

HIV TESTING OF HEALTH CARE WORKERS: CONFLICT BETWEEN THE COMMON LAW AND THE CENTERS FOR DISEASE CONTROL

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INTRODUCTION

On September 26, 1991, national attention focused on the congressional testimony of Kimberly Bergalis, a young woman dying of acquired immune deficiency syndrome (AIDS).¹ Bergalis had con-

1. See Philip J. Hilts, *AIDS Patient Urges Congress to Pass Testing Bill*, N.Y. TIMES, Sept. 27, 1991, at A12 (describing circumstances surrounding testimony of 23-year-old AIDS victim Kimberly Bergalis). AIDS occurs from weakened cell-mediated (T-cell) immunity, which causes the patient to become increasingly prone to opportunistic infections and unusual cancers. See generally JAMES DARNELL ET AL., *MOLECULAR CELL BIOLOGY* 978 (2d ed. 1990) (explaining genetic makeup and functioning of AIDS virus); PROFESSIONAL GUIDE TO DISEASES 366 (Springhouse 2d ed. 1987) [hereinafter GUIDE TO DISEASES] (describing, in general terms, characteristics of AIDS). The cause of AIDS is the human immunodeficiency virus (HIV), of which there are two strains: HIV-1 and HIV-2. DARNELL, *supra*, at 979 (describing schematic structure of both strains). Researchers believe the virus is transmitted by direct inoculation through intimate sexual contact, especially associated with rectal mucosal trauma, and also through blood transfusions, contaminated needles, and transplacental contact between a mother and her fetus. GUIDE TO DISEASES, *supra*, at 366. Symptoms manifest themselves, on average, within one to three years after exposure to HIV. *Id.*

AIDS gets its name from the fact that the virus, once in the body, kills cells involved in the body's immune system. DARNELL, *supra*, at 980. Other viruses, conversely, transform rather than kill their host cells. *Id.* As a result, the AIDS victim becomes increasingly susceptible to "opportunistic infections." *Id.* The first sign of the virus is typically the development of Kaposi's sarcoma, a vascular tumor that produces purple and brown "plaques" or "nodules" on the lower legs and often on other parts of the body when associated with AIDS. GUIDE TO DISEASES, *supra*, at 367. Other symptoms of the disease include fatigue, afternoon fevers, night sweats, weight loss, diarrhea, and coughing. Typically, two or more of the symptoms will occur concurrently. *Id.* The virus can also attack the brain and cause severe mental deterioration. DARNELL, *supra*, at 980. The most common cause of death results from a pneu-

tracted AIDS from her dentist, Dr. David Acer, during oral surgery.² She appeared before the House Subcommittee on Health and the Environment of the Committee on Energy and Commerce in support of a bill that would require doctors and other health care workers (HCWs) to be tested for the human immunodeficiency virus (HIV).³ Since Bergalis' testimony, Congress has yet to enact any law mandating HIV testing of HCWs.⁴ Congress has passed, however, a law requiring state legislatures to enact practice guidelines for HIV-positive HCWs based on the guidelines promulgated by the Centers for Disease Control (CDC).⁵ The states may adopt either the CDC

monic infection against which the body cannot defend itself. *GUIDE TO DISEASES, supra*, at 367.

Homosexual and bisexual men who are sexually active with multiple partners comprise the group most at risk for HIV infection. *Id.* at 366. Other at-risk groups include intravenous drug users (from contaminated needles), hemophiliacs, and children born to persons with the disease. *Id.* There is currently no cure for AIDS. *Id.* at 367. Drug research has centered around attempting to stop the growth of the virus and to restore the body's immune system. *Id.* Once the disease manifests itself as AIDS, more than 75% of the disease's victims die within two years. *Id.* at 366.

2. Hiltz, *supra* note 1, at A12. It remains unclear how the virus was transmitted from the doctor to Bergalis. *Id.* Bergalis died from AIDS on December 8, 1991. Don Aucoin, *Testing Debate Is Still Raging*, *BOSTON GLOBE*, Dec. 9, 1991, at 1 (discussing debate over mandatory HIV testing of medical personnel in context of Bergalis' death).

3. See H.R. 2788, 102d Cong., 1st Sess. (1991) (proposing establishment of protections against transmission of certain communicable diseases for both health care workers and patients); see also *Prevention of HIV Transmission: Hearings on H.R. 2788 Before the Subcomm. on Health and the Environment of the Comm. on Energy and Commerce*, 102d Cong., 1st Sess. 128 (1991) [hereinafter *Hearings on H.R. 2788*] (statement of Kimberly Bergalis, AIDS victim). The brief statement of Ms. Bergalis reads:

I would like to say that AIDS is a terrible disease which we must take seriously. I did nothing wrong, yet I am being made to suffer like this. My life has been taken away. Please enact legislation so that no other patient or health care provider will have to go through the hell that I have.

Hearings on H.R. 2788, supra, at 128.

4. A bill sponsored by Representative William E. Dannemeyer (R-Cal.) and introduced in the House on June 26, 1991 is still pending. H.R. 2788, 102d Cong., 1st Sess. (1991); see *infra* note 243 and accompanying text (discussing Representative Dannemeyer's bill).

5. See Treasury, Postal Service and General Government Appropriations Act of 1992, Pub. L. No. 102-141, § 633, 105 Stat. 834, 876 (to be codified at 42 U.S.C. § 300ee-2) (detailing steps states must take regarding prevention of HIV and hepatitis-B virus (HBV) transmission in order to avoid becoming ineligible for assistance under Public Health Service Act). Senator Jesse Helms, a North Carolina Republican, originally succeeded in persuading the Senate to pass an amendment to this Appropriations Act that would have subjected HCWs to fines and prison terms in situations where an HCW knows that he or she is HIV positive and intentionally performs invasive medical procedures without giving the patient prior notification of his or her condition. See 137 CONG. REC. S10,363 (daily ed. July 18, 1991) (listing results of vote on Helms amendment); *infra* note 244 and accompanying text (discussing and quoting Helms amendment); see also 137 CONG. REC. S9778 (daily ed. July 11, 1991) (providing language of Helms amendment). Although Helms' initiative passed in the Senate, a conference committee subsequently rejected the amendment. 137 CONG. REC. H7385 (daily ed. October 3, 1991). According to one source, the Helms amendment was killed "because it was recognized up front that the House would never accept it with that language in it." See Joyce Price, *AIDS Testing Likely To Pass*, *WASH. TIMES*, Sept. 29, 1991, at A3 (quoting Bob Maynes, spokesperson for Sen. Dennis DeConcini, ranking Democrat on conference committee). Instead, the conference committee adopted an amendment introduced by Senator Robert Dole (R-Kan.) that had previously passed by unanimous consent in the Senate. 137 CONG. REC.

guidelines as promulgated or ones "equivalent" to those of the CDC.⁶ Additionally, the federal law requires a state's public health official to certify to the director of the CDC within a year of the bill's signing that guidelines have been instituted in the state.⁷ Failure to issue such guidelines will render the state ineligible for federal monies under the Public Health Service Act.⁸

Specifically, the CDC guidelines do not require mandatory testing of HCWs, but rather urge HCWs to undergo voluntary testing for HIV infection.⁹ According to the guidelines, those HCWs who test positive for the virus should generally refrain from practicing "exposure-prone" procedures.¹⁰ Interestingly, the CDC leaves to each hospital and institution the responsibility of defining for itself what procedures should be classified as "exposure-prone."¹¹ Further-

S10,348-50, 10,363 (daily ed. July 18, 1991) (providing language of Sen. Dole's amendment and listing results of vote on amendment); *infra* note 6 (printing portion of Dole's amendment). Section 633 of the Treasury, Postal Service and General Government Appropriations Act of 1992 subsequently incorporated the substance of Senator Dole's amendment and was enacted into law. Pub. L. No. 102-141, § 633, 105 Stat. at 876 (to be codified at 42 U.S.C. § 300ee-2).

6. Pub. L. No. 102-141, § 633, 105 Stat. at 876 (to be codified at 42 U.S.C. § 300ee-2). The statute reads, in pertinent part:

[E]ach State Public Health Official shall, not later than one year after the date of enactment of this Act, certify to the Secretary of Health and Human Services that guidelines issued by the Centers for Disease Control, or guidelines which are equivalent to those promulgated by the Centers for Disease Control concerning recommendations for preventing the transmission of the human immunodeficiency virus and the hepatitis B virus during exposure prone invasive procedures . . . have been instituted in the State.

Id. The legislative history of the statute reveals that Congress intended for the CDC to determine whether guidelines other than those issued by the CDC are "equivalent" to the CDC guidelines. H.R. REP. NO. 234, 102d Cong., 1st Sess. 48-49 (1991) (discussing process by which states will be reviewed regarding compliance with equivalency requirement of statute).

7. Pub. L. No. 102-141, § 633, 105 Stat. at 876 (to be codified at 42 U.S.C. § 300ee-2) (stipulating that guidelines apply to all health officials practicing within states and that compliance with guidelines is responsibility of state public health officials).

8. *Id.* (providing ineligibility requirement that allows for extension of time period where state shows that additional time is required to institute guidelines); *see also* Public Health Service Act, 42 U.S.C. §§ 201 to 300aaa-13 (1988) (detailing organization, function, and powers of Public Health Service).

9. *See Recommendations for Preventing Transmission of Human Immunodeficiency Virus, Hepatitis B Virus to Patients During Exposure-Prone Invasive Procedures*, 40 MORBIDITY & MORTALITY WKLY. REP. 1, 5 (1991) [hereinafter *Recommendations for Preventing Transmission*] (reprinting CDC guidelines, which state that HCWs performing exposure-prone procedures should know their HIV status but that available data on risk of transmission of HIV virus from HCW to patient "does not support the diversion of resources that would be required to implement mandatory testing programs"); *see also* 137 CONG. REC. S9978-79 (daily ed. July 15, 1991) (reprinting CDC guidelines as published on July 12, 1991).

10. *Recommendations for Preventing Transmission*, *supra* note 9, at 5.

11. *Recommendations for Preventing Transmission*, *supra* note 9, at 5. The CDC report does, however, briefly characterize which procedures are likely to be exposure prone. The report states that the "characteristics of exposure-prone procedures include digital palpitation of a needle tip in a body cavity or the simultaneous presence of the HCW's fingers and a needle or other sharp object in a poorly visualized or highly confined anatomic site." *Id.* at 4. Such a description could only have been intended to serve as a guide to hospitals and institutions

more, an infected HCW may perform exposure-prone procedures only if he or she first seeks the counsel of an "expert review panel," which will advise the HCW as to the circumstances, if any, under which he or she may continue to perform these procedures.¹² Lastly, the CDC guidelines suggest that doctors seek consent from patients if the treating HCW is HIV-positive, but, in instances where an HIV-positive HCW performs an exposure-prone procedure without the patient's consent, postoperative notification of the patient should be decided on a case-by-case basis.¹³

This Comment addresses two issues arising from the CDC guidelines: first, the distinction between voluntary and mandatory testing, and second, whether HCWs who are HIV positive should be required to obtain informed consent from patients. Part I analyzes the state of the law regarding principles of risk determination and mandatory testing. Part II discusses ways that the application of theories of informed consent and duty to warn third parties compel an HCW, under certain conditions, to reveal that he or she is HIV positive. Part III examines the CDC guidelines in detail and in relation to the legal principles discussed in Parts I and II. Questions discussed here include whether the CDC guidelines are consistent with or contradict the current state of the common law, and whether the CDC has provided effective guidance for the medical community. Part IV predicts future liabilities and litigation arising from current CDC guidelines and concludes with specific recommendations for future governmental and medical action.

I. COMMON LAW BACKGROUND, PRE-CDC GUIDELINES

The purpose of the CDC guidelines is to lessen the risk of transmission from HCWs to patients during invasive procedures.¹⁴ The guidelines define invasive procedures as those involving "surgical entry into tissues, cavities, or organs or repair of major traumatic injuries."¹⁵ The guidelines offer recommendations to the medical

given the fact that the guidelines expressly decline to set forth a blanket definition of what constitutes an "exposure-prone procedure." *Id.* at 5.

12. *Recommendations for Preventing Transmission*, *supra* note 9, at 5 ("Such circumstances would include notifying prospective patients of the HCW's seropositivity before they undergo exposure-prone procedures.").

13. *Recommendations for Preventing Transmission*, *supra* note 9, at 6 (noting that case-by-case analysis should take into consideration "an assessment of specific risks, confidentiality issues, and available resources").

14. *See Recommendations for Preventing Transmission*, *supra* note 9, at 1 (suggesting that risk of HIV transmission from HCW to patient is not yet quantifiable, but that guidelines provide effective recommendations to prevent transmission in medical settings).

15. *Recommendations for Preventing Transmission*, *supra* note 9, at 9. The CDC considers these types of procedures invasive when they are associated with:

community to reduce the risk of transmission during these procedures.¹⁶

Legal efficacy of the CDC guidelines may be analyzed using a framework that courts have developed covering tort principles.¹⁷ Principles of tort law address risk of harm and its prevention. These principles give rise to duties of care¹⁸ that define the actions and precautions parties must take with respect to a particular risk so as to minimize the harm's chance of occurrence or lessen its effect, thereby protecting the safety of others.¹⁹

A. Risk Analysis in Tort for Determining Duties of Care

One commentator suggests that in the health care context, an analysis of the magnitude of harm and the probability of its occurrence determines whether a risk is unacceptable.²⁰ Specifically, section 293 of the *Restatement (Second) of Torts* provides an analytical framework to use in making this risk assessment. The Restatement's framework includes an examination of (1) the social value the law attaches to the threatened interests; (2) the probability that the actor's conduct will invade the interests of another; (3) the possible extent of harm to the threatened interest; and (4) the number of persons potentially hurt if the harm were to occur.²¹ This commen-

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

Id.

16. *Recommendations for Preventing Transmission*, *supra* note 9, at 1.

17. *See infra* notes 20-63 and accompanying text (setting forth framework courts have developed).

18. *See* W. PAGE KEETON ET AL., PROSSER AND KEETON ON THE LAW OF TORTS § 53, at 356-59 (5th ed. 1984) (defining tort concept of duty). Specifically, a legal duty is "only an expression of the sum total of those considerations of policy which lead the law to say that the plaintiff is entitled to protection." *Id.*

19. *See id.* § 56, at 383-85 (listing custodial relationships that require parties to guard against foreseeable harm arising from protective element of relationships).

20. *See* Gordon G. 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, 604 (1990) (referring to § 293 of the *Restatement (Second) of Torts*). In his article, Keyes discusses the risk assessment analysis in the context of a Fifth Circuit case. *Id.*; *see* *Usery v. Tamiami Trail Tours, Inc.*, 531 F.2d 224, 236 (5th Cir. 1976) (upholding tour-bus company's policy requiring its drivers to be less than 40 years old for safety reasons). Keyes writes that "[i]n upholding the bus company's rule, the court recognized that in assessing safety requirements it must consider both the likelihood and severity of the threatened harm. The greater the likelihood and severity of harm, the more stringent the job qualifications to promote safety may be." Keyes, *supra*, at 604.

21. RESTATEMENT (SECOND) OF TORTS § 293 (1981). Additionally, the American Medical Association (AMA) articulated its risk framework for HIV-positive HCWs in its *amicus curiae* brief in *School Board v. Arline*, 480 U.S. 273, 288 (1987). The AMA framework examines:

tator contends that this analysis should not attempt to determine the precise risk of an HIV-infected HCW transmitting the disease to a patient,²² but rather, the analysis should balance the value of having the HCW perform the invasive procedure against the degree of risk of disease transmission.²³ This approach seems to imply that whenever practical, a non-HIV-positive HCW should perform the invasive procedure. Several issues remain unanswered by this analysis, however, such as how great the risk of transmission must be to compel an HCW to stop performing invasive procedures.²⁴ And once an HCW is infected, the question becomes whether hospitals should restrict all or only some procedures that the HCW may perform. Courts use the above tort theories to address issues raised by HIV-positive HCWs.

1. Tort analysis of transmission risk in case law

Recent cases have adopted the framework of section 293 of the *Restatement (Second) of Torts*, but have introduced additional and arguably more dispositive elements into the analysis.²⁵ In *Estate of Behringer v. Medical Center*,²⁶ a New Jersey appellate court considered the proposition that courts should balance the risk of transmission against the utility of having infected HCWs perform invasive proce-

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

Brief of the American Medical Association as *Amicus Curiae* in Support of Petitioners' at 19, *School Bd. v. Arline*, 480 U.S. 273 (1987) (No. 85-1277).

22. See *Keyes*, *supra* note 20, at 603-04 (stating that analytical structure and language of classic tort law offer sound framework for analyzing risk).

23. See *Keyes*, *supra* note 20, at 603-04 (basing supposition on probable availability of other qualified HCWs).

24. Cf. *Keyes*, *supra* note 20, at 603-04 (suggesting that attempting to determine actual rate of transmission is futile and counterproductive).

25. See, e.g., *Leckelt v. Board of Comm'rs*, 714 F. Supp. 1377, 1392 (E.D. La. 1989) (concluding that social value attached to plaintiff's not revealing HIV status to defendant hospital is necessarily subordinated to hospital's need to know plaintiff's HIV status in order to protect not only patients and co-workers, but plaintiff himself), *aff'd*, 909 F.2d 820 (5th Cir. 1990); *Glover v. Eastern Neb. Community Office of Retardation*, 686 F. Supp. 243, 249-50 (D. Neb. 1988) (concluding that as actor's conduct involved only casual contact between staff and clients, probability of transmission was zero, and therefore Fourth Amendment concerns prevailed over requirement of mandatory HIV testing of staff), *aff'd*, 867 F.2d 461 (8th Cir.), *cert. denied*, 493 U.S. 932 (1989); *In re Milton S. Hershey Medical Ctr.*, 595 A.2d 1290, 1295, 1300 & n.6 (Pa. Super. Ct. 1991) (discussing state statute prohibiting disclosure of confidential HIV information absent compelling public need to prevent spread of AIDS), *appeal docketed*, No. 196 (Pa. Aug. 7, 1992). In addition, in *School Board v. Arline*, 480 U.S. 273 (1987), the Supreme Court adopted the AMA's criteria for determining the medical risks of employing someone with a contagious disease. These factors included the duration and severity of the condition, as well as the probability of transmission to others. *Id.* at 288.

26. 592 A.2d 1251 (N.J. Super. Ct. Law Div. 1991).

dures,²⁷ particularly in instances in which other non-HIV-positive HCWs qualified to perform the procedures are available.²⁸ More importantly, this court looked beyond tort theory by employing a patient-centered approach to health care risk analysis.²⁹ Fundamentally, the court found that where there is any risk of transmission to a patient of any disease, the HCW must refrain from performing invasive procedures.³⁰ The court's rationale for this rule rested on the fact that transmission of HIV means certain death for the infected patient.³¹ The court found that hospitals have a duty to restrict HCWs from performing invasive procedures where the procedures pose "any risk" of harm to the patient.³² In this case, the court determined that such a risk was present.³³ Thus, the court held that the medical center acted properly by prohibiting the plaintiff, Dr. Behringer, from performing further surgery.³⁴ The court

27. *Estate of Behringer v. Medical Ctr.*, 592 A.2d 1251, 1282 (N.J. Super. Ct. Law Div. 1991) (quoting Keyes, *supra* note 20, at 603-04 n.114) (discussing framework for assessing risk).

28. *See id.* at 1283 (adopting view that availability of another equally competent physician is factor that patient must have opportunity to consider when practicing HCW is seropositive for AIDS); *see also* Larry Gostin, *Hospitals, Health Care Professionals, and AIDS: The "Right to Know" the Health Status of Professionals and Patients*, 48 MD. L. REV. 12, 23 (1989) (stressing that patients, if given choice, would generally not choose HCWs infected with HIV). In his article, Keyes also concluded that HCW substitution is a viable policy option because, in his view, only a small percentage of all providers will be excluded from performing only one aspect of health care, [so] restrictions due to HIV infection 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.

Keyes, *supra* note 20, at 603-04 n.114.

29. *See Behringer*, 592 A.2d at 1283 (rationalizing adoption of patient-centered approach on New Jersey's strong policy of supporting patient rights); *see also* Piller v. Kovarsky, 476 A.2d 1279, 1281 (N.J. Super. Ct. Law Div. 1984) (stating that New Jersey public policy supports patient-physician privilege because it enables "patient to secure medical services without fear of betrayal and unwarranted embarrassing and detrimental disclosure").

30. *See Behringer*, 592 A.2d at 1283 (discussing obligations of HIV-infected HCW to patient).

31. *See id.* at 1281-82 (contending that possibility that transmission to patient will result in death must be considered relevant factor in determining acceptable level of risk); *see also* David Orentlicher, *HIV-Infected Surgeons: Behringer v. Medical Center*, 266 JAMA 1134, 1135 (1991) (contending that court in *Behringer* adopted analysis that attempts to eliminate all risks of transmission). Orentlicher further argues that this "zero-tolerance" limit goes too far because it would permit discrimination against HCWs in violation of the federal antidiscrimination laws. Orentlicher, *supra*, at 1135. Instead, he suggests that hospitals, and thus courts, should adopt the "significant risk" standard when imposing practice restrictions, which can be found in antidiscrimination laws, as opposed to an "appreciable," "potential," or "theoretical" standard. *Id.* at 1136; *see also infra* notes 55-57 and accompanying text (discussing "significant risk" standard).

32. *See Estate of Behringer v. Medical Ctr.*, 592 A.2d 1251, 1283 (N.J. Super. Ct. Laws Div. 1991) ("Where the ultimate harm is death, even the presence of a low risk of transmission justifies the adoption of a policy which precludes invasive procedures when there is 'any' risk of transmission.").

33. *Id.* (finding there was "reasonable probability of substantial harm" if plaintiff continued to perform invasive procedures").

34. *Id.* The court was also persuaded by the fact that the Medical Center acted without "any suggestion of prejudice or arbitrariness." *Id.* Further, the court was convinced that

rejected any attempt to quantify the magnitude of the risk of transmission and instead concluded that hospitals must prohibit infected HCWs from performing invasive procedures so as to eliminate all chances of transmission.³⁵

According to the court in *Behringer*, an HIV-positive HCW who continues to perform invasive procedures increases, by definition, the probability of transmission of the virus to an unacceptable level.³⁶ In this analysis, even though the risk of transmission in an individual operation may be small, the fact that a surgeon may perform over 300 operations each year multiplies the opportunities for transmission.³⁷ If a seropositive³⁸ HCW is permitted to perform multiple operations after being diagnosed as HIV positive, the specter of an incident causing transmission of the virus from surgeon to patient is an increasing hazard. The court in *Behringer* found such a continuing risk unacceptable, especially as transmission of this virus results in certain death.³⁹

the Medical Center's decision represented "a reasoned and informed response to the problem." *Id.*

35. *See id.* (finding that because ultimate danger to patient is death, securing informed consent of patient combined with restrictions on performance of procedures presenting "any risk" to patient is justified).

36. *Id.*

37. *Id.* at 1283 n.20; *see* Ban Mishu et al., *A Surgeon with AIDS: Lack of Evidence of Transmission to Patients*, 264 JAMA 467, 467 (1990) (reporting study of Tennessee surgeon who died of AIDS and results of state investigation of possible transmission to patients). In January 1989 a general surgeon in Tennessee was diagnosed with AIDS. *Id.* Mishu and his colleagues developed a study to determine whether the surgeon had transmitted the HIV virus to any of his patients during surgery. *Id.* First, based on the HIV virus' median incubation interval, Mishu estimated that the surgeon may have been infected as early as 1982. *Id.* Mishu then compiled a list of patients on whom the surgeon had performed surgery between 1982 and 1988. *Id.* There were 2160 patients identified. *Id.* Only 1652 patients could be contacted, however. *Id.* Of these patients, 616 (37%) agreed to undergo testing for the HIV virus. *Id.* Only one of the 616 patients tested HIV positive, and his medical history strongly suggested that he had contracted the virus prior to undergoing surgery. *Id.* Based on the study's findings, Mishu concluded that the risk of surgeon-to-patient transmission is quite low. *Id.* at 470; *see also* Diana J. Schomu, *Files of H.I.V.-Infected Dentist To Be Transferred*, N.Y. TIMES, Jan. 31, 1992, at B1 (reporting that New York State Health Department ordered records of dentist who died of AIDS to be opened to determine whether any of dentist's 3060 patients had contracted HIV). The New York Health Department came to its decision to open the dentist's files because state investigators found evidence of poor sterilization and infection-control procedures practiced by the dentist. *Id.*

38. *See* James D. Henry, *AIDS in the Workplace*, in AIDS AND THE LAW 31, 35 (William H.L. Dornette ed., 1987) (defining seropositive for HIV as meaning patient is infectious, able to transmit virus, and blood will reveal presence of virus when tested); *see also* AMERICAN MEDICAL ASSOCIATION ENCYCLOPEDIA OF MEDICINE 895 (1989) (discussing use of blood testing to ascertain presence or absence of infectious organism in bloodstream, and thus in body).

39. *See* Estate of Behringer v. Medical Ctr., 592 A.2d 1251, 1280, 1283 n.20 (N.J. Super. Ct. Laws Div. 1991) (discussing fact that although risk to individual patient may be small, "cumulative risk to surgical patients . . . is higher" if infected surgeon continues to perform invasive procedures). In other words, the risk to an individual patient never changes, but as the HIV-infected HCW performs an increasing number of invasive procedures, the chance that he or she will infect one or more of his or her patients increases.

2. *Attempts to quantify the risk of transmission from infected HCW to patient*

To date, Kimberly Bergalis and four other patients of Dr. Acer are the only documented cases of HIV transmission from an HCW to his or her patient.⁴⁰ Nevertheless, the emerging consensus in the medical community is that, however small, the risk of transmission from HCW to patient is very real,⁴¹ and therefore, more research is needed to determine the exact level of this risk.⁴² As might be expected, the debate over the actual risk of transmission centers around those HIV-positive surgeons who perform invasive procedures.⁴³ It is these procedures that involve the highest potential for

40. *Update: Transmission of HIV Infection During an Invasive Dental Procedure—Florida*, 40 MORBIDITY & MORTALITY WKLY. REP. 21, 27 (1991) (summarizing findings of follow-up investigation in Bergalis case). The investigation revealed that, in addition to Bergalis, four other patients of Dr. Acer tested HIV positive. *Id.* at 21. Further, the investigation team found evidence to support the conclusion that at least three of these patients contracted HIV from the dentist himself. *Id.* at 26. The actual means of transmission in this case remains a mystery. *Id.* at 27.

41. See Letter from Nancy W. Dickey, AMA Trustee, to *The Journal of the American Medical Association*, 265 JAMA 2338, 2338 (1991) [hereinafter Letter from Nancy W. Dickey] (replying to letter from Dr. Michael M. Lederman to JAMA editor requesting that AMA withdraw its policy advising HIV-positive doctors to avoid performing invasive procedures). In her letter, Dickey recognizes that the risk of transmission from doctor to patient during invasive procedures has not been quantified. *Id.* Dickey contends, however, that the risk has been confirmed as "a small but real one." *Id.* Thus, Dickey asserts that "when there is a known but as yet unquantifiable risk of patient death that is avoidable, physicians should not engage in unnecessary procedures." *Id.*; see also Letter from Dr. Michael M. Lederman et al., Case Western Reserve University School of Medicine, to *The Journal of the American Medical Association*, 265 JAMA 2337, 2337-38 (1991) [hereinafter Letter from Dr. Michael M. Lederman] (arguing that risk of transmission from HIV-infected surgeon to patient is "not identifiable," but conceding that it cannot be said that no risk exists). Lederman's contention is that, absent more definitive data regarding the risk of transmission, the AMA should not have recommended that HIV-infected physicians either abstain from performing invasive procedures posing an identifiable risk of transmission, or inform their patients of their infection. *Id.*

42. See Letter from Nancy W. Dickey, *supra* note 41, at 2338 (stating that in order to formulate proper guidelines, better data are needed). Dickey contends that until better data can be acquired, "the burden of scientific uncertainty falls on the profession, not the patient." *Id.*; see also Mishu et al., *supra* note 37, at 470 ("Despite the substantial size of this study, a precise quantifiable risk to patients undergoing surgery is not yet possible. Future opportunities for similar investigations should further clarify this most important and difficult issue.").

43. See *Preliminary Analysis: HIV Serosurvey of Orthopedic Surgeons, 1991*, 40 MORBIDITY & MORTALITY WKLY. REP. 309, 309-10 (1991) [hereinafter *HIV Serosurvey of Orthopedic Surgeons*] (attempting to determine rate of HIV infection among orthopedic surgeons, who, by definition, perform invasive procedures). The study, conducted by the CDC, summarizes findings from a voluntary and anonymous survey of HIV status among orthopedic surgeons. *Id.* Out of 3420 participants, two tested HIV seropositive (0.06%). *Id.* at 310-11; see also *The Risk of Contracting HIV Infection in the Course of Health Care*, 265 JAMA 1872, 1872 (1991) [hereinafter *Risk of Contracting HIV*] (asserting that "[t]ransmission of HIV infection from infected health workers to patients will best be prevented by reemphasized careful and rigorous training of all health care workers"). The article maintained that HIV-infected surgeons pose a "very low" risk to their patients. *Risk of Contracting HIV*, *supra*, at 1872. In support of this position, the article notes that despite 10 years of experience with HIV infection and numerous retrospective case studies on HIV-infected HCWs and their patients, there has been only one documented case of transmission of HIV infection from an HCW to a patient. *Id.*; Frank S. Rhame, *The HIV-Infected Surgeon*, 264 JAMA 507, 507-08 (1990) ("I believe it is an essential exercise,

the surgeon to be injured during surgery,⁴⁴ causing HIV-infected blood to enter the patient's body cavity and thereby possibly causing inoculation.⁴⁵ Percutaneous (skin-piercing) injuries where a sur-

no matter how speculative, to estimate a probability of surgeon-to-patient HIV transmission before considering policy." Rhame estimates the probability of transmission from surgeon to patient at between one per 100,000 and one per million operations, although he cites no empirical data in support of this estimation. Rhame, *supra*, at 507. Rhame contends that, as long as the HIV-infected surgeon abstains from performing surgery requiring "blind, by feel manipulation of sharp instruments . . . the probability of an HIV transmission during other types of surgery is so low that no other proscription is warranted." *Id.* at 508.

44. Letter from Marek Szpalski, Center Hospitalier Molière Longchamp, Brussels, Belgium, to *The Journal of the American Medical Association*, 266 JAMA 1361, 1361 (1991) (relaying results of Belgian survey of 250 surgeons and 100 anesthetists in which 63% of surgeons and 45% of anesthesiologists reported experiencing injuries during performance of invasive procedures within preceding three months). Szpalski contends that, given the number of injuries occurring in the operating room, puncture-resistant glove materials must be developed. *Id.* Szpalski further reports that only 26% of surgeons in the survey take the elementary precaution of wearing double gloves during procedures on HIV-positive patients. *Id.* Further, only 15% wore protective eyewear during such procedures. *Id.*

Another study found that operating room personnel are exposed to 5.6 "sharp" or "percutaneous" injuries (injuries that pierce the skin) per 100 procedures. See James G. Wright et al., *Mechanisms of Glove Tears and Sharp Injuries Among Surgical Personnel*, 266 JAMA 1668, 1668-71 (1991) (studying causes of glove tears and sharp injuries among operating room personnel and determining that greatest risk of hand injury occurs "(1) when the hand is retracting tissue and (2) when the hand is stationary and holding forceps or suture material over the wound"). Other studies put this rate at 1.2 per 100 procedures for surgical staff. See Adalisa L. Panlilio et al., *Blood Contacts During Surgical Procedures*, 265 JAMA 1533, 1536 (1991) (describing and quantifying types of blood contact occurring during surgical procedures and attempting to assess risk factors for such contacts). From his study, Wright found that the sharp injuries reviewed caused bleeding in 85% of the reported incidents. Wright et al., *supra*, at 1670. According to Wright, this finding contradicts previous studies suggesting that most percutaneous exposures are "superficial." *Id.*

Conversely, percutaneous exposure of a surgeon's blood to a patient's blood has been calculated to occur in 1.7% to 4.9% of all surgical cases. Julie L. Gerberding & William P. Schecter, *Surgery and AIDS: Reducing the Risk*, 265 JAMA 1572, 1572 (1991). Further, the average risk of HIV transmission from patient to surgeon where a percutaneous needle stick has occurred is estimated at between 0.3% and 0.4%. *Id.* These ranges were derived by reviewing results of prior studies. *Id.*

At least one author disagrees with these studies. See Gostin, *supra* note 28, at 16-23 (citing various studies attempting to determine rates of transmission of HIV from HCWs to patients and vice versa, and concluding that risk in either direction is too low to "justify the personal and financial costs of systematic screening"). Gostin concludes that mandatory HIV screening of HCWs is not justified because (1) the risk of transmission would not be reduced significantly; (2) screening would not decrease the risk; and (3) the human and economic costs of mandatory HIV screening outweigh the benefit to be achieved. *Id.*

45. See Wright et al., *supra* note 44, at 1668-71 (discussing causes and types of exposures from HCW to patient in operating room). Wright's study classified exposures into three types: (1) glove tears, (2) sharp injuries, and (3) gown leaks. *Id.* at 1669. As part of its plan in promulgating the guidelines, the CDC chose not to include a list of invasive procedures that it considered risky to patients when performed by HIV-infected HCWs. *Recommendations for Preventing Transmission*, *supra* note 9, at 5. Instead, the CDC recommended that each hospital or other medical institution develop its own list, reflecting the procedures performed at the particular institution. *Id.* In response, the nation's major medical institutions and groups agreed to develop these lists, but after protests from members, the organizations refused to follow the CDC recommendations. *CDC Won't Dictate Rules on Health Workers, AIDS*, ATLANTA CONSTITUTION, June 16, 1992, at D4 (reporting that members opposed developing lists because such lists would be "medically unnecessary and scientifically unsound"). Subsequently, the CDC and the Department of Health and Human Services (HHS) proposed to amend the July 1991 guidelines, dropping the recommendation that medical groups and institutions de-

geon's blood is released are not uncommon.⁴⁶ Moreover, many percutaneous injuries occur during surgery performed blindly, or "by feel," so that there may be no way for an HIV-positive surgeon to know if his or her blood infected the patient.⁴⁷

Some medical and legal commentators regard the Bergalis incident as a tragic yet rare occurrence.⁴⁸ These authorities maintain that the risk of transmission is too low at present to meaningfully quantify.⁴⁹ A retrospective study done on patients of a surgeon who died of AIDS-related symptoms and had performed invasive procedures supports this view.⁵⁰ The study included tests of more than 600 of the surgeon's patients and found no evidence linking the surgeon to HIV infection in any of the patients.⁵¹ Furthermore, public health records indicate that in the seven years preceding the surgeon's death, none of the 2160 patients on whom the physician had operated reported incidences of HIV infection or AIDS that could be traced to him.⁵² The Bergalis incident, however, demonstrates that such a transmission can occur. This possibility is underscored by the fact that of roughly five million HCWs in this country, 3550,

velop these lists of at-risk procedures. See Marlene Cimons, *Plan to Ease Curbs on AIDS-Infected Doctors Is Scrapped*, L.A. TIMES, June 14, 1992, at A13 (reporting decision by federal health officials to abandon proposal easing restrictions on AIDS-infected HCWs). This proposal was dropped, however, after officials discovered that the newest recommendations might violate Congress' wishes. *Id.* Presently, no list of procedures is being considered. *Id.*; see also *infra* notes 275-79 and accompanying text (discussing effect of stalemate between CDC and medical groups regarding compilation of at-risk procedures list).

46. See Gerberding & Schechter, *supra* note 44, at 1572-73 (listing rates of percutaneous injuries among surgical staff).

47. See Rhame, *supra* note 43, at 507 (stating that exposure rate is strongly influenced by type of procedure and that "blind" procedures should have higher exposure rate). One study has shown that gynecological and trauma surgery have the highest rates of percutaneous injury among surgeons per procedure. Panlilio, *supra* note 44, at 1534 (detailing data collected regarding rates of percutaneous injuries experienced during various surgical procedures).

48. See *Risk of Contracting HIV*, *supra* note 43, at 1872-73 (advocating use of standardized surgical and invasive procedural precautionary measures as sufficient means, without mandatory HCW testing, to control spread of HIV from HCW to patient).

49. See Letter from Dr. Michael M. Lederman, *supra* note 41, at 2337 (arguing that risk of transmission from HIV-positive physician is not identifiable); cf. Scott H. Isaacman, *The Other Side of the Coin: HIV-Infected Health Care Workers*, 9 ST. LOUIS U. PUB. L. REV. 439, 452 (1990) (contending that it is virtually impossible to prove that HIV-positive HCWs do not pose threat to patients). Isaacman states that no studies have proven that HIV-positive HCWs pose an actual hazard to patients. Isaacman, *supra*, at 492. He thus calls for a resistance to blanket policies requiring mandatory testing of HCWs until more information about the actual risk posed is known. *Id.* Isaacman defends his "conservatism approach" by stating that "[o]nce we lose the expectations of privacy and fourth amendment rights, we may experience difficulty in trying to recover them." *Id.*

50. See Mishu et al., *supra* note 37, at 467-70 (detailing results of study of HIV-infected surgeon and his patients).

51. See Mishu et al., *supra* note 37, at 467-70 (reporting that only one patient tested HIV positive and that patient's medical history suggested that virus was not transmitted from surgeon). Two hundred and sixty-four of the surgeon's patients died prior to the commencement of the study. *Id.* None of those deaths could be attributed to HIV infection. *Id.*

52. Mishu et al., *supra* note 37, at 467-70.

or 0.07%, are seropositive for HIV.⁵³

Commentators and courts, however, are in disagreement as to the meaning of the data and the corresponding level of risk that should be tolerated. For example, the court in *Behringer* adopted a zero-risk standard.⁵⁴ One commentator criticizes this standard as unworkable.⁵⁵ This commentator argues that the "zero-tolerance" standard goes too far because it may induce discrimination against HCWs, thereby violating federal antidiscrimination laws.⁵⁶ This commentator suggests that hospitals, and thus courts, should instead adopt the "significant risk" standard⁵⁷ used in these antidiscrimination laws.⁵⁸ This author also contends that the zero-tolerance standard is unwarranted because it would suggest that no

53. Isaacman, *supra* note 49, at 443 & nn.22-24. In a June 1991 survey conducted on 3420 orthopedic surgeons, all of whom performed "invasive procedures," two were HIV seropositive (0.06%). *HIV Serosurvey of Orthopedic Surgeons*, *supra* note 43, at 309-11. Both of these surgeons reported having operated either on patients from a high-risk group or on patients known to have the HIV virus or AIDS. *Id.* Both surgeons also reported nonoccupational risk factors for HIV infection, however. Whether transmission from patient to surgeon occurred during an operation could therefore not be determined. *Id.*

54. See *supra* notes 26-35 and accompanying text (discussing patient-centered approach of court in *Behringer* whereby any risk of transmission from HCW to patient is not tolerated); cf. *In re Milton S. Hershey Medical Ctr.*, 595 A.2d 1290, 1297-98 (Pa. Super. Ct. 1991) (upholding hospital's decision to inform patients postoperatively of HCW's HIV infection based on risk of transmission, however slight). The Pennsylvania court added, "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." *Id.* (emphasis omitted). By this statement, the court adopted the patient-centered approach articulated by the New Jersey court in *Behringer*. See *id.* at 1297-99 (articulating theory of patient-centered approach to medicine and its application where AIDS is involved).

55. See Orentlicher, *supra* note 31, at 1136-37 (criticizing decision in *Behringer*).

56. Orentlicher, *supra* note 31, at 1135. According to Orentlicher, the "zero tolerance" risk standard violates the Americans with Disabilities Act. *Id.* He claims that the Act would protect HCWs from discrimination based on their HIV status unless the HCWs' infections posed a "significant risk" to their patients. *Id.*; see Americans with Disabilities Act of 1990, Pub. L. No. 101-336, §§ 101(3), 103(b), 104 Stat. 327, 330, 334 (to be codified at 42 U.S.C. §§ 12111, 12113) (using "significant risk" standard as threshold test for violations of antidiscrimination provisions of statute). Moreover, he says studies have failed to prove that HIV-infected HCWs pose a "significant risk" to their patients. Orentlicher, *supra* note 31, at 1135.

57. Orentlicher, *supra* note 31, at 1136; see also Larry Gostin, *The HIV-Infected Health Care Professional: Public Policy, Discrimination, and Patient Safety*, 18 LAW, MED. & HEALTH CARE 303, 307-08 (1990) (contending that "significant risk" standard is more reasonable given present-day infection control procedures and assessments of other risks inherent in medical environment).

58. See Civil Rights Restoration Act of 1987, Pub. L. No. 100-259, § 4, 102 Stat. 28, 29 (1988) (amending Rehabilitation Act of 1973, 29 U.S.C. § 794 (1990), by incorporating "significant risk" standard into Act); see also Americans with Disabilities Act of 1990, Pub. L. No. 101-336, §§ 101(2), 103(b), 104 Stat. 327, 330, 334 (to be codified at 42 U.S.C. §§ 12111, 12113) (stating that fact that qualified individual with disability poses "significant risk to health and safety of others that cannot be eliminated by reasonable accommodation" may be defense to charge of discrimination).

Both Professor Gostin and Professor Barnes cite the opinion in *School Board v. Arline* as the Supreme Court's adoption of the "significant risk" standard. Mark Barnes et al., *The HIV-Infected Health Care Professional: Employment Policies and Public Health*, 18 LAW, MED. & HEALTH CARE 311, 316 (1990); Gostin, *supra* note 57, at 307.

level of risk is acceptable, but, given present research, it remains unclear whether the actual risk of transmission has reached such a threshold level to invoke the significant risk standard, let alone the zero-tolerance one.⁵⁹

In 1988, the New York State Legislature adopted this significant risk standard and directed the state's Department of Health to define "significant risk."⁶⁰ The department's definition of the phrase did not include instances in which proper infection control/barrier practices were being used.⁶¹ Consequently, the definition permitted infected HCWs to continue to perform invasive procedures as long as the medical institution established proper infection-control

59. Orentlicher, *supra* note 31, at 1136.

60. See N.Y. PUB. HEALTH LAW § 2786(1) (McKinney Supp. 1992) (providing that "[t]he Commissioner . . . shall promulgate regulations to identify those circumstances which create significant risk of contracting, or transmitting HIV"); see also N.Y. COMP. CODES R. & REGS. tit. 10, § 63.9 (1992) (defining "significant risk" in context of HIV transmission). Under the New York State Official Compilation of Codes, Rules, and Regulations, three factors are necessary to create a significant risk of contracting or transmitting the HIV virus: "(1) the presence of a significant risk body substance; (2) a circumstance which constitutes significant risk for transmitting or contracting HIV infection; and (3) the presence of an infectious source and a noninfected person." N.Y. COMP. CODES R. & REGS. tit. 10, § 63.9(a) (1992). "Significant risk body substances" are defined as "blood, semen, vaginal secretions, breast milk, tissue and the following body fluids: cerebrospinal, amniotic, peritoneal, synovial, pericardial, and pleural." *Id.* § 63.9(b). Further, circumstances constituting a "significant risk of transmitting or contracting HIV infection" include:

(1) sexual intercourse (vaginal, anal, oral) which exposes a noninfected individual to blood, semen or vaginal secretions of an infected individual; (2) sharing of needles and other paraphernalia used for preparing and injecting drugs between infected and noninfected individuals; (3) the gestation, birthing or breast feeding of an infant when the mother is infected with HIV; (4) transfusion or transplantation of blood, organs, or other tissues from an infected individual to an uninfected individual, provided such blood, organs or other tissues have not tested negatively for antibody or antigen and have not been rendered noninfective by heat or chemical treatment; (5) other circumstances not identified in paragraphs (1) through (4) of this subdivision during which a significant risk body substance (other than breast milk) of an infected individual contacts mucous membranes (*e.g.*, eyes, nose, mouth), nonintact skin (*e.g.*, open wound, skin with a dermatitis condition, abraded areas) or the vascular system of a noninfected person. Such circumstances include, but are not limited to needle-stick or puncture wound injuries and direct saturation or permeation of these body surfaces by the infectious body substance.

Id. § 63.9(c). The New York State Legislature adopted the standard after New York courts experienced difficulty in determining what level of risk warranted the exclusion of HIV-infected HCWs from employment. See Barnes et al., *supra* note 58, at 315-16 (discussing derivation of New York State Department of Health's "significant risk" definition).

61. N.Y. COMP. CODES R. & REGS. tit. 10, § 63.9 (1992). The regulatory definition states that circumstances involving a significant risk do not include:

(1) exposure to urine, feces, sputum, nasal secretions, saliva, sweat, tears or vomitus that does not contain blood that is visible to the naked eye; (2) human bites where there is no direct blood to blood, or blood to mucous membrane contact; (3) exposure of intact skin to blood or any other substance; or (4) occupational settings where individuals use scientifically accepted barrier techniques and preventive practices in circumstances which would otherwise pose a significant risk.

Id. § 63.9(d) (emphasis added).

procedures.⁶²

Despite the inconclusiveness of the data regarding the rate of transmission of the HIV virus from an infected HCW to his or her patient, the law should not ignore the possibility of transmission. Indeed, the need for a legal framework will increase as the number of infected HCWs rises corresponding to the general population.⁶³ To address this need, common law concepts provide viable mechanisms to guide the medical and legal communities.

B. Common Law Creation of a Duty for Mandatory HIV Testing

Mandatory testing of individuals, with or without particularized suspicion,⁶⁴ is not a new practice in this country.⁶⁵ Courts have upheld the use of mandatory testing in a variety of circumstances, including examinations of blood-alcohol levels of persons arrested for drunk driving,⁶⁶ whether drugs or alcohol played a role in railroad accidents,⁶⁷ evidence of drug use in connection with job promotion

62. See Barnes et al., *supra* note 58, at 316 (noting that New York's final version of definition essentially allows HIV-positive HCWs to work unrestricted as long as they are competent in infection-control procedures, not epidemiologically linked to any previous incident of transmission, and functionally able to perform medical procedures at issue).

63. See *Heterosexual Contact Accounts for Most New HIV Cases*, WASH. POST, Feb. 13, 1992, at A10 (reporting that World Health Organization (WHO) estimates number of AIDS cases occurring since early 1980s stands at approximately two million). According to the WHO, the number of persons currently infected by the AIDS virus is between 10 to 12 million. *Id.* The organization predicts that this number will increase to between 30 and 40 million by the year 2000. *Id.*

64. See *INS v. Delgado*, 466 U.S. 210, 232, 233-34 (1984) (defining "particularized suspicion" as whether there is either cause or "reasonable grounds for believing that [a] person is involved in some unlawful activity" and holding that INS policy of indiscriminate questioning of all Hispanic factory employees to find illegal aliens is unconstitutional).

65. See, e.g., *National Treasury Employees Union v. Von Raab*, 489 U.S. 656, 668-77 (1989) (upholding mandatory drug testing for U.S. Customs Service agents where agents were applying for promotion to jobs involving drug interdiction and carrying of firearms); *Rushton v. Nebraska Pub. Power Dist.*, 844 F.2d 562, 566-67 (8th Cir. 1988) (upholding mandatory testing of nuclear plant employees for presence of illegal drugs as part of safety program); *Alverado v. Washington Pub. Power Supply Sys.*, 759 P.2d 427, 435-36 (Wash. 1988) (upholding testing program similar to that in *Rushton*), *cert. denied*, 490 U.S. 1004 (1989).

66. See *Schmerber v. California*, 384 U.S. 757, 770-71 (1966) (finding possibility of blood-alcohol level decreasing after short period of time justifies search due to threat of destruction of evidence); see also *Michigan Dep't of State Police v. Sitz*, 496 U.S. 444, 448-55 (1990) (upholding use of highway checkpoints for sobriety tests of drivers).

67. See *Skinner v. Railway Labor Executives' Ass'n*, 489 U.S. 602, 630-34 (1989) (upholding Federal Railroad Administration regulations requiring testing for drugs and alcohol, even in absence of individualized suspicion, in blood of certain employees involved in "safety-sensitive tasks" following certain specified events such as major train accidents).

procedures,⁶⁸ and indeed, the presence of the HIV virus.⁶⁹ As a rule, mandatory testing must pass constitutional muster before it will be upheld.

1. *Constitutional analysis of mandatory HIV testing*

Generally, mandatory testing implicates the Fourth Amendment's⁷⁰ search and seizure clause.⁷¹ Similar to developments in the criminal arena,⁷² courts have devised a Fourth Amendment balancing test that weighs the intrusion of mandatory testing on an individual's Fourth Amendment interests⁷³ against the promotion of legitimate or compelling state interests.⁷⁴ In determining the de-

68. See *National Treasury Employees Union v. Von Raab*, 489 U.S. 656, 668-79 (1989) (permitting Customs Service to require urinalysis of employees seeking transfer or promotion to positions involving drug interdiction or carrying of firearms, but remanding case for further findings of fact where handling classified material was condition of such transfer or promotion, although maintaining that testing may be justified in such instances where truly sensitive material is handled); see also *Harmen v. Thornburgh*, 878 F.2d 484, 491-93 (D.C. Cir. 1989) (sanctioning random drug testing of Department of Justice employees with access to classified information but not random testing for all federal prosecutors and employees with access to grand jury proceedings), *cert. denied*, 493 U.S. 1056 (1990).

69. See *Dunn v. White*, 880 F.2d 1188, 1195-97 (10th Cir. 1989) (upholding AIDS testing of federal prisoners), *cert. denied*, 493 U.S. 1059 (1990); see also *Local 1812, Am. Fed'n of Gov't Employees v. United States Dep't of State*, 662 F. Supp. 50, 53-55 (D.D.C. 1987) (upholding State Department policy of mandatory AIDS testing for all employees being sent overseas in order to test fitness for duty, not to control spread of AIDS).

70. See U.S. CONST. amend. IV (providing, in pertinent part, that "[t]he right of the people to be secure in their persons, houses, papers, and effects, against unreasonable searches and seizures, shall not be violated").

71. See *Schmerber v. California*, 384 U.S. 757, 767 (1966) (rejecting notion that constitutional concerns of mandatory testing center on Fifth Amendment self-incrimination privilege, but rather "plainly involve[] the broadly conceived reach of a search and seizure under the Fourth Amendment"). The Court in *Schmerber* held that the Fifth Amendment only protects a defendant from having to testify or "otherwise provide the state with evidence of a testimonial or communicative nature" against him or herself. *Schmerber*, 384 U.S. at 761. The forced withdrawal of blood, the Court stated, was not within the scope of this protection. *Id.* "[C]ompulsion which makes a suspect or the accused the source of 'real or physical evidence' does not violate [the Fifth Amendment's privilege]." *Id.* at 764; see also *Von Raab*, 489 U.S. at 665 (holding that mandatory drug testing program is subject to Fourth Amendment analysis).

72. See, e.g., *New Jersey v. T.L.O.*, 469 U.S. 325, 337-48 (1985) (balancing student's expectation of privacy in her purse against school officials' interest in preventing distribution of illegal drugs on school grounds).

73. Fourth Amendment interests are those interests that relate to an individual's expectations of privacy. See, e.g., *Maryland v. Buie*, 494 U.S. 325, 333 (1990) (discussing Buie's Fourth Amendment expectation of privacy in rooms police had not searched before his arrest); *O'Connor v. Ortega*, 480 U.S. 709, 719 (1987) (discussing balancing of "employees' legitimate expectations of privacy against the government [employer's] need for supervision, control, and the efficient operation of the workplace"); *Arizona v. Hicks*, 480 U.S. 321, 338 (1987) (suggesting that balancing of governmental interests and Fourth Amendment privacy interests supports "reasonable-suspicion standard for the cursory examination of items in plain view").

74. This balancing test was first articulated in *Camara v. Municipal Court*, 387 U.S. 523, 536-37 (1967) (stating that there is "no ready test for determining reasonableness other than by balancing the need to search [or seize] against the invasion which the search [or seizure] entails"). In *Camara*, the Court stated that to enforce minimum standards for housing codes, "routine periodic inspections" were required. *Id.* at 535-36. These decisions to inspect are

gree of intrusiveness caused by the state, courts look to the nature of the state action that the individual must endure. Examples of state action include requiring the individual to undergo questioning, detention, urinalysis, or the taking of blood.⁷⁵ Courts determine whether the interests of the state are legitimate by considering elements such as the purpose of the program,⁷⁶ whether the program is limited in scope,⁷⁷ and the program's effectiveness.⁷⁸ More specifically, mandatory testing falls within the subcategory of Fourth Amendment law known as administrative searches.⁷⁹

not based on a specific building's characteristics, but rather on the characteristics of an entire area. *Id.* at 536. In order to search private property, however, a warrant must be obtained. *Id.* at 538-39. It is here that the balancing test is applied. *Id.* at 539. If the anticipated intrusion is reasonable, that is, if a "valid public interest" exists, then there is probable cause for a warrant to be issued. *Id.*

The Supreme Court also employed this balancing test in the criminal context in *Terry v. Ohio*, 392 U.S. 1, 20-22 (1968), to develop a theory of reasonable suspicion to permit frisking for concealed weapons. The Court held that this type of search is justified for the protection of police officers and nearby people and must be confined to the discovery of weapons that would lead to assault. *Id.* at 29.

These cases provide the groundwork for the requirement that the government's mandatory testing program must be "sufficiently productive" to justify intrusion on Fourth Amendment protections. *See, e.g.*, *National Treasury Employees Union v. Von Raab*, 489 U.S. 656, 673 (1989) (citing *Delaware v. Prouse*, 440 U.S. 648, 658-59 (1979)) (finding that Delaware's random spot check program did not sufficiently aid in control of drunken driving to justify use of such coercive testing system under Fourth Amendment).

75. *See Skinner v. Railway Labor Executives' Ass'n*, 489 U.S. 602, 624-32 (1989) (permitting Federal Railroad Administration to obtain employee blood and urine samples to test for presence of drugs or alcohol absent particularized suspicion of drug or alcohol use); *Von Raab*, 489 U.S. at 665-66 (holding that Customs Service may require employees to submit to urinalysis before promotion to "sensitive positions within the Service" without particularized suspicion of drug use). *But see Ybarra v. Illinois*, 444 U.S. 85, 91-93 (1979) (requiring particularized suspicion to search individuals for concealed weapons when executing search warrant). The Court in *Ybarra* found that the *Terry* reasonableness analysis was not satisfied because police had searched individuals not mentioned in the warrant without any apparent danger to the police from these individuals. *Id.* at 93-94.

76. *See Skinner*, 489 U.S. at 622-24 (concluding that state regulations are legitimate because they were designed to establish whether railroad employees are under influence of drugs or alcohol at time of particular accident, not to prosecute individuals for drug or alcohol use while on job).

77. *See, e.g., Von Raab*, 489 U.S. at 666 (finding that employee's seeking of promotion to sensitive job automatically triggers requirement that employee undergo urinalysis testing, so there is no need to obtain warrant prior to testing because scope of testing is already limited to persons seeking such employment and is not subject to employer's discretionary determination); *Skinner*, 489 U.S. at 621-22 (finding that warrant would not further aim of having narrow and specific intrusions on employee privacy in use of urinalysis testing because regulations defining such intrusions were already narrow and specific); *Schmerber v. California*, 384 U.S. 757, 758, 770-71 (1966) (permitting extraction of blood for blood-alcohol test without warrant when petitioner was being treated for injuries at hospital after being arrested for drunk driving).

78. *See Skinner*, 489 U.S. at 629-30 (concluding that Fourth Amendment intrusion effectively deterred employees from alcohol and drug use while on job, provided valuable information of causes of train accidents, and protected public safety); *see also Von Raab*, 489 U.S. at 676 (determining that drug testing for promotions "bears a close and substantial relation to the Service's goal of deterring drug users from seeking promotion to sensitive positions").

79. *See generally* Steven T. Wax, *The Fourth Amendment, Administrative Searches and the Loss of Liberty*, 18 ENVTL. L. 911, 919-22 (1988) (discussing Supreme Court's approval of warrantless

2. *Mandatory testing as administrative search*

Many governmental searches conducted as part of an administrative plan have withstood judicial scrutiny. Courts have allowed drug testing for certain classes of employees,⁸⁰ in job hiring and promotion,⁸¹ and following railroad accidents.⁸² The Supreme Court's holding in *National Treasury Employees Union v. Von Raab*⁸³ solidified the legal standards for administrative searches. In *Von Raab*, unionized employees of the U.S. Customs Service brought suit to enjoin the Service from testing certain employees for the presence of drugs.⁸⁴ The Service's testing program covered employees seeking promotions or transfers to positions involving the direct interdiction of illegal drugs, carrying of firearms, or having access to sensitive information.⁸⁵ The union argued that the drug-testing plan constituted an unreasonable search in violation of the Fourth Amendment.⁸⁶ The district court agreed, finding the service's plan overly intrusive because it was predicated on a lack of probable cause or reasonable suspicion,⁸⁷ and therefore violated the employees' expectations of privacy.⁸⁸

The Supreme Court, however, upheld the Customs Service's testing program.⁸⁹ In doing so, the Court held that the program, as a

administrative searches); Lynn S. Searle, Note, *The "Administrative" Search from Dewey to Burger: Dismantling the Fourth Amendment*, 16 HASTINGS CONST. L.Q. 261, 267-68 (1989) (claiming that Supreme Court's rationale for warrantless administrative searches has failed to "develop[] and defin[e] consistent criteria," and that "[i]ts decisions . . . have dealt with cases on an ad hoc basis").

80. See *National Fed'n of Fed. Employees v. Cheney*, 884 F.2d 603, 610-15 (D.C. Cir. 1989) (upholding drug testing of civilian employees of U.S. military who work in critical job designations), cert. denied, 493 U.S. 1056 (1990); *Harmon v. Thornburgh*, 878 F.2d 484, 490-96 (D.C. Cir. 1989) (upholding drug testing of Department of Justice employees with top secret national clearances but not testing of all criminal prosecutors or employees with access to grand jury proceedings).

81. See *National Treasury Employees Union v. Von Raab*, 489 U.S. 656, 668-79 (1989) (upholding drug testing of Customs Service employees seeking transfer or promotion to positions directly involved with drug interdiction and use of firearms and, in general, upholding testing of employees with access to classified information).

82. See *Skinner v. Railway Labor Executives' Ass'n*, 489 U.S. 602, 630-34 (1989) (upholding testing of railroad employees for presence of drugs and/or alcohol following train accidents or other incidents).

83. 489 U.S. 656 (1989).

84. *National Treasury Employees Union v. Von Raab*, 489 U.S. 656, 663 (1989).

85. *Id.* at 660-61.

86. *Id.* at 663.

87. *National Treasury Employees Union v. Von Raab*, 649 F. Supp. 380, 387 (E.D. La. 1986) (holding that "dragnet approach" to drug testing at workplace without reasonable suspicion or probable cause is "overly intrusive and constitutionally infirm"), vacated, 816 F.2d 170 (5th Cir. 1987), aff'd in part and vacated in part, 489 U.S. 656 (1989).

88. *Id.* at 387.

89. *National Treasury Employees Union v. Von Raab*, 489 U.S. 656, 664 (1989) (vacating and remanding part of judgment upholding testing of applicants for positions that required handling classified materials).

search, must meet the Fourth Amendment's reasonableness requirement.⁹⁰ While a search generally must be preceded by the issuance of a warrant, the Court stated that this was not always necessary.⁹¹ Instead, it employed a balancing test to measure the relative importance of an individual's expectations of privacy versus the government's interests, where the government's interest was beyond "normal" law enforcement needs.⁹² The Court questioned whether a warrant based on individualized suspicion was required and whether it was impractical in this situation.⁹³ Furthermore, the Court held that the Service's interest in ensuring that employees involved in drug interdiction are beyond reproach in integrity and judgment was a compelling one.⁹⁴ In balancing this compelling interest against the degree of state intrusion, the Court found the level of intrusion sufficiently narrow and specific because administering officials work with limited discretion.⁹⁵ By balancing the compelling interest of the government with this limited degree of intrusion, the Court determined that the drug-testing program was reasonable and rationally related to the goal of ensuring the quality of the Service's agents.⁹⁶ Moreover, the Court found that employees requesting transfers or promotions to these "at-risk" positions should expect to be subjected to certain "operational realities," thereby resulting in a diminished expectation of privacy.⁹⁷

Generally, as articulated by *Von Raab*, when reviewing administrative searches that include mandatory testing programs, courts must undertake a balancing test that weighs the individual's expectation of privacy and a program's level of intrusiveness against the governmental interests that conflict with those expectations.⁹⁸ To warrant testing, there must be a clear nexus between the scope of an individ-

90. *Id.* at 665. Reasonableness depends on the circumstances of the case. *Skinner v. Railway Labor Executives' Ass'n*, 489 U.S. 602, 619 (1989).

91. *Von Raab*, 489 U.S. at 665.

92. *Id.*

93. *Id.* at 665-66 (positing that purpose of program is to stop promotion of drug users to sensitive positions and arguing that fact that test results cannot be used in criminal prosecution "justif[ies] departure from the ordinary warrant and probable cause requirements").

94. *Id.* at 670 (maintaining that nation's interest in protecting itself against drug trafficking could be "irreparably damaged" if Customs' officers were "unsympathetic to their mission of interdicting drugs").

95. *Id.* at 667 (finding that every employee seeking promotion or transfer knows of drug testing policy and procedures so that warrant would serve no real purpose).

96. *Id.* at 679. The Court, however, found that, while testing of employees with access to classified information is not in itself objectionable, the Customs Service's testing program was not shown to test only such employees. The Court therefore remanded the case for proceedings "to clarify the scope of this category of employees subject to testing." *Id.* at 677-78.

97. *Id.* at 671.

98. *Id.* at 665-66 (finding that testing program's purpose of stopping promotion of drug users to sensitive positions justifies abandonment of normal warrant requirement).

ual's responsibilities and the danger posed to the government by a compromised employee.⁹⁹ Furthermore, policy considerations may compel administrative searches where the government seeks to prevent the creation of a dangerous situation¹⁰⁰ that could not be effectively addressed if an individualized suspicion were necessary to authorize testing prior to every search.¹⁰¹ This point is germane to mandatory testing for AIDS in certain specific and defined situations.

Courts have upheld mandatory testing for the presence of AIDS in two instances. First, courts sustain mandatory testing for the AIDS virus for prisoners as a routine precaution prior to incarceration.¹⁰² In *Dunn v. White*,¹⁰³ the Court of Appeals for the Tenth Circuit used the balancing approach articulated in *Von Raab* to uphold this type of testing program.¹⁰⁴ In applying the balancing test, the court weighed the security interests of a prison against a prisoner's Fourth Amendment privacy interests.¹⁰⁵ The court required that there be a " 'valid, rational connection' " between the governmental interest at stake and the means proffered to protect that interest.¹⁰⁶

99. See *Harmon v. Thornburgh*, 878 F.2d 484, 490-91 (D.C. Cir. 1989) (declaring that Department of Justice testing program, without additional tailoring of program's scope, lacked sufficient nexus to its goals under *Von Raab*).

100. *Dunn v. White*, 880 F.2d 1188, 1193 (10th Cir. 1989) (quoting *National Treasury Employees Union v. Von Raab*, 489 U.S. 656, 667-68 (1989)), *cert. denied*, 493 U.S. 1059 (1990).

101. *Dunn*, 880 F.2d at 1193 (citing *Skinner v. Railway Labor Executives' Ass'n*, 489 U.S. 602, 613-17 (1989)).

102. See *Dunn*, 880 F.2d at 1195-97 (determining that mandatory AIDS test of incarcerated prisoners to control spread of disease is reasonable search under Fourth Amendment).

103. 880 F.2d 1188 (10th Cir. 1989), *cert. denied*, 493 U.S. 1059 (1990).

104. See *Dunn v. White*, 880 F.2d 1188, 1194, 1196 (10th Cir. 1989) (concluding that "prison's substantial interest [in preventing spread of AIDS] outweighs plaintiff's expectation of privacy"), *cert. denied*, 493 U.S. 1059 (1990); see also *Hudson v. Palmer*, 468 U.S. 517, 527-30 (1984) (employing similar Fourth Amendment balancing test to uphold prison administration use of random cell searches); *Bell v. Wolfish*, 441 U.S. 520, 558-60 (1979) (upholding body cavity searches of federal prisoners as reasonable under Fourth Amendment balancing test).

105. See *Dunn*, 880 F.2d at 1194-95 (stating that routine blood testing procedure was limited intrusion on prisoner's privacy and that prisoner's privacy interest is further reduced by incarceration, and that "attempt to ascertain the extent of [AIDS] problem is certainly a legitimate penological purpose"). The U.S. Court of Appeals for the Eighth Circuit similarly concluded that the prevalence of drug use in prisons warranted the drug testing of prisoners. *Spence v. Farrier*, 807 F.2d 753, 755 (8th Cir. 1986). *But cf. Berry v. District of Columbia*, 833 F.2d 1031, 1035-36 (D.C. Cir. 1987) (remanding case to determine whether drug testing of prisoners as condition of pretrial release is related either to prisoner's commission of crimes or failure to appear for scheduled hearings). The court in *Dunn* distinguished *Berry* by the fact that if the inmates refused to undergo drug testing, they would remain in custody, and therefore, testing had no impact on detention. *Dunn*, 880 F.2d at 1192. In addition, prison officials in *Berry* reasoned that drug testing would prevent the release of those prisoners at risk to society or that presented a flight risk while waiting for trial. *Berry*, 833 F.2d at 1035. Because there was not a sufficient factual connection between the means and purpose of the drug testing program in *Berry*, it was invalidated until more fact finding could be done. *Id.* at 1034.

106. *Dunn*, 880 F.2d at 1194 (quoting *Turner v. Safley*, 482 U.S. 78, 89-90 (1987)). Furthermore, the court of appeals in *Dunn* rejected the argument that a prison HIV testing pro-

In other words, for the testing plan to be rendered valid in *Dunn*, the use of a blood test to detect HIV infection had to be rationally related to the prevention and spreading of AIDS in the prison community.¹⁰⁷

The court in *Dunn* also upheld the HIV testing plan because the plan's routine implementation of mandatory HIV testing met the requirements of an administrative search.¹⁰⁸ Although the circumstances litigated in *Dunn* arose in a criminal context, the administrative search balancing test applies equally in the civil context.¹⁰⁹ In *Dunn*, the court found that the governmental interest in preventing the spread of AIDS, coupled with the prisoner's diminished expectation of privacy,¹¹⁰ were sufficiently strong and compelling factors to sustain mandatory testing.¹¹¹ The court, however, went a step further. It maintained that the government's interest in general public health may be strong enough to allow similar searches of "free world residents."¹¹²

In particular, the court noted its 1973 decision in *Reynolds v. Mc-Nichols*,¹¹³ where it upheld the City of Denver's power to test prostitutes for venereal diseases even though the prostitutes were neither

gram required individualized suspicion. *Dunn*, 880 F.2d at 1196. As the prison had a "substantial interest" in AIDS prevention, no requirement of individualized suspicion was necessary. *Id.* at 1196-97. In addition, the court suggested that a requirement of individualized suspicion would render the program inoperative. *Cf. id.* at 1193 (relying on *Skinner v. Railway Labor Executives' Ass'n*, 489 U.S. 602, 624 (1989), for proposition that nature of government's interest makes individualized suspicion, based on warrant requirement, unnecessary).

107. *Dunn*, 880 F.2d at 1196-97 (explaining that although allegations were made that prison lacked "current medical response" to AIDS epidemic, allegations would not control prison's collection of information for future action, because "[t]he prison will ultimately bear responsibility for decisions on segregation and treatment, and certainly it is reasonable [for the prison operators] to attempt to avoid making such decisions in a vacuum").

108. *See id.* at 1193 (relying on elements enunciated in *Von Raab* denoting routine administrative function designed to prevent hazardous conditions in work environment); *see also supra* notes 93-96 (discussing *Von Raab* elements).

109. *See id.* (concluding that administrative searches, whether ultimate governmental objectives are either civil or criminal, must still be analyzed by balancing level of governmental intrusion against privacy interests of individual); *see also O'Connor v. Ortega*, 480 U.S. 709, 723-26 (1987) (upholding work-related searches of employee offices generally after balancing government's interests in workplace against employee's privacy expectations in workplace); *Colorado v. Bertine*, 479 U.S. 367, 371-73, 375 (1987) (upholding governmental interest in conducting inventory search of automobiles before impoundment against individual's diminished expectation of privacy as long as search conducted according to standardized procedures).

110. *Dunn v. White*, 880 F.2d 1188, 1194-95 (10th Cir. 1989) (discussing fact that incarceration reduces prisoner's "privacy expectation in his [or her] body"), *cert. denied*, 493 U.S. 1059 (1990).

111. *Id.* at 1195 (asserting that attempt to learn extent of AIDS infection in prisons is "legitimate penological purpose").

112. *Id.* (suggesting that under certain circumstances, public health concerns may justify mandatory blood testing within suspicious class of citizens).

113. 488 F.2d 1378 (10th Cir. 1973).

ployee health protection while serving abroad,¹²² the addition of the HIV test created a means to ensure fitness of duty and was a rational way to reach that goal.¹²³ The court therefore refused to enjoin the State Department from implementing the testing program.¹²⁴

Governmental interests in HIV testing, however, have not always survived judicial scrutiny. A federal district court employed the Fourth Amendment balancing test to strike down mandatory HIV testing of state employees who supervise retarded patients in the state's care. In *Glover v. Eastern Nebraska Community Office of Retardation*,¹²⁵ the State of Nebraska had instituted a mandatory HIV testing program for staff members after two patients tested positive for the virus and after a staff member died from AIDS-related complications.¹²⁶ The testing policy itself applied to all employees whose positions "involve[d] extensive contact" with patients that might lead to injuries that could possibly draw infected blood.¹²⁷

The district court's application of the balancing test weighed the employees' reasonable expectations of privacy against the state agency's interest in a safe living environment for the patients in its care.¹²⁸ After determining that the involuntary blood test constituted a search and seizure under the Fourth Amendment,¹²⁹ the court in *Glover* balanced the competing interests to determine whether the mandatory test met a reasonableness standard.¹³⁰ Because there was no medical evidence linking casual contact, such as

122. See *id.* at 52-53 (articulating concerns about lack of proper medical care for AIDS patients abroad and higher rates of infectious diseases in foreign countries as factors motivating adoption of State Department policy).

123. *Id.* at 53.

124. *Id.* (finding present record insufficient to justify injunction based on likelihood that constitutional claim would prevail).

125. 686 F. Supp. 243 (D. Neb. 1988), *aff'd*, 867 F.2d 461 (8th Cir. 1989).

126. *Glover v. Eastern Neb. Community Office of Retardation*, 686 F. Supp. 243, 247 (D. Neb. 1988), *aff'd*, 867 F.2d 461 (8th Cir. 1989).

127. *Id.* In addition, the court stated that while there was some evidence of sexual abuse of clients at the centers, there was no evidence of a sexual abuse problem, and therefore, the court did not examine what affect this would have on its holding. *Id.* at 248.

128. *Id.* at 250 (acknowledging that court must not "over-react and permit unreasonable invasions into a carefully formulated and preserved constitutional right as a response to this concern" about AIDS).

129. *Id.*; see *Schmerber v. California*, 384 U.S. 757, 767-71 (1966) (holding that blood test constitutes Fourth Amendment search and seizure, but may be reasonable where suspect is arrested for drunk driving).

130. *Glover*, 686 F. Supp. at 250. There are other examples of ways in which this balancing test is applied. See *O'Connor v. Ortega*, 480 U.S. 709, 726 (1987) (maintaining that standard requires that goal and scope of intrusion are both reasonable); *United States v. Place*, 462 U.S. 696, 703-10 (1983) (weighing nature and extent of intrusion against individual's Fourth Amendment rights where suspect was stopped at airport on suspicion of carrying contraband and finding that brief stop would be reasonable but that length of time of this particular stop was unreasonable); *Camara v. Municipal Court*, 387 U.S. 523, 537-38 (1967) (balancing need to search buildings, which has "long history of judicial and public acceptance," and public interest to prevent "dangerous conditions" against "relatively limited inva-

the care performed by the state employees, to HIV transmission, the court struck down the mandatory testing policy.¹³¹ Furthermore, the court found that while the state's desire to protect its patients and employees from HIV infection was a worthy goal, the plan to accomplish that goal did not "reasonably serve that purpose."¹³²

The differences between the factual context of the mandatory HIV testing program in *Glover* and the "at-risk" procedures focused on by this Comment lead to a conclusion that the constitutionality of mandatory HIV testing of those HCWs who perform at-risk procedures remains an open question. The holding in *Glover* does not proscribe all mandatory HIV testing programs, but remains fact specific. It is conceivable, therefore, that a mandatory HIV testing program in a different factual context will be able to satisfy the Fourth Amendment balancing test as applied to administrative searches.¹³³ The prison cases discussed above lead to such a conclusion. Indeed, the court in *Dunn* suggested the point that, under the proper circumstances, mandatory HIV testing outside of the criminal context may withstand constitutional scrutiny.¹³⁴ An institutional HIV testing program has yet to be challenged in the courts, however. Interestingly, though, in response to the CDC guidelines examined by this Comment, many state legislatures have called for mandatory testing of HCWs.¹³⁵ The issue, therefore, may soon come directly before the courts.

3. *Creation of a duty to test HCWs*

a. *School Board v. Arline: Section 504 mandates inquiry into health condition of employees*

Section 504 of the Rehabilitation Act of 1973¹³⁶ prohibits dis-

sion of the urban citizen's privacy" in determining whether warrant must be obtained for such search).

131. *Glover*, 686 F. Supp. at 250-51.

132. *Id.* at 251. The state's policy was premised on the belief that it had a responsibility to "protect [patients] at all costs." *Id.* The court disagreed because the state acted with "little or erroneous medical knowledge," thereby impermissibly violating the constitutional rights of the employees. *Id.*

133. See *supra* notes 79-101 and accompanying text (discussing administrative searches).

134. See *supra* note 112 and accompanying text (suggesting that governmental interests may be so compelling as to permit mandatory HIV testing outside criminal environment).

135. See Del. H.B. 191, 136th Gen. Assembly, 1st Reg. Sess. (1991) (enacted) (amending title 16 of Delaware Code to add new chapter 29 requiring testing of HCWs for AIDS); Fla. H.B. 111, Reg. Sess. (1992) (proposed) (establishing program to test health care providers for HIV); Mich. H.B. 5062, 86th Leg., Reg. Sess. (1991) (proposed) (providing periodic AIDS testing for certain health care professionals); N.J. S.B. 3588, 204th Leg., 2d Reg. Sess. (1991) (proposed) (supplementing chapter 16C of title 26 of Revised Statutes to require mandatory HIV testing of all HCWs who may be exposed to another person's body fluids).

136. 29 U.S.C. §§ 791-796(i) (1988).

crimination against handicapped persons who are employed by government or who are working for private employers that receive federal aid or assistance.¹³⁷ The statute requires that an employer refrain from using a person's handicap as a basis for denying employment opportunities if the person is "otherwise qualified" to perform the job.¹³⁸ The Court in *School Board v. Arline*¹³⁹ examined this antidiscrimination provision.¹⁴⁰

In *Arline*, the county school board forced an elementary school teacher to resign after she suffered a series of tuberculosis relapses.¹⁴¹ In response, the teacher brought suit in federal court alleging that her discharge violated section 504 of the Rehabilitation Act.¹⁴² The Supreme Court agreed with the teacher, holding that tuberculosis is a disease, and therefore is covered under section 504.¹⁴³ Moreover, the Court unequivocally concluded that a contagious disease constitutes a "handicap" for purposes of section 504.¹⁴⁴ In so concluding, the Court found that if a handicapped party is "otherwise qualified" to perform a job, or if reasonable accommodations could be made to allow that person to continue to work in a related capacity, then the person may not be discharged on the basis of the handicap.¹⁴⁵ In applying this standard, employ-

137. Rehabilitation Act of 1973, Pub. L. No. 93-112, § 504, 87 Stat. 355, 394 (codified as amended at 29 U.S.C. § 794 (1988)).

138. Section 504 provides: "No otherwise qualified handicapped individual in the United States . . . shall, solely, by reason of his [or her] handicap, be excluded from participation in, be denied benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance . . ." Rehabilitation Act of 1973, § 504, 87 Stat. at 394 (codified as amended at 29 U.S.C. § 794). A "handicapped" individual under this provision is "any person who . . . has a physical or mental impairment which substantially limits one or more major life activities, . . . has a record of such an impairment, or . . . is regarded as having such an impairment." 45 C.F.R. § 84.3(j)(1) (1991). A "qualified handicapped person" means, "[w]ith respect to employment, a handicapped person who, with reasonable accommodation, can perform the essential functions of the job in question." *Id.* § 84.3(k)(1).

A person who has a contagious disease may not be considered "handicapped" for purposes of § 504 where he or she is an

individual who has a currently contagious disease or infection and who, by reason of such disease or infection, would constitute a direct threat to the health or safety of other individuals or who, by reason of the currently contagious disease or infection, is unable to perform the duties of the job.

29 U.S.C. § 706(8)(C) (1988).

139. 480 U.S. 273 (1987).

140. *School Bd. v. Arline*, 480 U.S. 273, 275 (1987).

141. *Id.* at 276.

142. *Id.*

143. *Id.* at 284-86.

144. *Id.* at 282, 285-86. The Court stated that "[a]llowing discrimination based on the contagious effects of a physical impairment would be inconsistent with the basic purpose of § 504 . . ." *Id.* at 284.

145. *Id.* at 287-88. The case was remanded to determine whether the teacher was "otherwise qualified" for her job or if reasonable accommodations could be made so that she could continue teaching. *Id.* at 277. In *Southeastern Community College v. Davis*, 442 U.S. 397 (1979), the Court discussed whether a woman with a hearing impairment who had to rely on

ers must "conduct an individualized inquiry" of employees, and should defer to the "reasonable medical judgments of public health officials" when making the requisite findings of fact.¹⁴⁶ Accordingly, this holding suggests that a medical institution employer, as part of its "individualized inquiry" into an employee's health, would need to know the status of the employee's disease if the employer is to make reasonable accommodations for that employee.¹⁴⁷ It follows, therefore, that to correctly determine an employee's suitability for continued employment, HIV testing of that individual may be required.

b. HIV testing of HCWs required under affirmative duty to provide safe work environment

Two recent cases place a prospective duty on health care institutions to know the HIV status of their HCWs, thus compelling, by implication, the use of individualized mandatory testing. In *Leckelt*

lipreading to understand speech was otherwise qualified to take part in a nursing training program, and whether the college had to make reasonable accommodations for her. *Id.* at 405-12. The Court stated that it was undisputed that the respondent could only participate in the nursing program if standards were "substantially lowered," and it held that § 504 did not require such "substantial modifications of standards to accommodate a handicapped person." *Id.* at 413. The Court wrote that "[a]n otherwise qualified person is one who is able to meet all of a program's requirements in spite of his [or her] handicap." *Id.* at 406. That is, if the handicapped person can perform "the essential functions" of the position, then that person is "otherwise qualified." 45 C.F.R. § 84.3(k)(1) (1991). If the handicapped person is attempting to gain admission into a postsecondary school, he or she cannot be denied admission if he or she meets the required "academic and technical standards." *Id.* § 84.3(k)(3).

"Reasonable accommodation" of a handicapped person includes: making facilities accessible to such persons, job restructuring, part-time work, or other modified work schedules. *Id.* § 84.12(b). The necessary accommodation cannot, however, impose "undue financial and administrative burdens" or require "a fundamental alteration in the nature of [the] program." *Southeastern Community College*, 442 U.S. at 410, 412; see also 45 C.F.R. § 84.12(a) (promulgating regulations quoted in *Southeastern Community College*). Where "reasonable accommodations" cannot be made, the failure to hire, promote, admit, or otherwise reconcile the special needs of a handicapped person does not constitute discrimination. See *Southeastern Community College*, 442 U.S. at 410-13 (refusing to demand that nursing college undergo undue hardship to accommodate handicapped student); see also *Alexander v. Choate*, 469 U.S. 280, 299-301 (1985) (discussing logic of *Southeastern Community College* case); *Strathie v. Department of Transp.*, 716 F.2d 227, 231-34 (3d Cir. 1983) (discussing fact that § 504 does not "guarantee the handicapped equal results from the provision of state Medicaid" and that accommodations for handicapped are unnecessary because equal access exists).

Based on the elements of § 504 of the Rehabilitation Act, the Court in *Arline* ultimately found that "reasonable accommodations" for the employee would not mean placing a teacher who is contagious for tuberculosis in a classroom with children. *School Bd. v. Arline*, 480 U.S. 273, 287 n.16 (1987).

146. *Arline*, 480 U.S. at 287, 288; see *supra* note 21 and accompanying text (discussing AMA's formula for determining risk of transmission for contagious diseases in health care context, which seems to suggest similar type of inquiry).

147. *Cf. Arline*, 480 U.S. at 287 n.16 (stressing that employee who poses "significant risk" of transmitting infectious disease in workplace will not "otherwise qualify[y]" for his or her job if reasonable accommodations cannot eliminate risk of transmission).

v. Board of Commissioners,¹⁴⁸ the court found that a hospital had an affirmative duty to provide a "safe environment, and safeguard[] the health of all patients and employees."¹⁴⁹ The court inferred this duty from the hospital's routine use of infection-control procedures and requirements intended to prevent the transmission of contagious diseases between patients and HCWs.¹⁵⁰ Accordingly, when an employee contracts a contagious disease or is suspected to be at risk of contracting such a disease, the hospital must reassign or restrict as necessary the operators and procedures that employee may perform.¹⁵¹ The hospital's ability to exercise this duty, however, is contingent upon it obtaining information regarding each employee's health. Therefore, in *Leckelt*, the health care institution had to know whether its employee was HIV positive,¹⁵² information that comes only from administering an HIV test.¹⁵³

In *Estate of Behringer v. Medical Center*,¹⁵⁴ the Superior Court of New Jersey ruled that a physician has an affirmative duty to withdraw from performing invasive procedures that pose risks to patients.¹⁵⁵ The court justified its adoption of this rule by relying on section 293

148. 714 F. Supp. 1377 (E.D. La. 1989), *aff'd*, 909 F.2d 820 (5th Cir. 1990).

149. *Leckelt v. Board of Comm'rs*, 714 F. Supp. 1377, 1379 (E.D. La. 1989) (quoting from hospital's infection control procedures), *aff'd*, 909 F.2d 820 (5th Cir. 1990).

150. *See id.* at 1377, 1388, 1392 (finding that it is reasonable under circumstances to require testing of employees exposed to infectious diseases in order to control spread of such diseases). Therefore, testing for HIV infection falls under the rubric of these procedures. *Id.* at 1379.

151. *Leckelt*, 714 F. Supp. at 1388-89. The Supreme Court's holding in *School Board v. Arline*, 480 U.S. 273 (1987), provided the justification, according to the court in *Leckelt*, for the hospital to investigate the health status of an employee to determine if "reasonable accommodations" are possible or not. *See Leckelt*, 714 F. Supp. at 1388 (concluding that *Arline* required health care institutions to investigate health of employees who are suspected of carrying contagious diseases). Absent such information, the hospital could not know what accommodations are "reasonable." *Id.* This knowledge is needed for both the benefit of patients coming into contact with the infected employee and for the employee's health. *See id.* at 1388 (concluding that infected employee stands at risk if treating patients infected with highly contagious diseases).

152. *Leckelt*, 714 F. Supp. at 1382, 1388. The court drew support from *Wright v. Olin Corp.*, 697 F.2d 1172 (4th Cir. 1982), for the principle that employers must sometimes discriminate against an employee based on his or her handicap where the performance of certain job-related tasks would expose the handicapped individual or others to a potential for injury or illness. *Leckelt*, 714 F. Supp. at 1388 (citing *Wright v. Olin Corp.*, 697 F.2d 1172, 1189 (4th Cir. 1982)). Again, it follows that the medical institution must know the employee's HIV status to fulfill that responsibility. *Leckelt*, 714 F. Supp. at 1388.

153. *Leckelt*, 714 F. Supp. at 1388-89 (holding that monitoring of HCW's health status is permitted "to protect patients and co-workers and to accommodate any current or future handicap of the employee").

154. 592 A.2d 1251 (N.J. Super. Ct. Law Div. 1991).

155. *Estate of Behringer v. Medical Ctr.*, 592 A.2d 1251, 1283 (N.J. Super. Ct. Law Div. 1991). The court found that the policy of restricting surgical privileges of HCWs who pose "any risk of HIV transmission to the patient" was a reasonable exercise of the hospital's authority. *Id.* at 1255.

of the *Restatement (Second) of Torts*.¹⁵⁶ Specifically, the court required the hospital to show that its policy of temporarily suspending and thereafter restricting a doctor's surgical privileges was substantially justified by a reasonable probability of harm to the patient.¹⁵⁷ This probability of harm, the court explained, arises not only from the probability of actual transmission, but also from the possibility that the occurrence of an accident during surgery would require postoperative testing for HIV infection.¹⁵⁸ The court stressed that testing in such circumstances is inherently traumatic for the patient and could potentially cause changes in the patient's lifestyle until his or her HIV status is ascertained.¹⁵⁹ Relying on these postulates as proof of potential harm, the court in *Behringer* determined that the policy of restricting the scope of HIV-infected surgeons' practices is a proper means of preventing transmission of the virus and of protecting the physical and emotional health of patients.¹⁶⁰

In summary, the courts in *Leckelt* and *Behringer* found that a compelling societal interest takes precedence over the individual Fourth Amendment rights of HCWs. Society's need to know a health care worker's HIV status leads to the inevitable topic of mandatory testing. Because these decisions hold that the government's interest in protecting patients from HCWs infected with HIV is paramount, the next logical step is that mandatory testing of HCWs is justified in certain circumstances.¹⁶¹

Accordingly, the court in *Leckelt* applied the "individualized inquiry" duty articulated in *Arline* and found that the requisite conditions existed to require that the HCW turn over the results of his HIV test to his employer, the hospital, because the hospital had a right to require HIV testing in order to fulfill its health care obliga-

156. *Id.* at 1281-82 (using analytical framework of *Restatement* to justify balancing risk against utility of HCW performing invasive procedures).

157. *See id.* at 1255 (finding that response of hospital was not based on arbitrariness or prejudice, but resulted from reasoned analysis).

158. *Id.*

159. *Id.* at 1266.

160. *See id.* at 1283 (holding that hospital acted reasonably in restricting plaintiff from performing invasive procedures as there was "reasonable probability of substantial harm") (quoting *Jansen v. Food Circus Supermarkets*, 541 A.2d 682, 688 (N.J. 1988)). Another factor in the court's analysis was that the risk of transmission involving this surgeon could be completely prevented by using a different surgeon. *Id.*; *see also supra* note 28 (discussing substitution of surgeons as "viable policy option").

161. *But see* Orentlicher, *supra* note 31, at 1135 (arguing that mandatory testing is unreasonable and unnecessary). Orentlicher contends that the court's attempt in *Behringer* to eliminate all risk of transmission from HCW to patient by a policy of mandatory testing and prohibition of all invasive procedures was unnecessary. *Id.* Additionally, he contends that voluntary testing is an adequate response because the moral, ethical, and legal obligations in the medical community are adequate to control the risk of transmission from HCW to patient. *Id.* at 1136-37.

tions.¹⁶² Because an HIV-positive individual is a "handicapped individual" as defined in section 504,¹⁶³ a hospital has a duty to determine if this HCW is otherwise qualified to do the job, or if it could provide reasonable accommodations so the HCW can perform his or her job.¹⁶⁴ Thus, the *Leckelt* court found that the only logical way for a hospital to fulfill its duty to accommodate a handicapped employee is to become informed about the employee's health status.¹⁶⁵ Furthermore, it found that protecting patients and co-workers of HIV-infected employees from being exposed to the virus is a legitimate reason for a health care institution to inquire into a worker's HIV status.¹⁶⁶ Accordingly, the hospital in *Leckelt* suspended the plaintiff's employment activities until his HIV test results became available.¹⁶⁷

As applied in *Leckelt*, therefore, *Arline* mandates that the suspected HCW be tested for the AIDS virus. Once the AIDS test result is received, the institution is able to evaluate the HCW's condition and, if the worker is infected, can determine whether the HCW poses a risk to patients or other employees and whether "reasonable accommodations" can be made to allow the HCW to work in some capacity.¹⁶⁸ The subsequent codification of *Arline*¹⁶⁹ resulted in an administrative policy classifying AIDS as a contagious disease and therefore as a handicap.¹⁷⁰ The statute seems also to require, at

162. *Leckelt v. Board of Comm'rs*, 714 F. Supp. 1377, 1379 (E.D. La. 1989), *aff'd*, 909 F.2d 820 (5th Cir. 1990); see *supra* notes 146-47 and accompanying text (describing *Arline* duty of "individualized inquiry" and discussing appropriate responses).

163. See *supra* note 138 and accompanying text (discussing relevant definitions contained in § 504 of Rehabilitation Act).

164. See *supra* note 138 (noting definition in § 504 that "qualified handicapped person" is one who, with reasonable accommodation, can perform job requirements).

165. *Leckelt*, 714 F. Supp. at 1389.

166. *Id.*

167. *Id.* at 1384-85; see *id.* at 1388 (observing that in order to begin evaluating and dealing with situation surrounding suspected infected HCW, knowledge of that HCW's HIV status is required).

168. See *id.* at 1388 (holding that inquiring into health status of suspected HIV-positive HCW is not enough because condition of infected HCW, once known, must be monitored as part of continuing duty under *Arline*). During congressional debate preceding codification of the *Arline* duty, Representative Don Edwards (D-Cal.) stated that the *Arline* duty requires "a medical assessment of whether exclusion is necessitated by the degree of risk involved in the particular situation. . . . The outcome of each case will depend on the medical facts concerning the particular infectious condition, how that infection is transmitted, and the nature of the job in question." 134 CONG. REC. H584 (daily ed. Mar. 2, 1988), *quoted in* *Leckelt v. Board of Comm'rs*, 714 F. Supp. 1377, 1388 (E.D. La. 1989), *aff'd*, 909 F.2d 820 (5th Cir. 1990). Representative Edwards further added that this amendment was fashioned "in such a way that the courts will continue to adjudicate cases involving AIDS, HIV infection and other communicable conditions on a case by case basis." 134 CONG. REC. H584 (daily ed. Mar. 2, 1988) (remarks of Rep. Don Edwards).

169. 29 U.S.C. § 706(8)(D) (Supp. II 1990) (codifying *Arline*).

170. See Memorandum from Douglas W. Kmiec, Acting Attorney General, U.S. Department of Justice, Office of Legal Counsel, to Arthur B. Culvahouse, Jr., Counsel to the Presi-

least in practice, that employees be tested. Employers can act best when they are informed of all pertinent facts, not when making decisions on the basis of prejudice and apprehension.¹⁷¹ Section 504, however, only applies to those institutions that receive federal monies.¹⁷² Nevertheless, the interpretation of section 504's requirement of an individualized inquiry may have broad implications even for those institutions not receiving federal monies. They too may have a duty to conduct this individualized inquiry.

II. INFORMED CONSENT AND "SPECIAL RELATIONSHIP" THEORIES COMPEL DISCLOSURE OF HIV-POSITIVE STATUS

The CDC guidelines address the issues of patient consent and the HIV-positive HCW. The guidelines specify whether and under what conditions an HIV-infected HCW has an affirmative duty to disclose the fact of his or her infection to patients. In considering these issues, courts have applied theories of medical malpractice and patient informed consent.

A. HIV-Positive Status as Material Information

The theory of medical malpractice arises from tort principles as HCWs perform work requiring special skills that demand a minimum of particularized knowledge and ability.¹⁷³ HCWs therefore must exercise care that is reasonable given their special skills, knowledge, and ability.¹⁷⁴ An HCW's liability for malpractice is predicated on the satisfaction of two conditions. First, an HCW must act or fail to act in such a way that his or her behavior is inconsistent with the medical profession's standards of practice.¹⁷⁵ Sec-

dent (Sept. 27, 1988) (issuing Reagan administration opinion that HIV infection qualifies as handicap under § 504 of Rehabilitation Act), *cited in* *Leckelt v. Board of Comm'rs*, 714 F. Supp. 1377, 1386 (E.D. La. 1989), *aff'd*, 909 F.2d 820 (5th Cir. 1990); *see also* Gostin, *supra* note 28, at 44 n.169 (detailing conceptual evolution of AIDS as "handicap" for purposes of § 504).

171. *Cf.* *School Bd. v. Arline*, 480 U.S. 273, 284 (1987) (finding that Congress, by enacting § 504, intended to counter adverse affects caused by societal myths and fears regarding capabilities of handicapped individuals).

172. 29 U.S.C. § 794(a) (1988).

173. *See* KEETON ET AL., *supra* note 18, § 32, at 185 (discussing level of conduct required of professional persons by law).

174. *See* KEETON ET AL., *supra* note 18, § 32, at 185 (discussing tort theory of professional malpractice).

175. *See* KEETON ET AL., *supra* note 18, § 32, at 187 (stating that physician should be judged according to "tenets of the school [of medicine] the doctor professes or follows" where experts disagree on minimum standards). Traditionally, allowances were made for differences in practice procedures between communities. *Id.* § 32, at 187-88. The ease by which information is distributed in today's society, however, has caused courts to reject this concept. *Id.* § 32, at 188. Instead, courts employ a national medical standard, especially in cases where medical specialties are involved. *Id.*; *see also* *Robbins v. Footer*, 553 F.2d 123, 129 & n.19

ond, violation of these standards of practice must cause injury to the patient.¹⁷⁶ Tort law imposes an affirmative duty on the HCW to inform the patient of the risks inherent in any proposed treatment and even in alternative treatments not being advocated by the HCW.¹⁷⁷ The difficulty arises when attempting to determine whether the information actually imparted to the patient satisfies the above requirements so that the patient is then capable of giving informed consent to the treatment.¹⁷⁸

Resolution of this difficulty is based on whether the information given, or, as the case may be, the information withheld, was "material" to the patient's decision to undergo the treatment.¹⁷⁹ Traditionally, the medical community was responsible for defining "material,"¹⁸⁰ but a modern trend has supplanted this approach

(D.C. Cir. 1977) (holding that medical specialists are held to national standard and not to standard of physician in local community); *East v. United States*, 745 F. Supp. 1142, 1149 & n.9 (D. Md. 1990) (setting duty of care owed by doctor based on national standard); *Sewell v. United States*, 629 F. Supp. 448, 455 (W.D. La. 1986) (assessing liability against physician where standard of care exercised by physician drops beneath national standard).

176. See, e.g., *Mann v. United States*, 904 F.2d 1, 2 (2d Cir. 1990) (requiring plaintiff who alleged that medical malpractice during surgery caused harm to prove that doctor failed to exercise average skill in performance of surgery); *Fitzgerald v. Manning*, 679 F.2d 341, 342-47 (4th Cir. 1982) (requiring plaintiff to prove that physician failed to provide standard of care where alleged malpractice caused patient to lose lung); *Sewell v. United States*, 629 F. Supp. 448, 455 (W.D. La. 1986) (holding that physicians are not held to standard of perfection but are liable where their actions fall below ordinary standard of care in case where alleged misdiagnosis resulted in neurological deficit and paraplegia); see also *Boyce v. Brown*, 77 P.2d 455, 457-58 (Ariz. 1938) (articulating general factors to be considered in determining presence of malpractice).

177. See *Marino v. Ballestas*, 749 F.2d 162, 167 (3d Cir. 1984) (indicating that patient needs to know alternative treatments and risks of those treatments before informed consent can be given); *KEETON ET AL.*, *supra* note 18, § 32, at 190 (discussing scope of disclosure necessary to enable patient to reach intelligent, informed decision). This duty arises out of the principle that each person has a right to determine what may be done to his or her body as a matter of personal autonomy. *KEETON ET AL.*, *supra* note 18, § 32, at 190; see also *Harbeson v. Parke Davis, Inc.*, 746 F.2d 517, 522 (9th Cir. 1984) (stating that doctrine of informed consent "is premised on the fundamental principle that a competent individual has a right to determine what shall be done with [his or] her own body"). Thus, the patient needs to be informed adequately to make an intelligent decision whether to consent to a particular treatment. *Harbeson*, 746 F.2d at 522.

178. *KEETON ET AL.*, *supra* note 18, § 32, at 190-91; see also *Marino v. Ballestas*, 749 F.2d 162, 167-68 (3d Cir. 1984) (recognizing need for patient to be informed of nature and possible consequences of operation before informed consent can be given); *Pegram v. Sisco*, 406 F. Supp. 776, 780 (W.D. Ark.) (treating patient consent to operation as ineffective where patient was not informed of dangers of operation), *aff'd mem.*, 547 F.2d 1172 (8th Cir. 1976); *Scott v. Bradford*, 606 P.2d 554, 557 (Okla. 1979) (holding that doctor may still breach duty to inform, even where consent is given, by failing to inform patient of options and risks, assuming injury occurs).

179. See *Harbeson*, 746 F.2d at 522 (stating that materiality is guide for disclosure); *Flanery v. President & Directors of Georgetown College*, 679 F.2d 960, 962-63 (D.C. Cir. 1982) (concluding that doctors have duty "to provide specific warnings of material risks"); *Lambert v. Park*, 597 F.2d 236, 238-39 (10th Cir. 1979) (choosing materiality rather than common practice of other doctors as guide for disclosure).

180. See *KEETON ET AL.*, *supra* note 18, § 32, at 191 (defining concept of "materiality" as being grounded in professional medical standard, which is gauged as what reasonable physi-

with a standard centered on the individual patient.¹⁸¹ In other words, the information is deemed material if the patient would consider such information necessary in reaching a decision whether or not to undergo treatment.¹⁸² Today courts adopt either a totally subjective approach, or they adopt an approach based on a reasonable person in the patient's position.¹⁸³ A reasonable patient is defined as a prudent person in the patient's position, taking into account the patient's medical history and any other factors that could help determine the materiality of risk to that patient.¹⁸⁴ Under either approach, tort principles require the injured patient to

cian would do in same circumstances); *see also* *Rush v. Miller*, 648 F.2d 1075, 1076 (6th Cir. 1981) (upholding statute that limits disclosure of material risk to standard established by medical community); *Cohen v. United States*, 540 F. Supp. 1175, 1182 (D. Ariz. 1982) (requiring physician to disclose material risks that reasonable physician in same community would disclose); *Pegram*, 406 F. Supp. at 779-80 (maintaining that physician must use skill and judgment of average peer in choosing what information qualifies as "material" and therefore must be disclosed).

Further, several state statutes have framed issues of informed consent in terms of medical community standards. *See, e.g.*, DEL. CODE ANN. tit. 18, § 6852 (1989) (requiring plaintiff to prove that health care provider did not furnish information that other health care providers with similar training and in same community would have provided); NEB. REV. STAT. § 44-2816 (1988) (defining scope of informed consent based on information that would be provided by health care provider in similar practice in community); TENN. CODE ANN. § 29-26-118 (1992) (requiring plaintiff to prove that health care provider did not furnish information in accordance with accepted professional standard); VT. STAT. ANN. tit. 12, § 1909 (1990) (attaching liability where health care provider failed to disclose risks that "reasonable medical practitioner under similar circumstances would have disclosed").

181. *See, e.g.*, *Davis v. Omitowaju*, 883 F.2d 1155, 1169 (3d Cir. 1989) (using subjective standard rather than reasonable person standard in determining whether physician gained patient's informed consent); *Harbeson*, 746 F.2d at 522 (using standard of reasonable person in patient's position to determine materiality of undisclosed information); *Hartke v. McKelway*, 707 F.2d 1544, 1548 (D.C. Cir.) (using standard of reasonable person in patient's position to determine materiality of risk), *cert. denied*, 464 U.S. 983 (1983); *Henderson v. Milobsky*, 595 F.2d 654 (D.C. Cir. 1978) (holding that patient, not medical community, determines scope of information needed to achieve informed consent); *Scott*, 606 P.2d at 557-58 (holding that standard for disclosure is set by patient's need to know and not by medical community); *see also* *Cobbs v. Grant*, 502 P.2d 1, 10 (Cal. 1972) (noting that "[u]nlimited discretion in the physician is irreconcilable with the basic right of the patient to make the ultimate informed decision").

182. *See* *Harbeson v. Parke Davis, Inc.*, 746 F.2d 517, 522 (9th Cir. 1984) (maintaining that patient must show that different course of treatment would have been chosen had material risk been disclosed); *Goldstein v. Kelleher*, 728 F.2d 32, 39 (1st Cir.) (requiring patient to show that surgery would have been declined had she been fully aware of risk), *cert. denied*, 469 U.S. 852 (1984); *Avakian v. United States*, 739 F. Supp. 724, 731 (N.D.N.Y. 1990) (requiring showing that reasonable person in plaintiff's circumstances would have refused to undergo treatment had risks been fully disclosed).

183. *Compare* *Scott v. Bradford*, 606 P.2d 554, 557-58 (Okla. 1979) (holding that risk is material and therefore must be communicated if it would likely affect patient's decision to go forward with treatment) *with* *Canterbury v. Spence*, 464 F.2d 772, 787 (D.C. Cir.) (attaching liability where "reasonable patient's" decision to undergo treatment would have been affected by disclosure of information in question), *cert. denied*, 409 U.S. 1064 (1972).

184. *See* *Canterbury*, 464 F.2d at 790-91 (rejecting subjective assessment of materiality and adopting reasonable patient in similar circumstances standard); *see also* *Hartke v. McKelway*, 707 F.2d 1544, 1548-51 (D.C. Cir.) (affirming use of reasonable patient standard and concluding that patient with history of gynecological problems implicated her physician's duty, and subsequent failure, to disclose risk of pregnancy), *cert. denied*, 464 U.S. 983 (1983).

show a breach of the HCW's duty and then a causal link from the breach to the injury.¹⁸⁵

An HCW's duty to obtain informed consent from patients is imposed by the tort system in an attempt to address the risks arising from prescribed treatments. The question remains, however, whether the HIV status of the responsible HCW is a material fact that must be conveyed to the patient as a prerequisite to obtaining informed consent.¹⁸⁶ The court in *Estate of Behringer v. Medical Center*¹⁸⁷ settled the issue by concluding that because there was a risk of transmission that would result in the death of the patient, the HIV-positive status of the surgeon was material.¹⁸⁸ The court did not focus on the risk of transmission inherent in the particular procedure, but based its decision on the fact that the possibility of transmission exists whenever an HIV-positive HCW performs an invasive procedure.¹⁸⁹ The court also considered that if an incident

185. See *Scott*, 606 P.2d at 559 (listing elements plaintiff must prove in action for medical malpractice). As enunciated in *Scott*, these elements are:

- 1) defendant physician failed to inform [the patient] adequately of a material risk before securing [the patient's] consent to the proposed treatment;
- 2) if [the patient] had been informed of the risks [the patient] would not have consented to the treatment;
- 3) the adverse consequences that were not made known did in fact occur and [the patient] was injured as a result of submitting to the treatment.

Id. The court concluded that "[a]s a defense, a physician may plead and prove plaintiff knew of the risks, [or] full disclosure would be detrimental to patient's best interests[,] or that an emergency existed requiring prompt treatment and patient was in no condition to decide" *Id.* at 559.

186. See *Mussivand v. David*, 544 N.E.2d 265, 269 (Ohio 1989) (discussing general tort liability for "negligent, fraudulent, or intentional" transmission of communicable disease). The court in *Mussivand* concluded that people who are aware that they are infected with a venereal disease have an affirmative duty to prevent the spread of the disease to those at risk of being infected. *Id.*; see also *Earle v. Kuklo*, 98 A.2d 107, 109 (N.J. Super. App. Div. 1953) (quoting 25 AM. JUR. *Health* § 45 (1940)) (discussing duty to prevent exposure of another to tuberculosis). Further, where a person is aware that his or her disease is communicable, failure to disclose that fact to a potential receiver may be grounds for an action based on negligent, fraudulent, or intentional transmission of the disease. See *B.N. v. K.K.*, 538 A.2d 1175, 1179-84 (Md. 1988) (finding liability for failure to disclose presence of venereal disease to sexual partner where partner contracts same disease); *S.A.V. v. K.G.V.*, 708 S.W.2d 651, 652 (Mo. 1986) (holding that spousal immunity did not bar wife from proceeding against husband for wrongfully and negligently transmitting herpes to her); *Maharam v. Maharam*, 510 N.Y.S.2d 104, 107 (App. Div. 1986) (allowing wife to maintain action against husband "for wrongful transmission of genital herpes on theories of either fraud or negligence"). These holdings imply that negligent transmission of AIDS to a sexual partner may be cognizable under the common law. See *infra* note 222 and accompanying text (examining possibility of liability for sexual transmission of AIDS).

187. 592 A.2d 1251 (N.J. Super. Ct. Law Div. 1991).

188. *Estate of Behringer v. Medical Ctr.*, 592 A.2d 1251, 1280 (N.J. Super. Ct. Law Div. 1991). The court stated that the "risk of accident and its implications thereof would be a legitimate concern to the surgical patient, warranting disclosure of this risk in the informed-consent setting." *Id.*

189. *Id.* at 1281 (noting that New Jersey cases address both risks inherent in procedures and "any attendant substantial risks" in determining materiality) (quoting *Largey v. Rothman*, 540 A.2d 504, 506 (N.J. 1988)). The court in *Behringer* also suggested, as another rationale for

does occur during surgery, the patient is subjected to HIV testing for a period of up to one year¹⁹⁰ to ascertain whether the HIV virus was transmitted.¹⁹¹ The court held that where invasive procedures are performed, a surgeon's HIV-positive status must be disclosed because it is a material element of informed consent.¹⁹²

Commentators, however, are not in agreement with the conclusions drawn by the court in *Behringer* regarding the necessity of patient informed consent.¹⁹³ Professor Gostin contends that the risk of transmission is too small to be controlling, and therefore, informed consent is not necessary.¹⁹⁴ Gostin offers two reasons for this conclusion. First, he argues that the theory of informed consent does not apply to the "highly remote or unforeseen risks" presented in this situation.¹⁹⁵ Second, Gostin asserts that requiring informed consent would invite irrational discrimination against infected HCWs, potentially ruining the HCWs' professional and personal lives.¹⁹⁶ Instead, Gostin argues that an infected HCW's employer and the licensing authorities should be informed.¹⁹⁷ These groups, according to Gostin, are better able to monitor the professional competency of the HCW and to determine whether any risks to patients are posed.¹⁹⁸ Gostin further believes that the infected HCW's HIV status should only be revealed where there is a sufficiently "compelling public health benefit" to be attained by releasing the information, but he contends that disclosure to patients does not

its decision, that there may be a duty to warn third parties requiring HIV-positive surgeons to disclose their HIV status to patients. *Behringer*, 592 A.2d at 1281 n.19.

190. *Id.* at 1266; see also GUIDE TO DISEASES, *supra* note 1, at 366 (stating that diagnosis of AIDS usually occurs between one and three years after exposure).

191. *Behringer*, 592 A.2d at 1280 (basing decision partially on fact that period of waiting for HIV test results will create great anxiety in patients and may induce changes in lifestyle and child-bearing decisions even if test results are negative).

192. *Id.* at 1279-83.

193. See Gostin, *supra* note 57, at 304 (discussing costs and benefits of disclosing HIV-positive status of HCWs to patients); Orentlicher, *supra* note 31, at 1136 (characterizing approach of court in *Behringer* to issue of informed consent as both "unnecessary and counterproductive").

194. Gostin, *supra* note 57, at 304.

195. Gostin, *supra* note 57, at 304 (comparing HCW's failure to disclose HIV-positive status with routine practice of not informing patients of other low risk items such as infections or relative skill of provider).

196. Gostin, *supra* note 57, at 304-05 (adding that retrospective disclosure of HCW's HIV status would create needless anxiety in patient and suggesting that problem be solved by making HIV testing of patients routine).

197. Gostin, *supra* note 57, at 304-05 (asserting that limiting scope of informed consent to benefits and risks of medical procedures is something that employers and licensing authorities can best evaluate).

198. Gostin, *supra* note 57, at 304 (asserting that informed consent alone cannot protect patients in absence of professional and licensing authorities' enforcement of professional standards).

meet this standard, and thus is not warranted in this situation.¹⁹⁹

The decision in *Behringer* has been criticized for its “zero-risk tolerance” standard. The American Medical Association (AMA) Office of the General Counsel contends that this standard is “both unnecessary and counterproductive”²⁰⁰ and that requiring informed consent would likely result in irrational discrimination.²⁰¹ Even if dissemination of an HCW’s HIV status were to remain ‘within a small group, the AMA argues, no patient would permit an HIV-positive HCW to perform any procedure, whether or not the procedure posed a health risk.²⁰² The result, of course, would be an effective end to any practice by an infected HCW.²⁰³ If representative of the medical community at large, the AMA commentaries indicate that a large gulf exists between the opinion of the medical community and the courts.

B. “Special Relationship” and the Duty to Control the Conduct of Others

The requirement of informed consent, predicated on both HCWs’ expertise and the need for patient autonomy over health care decisionmaking, mandates that infected HCWs reveal their conditions.²⁰⁴ The nature of the doctor-patient relationship dictates that the patient rely heavily on the ability, honesty, and integrity of the

199. Gostin, *supra* note 57, at 304 (contending instead that disclosure would create anxiety in patients and foster unjustified discrimination against HIV-positive HCWs). *But see In re Milton S. Hershey Medical Ctr.*, 595 A.2d 1290, 1295-96 (Pa. Super. Ct. 1991) (finding “compelling need” to disclose surgeon’s HIV-positive status to patients). The court in *In re Hershey* found this “compelling need” to disclose, based on a Pennsylvania statute, by balancing “the need for disclosure against the privacy interest of the individual and the public interests which may be harmed by disclosure.” *Id.* at 1295 (quoting 35 PA. CONS. STAT. ANN. § 7608(c) (1992)). The court considered the damage to the physician’s professional life, the effect of requiring disclosure on the price of medical care and malpractice insurance, and the disincentives for HCWs to treat HIV-positive patients. *Id.* The court found the interest in public health more compelling than these other factors and therefore required disclosure. *Id.* at 1296-97. More specifically, this “compelling need” to disclose had to be based on a “concrete medical need.” *Id.* at 1295 n.6 (stating that need for result of HIV test must be to make “important medical decision” and cannot be based on simple “desire to know”).

200. Orentlicher, *supra* note 31, at 1136 (suggesting that guidelines for disclosure established by “public health officials should guide decision to disclose risk of HIV transmission to patients”).

201. Orentlicher, *supra* note 31, at 1136 (asserting that patients are reluctant to receive care from HIV-positive physicians regardless of nature of contact).

202. Orentlicher, *supra* note 31, at 1136 (concluding that guidelines set by impartial public health officials are preferable to approach taken by court in *Behringer*, which required disclosure to patient).

203. *But see* Orentlicher, *supra* note 31, at 1136 (noting that even after disclosure patient may still choose “unusually qualified” HIV-positive surgeon to perform difficult procedure or that patient in rural area may still choose HIV-positive physician rather than travel considerable distance to see another physician).

204. *See supra* notes 174-91 and accompanying text (discussing informed consent and duty to reveal requirements where HCW is seropositive for HIV).

HCW.²⁰⁵ Patients place themselves, without reciprocation, into the hands of their doctors.²⁰⁶ Tort law recognizes this "special relationship" in several respects.²⁰⁷ Where the patient's conduct or emotional health poses a risk of harm to foreseeable third parties, the treating HCW has a duty to take action and attempt to prevent the harm from materializing by warning those parties put at risk.²⁰⁸

Legal theorists apply this concept of "special relationship" across a spectrum of societal relationships.²⁰⁹ The case of *Tarasoff v. Regents of the University of California*²¹⁰ stands as the benchmark for the application of this "special relationship" theory.²¹¹ In *Tarasoff*, the defendant, a psychologist named Dr. Lawrence Moore, counseled a patient who, during therapy, made specific death threats against Tatiana Tarasoff.²¹² Dr. Moore notified neither Tarasoff nor the police

205. See Keyes, *supra* note 20, at 605 (discussing ethical considerations involved in doctor-patient relationship); see also Arnold S. Relman, *What Market Values Are Doing to Medicine*, ATLANTIC MONTHLY, Mar. 1992, at 100 (describing privileged position of HCWs in society resulting from public belief that HCWs will "faithfully discharge [their] fiduciary responsibility" outlined in ethical codes).

206. See Keyes, *supra* note 20, at 605 (maintaining that while doctors are responsible for their own health and their patients', patients are neither responsible for or able to ascertain their doctor's health).

207. See RESTATEMENT (SECOND) OF TORTS, §§ 315, 319 (1985) (articulating concept that "special relation" may exist between actor and another which creates duty upon actor to control other person, especially where that party shows "dangerous propensities"); see also KEETON ET AL., *supra* note 18, § 56, at 383-85 (suggesting that certain relationships are custodial in nature, imposing duty to control party exhibiting dangerous propensities toward others); Fowler V. Harper & Posey M. Kime, *The Duty to Control the Conduct of Another*, 43 YALE L.J. 886, 888-98 (1934) (discussing theory that society recognizes certain human relationships as triggering affirmative duty to control another's behavior and thereby prevent unreasonable risk to third party).

208. See *infra* notes 210-17 and accompanying text (discussing duty to warn concept as developed in *Tarasoff v. Regents of the Univ. of Cal.*, 551 P.2d 334 (Cal. 1976)).

209. The duty to control another arises in the following situations, among others: parent and child, master and servant, schools and students, prison officials and prisoners, drivers and passengers, and hospitals and patients. RESTATEMENT (SECOND) OF TORTS §§ 315, 316 (1981) (commenting that duty arises from special relationship and not from ability to control another's conduct); KEETON ET AL., *supra* note 18, § 56, at 383 (maintaining that such relationships arise where relationship is protective or custodial in nature); Harper & Kime, *supra* note 207, at 888-98 (positing that duty arises where another person uses property in owner's presence, between parent and child, and in extraordinary situations).

210. 551 P.2d 334, 345-46 (Cal. 1976).

211. See generally Kenneth E. Labowitz, *Beyond Tarasoff: AIDS and the Obligation to Breach Confidentiality*, 9 ST. LOUIS U. PUB. L. REV. 495, 512-17 (1990) (discussing duty of HCWs to warn foreseeable third parties of risks of AIDS transmission); Michael D. Roth, *Dilemma of Tarasoff: Must Physicians Protect the Public or Their Patients?*, 11 LAW, MED. & HEALTH CARE 104, 105-10 (1983) (addressing concerns of medical community and advising HCWs to adhere to law); Dianne S. Salter, *The Duty to Warn Third Parties: A Retrospective on Tarasoff*, 18 RUTGERS L.J. 145, 146-54 (1986) (examining imposition of duty on mental health care worker to warn potential victims of patients).

212. *Tarasoff v. Regents of the Univ. of Cal.*, 551 P.2d 334, 339, 341 (Cal. 1976) (stating that patient informed Dr. Moore that he intended to kill woman whom he did not name but who was easily identifiable as Tarasoff, after her return from Brazil).

of these threats,²¹³ and soon thereafter, the patient carried through with his threats.²¹⁴ The California Supreme Court agreed with Tarasoff's estate, holding that Dr. Moore violated his duty to warn Tarasoff of the threats against her life.²¹⁵ This duty, the court held, is not absolute, but is created where a party "stands in some special relationship to either the person whose conduct needs to be controlled or in a relationship to the foreseeable victim of that conduct."²¹⁶ This duty to warn is limited, consequently, to harm that is foreseeable, and it is owed only to easily identifiable parties.²¹⁷ This principle could seemingly be extended to HCWs and hospitals where HIV-infected HCWs practice.²¹⁸

1. *Duty of HCWs: controlling themselves and patients*

The common law assesses liability against any person who negligently exposes another to an infectious or contagious disease.²¹⁹ To show negligence, a plaintiff must prove that a defendant knew of the disease's presence and of its contagious nature.²²⁰ For example, state courts have consistently held that persons infected with venereal disease must notify their sexual partners of their infection.²²¹

213. *Id.* at 340-41 (noting that Dr. Moore did notify campus police, who detained patient briefly, but released him after he promised "to stay away from Tatiana").

214. *Id.* at 339, 341.

215. *Id.* at 347-48 (stating that "[t]he protective privilege ends where the public peril begins").

216. *Id.* at 342-43 (failing to address question of whether foreseeability, in absence of special relationship, would create duty to protect another person from harm).

217. *Id.* at 342 (stating that foreseeability is "the most important . . . consideration in establishing duty").

218. *Cf. id.* at 343 n.7 (quoting *Vistica v. Presbyterian Hosp.*, 432 P.2d 193, 196 (Cal. 1967), which held that when hospital has knowledge of facts that put patient at risk, or its patient puts others at risk, hospital must use "reasonable care in the circumstances" to prevent that foreseeable harm); Harper & Kime, *supra* note 207, at 905 (discussing "elasticity" of duty to control conduct of another person). Harper and Kime concluded:

The principles governing the duty of one person to control the conduct of another have this general elasticity which characterizes other principles of tort law. When, therefore, novel cases involving the problem arise, it will become the duty of the judges to examine the analogies of such cases as are discussed here and to determine whether, in the light of human experience as reflected in these decisions, the relations of the parties fall into one or the other of the general divisions mentioned.

Harper & Kime, *supra* note 207, at 905. The authors conclude that the duty to control the conduct of another person arises in two situations: when a person has a special relationship with the potential victim or with the person whose conduct needs to be controlled. *Id.* at 904. In the case of an HIV-infected HCW, it is the provider's relationship with the patient at risk of contracting AIDS from the HCW that requires the provider to protect the patient.

219. *See, e.g.,* *Mussivand v. David*, 544 N.E.2d 265, 269 (Ohio 1989) (holding wife's lover, who was infected with venereal disease, liable for negligence for failing to warn wife's husband that wife was at risk of contracting disease and passing it to husband).

220. *Mussivand*, 544 N.E.2d at 269. *But cf. C.A.U. v. R.L.*, 438 N.W.2d 441, 444 (Minn. Ct. App. 1989) (indicating that constructive knowledge of presence of AIDS would suffice to show that defendant was negligent in passing AIDS to sexual partner).

221. *See, e.g.,* *Kathleen K. v. Robert B.*, 198 Cal. Rptr. 273, 276-77 (Ct. App. 1984) (hold-

Liability has been predicated on the failure to warn foreseeable third parties of the possibility of venereal disease transmission.²²² The opinion in *Tarasoff* suggests the next logical step: an HCW could be held "liable to persons infected by his [or her] patient if [the HCW] . . . fails to warn members of the patient's family."²²³ Under this reasoning, HCWs have a duty to warn the known sexual partners of HIV-positive patients of the risk of transmission. The court in *Behringer* acknowledged this duty and responded by extending it to require that HIV-infected HCWs must inform patients of the HCWs' infection.²²⁴ This holding suggests that HCWs must

ing that man could be held liable for transmitting venereal disease to women where he knew he had disease); *B.N. v. K.K.*, 538 A.2d 1175, 1181 (Md. 1988) (holding physician liable for transmitting genital herpes to nurse where physician was aware of disease's presence); *Maharam v. Maharam*, 510 N.Y.S.2d 104, 107 (App. Div. 1986) (holding that husband could be held liable for transmitting genital herpes to his wife where he was aware of his illness); *see also* *Barbara A. v. John G.*, 193 Cal. Rptr. 422, 426 (Ct. App. 1983) (allowing cause of action where man fraudulently told partner he was sterile and ectopic pregnancy resulted from subsequent sexual intercourse).

222. *See Mussivand*, 544 N.E.2d at 272 (holding defendant infected with venereal disease liable for failing to inform sex partner's husband that husband's wife, who was having affair with defendant, was at risk of contracting venereal disease from defendant and transmitting it to husband). The court based liability on foreseeability and public policy. *Id.* at 270-71. First, the court noted that the defendant was a doctor and should therefore be particularly aware of the presence of a venereal disease and the high rate of its transmission through sexual intercourse. *Id.* at 272. The court also noted that the defendant should have foreseen that a wife will have intimate relations with her husband. *Id.* at 270, 272-73. Second, the court asserted that there is a public interest in protecting the health of citizens, especially from serious diseases that are easily transmitted. *Id.* at 270, 271.

It is suggested by implication that negligent AIDS transmission creates similar liabilities. *See C.A.U. v. R.L.*, 438 N.W.2d 441, 442-44 (Minn. Ct. App. 1989) (refusing to find defendant liable for failing to inform fiancée of HIV infection where defendant had neither constructive nor actual notice of his condition). The Minnesota court began its analysis by recognizing that under state common law a defendant could be found liable for negligent transmission of dangerous, communicable diseases. *Id.* at 442-43 (citing *R.A.P. v. B.J.P.*, 428 N.W.2d 103, 106-07 (Minn. Ct. App. 1988) (discussing liability for transmitting genital herpes) and *Skills v. Allen*, 173 N.W. 663, 664 (Minn. 1919) (discussing liability for transmitting scarlet fever)). At the time of the parties' engagement, defendant was unaware of his HIV infection, although a few months later he began treatment for symptoms now known to be related to HIV infection. *C.A.U.*, 438 N.W.2d at 442. Upon being definitively diagnosed for AIDS, the defendant informed his fiancée. *Id.* Subsequently, she tested positive for the virus. *Id.* The defendant and plaintiff maintained a sexual relationship from approximately May 1984 to May 1985. *Id.* The court found that not until late May 1985 did it become known that AIDS could be transmitted through heterosexual contact. *Id.* In addition, it was not possible for an individual to obtain an anonymous HIV test until the end of July 1985. *Id.* (noting that prior to July 1985, test for AIDS was only used for screening blood in Minnesota). The court concluded, therefore, that because the defendant had no knowledge, either actual or constructive, of his condition during his sexual relations with the plaintiff, he had no duty to inform his fiancée of his condition. *Id.* at 443-44. Although the court did not impose liability, the implication arising from the court's analysis is that negligent or fraudulent transmission of the HIV virus will be treated no differently under the law than other communicable diseases. *Cf. id.* at 442-43 (discussing imposition of liability for negligent transmission of other communicable diseases).

223. *Tarasoff v. Regents of the Univ. of Cal.*, 551 P.2d 334, 344 (Cal. 1976).

224. *See Estate of Behringer v. Medical Ctr.*, 592 A.2d 1251, 1281 n.19 (N.J. Super. Ct. Law Div. 1991) (finding that physician's duty to warn sexual partner of HIV-positive patient also requires HIV-positive surgeon to warn patients of risk of transmission).

act based on their special relationship to patients. For the HIV-positive HCW, that duty requires that patients be warned.

2. *Duty on medical institutions: controlling behavior of HCWs*

Arguably, a "special relationship" also exists between HCWs and their associated hospitals. Where a hospital is aware of "dangerous propensities" of an employee, it must act to control that employee's behavior.²²⁵ Health care institutions therefore must, as the hospital did in *Behringer*, restrict the practice of an infected HCW.²²⁶ In *Behringer*, the risk of transmission was foreseeable, and the surgeon's patients were identifiable third parties.²²⁷ Absent practice restrictions on the performance of invasive procedures by infected HCWs, hospitals must enforce a policy of patient consent to treatment by seropositive HCWs.²²⁸ The "special relationship" between HCWs and hospitals additionally compels hospitals to inform patients postoperatively if the treating HCW subsequently tests positive for the AIDS virus.²²⁹ This prospective duty is predicated on hospitals having notice of an HCW's infection.²³⁰ Because hospitals must provide a safe environment for their employees and patients,²³¹ failure to inform and enact practice restrictions could open hospitals to nonfeasance liability.²³²

III. REVIEW OF CDC GUIDELINES

A. *History and Purpose of Guidelines*

The CDC guidelines were issued in July 1991²³³ amidst efforts within both the medical community and political arenas to address

225. See *supra* notes 209-18 and accompanying text (discussing liability arising from special relationships).

226. See *Behringer*, 592 A.2d at 1283 (noting that medical center's decision to bar surgeon from practicing invasive procedures "represents a reasoned and informed response to the problem").

227. See *id.* at 1283. But cf. Lawrence O. Gostin et al., *The Case Against Compulsory Casefinding in Controlling AIDS—Testing, Screening and Reporting*, 12 AM. J.L. & MED. 7, 47-50 (1987) (recognizing "special relationship" concept from *Tarasoff* but maintaining HCW's duty to warn in HIV context is limited to foreseeable sexual partners).

228. But cf. *supra* notes 194-99 and accompanying text (discussing Professor Gostin's theory that public disclosure of HIV status of HCW would destroy HCW's life, without proportionate benefit to patients or society at large).

229. But see Gostin, *supra* note 57, at 305 (arguing that postoperative disclosure creates needless anxiety and that better solution is routine mandatory HIV testing of patients).

230. See Keyes, *supra* note 20, at 611 (stating that institution has duty to protect patient where institution is aware that HCW is HIV positive).

231. See *supra* notes 148-60 and accompanying text (examining medical institutions' duty to provide safe work environment for employees and safe healing environment for patients).

232. See Keyes, *supra* note 20, at 612 (discussing applicability of *Tarasoff* principle to health care institutions and their patients).

233. *Recommendations for Preventing Transmission*, *supra* note 9, at 1-9.

the issues raised by HIV-positive HCWs.²³⁴ In January 1991, the American Dental Association (ADA) and the AMA announced their policies regarding HIV-infected dentists and doctors.²³⁵ The ADA adopted a policy whereby HIV-infected dentists either must notify their patients of their infection before performing any dental surgery or stop performing such procedures.²³⁶ The AMA's statement cited an ethical responsibility on the part of infected HCWs not to perform any procedures that might pose a risk of transmitting the virus to their patients.²³⁷ In addition, the AMA encouraged all doc-

234. See *infra* notes 235-49 and accompanying text (discussing positions taken by major medical associations on issues of informed consent and mandatory testing and legislative efforts to address same problems).

235. The AMA's statement reads as follows:

The health of patients must always be the paramount concern of physicians. Consequently, until the uncertainty about transmission is resolved, the American Medical Association believes that HIV infected physicians should either abstain from performing invasive procedures which pose an identifiable risk of transmission or disclose their seropositive status prior to performing a procedure and proceed only if there is informed consent. As a corollary, physicians who are at risk of acquiring HIV infection, and who perform invasive procedures, should determine their HIV status.

In re Milton S. Hershey Medical Ctr., 595 A.2d 1290, 1295 n.15 (Pa. Super. Ct. 1991) (quoting AMERICAN MEDICAL ASSOC., STATEMENT ON HIV-INFECTED PHYSICIANS (Jan. 17, 1991)); see also Nancy W. Dickey, *Physicians Infected with AIDS*, 265 JAMA 2293, 2337-38 (1991) (defending AMA statement in response to critical letter); Rogers Worthington, *New Rules for Doctors, Dentists with AIDS*, CHI. TRIB., Jan. 18, 1991, at 17 (reporting that AMA statement went further than ADA statement by recommending that doctors determine own HIV status).

236. Worthington, *supra* note 235, at 17. Philip Weintraub, the ADA's spokesperson, stated that "[u]ntil the uncertainty about transmission is resolved, the ADA believes that HIV (AIDS virus)-infected dentists should refrain from performing invasive procedures or should disclose their seropositive (infected) status." *Id.* at 17; see also Lawrence K. Altman, *AIDS-Infected Doctors and Dentists Are Urged to Warn Patients or Quit*, N.Y. TIMES, Jan. 18, 1991, at A18 (quoting statement of ADA issued Jan. 17, 1991).

237. Altman, *supra* note 236, at A18 (quoting AMA sources as stating that physicians have right to continue careers in professions that would pose no risk of transmission to patients and adding that AMA would help HIV-positive doctors find alternative careers). This suggestion follows earlier guidelines produced by the AMA's Council on Ethical and Judicial Affairs, which state:

If the risk of transmission of an infectious disease from a physician to a patient exists, disclosure of that risk to patients is not enough; patients are entitled to expect that their physicians will not increase their exposure to the risk of contracting an infectious disease, even minimally. . . . [I]f a risk does exist, the physician should not engage in the activity.

Karen H. Rothenberg et al., *The AIDS Project: Creating a Public Health Policy—Rights and Obligations of Health Care Workers*, 48 MD. L. REV. 93, 119 (1989) (quoting from Council on Ethical & Judicial Affairs, *Ethical Issues Involved in the Growing AIDS Crisis*, 259 JAMA 1360, 1361 (1988)). This 1988 AMA statement has been construed as the definitive position of the medical community in its examination of the ethical problems inherent in HIV-infected HCWs' practices. See *Estate of Behringer v. Medical Ctr.*, 592 A.2d 1251, 1259 (N.J. Super. Ct. Law Div. 1991) (stating that AMA report set forth standard that had not previously existed). *But cf.* Barnes et al., *supra* note 58, at 315 (stating that other professional and public health organizations have opposed both screening of HCWs and banning them from areas of practice). This position, however, has not met with universal approval within the medical community. The AMA position, it is argued, seeks to implement a "no identifiable risk" standard that is unobtainable in practice. *Id.* For example, most HCWs normally carry with them many infectious conditions; these conditions are present during medical procedures because they cannot be eliminated

tors who perform surgery or other invasive procedures to be tested for the HIV virus.²³⁸

On mandatory testing for HCWs, the major national medical associations have been equally consistent in their belief that mandatory testing is unwarranted and unnecessary. In June 1991, the AMA passed a resolution urging physicians to submit voluntarily to HIV testing.²³⁹ The purpose of this resolution was to provide support for the positions previously taken by the AMA that it is a doctor's ethical responsibility to ensure that patients are not exposed to unwarranted risks of transmission and that physicians who perform invasive procedures should know whether they are HIV positive.²⁴⁰ For similar reasons, the American Nurses Association (ANA) adopted a resolution in July 1991 calling for voluntary testing and disclosure by nurses.²⁴¹

Concurrent with the debate over these resolutions, Congress examined several differing proposals addressing the issue.²⁴² In the House of Representatives, Representative William Dannemeyer (R-Cal.) introduced a bill to amend Title XXVI of the Public Health Service Act by calling for mandatory testing of all HCWs who perform invasive procedures.²⁴³ Following news of the Bergalis story,

completely. *Id.* at 314. Carrying this no identifiable risk standard to its logical end, these authors contend, would mean that no medical care would ever be possible. *Id.* at 314-15. Applying this standard to HIV-infected HCWs is inconsistent with permitting HCWs to work despite having other transferable ailments or physical impairments. *Id.* at 315.

238. Worthington, *supra* note 235, at 17.

239. Michael L. Millensen, *AMA Votes Down Mandatory AIDS Tests for Doctors*, CHI. TRIB., June 27, 1991, at 1. Also, the AMA convention developed plans to make it easier to test patients for HIV by reducing the size and complexity of the consent form and even by using oral consent to administer the test to a patient. *Id.*

240. Millensen, *supra* note 239, at 1 (discussing conflicting stances taken by delegates during debate and passage of resolution by AMA's House of Delegates).

241. *Nurses Reject Aids Test*, N.Y. TIMES, July 2, 1991, at C6 (stating that ANA's position was based on belief that test for HIV status is not reliable and that compulsory, universal testing is prohibitively expensive).

242. See Don Aucoin, *Testing Debate Is Still Raging*, BOSTON GLOBE, Dec. 9, 1991, at 1 (describing Sen. Jesse Helms' proposal to imprison and fine infected HCWs for failure to notify patients and Rep. William Dannemeyer's provision to force mandatory AIDS testing on all HCWs).

Additionally, the cost of testing is an issue. An HIV test costs between \$20 and \$25 and another \$200 if the first test is positive. Millensen, *supra* note 239, at 1. A company recently received FDA approval to market a test costing only \$5, but the test can only be used at institutions that already have sophisticated laboratory equipment. Scott Williams, *Genetic Systems May Add 85 Jobs—FDA Approval of AIDS Test Gives Firm Boost*, SEATTLE TIMES, Oct. 2, 1991, at D4. It is estimated that the cost of testing all HCWs in New York City would cost approximately \$13 million. Jessie Mangaliman, *High-Cost AIDS Test*, NEWSDAY, Sept. 12, 1991, at 33. It is estimated that the cost of testing HCWs performing invasive procedures in Maryland would cost \$1.5 million. Wendy Melillo, *Protecting Patients from Infection*, WASH. POST, Mar. 3, 1992, at 77 (Health Section).

243. H.R. 2788, 102d Cong., 1st Sess. (1991). Representative Dannemeyer's bill was introduced on June 26, 1991. 137 CONG. REC. H5209 (daily ed. June 26, 1991) (statement of Rep. Dannemeyer). This bill, entitled "The Kimberly Bergalis Bill: Protect Patients and

Senator Jesse Helms (R-N.C.) succeeded in persuading the Senate to pass an amendment to the bill, once it was introduced into the Senate, that would have created fines and possible prison sentences for HCWs who, if aware they are HIV positive, do not notify their patients before performing invasive procedures.²⁴⁴ A conference committee rejected the Senate amendment²⁴⁵ and instead adopted an amendment proposed by Senator Robert Dole (R-Kan.), which had previously passed in the Senate²⁴⁶ and called for voluntary HIV testing of HCWs as expressed in the CDC guidelines.²⁴⁷ Congress also adopted a provision requiring states to enact the CDC guidelines or their equivalent within one year of the bill's signing.²⁴⁸

Health Providers from Communicable Diseases," calls for mandatory screening of health care providers by states and allows physicians to test patients for HIV, without consent, if the physician had reason to believe the patient is HIV positive. See 137 CONG. REC. H2376-78 (daily ed. June 26, 1991). Several co-sponsors joined to support this bill after its introduction. See 137 CONG. REC. H5342 (daily ed. July 10, 1991) (adding eight sponsors to bill); 137 CONG. REC. H5515 (daily ed. July 16, 1991) (adding four sponsors to bill); 137 CONG. REC. H6799 (daily ed. Sept. 24, 1991) (adding six sponsors to bill); 137 CONG. REC. 8919 (daily ed. Oct. 31, 1991) (adding two sponsors to bill). The bill is currently pending. Hilts, *supra* note 1, at A12. Besides calling for mandatory testing of all HCWs, Representative Danneymeyer's bill seeks a blanket prohibition against infected HCWs performing invasive procedures and also would permit HCWs to test patients for the HIV virus without their consent. H.R. 2788, 102d Cong., 1st Sess. (1991).

244. 137 CONG. REC. S10,363 (daily ed. July 18, 1991). The amendment, entitled "Deliberate Transmission of the AIDS Virus," states:

(a) Whoever, being a registered physician, dentist, nurse, or other health care provider, knowing that he [or she] is infected with the Human Immunodeficiency Virus, intentionally provides medical or dental treatment to another person, without prior notification to such person of such infection, shall be fined not more than \$10,000, or imprisoned not less than ten years, or both.

137 CONG. REC. S9778 (daily ed. July 11, 1991).

245. 137 CONG. REC. H7385 (daily ed. Oct. 3, 1991). While discussing the Helms amendment to the bill, Representative David E. Skaggs (D-Colo.) stated the following:

While the conference committee wisely rejected the Senate-passed provision requiring a mandatory jail sentence for any HIV-infected health care worker who does not inform patients of their [sic] infected status, we were forced by Senate negotiators to accept this alternative language. Make no mistake about it, the language before us is a vast improvement over what the Senate passed.

Id. The language referenced by Representative Skaggs that was before the House was contained in an amendment proposed by Senator Robert Dole (R-Kan.) and passed by the Senate on July 18, 1991. 137 CONG. REC. S10,348-50, 10,356-63 (daily ed. July 18, 1991). This amendment requires states to adopt guidelines from the CDC that are designed to prevent HCWs from transmitting HIV to patients. 137 CONG. REC. 10,348-50 (daily ed. July 18, 1991). The House subsequently concurred in this amendment, following the recommendation of the conference committee. 137 CONG. REC. H7404-05 (daily ed. Oct. 3, 1991).

246. 137 CONG. REC. S10,348-50, 10,363 (daily ed. July 18, 1991).

247. Congress adopted the following language from the CDC guidelines: "'These guidelines [do] not include specific recommendations on testing HCWs for HIV or HBV infection[.]" and "'HCWs who perform exposure-prone procedures should know their HIV antibody status.'" 137 CONG. REC. S9978-79 (daily ed. July 15, 1991) (quoting from *Recommendations for Preventing Transmission*, *supra* note 9, at 1, 5).

248. Treasury, Postal Service and General Government Appropriations Act of 1992, Pub. L. No. 102-141, § 633, 105 Stat. 834, 876-77 (to be codified at 42 U.S.C. § 300ee-2). Specifically, the provision states the following:

Notwithstanding any other provision of law, each State Public Health Official shall,

States that fail to meet this requirement risk losing Public Health Service Act funds provided by the Federal Government to the states.²⁴⁹

B. Details of Guidelines

The CDC guidelines as released attempt to find a middle ground between the positions of advocates who call for mandatory testing of all HCWs and of those who argue that no testing should be required.²⁵⁰ The guidelines encourage that HCWs performing "at risk" procedures should undergo HIV testing voluntarily²⁵¹ and that medical institutions should define for themselves what procedures to consider "at risk."²⁵² The guidelines do not mandate practice restrictions for HIV-positive HCWs, but rather suggest that an expert medical panel impose restrictions after review of each individual case.²⁵³ Patient consent for "at risk" procedures is needed if the practicing HCW is infected,²⁵⁴ but postoperative notification is again left to the discretion of the medical institution.²⁵⁵ Much of the CDC's analysis is based on its reliance on the efficacy of "universal precautions" (UPs) as the procedures best able to reduce the risks of

not later than one year after the date of enactment of this Act, certify to the Secretary of Health and Human Services that guidelines issued by the Centers for Disease Control, or guidelines which are equivalent to those promulgated by the Centers for Disease Control concerning recommendations for preventing transmission of the human immunodeficiency virus and the hepatitis B virus during exposure prone invasive procedures, except for emergency situations when the patient's life or limb is in danger, have been instituted in the state.

Id. § 633, 105 Stat. at 876 (to be codified at 42 U.S.C. § 300ee-2).

249. *Id.* The provision makes the following statement:

Compliance with such guidelines shall be the responsibility of the State Public Health Official. Said responsibility shall include a process for determining what appropriate disciplinary or other actions shall be taken to ensure compliance. If such certification is not provided under this section within the one-year period, the state shall be ineligible to receive assistance under the Public Health Service Act . . . until such certification is provided, except that the Secretary may extend the time period for a State, upon application of such State, that additional time is required for instituting said guidelines.

Id. § 633, 105 Stat. at 876-77 (to be codified at 42 U.S.C. § 300ee-2).

250. See Lawrence K. Altman, *U.S. Would Curtail Doctors with AIDS*, N.Y. TIMES, July 16, 1991, at A1 (stating that guidelines excluded mandatory testing, much to surprise of those fearing CDC would call for such testing and anger of those advocating it). But see Malcolm Gladwell, *CDC Urges AIDS Testing for All Hospital Patients*, WASH. POST, Sept. 20, 1991, at A3 (discussing draft report of CDC recommending that all patients be offered and encouraged to take test for HIV as routine procedure).

251. *Recommendations for Preventing Transmission*, *supra* note 9, at 5-6 (suggesting that HCWs who perform procedures that are prone to transmission should know whether they are HIV positive, though not through mandatory testing).

252. *Recommendations for Preventing Transmission*, *supra* note 9, at 5.

253. *Recommendations for Preventing Transmission*, *supra* note 9, at 5.

254. *Recommendations for Preventing Transmission*, *supra* note 9, at 5 (requiring patient notification for at risk procedures).

255. *Recommendations for Preventing Transmission*, *supra* note 9, at 6.

transmission to acceptable minimums.²⁵⁶ An analysis of the guidelines' provisions follows.

1. *Efficacy of universal precautions (UPs)*

The CDC's philosophy in advocating UPs is that the best way to reduce the risk of transmission is to reduce the incidence of exposure.²⁵⁷ UPs include the use of various barrier devices and procedures to prevent contact with blood and certain other bodily fluids that are considered infectious for HIV, hepatitis-B (HBV), or other bloodborne pathogens, whether or not the fluids actually contain these viruses.²⁵⁸ The devices and procedures include hand washing, protective barriers,²⁵⁹ certain handling and disposal techniques for needles and other sharp instruments, and high-level sterilization of equipment that comes in contact with blood and other fluids that could contain pathogens.²⁶⁰ It is the CDC's belief that proper training, use, and monitoring of UPs will reduce the chance of transmission of infectious diseases to an acceptable minimum.²⁶¹

256. See *Recommendations for Preventing Transmission*, *supra* note 9, at 1-2 (stating that precise application of UPs will help decrease risks of transmission of HIV between HCWs and patients).

257. *Recommendations for Preventing Transmission*, *supra* note 9, at 5 (recommending UPs in order to reduce risk of transmission and implying that risk of exposure will decrease as result); see *OSHA: Occupational Exposure to Bloodborne Pathogens*, 56 Fed. Reg. 64,023 (1991) (comments to final rule) (rule to be codified at 29 C.F.R. § 1910.1030) [hereinafter *OSHA Comments on Bloodborne Pathogens*] (explaining Occupational Health and Safety Administration's (OSHA) methodology in developing safety regulations for bloodborne pathogens in work environments based on assessments of methods and rates of transmission). OSHA views bloodborne pathogens differently from, for example, toxic chemicals, where the risk in the latter case is associated with cumulative dosages over a period of time. *OSHA Comments on Bloodborne Pathogens*, *supra*, at 64,023. Exposure to HBV or HIV may or may not result in transmission. *Id.* Repeated exposure increases the likelihood of transmission, but each instance presents the same risk, which depends on the "virulence of the pathogen, the size of the delivered dose, and the route of exposure, among other factors, and not upon any prior exposure." *Id.* OSHA has therefore concluded that for bloodborne pathogens, "the best way to reduce the risk of transmission [sic] is by reducing the exposure." *Id.*

258. See *OSHA: Occupational Exposure to Bloodborne Pathogens*, 56 Fed. Reg. 64,175-82 (to be codified at 29 C.F.R. § 1910.1030) [hereinafter *OSHA Rule on Bloodborne Pathogens*] (listing standards of prevention employers must implement, including UPs).

259. See *Recommendations for Preventing Transmission*, *supra* note 9, at 2, 5 (providing examples of protective barrier measures, including double gloving, eye goggles, gowns, and masks to cover HCWs' mouths and noses).

260. *Recommendations for Preventing Transmission*, *supra* note 9, at 2. The recent OSHA final rule on bloodborne pathogens requires employers, both in the health industry and otherwise, to develop an appropriate program of UPs and to bear the cost of protecting their employees. *OSHA Comments on Bloodborne Pathogens*, *supra* note 257, at 64,124-39.

261. *Recommendations for Preventing Transmission*, *supra* note 9, at 2 ("Proper application of these principles will assist in minimizing the risk of transmission of HIV . . . from patient to HCW, HCW to patient, or patient to patient."). Studies appear to bear out the CDC's position, at least to some extent. See Edward S. Wong et al., *Are Universal Precautions Effective in Reducing the Number of Occupational Exposures Among Health Care Workers?*, 265 JAMA 1123, 1126 (1991) (discussing results of UPs efficacy study). The study determined that the use of UPs lowered the number of occupational exposures that resulted in direct contact with blood and

Despite the CDC's support for UPs and the favorable view the medical community holds of them,²⁶² there are problems with UPs that suggest serious deficiencies. First, although the key provision in UPs is the use of gloves for invasive procedures and for other procedures involving blood or bodily fluids,²⁶³ there are drawbacks to a strong dependency on the efficacy of gloves. A recent study found that most glove tears are the result of an unknown mechanism.²⁶⁴ For example, a tear may be noticed incidentally during or at the end of a procedure, after the patient's blood or open body cavity has already been exposed to the surgeon's skin or blood released from a percutaneous injury.²⁶⁵ The study advocated the use of double gloving as an added precaution.²⁶⁶ Double gloving, however, has not met with universal approval for certain at-risk procedures.²⁶⁷ The use of two gloves, or even of a single glove, albeit to a lesser degree, reduces tactile ability during surgical procedures and results in greater numbers of injuries caused by sharp instruments.²⁶⁸

thus, by implication, reduced the risk of transmission accordingly. *Id.* The authors indicated, however, that the potential for exposure was not reduced, but rather that UPs provided effective barriers to those exposures. *Id.* The study found that the rate of exposure incidence was not affected by the implementation of UPs but that the likelihood of avoiding exposures increased threefold with the use of barrier devices. *Id.*

262. See, e.g., Wong et al., *supra* note 261, at 1123 (discussing study conducted by doctors in which 277 physicians participated and concluded, based on efficacy of UPs, that UPs were beneficial to medical community).

263. See Wong et al., *supra* note 261, at 1126 (concluding that use of gloves is "largest contributor to the efficacy of UPs"). OSHA's recent ruling on workplace bloodborne pathogens strenuously urged the use of gloves in all procedures involving blood or other potentially contagious body fluids and not only in procedures where sharp instruments are being used. See *OSHA Comments on Bloodborne Pathogens*, *supra* note 257, at 64,133 (reporting that OSHA deems gloves to be "a basic precept of prevention of occupational transmission of bloodborne pathogens").

264. Wright et al., *supra* note 44, at 1668-69 (reporting that in 168 of sample of 249 glove tears (67%) mechanism causing tear could not be ascertained).

265. Wright et al., *supra* note 44, at 1670 (noting that glove tears caused by unknown mechanisms are less noticeable and therefore are more likely to result in prolonged exposure of patient to HCW's blood and vice versa).

266. Wright et al., *supra* note 44, at 1670 (suggesting that regular use of double gloves "may significantly reduce the exposure to blood-borne pathogens").

267. See *OSHA Comments on Bloodborne Pathogens*, *supra* note 257, at 64,012 (noting that gloves and other protective devices cannot consistently prevent against wounds arising from use of sharp instruments, including needles); *id.* at 64,133-34 (listing arguments made by HCWs who perform phlebotomies (drawing of blood) that even single gloves should not be required because they reduce tactile ability and cannot prevent needle sticks); see also Wright et al., *supra* note 44, at 1670 (maintaining that injuries caused by sharp instruments are especially serious and that simple barrier devices cannot always prevent such injuries and accompanying potential pathogen exposures).

268. See Wong et al., *supra* note 261, at 1123 ("The possibility exists that UPs may even increase certain kinds of exposures; for example, the use of gloves may interfere with tactile input and increase the number of injuries with sharp instruments during procedures."); see also Wright et al., *supra* note 44, at 1669 (noting that although impenetrable gloves would completely eliminate glove tears and injuries from sharp instruments, those available today have proved too stiff and thick to use for delicate surgical procedures that cause majority of

Second, it has been suggested that HCWs often do not adhere to UPs with consistency, due to the high cost of implementing the procedures.²⁶⁹ Estimates of the cost of implementing UPs are not insignificant, averaging \$327 million per year for the necessary personal protection equipment²⁷⁰ and additional annual sums of \$134 million for training,²⁷¹ \$107 million for vaccination for HBV and postexposure follow-up treatment,²⁷² and \$102 million for house-keeping.²⁷³ OSHA's Final Rule on Bloodborne Pathogens, specifically HBV and HIV, has put the cost burden on hospitals and other health care institutions to provide protective barriers for their employees.²⁷⁴

The CDC is less than clear as to the procedures it considers "at-risk." The agency separates invasive procedures into two classes, comprised of invasive procedures generally and "exposure-prone procedures."²⁷⁵ Exposure-prone procedures are those invasive procedures for which, according to the CDC, UPs are ineffective in preventing transmission from HCW to patient, although UPs may safeguard other classes of invasive procedures.²⁷⁶ Although it has named the classes of procedures in generalities,²⁷⁷ the CDC has reserved to individual institutions the responsibility for determining which procedures are exposure prone.²⁷⁸ This decision has caused

injuries to HCWs). The CDC has as much as admitted this fact. In its recommendations to HCWs, the CDC agreed that routine use of gloves neither prevents most injuries from sharp instruments nor eliminates the risk of transmission from HCW to patient. *Recommendations for Preventing Transmission*, *supra* note 9, at 3.

269. See Wong et al., *supra* note 261, at 1126 (noting that physicians performing emergency procedures used barrier devices and other precautions with much less frequency than physicians performing non-emergency procedures); see also Gerberding & Schecter, *supra* note 44, at 1573 (citing studies indicating that despite availability of UPs, only 50% of surgeons sampled recommended them and only 24% double gloved as matter of course).

270. *OSHA Comments on Bloodborne Pathogens*, *supra* note 257, at 64,039.

271. *OSHA Comments on Bloodborne Pathogens*, *supra* note 257, at 64,039.

272. *OSHA Comments on Bloodborne Pathogens*, *supra* note 257, at 64,039.

273. *OSHA Comments on Bloodborne Pathogens*, *supra* note 257, at 64,039.

274. *OSHA Rule on Bloodborne Pathogens*, *supra* note 258, at 64,177 ("The employer shall ensure that appropriate personal protective equipment in the appropriate sizes is readily accessible at the worksite or is issued to employees.").

275. *Recommendations for Preventing Transmission*, *supra* note 9, at 4 (noting that procedures considered exposure prone include those in which transmission of HBV from HCW to patient has occurred, despite use of UPs, and those in which percutaneous injury often occurs).

276. *Recommendations for Preventing Transmission*, *supra* note 9, at 4.

277. See *Recommendations for Preventing Transmission*, *supra* note 9, at 4 (naming certain oral, cardiothoracic, colorectal, and obstetric/gynecologic procedures as examples of exposure-prone procedures). General surgery, orthopedic, and trauma services are also considered exposure prone. *Id.*

278. See *Recommendations for Preventing Transmission*, *supra* note 9, at 5 (recommending that individual medical institutions identify for themselves those procedures to be considered "exposure prone"). The medical community, however, has so far refused to take this step and is pushing the CDC to come up with a definitive list. See Norman Daniels, *HIV-Infected Professionals, Patient Rights, and the 'Switching Dilemma'*, 267 JAMA 1368, 1368 (1992) (noting that because medical organizations refused to create lists of exposure-prone procedures as requested

a rift between the CDC and the medical community, resulting in a less than clear delineation as to what procedures are at risk and who makes that determination.²⁷⁹

Indeed, the CDC and the Department of Health and Human Services (HHS) agreed in December 1991 to amend the guidelines, dropping the provision that local health officials develop the list of at-risk procedures.²⁸⁰ Subsequently, the CDC and HHS removed themselves from responsibility for this task as well, instead advising state and local health officials to decide on a case-by-case basis whether an infected HCW poses any risk to patients.²⁸¹ This response has been heavily criticized as "pandering" to election-year political concerns.²⁸² Despite this inconsistent federal action, Con-

by CDC in November 1991, CDC issued draft revisions of its own guidelines); Bernard Lo & Robert Steinbrook, *Health Care Workers Infected with the Human Immunodeficiency Virus - The Next Steps*, 267 JAMA 1100, 1102 (1992) (stating that no professional group agreed to supply list of exposure-prone procedures); Lawrence K. Altman, *Health Units Defy U.S. on AIDS Rules*, N.Y. TIMES, Aug. 30, 1991, at A1 (noting that many medical groups refuse to devise list of high-risk procedures for infected HCWs); Marlene Cimons, *Doctors Flout CDC Curbs on Physicians with AIDS*, L.A. TIMES, Nov. 1, 1991, at A1 (reporting that numerous medical groups have denied CDC's request for list of exposure-prone procedures).

279. See Daniels, *supra* note 278, at 1368 (relating medical community's refusal to draw up lists of exposure-prone procedures and examining CDC's draft revisions that recommend risks imposed by infected HCWs be reviewed on case-by-case basis); Altman, *supra* note 278, at A19 (stating that many health care experts are very concerned about having many different interpretations of exposure-prone procedures and chaos that could result); Cimons, *supra* note 278, at A1, A26 (describing refusal of medical groups to submit requested lists of exposure-prone procedures to CDC and explaining that refusal is rooted in argument that no "scientific basis" exists to require designating procedures as "at-risk").

280. Marlene Cimons, *Plan To Ease Curbs on AIDS-Infected Doctors Is Scrapped*, L.A. TIMES, June 14, 1992, at A13. The CDC also agreed to drop the provision requiring HIV-positive HCWs to inform their patients of their infection. *Id.* The Federal Government decided to rewrite the July 1991 guidelines after further study revealed no additional cases of virus transmissions to patients from HIV-positive HCWs, other than the Bergalis incident. *Id.*

281. Lawrence K. Altman, *U.S. To Let States Set Rules on AIDS-Infected Health Workers*, N.Y. TIMES, June 16, 1992, at C7 (reporting CDC and HHS's decision to allocate authority to states). Dr. William L. Roper, head of the CDC, said of this shift of responsibility to the states:

We think we will learn more by letting states do various things on a state-to-state basis and seeing what we learn over the next few years. We may well come back to the issue in the future, but we do not plan a new set of guidelines or a single Federal list of exposure-prone procedures.

Id. Professor Gostin has called this decision untenable, saying that the Federal Government could be making "a very big mistake. The whole purpose of having the CDC come up with regulations is to make sure states don't pander to local constituencies and victimize HIV-positive health-care workers." Laurie Garrett, *AIDS 'Rules' for Health Workers KO'd; Move Leaves Policing to States*, NEWSDAY, June 16, 1992, at 4, 28. Other commentators pointed out that the states had a relatively short period of time, until only October 1, 1992, to develop these lists, compared to the CDC, which failed to accomplish the task in more than two years of study and hearings. *Id.* Dr. Neil Schram, head of the AIDS Task Force for the American Physicians for Human Rights, said the situation will force states to create "atrocious guidelines," resulting in absolute chaos between the states. *Id.*; see also Cimons, *supra* note 280, at A13 (quoting Dr. Schram as predicting havoc among states over creation of guidelines).

282. See Cimons, *supra* note 280, at A13 (noting that detractors of CDC guidelines charged that CDC's action was politically motivated); Garrett, *supra* note 281, at 4 (reporting that election year politics have led CDC and HHS to avoid taking clear position in guidelines). Critics suggest that states will also bow to political pressure in responding to the HHS recommenda-

gress' requirement that states develop guidelines by the end of October 1992 or risk losing federal health care funding remains in effect.²⁸³

2. Comparing HIV to HBV

The CDC's recommendations stress the use of UPs for prevention of HIV transmission by drawing on the experience of health care officials dealing with hepatitis-B virus.²⁸⁴ The transmission of HBV to patients from HCWs, and vice versa, is a comparatively common occurrence.²⁸⁵ Since the early 1970s, when serologic testing for HBV infection was introduced, there have been reports of over 300 patients infected with HBV through treatment by an HBV-infected HCW.²⁸⁶ Most of these reported transmissions occurred before health care officials were aware of the risk presented by bloodborne pathogens, as well as before the use of UPs was stressed.²⁸⁷ All the same, there is evidence that some instances of transmission still occurred after HCWs began wearing gloves.²⁸⁸ Because the AIDS virus has been found to be transmitted similarly to HBV, although at rates twelve to sixty times slower,²⁸⁹ the CDC applies the same theories of prevention for both HIV and HBV. There is a fundamental difference, however, between HBV and HIV. Unlike HIV, both im-

tions. Garrett, *supra* note 281, at 28 (quoting Gostin as saying that purpose of CDC guidelines is to prevent states from catering to local constituencies).

283. See Melillo, *supra* note 242, at 7 (noting that "[f]ailure to develop policies by Oct. 28 could mean the loss of as much as \$2 billion nationally in Public Health Service Funds, which include grants for treatment of alcohol and drug abuse and mental illnesses as well as money to help prevent the spread of acquired immune deficiency syndrome (AIDS)").

284. See *Recommendations for Preventing Transmission*, *supra* note 9, at 2-3 (discussing background of infection control practices and 20-year history of published reports of HBV transmission).

285. See *OSHA Comments on Bloodborne Pathogens*, *supra* note 257, at 64,009 (referring to CDC estimates that there are approximately 8700 HBV infections of HCWs per year attributed to occupational exposure, causing 2100 cases of acute hepatitis with roughly 200 deaths of HCWs annually). The risk that an HCW will become infected through percutaneous exposure to HBV-positive blood is approximately 30%. *Recommendations for Preventing Transmission*, *supra* note 9, at 3.

286. *Recommendations for Preventing Transmission*, *supra* note 9, at 2.

287. *Recommendations for Preventing Transmission*, *supra* note 9, at 3.

288. See *OSHA Comments on Bloodborne Pathogens*, *supra* note 257, at 64,012 ("Some HCWs continued to transmit HBV to patients in spite of the use of gloves and additional precautions."); *Recommendations for Preventing Transmission*, *supra* note 9, at 2-3 (noting that in 8 of 20 reported "clusters," or multiple transmissions associated with single sources of HBV transmission by HCWs to patients, transmission occurred despite glove use by HCWs). There have been 20 reported clusters of HBV transmission from HCWs to patients. *OSHA Comments on Bloodborne Pathogens*, *supra* note 257, at 64,012. A few clusters occurred where the HCWs, obstetricians/gynecologists and cardiovascular surgeons, were wearing gloves at the suspected time of transmission. *Recommendations for Preventing Transmission*, *supra* note 9, at 3.

289. Jerome A. Boscia, *Surgery, AIDS, and Hepatitis B*, 266 JAMA 1360, 1361 (1991) (citing public health study that found "the risk of infection to a health care worker following a needle stick from a carrier of the hepatitis B virus is between 6% and 30%, or 12 to 60 times greater than the risk following a needle stick from a patient infected with HIV").

munization and vaccination exist for the hepatitis-B virus.²⁹⁰

The current vaccine for HBV was licensed in 1986²⁹¹ and has been found to be 85% to 97% effective.²⁹² In addition, pre-contraction immunization is equally effectual.²⁹³ As a result, the number of reported HBV cases between 1982 and 1988 dropped by 75%.²⁹⁴ Both OSHA and the CDC recommend that any HCW who has been exposed to a patient's blood receive the HBV vaccine if they have not already been immunized.²⁹⁵ Immunization or vaccination combined with the use of UPs has proved successful in minimizing the risk of HBV transmission.²⁹⁶ It follows that the same preventive procedures would be equally effective in battling HIV transmission. But there is no vaccine for HIV, and the virus amounts to a certain death sentence for infected persons.

Currently, the CDC guidelines permit HBV-infected HCWs to perform invasive procedures.²⁹⁷ Typically, employment restrictions are not imposed until the HCW infects a patient.²⁹⁸ When a transmission occurs, health officials are advised to review infection-control procedures in place during the time of the transmission and to make changes, including educating or restricting the HCW's practice, or both, to guard against future incidents.²⁹⁹ One author sug-

290. *Id.* at 1360-61 (discussing effectiveness of HBV vaccine and immunization).

291. Centers for Disease Control, *Recommendations of the Immunization Practices Advisory Committee Update on Hepatitis B Prevention*, 36 MORBIDITY & MORTALITY WKLY. REP. 353, 355 (1987) (discussing formulation of new HBV vaccine called Recombivax H, which was licensed by U.S. Food and Drug Administration in July 1986). An earlier vaccine manufactured from human plasma has been available in the United States since 1982. *Id.* at 353. The new vaccine is created when "a plasmid containing the gene for the hepatitis B surface antigen (HBsAg) subtype a & w" is inserted into common baker's yeast and then is harvested, purified, and filtered. *Id.* at 355.

292. *OSHA Comments on Bloodborne Pathogens*, *supra* note 257, at 64,012.

293. *See* Boscia, *supra* note 289, at 1360-61 (noting that immunization is one of most important weapons used to combat HBV).

294. Boscia, *supra* note 289, at 1361. In addition, since the introduction of these vaccines, OSHA estimates that 2,568,974 persons (2,029,189 HCWs) have been vaccinated for HBV in the United States. *OSHA Comments on Bloodborne Pathogens*, *supra* note 257, at 64,012.

295. *OSHA Comments on Bloodborne Pathogens*, *supra* note 257, at 64,013; *Recommendations for Preventing Transmission*, *supra* note 9, at 2 (recommending that hepatitis-B vaccine be given during period of professional training and before any foreseeable exposures can occur). Practitioners also make this same recommendation. *See* Boscia, *supra* note 289, at 1361 (recommending immunization of those HCWs who may be exposed to HBV).

296. *See* *OSHA Comments on Bloodborne Pathogens*, *supra* note 257, at 64,058 (noting that 87% of occupationally induced HBV exposure could be avoided by combination of vaccination, engineering controls, work practices, protective clothing, housekeeping, and training).

297. *See* Barnes et al., *supra* note 58, at 319, 328 nn.98 & 103 (discussing CDC guidelines and citing Walter W. Williams, *Guideline for Infection Control in Hospital Personnel*, 4 INFECTION CONTROL 326, 332 (1983) (recommending precautions but not practice restrictions)).

298. Barnes et al., *supra* note 58, at 320 ("Employment restrictions on workers with chronic HBV infection have not been routinely imposed unless and until the worker has infected a patient.").

299. *See* Barnes et al., *supra* note 58, at 320 (discussing process following transmission of HBV from HCW to patient, including: modification of infection control strategy, temporary

gests that this experience with HBV should be applied in situations involving HIV-infected HCWs.³⁰⁰ This proposition, however, is misplaced. While it is true that HIV is more difficult to transmit than HBV,³⁰¹ both an inoculation and a vaccine exist for treatment or prevention of HBV, whereas neither option yet exists for HIV.

3. *Voluntary testing of HCWs recommended*

The CDC's guidelines do not recommend mandatory testing of HCWs to determine either their HBV or HIV status.³⁰² The guidelines do state, however, that HCWs who perform exposure-prone procedures should know their HIV and HBV status.³⁰³ In other words, it is left to the individual HCW to decide whether to be tested for the viruses.³⁰⁴ This discretion conflicts with the prospective duty courts have assigned to hospitals and other institutions to provide a safe environment for their employees and patients,³⁰⁵ and, under section 504 of the Rehabilitation Act, conflicts with the requirement to test for infectious viruses in order to conduct the necessary inquiry into the health and safety risks posed by HCWs.³⁰⁶ To carry out this duty, medical institutions must have a right to investigate the health status of their employees.³⁰⁷ In addition, tort principles place a similar duty on parties to reduce or eliminate if

withdrawal of HCW from practice, re-education of HCW, and change of HCW's practice techniques).

300. See Barnes et al., *supra* note 58, at 320 (inquiring rhetorically why HIV-infected HCWs should be treated differently than HCWs carrying HBV). Barnes implies that the two diseases are sufficiently similar to warrant applying HBV infection-control procedures to HIV, as opposed to establishing guidelines that call for a "case-by-case" review of HCWs or practice restrictions. *Id.*

301. See Barnes et al., *supra* note 58, at 320 (noting that HBV is much more infectious and easily transmitted than HIV).

302. See *Recommendations for Preventing Transmission*, *supra* note 9, at 6 ("Mandatory testing of HCWs for HIV antibody or [HBV antibody] is not recommended. The current assessment of the risk that infected HCWs will transmit HIV or HBV to patients during exposure-prone procedures does not support the diversion of resources that would be required to implement mandatory testing programs.").

303. See *Recommendations for Preventing Transmission*, *supra* note 9, at 5 ("HCWs who perform exposure-prone procedures should know their HIV antibody status. HCWs who perform exposure-prone procedures and who do not have serologic evidence of immunity to HBV from vaccination or from previous infection should know their HBsAg [hepatitis-B surface antigen, which is early indicator of hepatitis-B viral infection] status and, if that is positive, should also know their HBeAg [hepatitis-B e antigen, whose presence is associated with higher levels of hepatitis in blood] status.").

304. See *Recommendations for Preventing Transmission*, *supra* note 9, at 5-6 (recommending that HCWs who perform exposure-prone procedures should be aware of their HIV status by undergoing voluntary testing).

305. See *supra* notes 148-60 and accompanying text (outlining duty of medical institutions to provide safe environment for patients and employees).

306. See *supra* notes 136-47 and accompanying text (discussing required inquiry under § 504 of Rehabilitation Act).

307. See *supra* notes 143-47 and accompanying text (outlining duty to conduct "individualized inquiry" under *Arline*).

possible the risk of infection where the danger is great and there is a rational means to do so.³⁰⁸ Therefore, a program imposing mandatory testing of HCWs where suspicion of infection and risk of transmission exists is justifiable.³⁰⁹ By leaving the decision whether to test individual HCWs, the CDC's guidelines fail to meet the obligations of health care institutions as enunciated by the courts.³¹⁰

4. *Infected HCW and subsequent practice restrictions*

The next step after an HCW has been diagnosed with the AIDS virus is to determine what, if any, restrictions should be placed on the practice of that HCW. This determination is particularly important if the professional performs invasive procedures. The CDC has provided less than a definitive answer to this question, however.

According to the CDC, those HCWs who are either HBV or HIV infected should not continue to perform exposure-prone procedures until they have received guidance from an "expert review panel."³¹¹ This panel should determine on a case-by-case basis those circumstances, if any, under which the infected HCW may continue to perform at-risk procedures.³¹² This requirement parallels the "individualized inquiry" required by section 504 and articulated in *School Board v. Arline*.³¹³ If the review panel modifies the HCW's practice as a result of his or her infection, then whenever possible, the panel should also provide the HCW with "opportunities to continue appropriate patient-care activities,"³¹⁴ which may

308. See *Estate of Behringer v. Medical Ctr.*, 592 A.2d 1251, 1281-83 (N.J. Super. Ct. Law Div. 1991) (reviewing tort theories of risk and practical solutions); see also RESTATEMENT (SECOND) OF TORTS § 293 (1981) (describing tort theories of risk analysis); *supra* notes 19-21 and accompanying text (discussing tort duties in high-risk situations).

309. Cf. *supra* notes 148-53 and accompanying text (discussing *Leckelt v. Board of Commissioners* requirement of mandatory testing when certain conditions are present).

310. See *supra* note 149 and accompanying text (discussing holding in *Leckelt* that hospitals have duty to test HCWs for HIV); see also *supra* notes 155, 160 (stating opinion in *Behringer* that found medical center's policies on testing and restricting HIV-infected HCWs were justified).

311. *Recommendations for Preventing Transmission*, *supra* note 9, at 5. The panel may include, *inter alia*, "a) the HCW's personal physician(s), b) an infectious disease specialist with expertise in the epidemiology of HIV and HBV transmission, c) a health professional with expertise in the procedures performed by the HCW, and d) state or local public health official(s)." *Id.*

312. See *Recommendations for Preventing Transmission*, *supra* note 9, at 5 ("HCWs who are infected with HIV or HBV . . . should not perform exposure-prone procedures unless they have sought counsel from an expert review panel and been advised under what circumstances, if any, they may continue to perform these procedures.").

313. 480 U.S. 273, 287 (1987) (holding that individualized inquiry is required under § 504 of Rehabilitation Act to effectively protect handicapped individuals while giving concurrent consideration to health and safety of others); see *supra* notes 138, 144-47 (describing provisions of § 504 and *Arline's* interpretation of them).

314. *Recommendations for Preventing Transmission*, *supra* note 9, at 6. For HBV infection, an HCW's practice may be modified as needed but should also be completely reinstated when re-evaluation determines that the HCW's status has changed due to successful treatment of the

include exposure-prone procedures.³¹⁵

The CDC's position is predicated on the belief that UPs, when appropriately employed, will minimize the risk of transmission.³¹⁶ As has been explained, UPs do reduce the risk of transmission, but they do not eliminate it.³¹⁷ The CDC itself recognizes that certain procedures are by nature "at-risk," despite the use of UPs.³¹⁸ The CDC should mandate that once an HCW is found to be infected with the AIDS virus, all invasive procedures, whether "exposure prone" or not, must completely stop. The acceptable minimization of risk is the elimination of the risk.³¹⁹ As a result of the availability of a vaccine, the use of an "expert review panel" makes sense where the HCW is infected with HBV. With HIV, however, the panel's use is a dangerous denial.

5. *Requirements of patient consent and notification*

The CDC has taken a solid stand with respect to informed consent; the guidelines unequivocally call for patient consent before either an HBV- or HIV-positive HCW performs any exposure-prone procedures.³²⁰ This provision satisfies the duties created by the courts.³²¹ When the expert review panel determines the circumstances under which the infected HCW may work, one fundamental prerequisite must be notification of prospective patients of the HBV or HIV status of their physician before any at-risk procedures are performed.³²² The CDC has acknowledged that patient awareness

infection. *Id.* The CDC also recommends that career counseling and job retraining be made available to all HBV- and HIV-infected HCWs. *Id.*

315. *Cf. Recommendations for Preventing Transmission, supra* note 9, at 5 (implying that expert panel has discretion to allow infected HCWs to continue to perform exposure-prone procedures).

316. *See Recommendations for Preventing Transmission, supra* note 9, at 5 (stating that infected HCWs who follow precautions pose small risk of transmitting HBV and smaller risk of transmitting HIV). On this point, the CDC's recommendations include: (1) all HCWs should follow universal precautions, and (2) those HCWs who have skin conditions ("exudative lesions or weeping dermatitis") that may pose a risk of transmission should refrain from all direct patient care and from handling patient-care equipment that is used in performing invasive procedures. *Id.*

317. *See supra* notes 257-74 and accompanying text (discussing arguments relating to efficacy of UPs).

318. *See Recommendations for Preventing Transmission, supra* note 9, at 4 ("Performance of exposure-prone procedures presents a recognized risk of percutaneous injury to the HCW, and—if such an injury occurs—the HCW's blood is likely to contact the patient's body cavity, subcutaneous tissues, and/or mucous membranes.").

319. *See supra* notes 31-32, 55-62 (discussing debate on issue of acceptable level of risk).

320. *Recommendations for Preventing Transmission, supra* note 9, at 5. If an HIV-positive HCW were to be restricted from performing these procedures, the issue of informed consent could obviously be avoided.

321. *See supra* notes 186-99 and accompanying text (analyzing theory of informed consent where practicing HCW is HIV positive).

322. *Recommendations for Preventing Transmission, supra* note 9, at 5.

about his or her HCW's health status is material information integral to the giving of consent.³²³

The CDC, however, has been less clear when addressing postoperative notification of a patient when an infected HCW has performed an exposure-prone procedure. According to the guidelines, patient notification should only be considered after balancing an assessment of the "specific risks" and "confidentiality issues" with "available resources."³²⁴ Implicitly then, the CDC leaves this decision to the discretion of the involved HCWs and the health care institution. This result is inconsistent with judicial interpretation of patient consent requirements.³²⁵ A patient must receive information that is "material" to making a decision before undergoing a particular procedure.³²⁶ The risk attendant to a seropositive HCW performing an invasive procedure qualifies as material information.³²⁷ Surgical injuries are quite common, especially during the invasive procedures where the virus is most easily transmitted.³²⁸ Doctors must give patients the opportunity to decide whether they want to be tested for the virus. The CDC's policy takes that decision out of the patient's hands and places it in the hands of the HCW. Given the certain outcome once HIV is contracted, this policy is unacceptable.

6. *Questions left unanswered by guidelines*

The CDC's guidelines leave decisions regarding HIV-positive HCWs, on the issues of voluntary testing, discretionary restrictions on practice, and postoperative notification, with individual HCWs and health care institutions.³²⁹ Only one policy, informing patients of their physician's seropositive status where known before performing at-risk procedures, satisfies the requirements as outlined by the

323. Cf. *Recommendations for Preventing Transmission*, *supra* note 9, at 5 (highlighting importance of patient notification of HCW's infection before exposure-prone procedures are performed).

324. *Recommendations for Preventing Transmission*, *supra* note 9, at 6 (stating that "[t]he public health benefit of notification of patients who have had exposure-prone procedures performed by HCWs infected with HIV . . . should be considered on a case-by-case basis," with careful consideration of related factors).

325. See *supra* notes 177-83 and accompanying text (describing medical and legal emphasis on patient-centered approach to medicine).

326. See *supra* notes 179-83 and accompanying text (noting different interpretations of "material" information as related to patient's decision).

327. Cf. *supra* notes 179-83, 186-91 and accompanying text (discussing "material information" concept of informed consent).

328. See *supra* notes 37-49 and accompanying text (outlining studies that indicate that percutaneous injuries are common during surgery).

329. See *supra* notes 304, 315, 324 and accompanying text (detailing CDC guidelines on issues of voluntary testing, restrictions on practice, and postoperative notification, respectively).

court in *Behringer*.³³⁰ Moreover, the CDC's position ignores and possibly encourages HCW conflict of interest.

Most hospitals and HCWs believe that their approach to medicine is patient centered.³³¹ The law attempts to reflect this philosophy.³³² The court in *Estate of Behringer v. Medical Center*³³³ expressly addressed HCW conflict of interest problems surrounding HIV.³³⁴ The CDC gives broad, perhaps overly broad, discretion to the medical community.³³⁵ Decisions to restrict an HCW's practice could threaten his or her career or livelihood,³³⁶ so expecting HCWs to make these decisions with objectivity is naive.

In *Behringer*, the court upheld the hospital's imposition of practice restrictions but found the hospital liable because it failed to protect the infected HCW's ability to practice by negligently revealing his condition.³³⁷ The court, however, found that career concerns cannot come before patient protection.³³⁸ Courts must guard against this potential conflict and thus in *Behringer* the court stood by New Jersey's strong commitment to the concept of a fully informed patient.³³⁹ The plaintiff in *Behringer* argued that requiring the hospital to inform the patient regarding the surgeon's positive HIV status would result in a complete destruction of his surgical practice.³⁴⁰ The court recognized this concern,³⁴¹ but nevertheless acted to eliminate the "self-interest or self-protection"³⁴² pressures that could inhibit an HCW's ability to make a sound judgment about

330. See *supra* note 188 (discussing holding in *Behringer* that HCW's HIV-positive status must be disclosed before at-risk procedures are performed because it is material element of informed consent).

331. See *Estate of Behringer v. Medical Ctr.*, 592 A.2d 1251, 1280 (N.J. Super. Ct. Law Div. 1991) (discussing that New Jersey courts and medical practitioners adhere to concept of "fully informed" patient).

332. See *supra* notes 26-35 and accompanying text (discussing court's attempt in *Behringer* to eliminate all risk of transmission where HCW performs invasive procedures).

333. 592 A.2d 1251 (N.J. Super. Ct. Law Div. 1991).

334. See *Estate of Behringer v. Medical Ctr.*, 592 A.2d 1251, 1278 (N.J. Super. Ct. Law Div. 1991) (discussing HIV-infected HCW's possible difficulties in making business decisions regarding his or her practice and medical judgments regarding his or her patients).

335. See *supra* notes 311-15 and accompanying text (discussing provision of CDC guidelines granting review power to expert panel and examining broad scope of discretion exercised by this group).

336. See *Behringer*, 592 A.2d at 1277-78 (discussing difficulties in decisionmaking experienced by medical centers and HCWs faced with HIV infection).

337. *Id.* at 1273-74 (predicating liability on medical center's breach of duty and obligation to keep infected HCW's records confidential).

338. *Id.* at 1283.

339. *Id.* at 1280.

340. *Id.* ("Plaintiff argues that the use of the informed consent form is tantamount to a *de facto* termination of surgical privileges."). Plaintiff also raised confidentiality concerns, upon which the hospital was held liable. *Id.* at 1273-74.

341. *Id.* at 1274.

342. *Id.* at 1277-78 (quoting *In re Quinlan*, 355 A.2d 647, 668 (N.J. 1976)).

whether to release the information about his or her HIV infection.³⁴³ Because the risk of transmission could not be eliminated, the HCW was required to inform the patient before performing any at-risk procedures.³⁴⁴

The CDC guidelines invite similar risks, as too much discretion is given to individual HCWs and their institutions. This discretion improperly puts patients at risk by subordinating their interests to those of the individual HCW. Voluntary testing, open-ended practice restrictions, and lack of patient notification serve the private interests of the medical community, not their patients. As the national institution that guides medical policy, the CDC must work to maintain the patient-centered philosophy that ethics and the law require. These guidelines fail to do so.

7. State responses

The ambiguity of the CDC guidelines is manifest in state responses to the congressional mandate that states enact either the CDC or similar guidelines. For example, many states have passed legislation calling for mandatory HIV testing of all HCWs.³⁴⁵ Given constitutional concerns, it is questionable whether these laws will withstand judicial scrutiny.³⁴⁶ In addition, a number of states have

343. *Id.* at 1278 (mandating use of informed consent doctrine to provide patient control over his or her risk of being exposed to infectious diseases, which is lacking when only HCWs are deciding whether to release information regarding their health).

344. *Id.* at 1283.

345. *See generally* Del. H.B. 191, 136th Gen. Assembly, Reg. Sess. (1992) (proposing AIDS and HIV testing of HCWs by state every six months); Fla. H.B. 111, Reg. Sess. (1992) (establishing program requiring periodic testing of HCWs); Fla. S.B. 122, Reg. Sess. (1992) (requiring testing of HCWs in specific circumstances); La. H.B. 1164, Reg. Sess. (1992) (mandating testing for health care providers); Md. S.B. 18, 398th Leg., Reg. Sess. (1992) (requiring HIV testing of HCWs under certain circumstances); Md. H.B. 644, 398th Leg., Reg. Sess. (1992) (calling for periodic HIV testing of HCWs); Mich. H.B. 5062, 86th Leg., Reg. Sess. (1992) (requiring periodic AIDS testing of HCWs); N.H. H.B. 1404, 152d Leg., Reg. Sess. (requiring HCWs and patients to be tested for infectious diseases); N.H. S.B. 312, 152d Leg., Reg. Sess. (mandating that HCWs and patients be tested for HIV infection); N.J. S.B. 3588, 204th Leg., 2d Reg. Sess. (1991) (mandating that hospital HCWs submit to HIV testing); S.C. H.B. 4151, Statewide Sess. (1992) (mandating that HCWs undergo HIV test at time of application for licensure, registration, or reapplication); Tenn. S.B. 810, 97th Gen. Assembly, 2d Reg. Sess. (1992) (requiring HIV testing of HCWs in certain cases); Tenn. H.B. 945, 97th Gen. Assembly, 2d Reg. Sess. (1992) (proposing HIV testing for HCWs).

346. *See, e.g.,* Michael L. Closten, *A Call for Mandatory HIV Testing and Restriction of Certain Health Care Professionals*, 94 ST. LOUIS U. PUB. L. REV. 421, 431 (1990) (arguing for government mandated HIV testing for HCWs who engage in invasive procedures, although admitting that it is unclear whether such testing would be constitutional); Donald J. McNeil & Laurie A. Spieler, *Mandatory Testing of Hospital Employees Exposed to the AIDS Virus: Need To Know or Unwarranted Invasion of Privacy?*, 21 LOY. U. CHI. L.J. 1039, 1065-66 (1990) (citing cases as examples that state constitution may impose great restrictions on HIV testing of HCWs); Patricia S. Atkins, Comment, *The Constitutional Implications of Mandatory AIDS Testing in the Health Care Industry*, 17 SW. U. L. REV. 787, 799 (1988) (noting that state laws calling for mandatory AIDS tests by private employers would be subject to constitutional scrutiny and courts could find

enacted the CDC guidelines without modification,³⁴⁷ and thus, which procedures are to be regulated remains an open question.³⁴⁸

IV. RECOMMENDATIONS FOR A TESTING PLAN

A. *CDC Guidelines Fail to Anticipate Liabilities*

By requiring that states enact the CDC guidelines or similar ones,

such laws unconstitutional on their face or because of their purpose and effect); William A. DeLoach III, Note, *Mandatory AIDS Testing - A Fourth Amendment Analysis: Glover v. Eastern Nebraska Community Office of Retardation*, 23 CREIGHTON L. REV. 693, 709-15 (1990) (stating that holding in *Glover* that mandatory AIDS testing was invalid resulted from balancing of government's and employees' interests and that these interests were not compelling enough to uphold mandatory testing after judicial scrutiny); *see also supra* notes 72-99 and accompanying text (discussing judicial use of administrative search theories in warranting limited HIV testing where "compelling governmental need" exists after balancing of competing interests).

347. *See, e.g.*, CAL. HEALTH & SAFETY CODE § 1250.11 (West 1992) (requiring California Department of Health to develop guidelines to minimize transmissions of bloodborne infectious diseases and, in doing so, consider CDC's recommendations, existing state regulations, and input from associations that represent HCWs); CAL. BUS. & PROF. CODE § 2221.1 (West 1992) (protecting Californians from infected HCWs by allowing Medical Board of California to take disciplinary action against HCWs who do not follow UPs as recommended by CDC guidelines); MO. REV. STAT. § 191.694 (1992) (following CDC guidelines on adherence to UPs, expert review panel, practice restrictions, patient consent, and voluntary HCW testing); TEX. HEALTH & SAFETY CODE ANN. §§ 85.201-206 (West 1992) (reviewing findings of CDC; defining relevant terms; requiring HCWs to adhere to UPs, to refrain from performing exposure-prone procedures unless given permission from expert review panel and, then, to obtain patient consent; imposing disciplinary action on failures to comply; and explicitly rejecting mandatory testing of HCWs); ARIZ. H.B. 2024, 406th Leg., Reg. Sess. (1992) (assigning responsibility to director of Arizona Department of Health Services to create standards that conform with CDC guidelines); ILL. H.B. 3048, 87th Gen. Assembly, Reg. Sess. (1991-1992) (requiring HCWs who have HIV to inform patients of that fact prior to invasive procedures and also requiring patients who know that they are HIV positive to inform HCWs before receiving services); MD. H.B. 388, 398th Leg. Sess., Reg. Sess., 1992 Md. Laws 154 (to be codified at MD. CODE ANN., HEALTH-GEN. § 19-319(h)) (requiring hospitals and other health care facilities to comply with CDC's guidelines on UPs); MICH. H.B. 5291, 86th Leg., Reg. Sess. (1992) (adopting UPs and regulating practices and activities of HIV-positive HCWs); N.H. S.B. 410, 152d Leg. Sess., Reg. Sess. (1991-1992) (requiring HCWs to follow UPs established by federal and state government); N.Y. S.B. 4732, 214th Gen. Assembly, 2d Reg. Sess. (1992) (following guidelines in creating duty in HCWs to disclose positive HIV status prior to performing invasive procedures); OHIO H.B. 419, 119th Gen. Assembly, Reg. Sess. (1991-1992) (mandating that HIV-positive HCWs inform health care facility employer and certain patients of infection).

A number of state legislatures have introduced legislation that is stricter than that called for by the CDC guidelines. DEL. H.B. 191, 136th Gen. Assembly, Reg. Sess. (1991-1992) (requiring testing of HCWs every six months and following guidelines with respect to practice restrictions and informed consent); FLA. H.B. 111, Reg. Sess. (1992) (specifying periodic testing of HCWs and calling for publication of lists of invasive procedures); FLA. S.B. 122, Reg. Sess. (1992) (requiring testing for HIV as applied to physicians, chiropractors, podiatrists, nurses, optometrists, dentists, and midwives); LA. H.B. 1164, Reg. Sess. (1992) (mandating HIV testing of all HCWs).

Other states have considered similar bills but have rejected or withdrawn them. *See* N.H. S.B. 312, 152d Leg., Reg. Sess. (1991-1992) (failing to pass Senate); S.C. H.B. 4151, State-wide Sess. (1992) (withdrawn from committee in which it was introduced).

348. *See supra* notes 275-82 and accompanying text (discussing disagreement between state and federal health care groups over responsibility of developing list of at-risk procedures).

Congress created a national regulatory standard.³⁴⁹ As a result, the CDC guidelines now supersede the common law. The guidelines fail, however, to account for standard of care requirements that courts have enforced. This discrepancy will open HCWs and their affiliated hospitals to liabilities that would otherwise be contained.

The courts have created four sets of duties for HCWs and hospitals faced with an HIV-infected HCW. First, a hospital has an affirmative duty to provide a safe and healthy environment for its employees and its patients.³⁵⁰ When an HCW who performs at-risk procedures is suspected of carrying the virus, the hospital has an obligation to have the HCW tested as required by section 504's "individualized inquiry."³⁵¹ Second, when an HCW is found to be HIV positive, practice restrictions must be imposed forbidding the infected HCW from performing additional at-risk procedures.³⁵² Third, if an infected HCW is to perform an at-risk procedure, the fact that the HCW is infected is material and thus requires disclosure to the patient.³⁵³ Fourth, the common law places an affirmative duty on hospitals and infected HCWs as parties in a "special relationship" to warn identifiable third parties of potential harm from their patients.³⁵⁴ Under the common law, in sum, HCWs and hospitals know precisely what action is required to minimize risk on a proactive basis.

The CDC guidelines, on the other hand, delegate key decisions to discretionary interpretation, thereby leaving both HCWs and hospitals open to unnecessary liabilities. First, the CDC recommends that HCWs undergo testing on a voluntary basis.³⁵⁵ Second, the guidelines permit an infected HCW to continue to perform at-risk procedures if sanctioned by an expert medical panel.³⁵⁶ Fundamentally,

349. Lawrence K. Altman, *U.S. to Let States Set Rules on AIDS-Infected Health Workers*, N.Y. TIMES, June 16, 1992, at C7. Traditionally, CDC guidelines serve as nonbinding recommendations that states may or may not follow. Marlene Cimons, *Plan to Ease Curbs on AIDS-Infected Doctors Is Scrapped*, L.A. TIMES, June 14, 1992, at A13.

350. See *supra* notes 149-60 and accompanying text (discussing *Estate of Behringer v. Medical Center* and *Leckelt v. Board of Commissioners* and those cases' treatment of hospital's duty to furnish safe environment for employees and patients).

351. See *supra* notes 161-71 and accompanying text (examining *Behringer* and *Leckelt's* mandatory testing and individualized inquiry standards).

352. See *supra* notes 151, 157 and accompanying text (repeating courts' holdings that hospitals have duty to restrict HIV-positive HCWs from performing certain procedures).

353. See *supra* notes 188-89 (noting *Behringer* court's conclusion that HCWs' health status must be disclosed as material element of informed consent).

354. See *supra* note 207 and accompanying text (outlining tort concept of "special relationship" and duties arising from it).

355. *Recommendations for Preventing Transmission*, *supra* note 9, at 5.

356. See *Recommendations for Preventing Transmission*, *supra* note 9, at 5 (noting that expert review panel should advise infected HCWs under what circumstances, if any, they may continue to perform exposure-prone procedures).

the guidelines fail to provide hospitals and HCWs with the mechanisms needed to acquire knowledge about potential infection and transmission risks.³⁵⁷ The CDC guidelines do not reflect the affirmative duty on hospitals to provide a safe environment for employees and patients because they fail to acknowledge the individualized inquiry requirements of section 504.³⁵⁸ Moreover, once knowledge of HCW infection is acquired, there are no provisions in the guidelines to instruct hospitals and HCWs as to the next step of action. For example, failure to act to prevent foreseeable harm opens hospitals and HCWs to personal injury liability to plaintiffs who could be either patients of suspected HIV-positive HCWs or identifiable third parties put at risk by infected HCWs. Already, doctors are advertising to the public that they are HIV negative.³⁵⁹ Therefore, to protect both the medical community and patients, guidelines more closely aligned with the common law need to be enacted.

B. Elements of a Workable Testing Plan

The common law interpretations enunciated in *Leckelt v. Board of Commissioners*³⁶⁰ and *Estate of Behringer v. Medical Center*³⁶¹ best articulate the actions appropriate to the HIV-infected HCW. The court in *Behringer*, for example, based its holding on the analysis provided by section 293 of the *Restatement (Second) of Torts* and noted that the interests being threatened, patient health and the rights of HCWs, are given great deference in our society.³⁶² Therefore, the acceptable magnitude of risk must be justifiably small, or, if possible, eliminated. Hence, the court in *Behringer* upheld the practice restrictions implemented by the hospital in that case. Clause (b) of section 293 of the *Restatement*, dealing with probability of occurrence, addresses the risk of transmission.³⁶³ Where an HIV-infected HCW performs

357. See *supra* notes 277-79, 315, 324 and accompanying text (discussing ambiguities in CDC guidelines).

358. See *supra* notes 137-72 (discussing individualized inquiry under § 504 and court interpretations of requirement).

359. See Betsy A. Lehman, *AIDS Tests for Health Caregivers?*, BOSTON GLOBE, Aug. 10, 1992, at 27 (describing telephone listing service for HCWs to advertise that they are HIV negative). The service, called "AIDS Negative Healthcare Professionals, Inc.," charges HCWs \$99 a year to be listed as HIV negative. *Id.* The HCWs send in their test results, receive certificates to hang in their offices, and are put on a list available to the public to call by a toll-free number to see if an HCW is listed. *Id.*

360. 714 F. Supp. 1377 (E.D. La. 1989), *aff'd*, 909 F.2d 820 (5th Cir. 1990).

361. 592 A.2d 1251 (N.J. Super. Ct. Law Div. 1991).

362. *Estate of Behringer v. Medical Ctr.*, 592 A.2d 1251, 1281 (N.J. Super. Ct. Law Div. 1991) (noting that social value that law attaches to threatened interest is important criterion to consider in determining magnitude of risk to patient); see RESTATEMENT (SECOND) OF TORTS § 293 cmt. a (1981) (stating that "as the social value of the interest imperiled increases, the magnitude of the risk which is justified diminishes").

363. See RESTATEMENT (SECOND) OF TORTS § 293 cl. b (1981) (stating that one factor to be

one at-risk procedure, the risk of transmission is small. But the likelihood that an individual HCW will infect a patient becomes greater as the infected HCW performs more and more operations. In addition, the number of infected HCWs will rise as the AIDS population in general increases.³⁶⁴ In other words, the chance of a particular transmission is small, but the likelihood of that transmission occurring is growing greater over time. Clause (c) of the *Restatement*, the extent of the harm likely to occur, becomes superfluous in this situation because the result of transmission is certain death.³⁶⁵ The only question that remains is how long death will take. Under this clause a risk of transmission, however small, can never be justified because the result of infection is death. Clause (d) of section 293, addressing the fact that a higher proportional duty results as more people may potentially be affected,³⁶⁶ is especially relevant in this situation because a surgeon may perform numerous operations.³⁶⁷ Based on this analysis, the court in *Behringer* reasoned that certain bright lines needed to be drawn.³⁶⁸

Some commentators advocate mandatory HIV testing for all HCWs who perform invasive procedures³⁶⁹ and argue that those who refuse to be tested should be denied licenses to perform at-risk procedures.³⁷⁰ A more reasonable plan, however, one based on programs already in place, is achievable. The courts in *Leckelt* and

considered in determining magnitude of risk is "the extent of the chance that the actor's conduct will cause an invasion of any interest of the other or one of a class of which the other is a member"). The comment on clause (b) suggests that the utility needed to justify risk increases as the probability increases. *Id.* § 293 cmt. b. Therefore, this clause begs the question presented in *Behringer* that in most instances a noninfected HCW can be substituted, reducing the utility of having a surgeon who is HIV positive perform that procedure. *Behringer*, 592 A.2d at 1282 (quoting *Keyes*, *supra* note 20, at 603-04, that noninfected HCWs can adequately be substituted to perform invasive procedures without risk of transmission).

364. See Lehman, *supra* note 359, at 27 (citing CDC estimation that of approximately 4.5 million HCWs in United States, 360 surgeons, 1200 dentists, 5000 physicians, and 35,000 other HCWs are HIV infected).

365. Cf. RESTATEMENT (SECOND) OF TORTS § 293(c) (1981) (stating proposition that costs to prevent harm may increase as severity of harm and its likelihood increases).

366. *Id.* § 293(d) (considering number of individuals whose "interests are likely to be invaded if the risk takes effect in harm").

367. See Mishu et al., *supra* note 37, at 467 (reporting results of study to assess risk of transmission from surgeon with "busy practice" of approximately 300 surgical procedures per year).

368. See *Estate of Behringer v. Medical Ctr.*, 592 A.2d 1251, 1283 (N.J. Super. Ct. Law Div. 1991) (adopting clear policy that precludes infected HCWs from performing any invasive procedures when there is any risk of transmission).

369. E.g., Closen, *supra* note 346, at 422.

370. See Closen, *supra* note 346, at 434-36 (arguing that all HCWs who perform invasive procedures, including dentists, doctors, nurses, and emergency medical technicians, should be tested and retested on regular basis as requirement for licensing). The author also contends that the onus should be on the HCW to arrange and pay for the test and provide the results to the licensing authority. *Id.* at 435. Failure to provide evidence of a negative result would bar that professional from certain practices. *Id.* at 436.

Behringer found that hospitals have an affirmative duty to provide a safe environment for patients and employees.³⁷¹ For instance, both courts found that hospitals have a duty to conduct an inquiry into the employee's health and also to examine the degree of risk that an infected HCW will transmit a contagious disease to another person.³⁷² To carry out these responsibilities, health care institutions must know their employees' HIV status. Therefore, as these courts held, blanket mandatory testing is not necessary, but HIV testing is compelled where the medical institution has a reasonable suspicion that an employee may be putting him or herself, other employees, or patients at risk.

Where the hospital has a reasonable basis to suspect that an employee performing invasive procedures may be infected, either because the HCW is a member of an at-risk group or operates on known or suspected HIV-positive patients, that HCW should be tested and retested based on the evolution of the disease.³⁷³ If the HCW tests positive for the virus, the hospital should prohibit any further invasive procedures by that HCW, as the medical center did in *Behringer*. This is a blanket prohibition, regardless of the physical and mental capability of the HCW to perform the procedure. At this point, the health care institution must work with the infected professional to make a noninvasive procedural practice available to

371. See *Leckelt v. Board of Comm'rs*, 714 F. Supp. 1377, 1379 (E.D. La. 1989) (holding hospital's obligations to provide safety and infection control to patients and employees allow it to require HIV testing of hospital staff), *aff'd*, 909 F.2d 820 (5th Cir. 1990); *Estate of Behringer v. Medical Ctr.*, 592 A.2d 1251, 1276, 1283 (N.J. Super. Ct. Law Div. 1991) (concluding that medical center acted reasonably and indeed as it was obligated to do when it decided not to allow HIV-positive plaintiff to perform invasive procedures, based on safety of patients and other hospital personnel).

372. See *supra* notes 148-71 and accompanying text (discussing determinations of courts in *Leckelt* and *Behringer* that in order for hospitals to comply with duty to provide safe environment, hospitals have duty to investigate employees' health status).

373. It is estimated that roughly 40,000 to 80,000 people become infected with HIV each year. Erik Eckholm, *A Casualty Report; AIDS, Fatally Steady in the U.S., Accelerates Worldwide*, N.Y. TIMES, June 28, 1992, § 4 (Week in Review), at 5. Approximately one third are drug abusers, another third are gay men, and most of the remaining third, who contracted the disease through heterosexual contact, are black and hispanic women. *Id.* Minority women account for the fastest-growing segment of the HIV-infected population. Maria Navarro, *AIDS in Women Rising, but Many Ignore the Threat*, N.Y. TIMES, Dec. 28, 1990, at B1, B2 (reporting that from 1988 to 1989, CDC officials say, number of AIDS cases in American women increased 29%, compared with 18% in men). Many of these women are poor minorities. *Id.*; see also Laura Blumenfeld, *The New Sexual 'Reality'; Now, a Condom for Women*, WASH. POST, Mar. 9, 1992, at B5 (quoting Surgeon General Antonia Novello as saying most women infected with AIDS are minorities). AIDS cases in 1991 rose 17% among women, compared with 4% among men. Blumenfeld, *supra*, at B5. In addition, the prevalence of AIDS among teenagers is believed to be on the rise. See Amy Goldstein, *D.C. Unveils Anti-AIDS Campaign*, WASH. POST, May 13, 1992, at A1 (noting that percentage of D.C. teenagers infected with HIV has increased five-fold since 1987, doubling in last year alone). In May 1992, the District of Columbia joined 11 other cities in distributing condoms in schools in response to the teen AIDS problem. *Id.* at A4.

him or her, thereby eliminating the risk of transmission in a reasonable and effective manner.

Commentators argue that this approach invites discrimination against suspected at-risk HCWs or, at worst, encourages institutional "witch hunts" against segments of the population.³⁷⁴ While this is a valid concern, as the courts in *Leckelt* and *Behringer* pointed out, hospitals have a proactive duty to provide a safe environment for HCWs, patients, and foreseeable third parties.³⁷⁵ These commentators seem to suggest that hospitals should refrain from acting until they are confronted by an incident of actual transmission or similar occurrence.³⁷⁶

Regarding informed consent, a bright-line rule compelling disclosure where HIV-positive doctors are performing invasive procedures is another possible solution. On the other hand, HIV-positive HCWs could be required to disclose their conditions to their patients regardless of the procedures they intend to perform. This second approach, however, has been rejected as overbroad,³⁷⁷ with commentators arguing that disclosure should only be required on a case-by-case basis because a bright-line rule is too all-encompassing.³⁷⁸ Others contend that information regarding an HCW's infection is never material with respect to consent; therefore, patients need not know that their doctors are HIV positive.³⁷⁹

374. See Barnes et al., *supra* note 58, at 321 (criticizing *Leckelt* holding as creating institutional paranoia based on "suspicions of sexual history and drug use or on race and ethnicity"); Gostin, *supra* note 57, at 308 (contending that court in *Leckelt*, by defining "invasive" procedures broadly, invites categorized, overbroad determinations of procedures in question such that noninfected HCWs may be forced to be tested because of their practice areas). Also, Barnes argues that such a program would be inherently underinclusive because HCWs under these conditions would be less likely to come forward for voluntary testing and to reveal their condition to their employer medical institution. Barnes et al., *supra* note 58, at 321-22.

375. See *supra* notes 148-71 and accompanying text (discussing affirmative duty on hospitals to protect its workers and patients).

376. Cf. Barnes et al., *supra* note 58, at 319-20 (suggesting that there is no reason why HIV policy should differ from HBV policy where hospitals wait until transmission has occurred before acting). *But see* Gostin, *supra* note 57, at 306 (arguing that CDC cannot allow possible transmission of HIV before acting because HIV is always lethal, whereas HBV is not).

377. See Gostin, *supra* note 57, at 304-05 (arguing that HCWs should not be required to disclose their infection status to patients). Gostin does believe, however, that infected HCWs should be restricted in their practices of "seriously invasive procedures." *Id.* at 306. ("Waiting for cases of transmission of a lethal infection like HIV before taking any action [as we do with HBV] would undermine trust in the health care system. The CDC simply could not tolerate possible transmission of HIV through a mode which is well documented.")

378. See Orentlicher, *supra* note 31, at 1136 (advocating that HCWs follow CDC guidelines of determining in each instance whether patient should be informed of HCW's HIV status). *But see* Keyes, *supra* note 20, at 610 (arguing that HIV-infected HCW has duty to disclose that fact to patient where invasive procedures are to be performed).

379. See Daniels, *supra* note 278, at 1370-71 (contending that actual risk is too small to be material and therefore require patient consent, but subjective belief by public that HIV status is material implicates, if patients' rights predominate, that patient will switch from infected

If HIV-positive HCWs are prohibited from performing invasive procedures, the question of informed consent is moot as there is no proven risk of transmission from casual contact. It follows, therefore, that where HIV-positive HCWs do not perform at-risk procedures, there is no need to release the fact of infection to their patients. Moreover, courts have levied on institutions a duty to protect the privacy of an infected HCW by not disseminating such information to the general community.³⁸⁰ Releasing that information to a patient where no proven risk of transmission exists would violate the institution's duty.

In the rare instance in which an HIV-positive HCW is the only one capable of performing a needed procedure, there is a clear requirement to inform the patient of the HCW's condition. In *Behringer*, the hospital board eventually adopted a policy permitting an HIV-positive HCW to perform invasive procedures, as long as the hospital still required the patient's consent to the procedure *after* being informed of the surgeon's HIV-positive status.³⁸¹ The court's decision was predicated on concern for the emotional trauma that potential postoperative testing procedures might cause in a patient, even if the patient did not become seropositive for HIV.³⁸² The risk of transmission in combination with this trauma was too much. The court wrote that "it is untenable to argue against informed consent combined with a restriction on procedures which present 'any risk' to the patient."³⁸³ Where HIV-positive HCWs perform invasive procedures, their patients must be informed as part of the consent procedure. Law and ethics require no less.

CONCLUSION

The prevalence of AIDS in society is a concern that grows every day. Homosexuals and intravenous drug users are no longer the only groups being affected by the disease. Of all identifiable demographic groups, the fastest growing group of infected individuals is

HCW to uninfected HCW, which would irrationally discriminate against infected HCWs who actually pose no risk of harm).

380. See *Estate of Behringer v. Medical Ctr.*, 592 A.2d 1251, 1273-74 (N.J. Super. Ct. Law Div. 1991) (holding that hospital violated plaintiff's right to confidentiality by allowing public access to plaintiff's medical records, resulting in effective end to plaintiff's practice).

381. See *id.* at 1258-59 (explaining final policy by hospital to continue to treat AIDS patients without discrimination and to allow HIV-positive HCW to treat patients as long as no risk of transmission is presented, but also to require that patient be informed of any risk and physician obtain written informed consent before surgical procedure is performed).

382. See *id.* at 1266 (discussing expert testimony presented at trial explaining that informed consent is necessary to avoid emotional anxiety that would occur if patient is informed of possible transmission only after at-risk procedure or surgical accident).

383. *Id.* at 1283.

heterosexuals. In comparison, the risk of transmission from HCWs to patients may seem insignificant, notwithstanding the publicity and the politics surrounding Kimberly Bergalis' case. Addressing the issue of the HIV-infected HCW should nonetheless be part of a national, concerted effort to control the spread of the disease. While the CDC guidelines attempt to fulfill this role, they will be ultimately unsuccessful.

Common law response to the HIV-infected HCW provides a more efficacious framework for hospitals and HCWs to use in resolving these problems. The common law, within the tort theory of the "special relationship" among HCWs, medical institutions, and patients, articulates the duties triggered in this situation, delineates the proper actions, and effectively minimizes liabilities. The CDC guidelines, on the other hand, fail both to articulate specific duties and to delineate alternatives. Guidelines setting national standards are necessary and should be binding as regulations. The CDC guidelines, however, should be amended to reflect more accurately the state of the common law, which assumes a greater duty on the part of the hospital in confronting the HIV-infected HCW.

