control recommendations for handling blood and body fluids.[77] Three months after the update, the CDC issued a special set of recommendations for health-care workers.[78] This set of guidelines emphasizes that blood and body fluids from *all* patients should be treated as potentially infected, an approach referred to as "universal blood and body fluid precautions."[79] This approach, adopted by many hospitals in recognition of the threat of undetected seropositive patients,[80] underscores the industry's growing awareness of the looming threat AIDS poses to health-care workers[81] and stands in contradiction to assertions that workers are not at risk.

Although health agencies have at least attempted to address the concerns of health-care personnel in the area of HIV risks, most lawmakers are blissfully unaware that any problems exist. In the area of workers' compensation, statutory schemes and definitions fail to account for the unusual characteristics of AIDS, and as a result unintentionally exclude many AIDS related disabilities. The second part of this Note focuses on three such deficiencies in the Virginia Workers' Compensation Act.

IV. AIDS, Health-Care Workers, and Workers' Compensation

A. *The Virginia Workers' Compensation Act: An Overview*

The main purpose of workers' compensation acts is to furnish "a mechanism from providing cash-wage benefits and medical care to victims of work-connected injuries."[82] The Supreme Court of Virginia has delineated the objectives of the Virginia Workers' Compensation Act,[83] stating that the Act

> was for the beneficent purpose of providing compensation . . . to a workman or his dependents, in the event of his injury or death, for loss of his opportunity to engage in gainful employment when disability or death was occasioned by an accidental injury or occupational disease, to the hazard or risk of which he was exposed as an employee.[84]

---

77. *1987 Study Update*, *supra* note 75, at 285.

78. *1987 CDC Health-Care Recommendations*, *supra* note 10.

79. *Id.* at 5S.

80. *See, e.g.*, *MCVH-VAH Infection Control Guidelines for Human Immunodeficiency Virus Infection* (1987). This 51-page set of regulations promulgated by the Medical College of Virginia Hospitals spans 18 departments and goes far beyond what is recommended by the CDC.

81. At the other end of the worker protection spectrum is Bernales v. City and County of San Francisco, 184 Daily Lab. Rep. (BNA) A-6 (Sept. 23, 1985). In *Bernales*, a city hospital refused to allow nurses to wear gowns, gloves and masks while attending AIDS patients. The Labor Commissioner ruled that the hospital followed the latest CDC procedures and that the nurses' statutory rights had not been violated.

82. 1 A. Larson, The Law of Workmen's Compensation § 1:00 (1985).

83. Va. Code Ann. § 65.1-1 to -163 (Repl. Vol. 1987).

84. Fauver v. Bell, 192 Va. 518, 521, 65 S.E.2d 575, 577 (1951).

In Virginia, workers' compensation benefits are awarded only for "injury by accident, or occupational disease . . . arising out of and in the course of . . . employment."[85] Injury, for the purposes of the Act, has been defined as any "lesion or change in any part of the system [which] produces harm or pain or a lessened facility of the natural use of any bodily activity or capability."[86] An accident is an identified incident occurring at a definite time. The claimant cannot recover benefits if he cannot identify an incident which caused his injury.[87] The injury itself must "arise out of" the course of employment, meaning the claimant must be able to show a causal connection between the work performed and the injury received.[88] The claimant must also prove that the injury was received in the course of employment, by showing that it happened during a period of employment, while the employee was fulfilling his duties and in a place his duties reasonably required him to be.[89] Both the "arise out of" and "in the course of" requirements must be satisfied for an injury to be compensable.[90] The claimant has the burden of satisfying the requirements of proof under the Act by a preponderance of the evidence.[91]

The Virginia Workers' Compensation Act also has sections specifically applicable to occupational diseases which contain special definitions and burdens of proof.[92] An occupational disease, as defined by statute, is a disease "arising out of and in the course of employment, but not an ordinary disease of life to which the general public is exposed outside of employment."[93] The statute then lists six criteria by which it is determined whether the disease arose out of the employment.[94] Although section

85. VA. CODE ANN. § 65.1-7.

86. Burlington Mills Corp. v. Hagood, 177 Va. 204, 209, 13 S.E.2d 291, 293 (1941) (quoting Wasmuth-Endicott Co. v. Karst, 77 Ind. App. 279, 133 N.E. 609, 610 (1922)). The Virginia Act, as originally passed in 1918, was modeled after the Indiana Workmen's Compensation Act; thus Indiana cases are often referred to as precedent. L. HINER, *Introduction to the Virginia Workers' Compensation Act*, in WORKERS' COMPENSATION FOR THE EMPLOYER'S ATTORNEY AND CLAIMANT'S ATTORNEY 1-4 (L. Pascal ed. 1987).

87. Badische Corp. v. Starks, 221 Va. 910, 914, 275 S.E.2d 605, 607 (1981).

88. Conner v. Bragg, 203 Va. 204, 123 S.E.2d 393, 396-97 (1962). The *Conner* court adopted an "actual risk test" as a standard to decide whether an injury arose out of the employment:

> [I]f the injury can be seen to have followed as a natural incident of the work and to have been contemplated by a reasonable person familiar with the whole situation as a result of the exposure occasioned by the nature of the employment, then it arises out of the employment.

Id. at 208-09, 123 S.E.2d at 397.

89. *Id.* at 208, 123 S.E.2d at 396; *see, e.g.*, Lucas v. Lucas, 212 Va. 561, 186 S.E.2d 63 (1972). This requirement refers only to the circumstances, place and time of the incident. *Id.*

90. Grand Union Co. v. Bynum, 226 Va. 140, 307 S.E.2d 456 (1983).

91. *See* Van Geuder v. Commonwealth, 192 Va. 548, 65 S.E.2d 565 (1951).

92. VA. CODE ANN. §§ 65.1-46, -46.1 (Repl. Vol. 1987).

93. *Id.* § 65.1-46.

94. *Id.*

65.1-46 specifically excludes ordinary diseases of life from coverage under the Act, the 1986 amendments added section 65.1-46.1, which provides that ordinary diseases of life may be treated as occupational diseases if the claimant proves by clear and convincing evidence that the criteria of section 65.1-46 are met, and if the disease falls under one of three categories of exceptions listed.[95]

B. *HIV Infection as a Disabling Injury*

A necessary prerequisite to considerations of compensability is proof of the existence of an injury. An injury must involve "an obvious sudden mechanical or structural change in the body" of the claimant.[96] The injury also must prevent the claimant from working, since it is an inherent feature of workers' compensation systems that "the only injuries compensated for are those which produce disability and thereby presumably affect earning power."[97]

Clearly a case of ARC or AIDS would constitute both a sudden change in the body and a disabling condition which would prevent the claimant from working. The individual who is seropositive but asymptomatic, however, has little chance of classifying his infection as an injury. The seropositive state would not prevent the individual from continuing his job in the health-care field, since there are no disabling symptoms and transmission from worker to patient is considered highly unlikely.[98] Although there is a possibility that the worker could develop ARC or AIDS, mere possibilities are not compensable.[99] This is not to say that the worker has not been impaired by his work-related exposure to HIV; his seropositive state may impair him emotionally and in his social and sexual relations with others. However, unless the emotional impairment renders the worker psychologically unable to work,[100] it would not be compensable.

---

95. *Id.* § 65.1-46.1.

96. Bradley v. Philip Morris, 1 Va. App. 141, 144, 336 S.E.2d 515, 517 (1985) (citations omitted).

97. 1 A. LARSON, *supra* note 82, § 2.40.

98. *See 1987 CDC Health-Care Recommendations*, *supra* note 10, at 155. If a health-care worker was fired because of a positive HIV antibody test, the action could result in charges of discrimination, a topic which is beyond the scope of this Note. *See* Carey, *The Developing Law of AIDS in the Workplace*, 46 MD. L. REV. 284 (1987).

99. *See* Smith v. Fieldcrest Mills, Inc., 224 Va. 24, 294 S.E.2d 805 (1982) (holding that the claimant must establish the existence of an occupational disease and show that the disease is a contributing factor in a disability).

100. Virginia has compensated employees for employment-related emotional disorders rendering them unable to work. *See* Burlington Mills Corp. v. Hagood, 177 Va. 204, 13 S.E.2d 291 (1941) (holding that traumatic neurosis produced by the fright of seeing an electric flash from a window is compensable).

Similarly, the impairment of the worker's sexual relations is not related to his ability to perform his job, and is therefore not compensable.[101]

Assuming AIDS could be compensable as an occupational disease,[102] the seropositive health-care worker, with the possibility of developing AIDS or ARC within seven to ten years, could find himself in a somewhat morbid race with the applicable statutes of limitations.[103] Under Virginia's statute of limitations for occupational diseases, a claim must be made within two years after diagnosis of the disease is communicated to the employee, or within five years of the date of the last injurious exposure, whichever comes first.[104] Thus, when a health-care worker has a parenteral exposure to potentially infected blood or body fluids, there is a possibility that the statute of limitations will run out before the worker develops symptoms which can be classified as injurious. If the worker is tested and is seropositive, he would have two years under the statute before his right to compensation for that exposure is barred.[105] If the worker is not tested, or if a positive HIV antibody test does not qualify as a diagnosis of the resulting AIDS condition, the worker would then have five years from the date of the last injurious exposure before compensation for that exposure is barred. Since AIDS generally takes seven years to develop, it is doubtful that a health-care worker in either instance could be compensated under the existing limitations provisions.

C. *AIDS as an Occupational Disease*

A health-care worker who has a parenteral exposure to HIV, and subsequently develops AIDS or ARC, would seem to have a compensatory question which is directly addressed by the provisions of sections 65.1-46 and 65.1-46.1 of the Virginia Workers' Compensation Act.[106] Although HIV would be considered a virus "to which the general public is exposed outside"[107] of the hospital, making it a non-compensable "ordinary disease of life" under section 65.1-46, there are three exceptions contained in section 65.1-46.1 under which an ordinary disease of life may be compensable as an occupational disease. The exception which applies to the in-

---

101. *See* Heidler v. Industrial Comm'n, 14 Ariz. App. 280, 482 P.2d 889 (1971) (holding that since claimant's only disability from an industrial accident was sexual impotence, which did not affect his earning capacity, claimant was not entitled to compensation).

102. *See infra* notes 106-24 and accompanying text.

103. *See* VA. CODE ANN. § 65.1-52(3) (Repl. Vol. 1987).

104. *Id.*

105. This reasoning is based upon the assumption that seropositivity would later be seen as the initial diagnosis of the resulting conditions of AIDS and ARC. Under CDC recommendations, however, diagnosis may only be made through the identification of symptoms. It is possible that five years would elapse before the worker's seropositive condition developed into AIDS, and the claim would be barred under the second statute of limitations based on time elapsed since injurious exposure.

106. VA. CODE ANN. § 65.1-46 to -53 (Repl. Vol. 1987).

107. *Id.* § 65.1-46.

stant problem states that an ordinary disease of life is compensable as an occupational disease if "[i]t is an infectious or contagious disease contracted in the course of one's employment in a hospital or sanitarium or public health laboratory."[108] This provision, enacted in 1986, has not been the subject of any decisions in Virginia, although its pre-amendment predecessor, section 65.1-46(2),[109] frequently had been interpreted as al-

---

108. *Id.* § 65.1-46.1.

109. *Id.* § 65.1-46(2). The pre-amendment section on occupational diseases was a combination of the current §§ 65.1-46 and 65.1-46.1, and read as follows:

> "Occupational disease" defined.—As used in this Act, unless the context clearly indicates otherwise, the term "occupational disease" means a disease arising out of and in the course of the employment. No ordinary disease of life to which the general public is exposed outside of the employment shall be compensable, except:
>
> (1) When it follows as an incident of occupational disease as defined in this title; or
>
> (2) When it is an infectious or contagious disease contracted in the course of employment in a hospital or sanitarium or public health laboratory.
>
> A disease shall be deemed to arise out of the employment only if there is apparent to the rational mind, upon consideration of all the circumstances:
>
> (1) A direct causal connection between the conditions under which work is performed and the occupational disease,
>
> (2) It can be seen to have followed as a natural incident of the work as a result of the exposure occasioned by the nature of the employment,
>
> (3) It can be fairly traced to the employment as the proximate cause,
>
> (4) It does not come from a hazard to which workmen would have been equally exposed outside of the employment,
>
> (5) It is incidental to the character of the business and not independent of the relation of employer and employee, and
>
> (6) It must appear to have had its origin in a risk connected with the employment and to have flowed from that source as a natural consequence, though it need not have been foreseen or expected before its contraction.

After the 1986 amendments, however, the section was redrafted into two parts:

> § 65.1-46. "Occupational disease" defined.—As used in this Act, unless the context clearly indicates otherwise, the term "occupational disease" means a disease arising out of and in the course of employment, but not an ordinary disease of life to which the general public is exposed outside of the employment.
>
> (1), (2) [Repealed.]
>
> A disease shall be deemed to arise out of the employment only if there is apparent to the rational mind, upon consideration of all the circumstances:
>
> (1) A direct causal connection between the conditions under which work is performed and the occupational disease.
>
> (2) It can be seen to have followed as a natural incident of the work as a result of the exposure occasioned by the nature of the employment.
>
> (3) It can be fairly traced to the employment as the proximate cause.
>
> (4) It is neither a disease to which an employee may have had substantial exposure outside of the employment, nor any condition of the neck, back or spinal column.
>
> (5) It is incidental to the character of the business and not independent of the relation of employer and employee, and
>
> (6) It had its origin in a risk connected with the employment and flowed from that source as a natural consequence, though it need not have been foreseen or expected before its contraction.
>
> § 65.1-46.1. "Ordinary diseases of life" coverage.—An ordinary disease of life to which the general public is exposed outside of the employment may be treated as an occupational

lowing recovery for infectious hepatitis contracted by health-care workers,[110] a disease similar in epidemiology to AIDS.[111]

Unfortunately, the hepatitis cases decided under the pre-amendment version of section 65.1-46 would not be analogous to an AIDS case decided under the present version, because the two statutes differ in the standards of proof required for ordinary diseases of life to be compensable as occupational diseases. The pre-amendment version of section 65.1-46 was interpreted to mean that any disease which satisfied the six-part test of the statute qualified as a compensable occupational disease, and any disease that could not pass the six-part test was an ordinary disease of life, which was not compensable unless it fell within one of the statute's exceptions.[112] Under the current sections 65.1-46 and 65.1-46.1, the burden of proof the claimant must meet is much higher. If the claimant has an ordinary disease of life to which the public is exposed outside of the employment, he may receive compensation only if the ordinary disease falls under one the exceptions of section 65.1-46.1 *and* passes the six-part test of section 65.1-46.[113] Under the previous version, the claimant still received compensation if he was unable to meet the six-part burden of proof, but fell under one of the ordinary disease exceptions.

The burden of proof required by section 65.1-46.1 may be impossible for a health-care worker infected with HIV to meet. First, the claimant must show that he qualifies under one of the three exceptions, since HIV is an ordinary disease of life to which the public is exposed. As noted previously, a health-care worker infected with HIV on the job fits neatly into the second exception of section 65.1-46.1.[114] Second, the claimant must establish "by clear and convincing evidence, to a reasonable medical certainty, that [the disease] arose out of and in the course of employment

---

disease for purposes of this Act if it is established by clear and convincing evidence, to a reasonable medical certainty, that it arose out of and in the course of employment as provided in § 65.1-46 with respect to occupational diseases and did not result from causes outside of the employment, and that:

(1) It follows as an incident of occupational disease as defined in this title; or

(2) It is an infectious or contagious disease contracted in the course of one's employment in a hospital or sanitarium or public health laboratory or nursing home as defined in subdivision 2 of § 32.1-123, or in the course of employment as emergency rescue personnel and those volunteer emergency rescue personnel as are referred to in § 65.1-4.1; or

(3) It is characteristic of the employment and was caused by conditions peculiar to such employment.

110. *See* Scott, *Workers' Compensation for Disease in Virginia: The Exception Swallows the Rule*, 20 U. RICH. L. REV. 161, 170 n.64 (1985) (exhaustive list of hepatitis awards under pre-amendment section 65.1-46).

111. *See supra* note 59.

112. Scott, *supra* note 110, at 167. See text of pre-amendment statute *supra* note 109.

113. *See* current versions of statutes *supra* note 109.

114. *Id.*

as provided in § 65.1-46 . . . and did not result from causes outside of the employment."[115] This language incorporates the six requirements of section 64.1-46, all of which the worker must satisfy to be compensated. The HIV-infected health-care worker can satisfy five of these requirements. A parenteral exposure to HIV serves as a sufficient connection between the work performed and the disease,[116] follows "as a natural incident of the work as a result of the exposure,"[117] and serves as a link for proximate causation.[118] Exposure to blood and body fluids is incidental to the character of the health-care profession, and is a risk connected with the employment.[119]

The health-care worker may not be able to prove that HIV is not "a disease to which [he] may have had substantial exposure outside of the employment."[120] At this juncture, any possible risk group behavior in the employee's past could be used against him to deny workers' compensation benefits. Since the "claimant has the burden of proving by a preponderance of the evidence that his disease is occupationally related,"[121] the claimant has not sustained the burden if the evidence shows that it is just as probable that the injury resulted from a non-compensable cause.[122] Therefore, if a health-care worker has previously engaged in risk group behavior, an argument could be made that such behavior was the cause of the HIV infection, not the recent parenteral, work-related exposure. The worker could argue that the nature of his work increased his chances of occupational exposure, and therefore it is not just as probable that he was infected by a source outside the employment. Merely showing that the chances of infection are greater in the place of employment, however, does not satisfy the burden of proof when the worker could also have been infected outside of the employment.[123] Further, the hospital could argue that AIDS studies rule out occupational transmission for health-care workers with risk group status, and an employer is thus justified in applying the same analysis to compensation cases. Therefore, as AIDS becomes more prevalent outside of the hospital setting, and the base of infected individuals expands, it will become even more difficult for a health-care worker to prove an AIDS related workers' compensation claim

115. VA. CODE ANN. § 65.1-46.1 (Repl. Vol. 1987).
116. *See id.* § 65.1-46(1).
117. *Id.* § 65.1-46(2).
118. *Id.* § 65.1-46(3).
119. *Id.* § 65.1-46(5), (6).
120. *Id.* § 65.1-46(4).
121. *See* Virginia Dept. of State Police v. Talbert, 1 Va. App. 250, 253, 337 S.E.2d 307, 308 (1985).
122. Van Geuder v. Commonwealth, 192 Va. 548, 65 S.E.2d 565 (1951).
123. *Id.*

under section 65.1-46.1, because he will be unable to prove that he has not been exposed to the same disease outside of the workplace.[124]

D. *AIDS as an Accidental Infectious Disease*

Although the distinction between accidental infectious diseases and occupational diseases is becoming something of an anachronism in workers' compensation law,[125] it could prove useful for health-care workers. Prior to 1944, Virginia's workers' compensation laws did not provide coverage for occupational diseases, which were considered to be diseases acquired or developed gradually over a period of time.[126] The Act did cover diseases arising from specifically identifiable incidents in the workplace, which were deemed diseases from injury by accident and held compensable.[127] The relevant statute, section 65.1-7, retains the language which created the distinction between occupational and accidental infectious diseases. The statute states that " 'injury' and 'personal injury' mean only injury by accident or occupational disease . . . and do not include a disease in any form, *except* when it results naturally and unavoidably from *either* of the foregoing causes."[128] A disease which results from an injury by accident would, according to this language, be compensable under the Act. The claimant, to satisfy his burden of proof under section 65.1-7, must prove that the injury itself, in this case the exposure to germs or virus, happened by accident, and that the injury arose out of and in the course of employment.[129] A medical statement showing probable cause to believe that the injury and incapacity are related to employment is sufficient to satisfy this burden.[130] There is no requirement that the employee show that he was not exposed to the infection outside of the employment.

There are no current cases on accidental infectious disease in Virginia, but Larson, in his treatise on workmen's compensation,[131] thoroughly discusses the applicability of the accidental infectious disease statutes of Virginia and seventeen other states with similar laws. The oldest and most widely accepted form of accidental infectious disease occurs by the abnormal entry of germs through a scratch or lesion.[132] An occupational scratch or wound qualifies as an accidental injury, but it is not essential that the scratch or wound occur during employment. The wound through

---

124. The large number of asymptomatic seropositive individuals who are unaware of any risk group status must be taken into account as a factor contributing to a worker's inability to be sure of the source of infection. A worker could be exposed to HIV during sexual relations and be completely unaware of such exposure.

125. 1 A. LARSON, *supra* note 82, § 41.00.

126. *See* Fultz v. Virginia Fireworks Co., 7 O.I.C. 225 (1925).

127. *See* Scott, *supra* note 110, at 167.

128. VA. CODE ANN. § 65.1-7 (Repl. Vol. 1987) (emphasis added).

129. *See* Southern Motor Lines Co. v. Alvis, 200 Va. 168, 104 S.E.2d 735 (1958).

130. Smith v. Fieldcrest Mills, 224 Va. 24, 294 S.E.2d 805 (1982).

131. 1 A. LARSON, *supra* note 82, § 40.10.

132. *Id.* § 40.20.

which the germs enter may be pre-existing, and the entrance of germs itself has been deemed an accident.[133] Compensation has repeatedly been granted under statutes similar to Virginia's for diseases contracted through a scratch on the hand, through abrasions on the body and through old wounds on the feet.[134] An argument can be made, therefore, that compensation should be provided in Virginia for health-care workers who become HIV positive after a needlestick,[135] cut,[136] or exposure of hand sores to infected blood or body fluids.[137]

Courts have also held that incidents creating mucous membrane exposure to disease-carrying fluids are accidental injuries, and the resulting disease is therefore compensable.[138] A worker who caught tuberculosis when an infected co-worker coughed in his face and sprayed him with infected spittle was held to have a compensable claim, as was a sewer inspector whose face was splashed with sewage containing typhoid germs,[139] despite the fact that both could have been exposed to the same diseases outside of the employment. By analogy, health-care workers who spill blood on their bodies or are splashed with blood, resulting in mucous membrane exposure,[140] should have the same rights to compensation in Virginia.

V. CONCLUSION

Because the focus of the burden of proof for accidental infectious diseases is on the injury, not on the infection and its possible alternative sources outside the employment, health-care workers who become infected with HIV on the job have a better chance of proving claims under section 65.1-7[141] than under section 65.1-41.1.[142] However, under both statutes a seropositive health-care worker will have difficulties proving that his infection is a disabling injury because of the asymptomatic nature of the seropositive state. Additionally, as the wait for the possible development of AIDS begins, the statute of limitations on exposure starts to run.

---

133. *Id.*

134. *Id.*

135. *See supra* note 76.

136. *See Update: Evaluation of Human T-Lymphotropic Virus Type III/Lymphadenopathy - Associated Virus Infection in Health-Care Personnel - United States*, *supra* note 7 (lab worker seroconverts after spilling infected blood on a cut hand).

137. *See 1987 Study Update*, *supra* note 75.

138. 1 A. LARSON, *supra* note 82.

139. *Id.*

140. *See 1987 Study Update*, *supra* note 75, at 286.

141. VA. CODE ANN. § 65.1-7 (Repl. Vol. 1987).

142. *Id.* § 65.1-41.1.

While it might be possible for health-care workers to make claims for occupational HIV infection, too many difficulties are present in the existing statutory definitions and provisions for the Act to accomplish its stated goals. The legislature must make a conscious effort to update workers' compensation laws to accommodate AIDS victims, not only in the health-care industry, but in all industries.

M. Grey Sweeney