Fairfield UNIVERSITY

North East Journal of Legal Studies

Volume 3 *Spring 1995* Article 1

Spring 1995

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Audrey Wolfson Latourette

AIDS: LEGAL AND ETHICAL IMPLICATIONS FOR HEALTH CARE PROVIDERS*

by

Audrey Wolfson Latourette**

AIDS is a tragic disease of epidemic proportions. It constitutes the most serious public health problem confronting the United States. In the 1980's human immunodeficiency virus (HIV) infection emerged as a leading cause of death in the United States. Reports emanating from the Centers for Disease Control (CDC) indicate that HIV infection/acquired immunodeficiency syndrome (AIDS) will continue to cause an increasing proportion of all deaths.[1] This contagious, devastating and fatal disease has as of September 30, 1993 heen contracted by 339,250 Americans since 1981, and of that number 204,390 AIDS patients have died.[2] The Centers for Disease Control have reported an acceleration in the number of diagnoses made; thus, while it took eight years for the first 100,000 cases to be diagnosed, it only took two years, between September 1989 and November 1991, for the second 100,000 cases to be determined. Moreover, the CDC estimates that only twenty percent of the one million Americans who have contracted the human immunodeficiency virus which causes AIDS have been diagnosed with the disease. While male homosexuals still comprise the majority of AIDS cases, the CDC has concluded that the incidence of the disease is spreading most rapidly among heterosexuals, and the percentage of AIDS cases is increasing among blacks, Hispanics and women.[3] The largest proportionate increase of AIDS cases was experienced by heterosexuals, jumping 130 percent,

* This Article received the Hoehlein Award for Distinguished Paper at the 1994 Annual Conference of the North East Academy of Legal Studies in Business in Cooperstown, New York.

** Professor of Law, Richard Stockton College of New Jersey.

from 4,045 in 1992 to 9,288 in 1993. This dramatic rise in numbers helped boost the overall growth in AIDS cases in 1993 by 111 percent, far greater than the 75 percent increase the CDC had earlier anticipated.[4] Further, the World Health Organization, in a report assessing the future dimensions of the AIDS pandemic, stated that by early 1992 ten to twelve million people world wide had contracted HIV. The agency anticipates that by the year 2000 the number of infections will have tripled and possibly quadrupled.[5]

Scientists have indicated that AIDS is caused by infection with the human immunodeficiency virus (HIV). AIDS is transmitted through sexual contact with an infected person, exposure to tainted blood or blood products and perinatal exposure. Notwithstanding the fact that scientific evidence does not support the transmission of AIDS through casual contact or exposure to saliva, tears or other bodily fluids, the public through fear or a lack of knowledge perceives the disease as an ominous threat, and this perception has prompted numerous instances of discrimination against actual or suspected carriers of the AIDS virus.[6] Thus, HIV carriers bave been denied adequate medical care where dentists and physicians have refused to treat them.[7] Access to schools has been denied by school boards who have voted to bar any student from attending class who has AIDS or is suspected of having it.[8] Many bave been removed from employment, including a flight attendant, a university professor and a nurse.[9] Evictions or refusals to rent have occurred where landlords have regarded tenants as homosexuals or as AIDS carriers.[10] Morticians have refused to provide proper funeral services or transferred the decedent to another funeral home, upon discovering that the death was caused by AIDS.[11] Ambulance workers have refused to transport AIDS patients to hospitals.[12]

These acts of discrimination have engendered numerous lawsuits. AIDS has in fact prompted more litigation than any other disease in history. As reported by AIDS Litigation Project, an activity of the U.S. Public Health Service's AIDS program, the number of AIDS lawsuits currently pending or decided exceeds 1,000.[13] This figure reflects a far greater number of cases than can be attributable to any other public health problem. While the majority of cases involve discrimination against people with AIDS, other cases focus on the responsibility of blood banks, physicians and hospitals for AIDS tainted hlood transfusions. Commentators have noted that a significant trend in AIDS discrimination litigation is the exploration of the duty to treat issues in health care.[14] The concomitant issues of testing of patients and providers, issues of privacy and confidentiality as related to those tests, and issues of ethical duties to inform patients and providers of one's AIDS status and to warn third parties about the AIDS status of a patient or

provider, are emerging as issues of particular importance to the health care provider.

A myriad of legal issues have thus been raised by the AIDS disease; it has become as much of a legal and ethical dilemma as a medical crisis. This article will discuss those legal issues which particularly relate to the health care field, including the major pieces of pertinent federal legislation and court interpretations as to their applicability to AIDS victims; state legislative enactments regarding AIDS; and official postures of the judiciary, the CDC and the American Medical Association with regard to the ethical and legal issues raised by AIDS.

Federal Legislation Which Protects The Disabled

Section 504 of the Rehabilitation Act of 1973[15] prohibits employment discrimination against handicapped individuals who are otherwise qualified in federally funded programs. Section 504 defines as handicapped an individual who has a mental or physical impairment which substantially limits one or more major life activities, has a record of such impairment, or is perceived by others as having such an impairment. Pursuant to this statute, an "otherwise qualified" disabled employee is afforded protection if with reasonable accommodation on the part of the employer, the employee can perform the essential functions of the job. Further, the nature, severity and duration of the risk such an employee may pose to co-workers is examined. While AIDS is not specifically included within the statutory language as a handicap, the statute has been interpreted by the lower federal courts,[16] the Department of Health and Human Services and the United States Department of Justice[17] to encompass victims of contagious disease, including symptomatic and asymptomatic AIDS carriers.

It is interesting to note that the original posture of the U.S. Department of Justice with regard to whether AIDS constitutes a handicap under section 504 was that an asymptomatic carrier of HIV was not included within the purview of the statute.[18] The United States Supreme Court in School Board of Nassau County v. Arline[19] decided shortly thereafter rejected much of the Justice Department's reasoning and concluded that a contagious disease, in this instance tuberculosis, constituted a section 504 handicap. While the Court declined to address the issue of whether a carrier of AIDS could be deemed handicapped, a number of lower federal courts have relied upon the Court's reasoning in Arline to conclude that symptomatic and asymptomatic carriers of HIV are handicapped.[20] Further, the Department of Justice, citing Arline, amended its position to assert that section 504 of the Rehabilitation Act does protect both symptomatic and asymptomatic carriers

of HIV.[21] The scope of this statute is limited, however, inasmuch as it does not prohibit discrimination by private persons or entities.

The landmark civil rights legislation, Americans With Disabilities Act (ADA) of 1990[22] is far more expansive in scope, prohibiting discrimination against the disabled in employment, public services, and public accommodations which would include doctors, dentists and any health care provider. Moreover, the statute was drafted to specifically include HIV infection as a covered disability, whether it be asymptomatic or symptomatic, thus affording HIV patients support in filing discrimination lawsuits against hospitals and physicians. Pursuant to this statute an employer must make reasonable accommodations for a qualified disabled employee unless so doing would create an undue hardship for the employer. Private persons or entities are included within this act; specifically those employing 25 or more as of July 26, 1992 and those employing 15 or more as of July 26, 1994. In some cases state statutes may apply similar restrictions with respect to employers of less than 15 employees.

In accordance with the restraints imposed by ADA, queries can be made by an employer as to the ability of a job applicant to perform the essential functions of the job, but inquiries as to the nature or severity of an applicant's disability are not permitted. Once an applicant has been offered a job, but has not commenced work, an employer may require a medical examination, including an HIV test, if all applicants must take the same exam. However, the employer may not withdraw the job offer subsequent to such tests unless he or she can prove the employee is not "qualified" and cannot perform the essential functions of the job because of the disability. With respect to current employees, an employer may not require an HIV test unless he or she can prove the test is necessary for the employee to perform the job. For those who are too ill to adequately perform a job because they are afflicted with full blown AIDS or with the opportunistic diseases to which HIV victims succumb, such as the deadly, drug resistant and contagious form of tuberculosis that has recently emerged, the ADA does not afford protection from discrimination. An employer need only make reasonable accommodations for a qualified employee.[23]

State Legislative Enactments Regarding AIDS

States are confronted with a two fold problem with regard to the AIDS epidemic. On one hand they seek to stem the tide of AIDS cases and to ease public fears through a variety of public health measures which include quarantine, contact tracing (notification of sexual partners and others at risk), voluntary testing

and counseling and reporting of results. On the other hand many states have endeavored to reduce the discrimination directed towards AIDS victims by enacting statutes which parallel the federal legislation and treat AIDS and HIV infection as protected handicaps.[24] Several states have enacted legislation which prohibits discrimination against individuals with HIV infection or AIDS.[25] Other states such as New Jersey have accorded homosexuals (who are still disproportionately affected by AIDS) a protected status, barring discrimination based on affectional or sexual orientation.[26]

Historically the legislative response to other communicable diseases has entailed the use of public health measures similar to those currently being used or considered for AIDS. Every state has forms of quarantine laws that relate to communicable diseases such as smallpox, typhoid or venereal disease and their use has traditionally been upheld by the courts. Recently several states such as California, Michigan, Florida and Oklahoma have applied quarantine laws to recalcitrant AIDS carriers who pose an ominous threat to the public. In these cases the carriers engaged in repetitive unprotected sex with partners who were not forewarned of their disease.[27] The Presidential Commission on AIDS supports the use of quarantine to control harmful behavior by AIDS victims such as the selling of blood, sperm, organs and sexual services but does not support the use of quarantine to penalize a person who has AIDS or is HIV positive. The CDC presently recommends quarantine only for patients who refuse treatment for extreme cases of drug resistant tuberculosis.

Contact tracing is a public health strategy that has been utilized since the 1940's for diseases such as syphilis and tuberculosis. It endeavors to identify those persons who have been exposed to a sexually transmitted or contagious disease. The rationale supporting its use is that it is an effective control measure which treats infected third parties at risk as early as possible. The primary negative aspect to its use is that it invades the privacy of the afflicted disease carrier. With regard to AIDS the CDC has recommended that sexual partners of AIDS carriers be notified. Some states such as Colorado do engage in contact tracing on an active basis. Commentators have suggested that physicians and health care workers be mandated to engage in contact tracing in the AIDS context.[28]

Legal and Ethical Obligation To Treat AIDS Patients

Traditionally those in the health care field were free to accept or reject patients except in emergencies. Both the American Medical Association (AMA) and the Association of American Physicians and Surgeons set forth this standard in

their respective codes of ethics. This posture, however, has recently undergone marked change. The AMA has now deemed it unethical to refuse the treatment of AIDS patients even in nonemergency situations.[29] Moreover, several courts have held health care providers civilly liable in damages for refusing to treat HIV infected patients, premised on statutes prohibiting discrimination against those who are infected with AIDS.[30] Finally, pursuant to the Americans with Disabilities Act of 1990 a health care provider would be prohibited from refusing to treat an individual due to that person's HIV status.

Ethical Obligation of the HIV Positive Health Care Provider

Commentators and courts regard the provider-patient relationship as one of a fiduciary nature. The physician or provider possesses an expertise and knowledge the other party lacks, and is entrusted to utilize that expertise in the best interests of the patient. Arguably then, health care providers and institutions have an ethical responsibility to perform only those procedures which pose no risk of transmission of AIDS. Further, the argument is advanced that disclosure of the providers' HIV status should be made to the patients so that they can fully appreciate the risks inherent in a given situation and give fully informed consent for the treatment to be provided. Without such disclosure a potential cause of action for negligence or intentional infliction of emotional distress exists. Significantly, no corresponding duty to disclose one's HIV status to the health care provider exists for the patient.[31] The posture of the CDC, and the Department of Health and Human Services is that the providers' reliance on universal blood and body fluid precautions is the best defense against workplace transmission of HIV. Such precautions entail the use of gloves and protective clothing and the avoidance of skin punctures caused by needles and sharp instruments.[32]

The case of David Acer, the Florida dentist who transmitted the HIV virus to five of his patients, none of whom were aware of his AIDS, prompted calls in Congress for the mandatory AIDS testing of all health care workers engaging in invasive procedures.[33] Although the measure did not pass, the CDC issued guidelines which recommend that doctors and dentists who perform invasive medical procedures refrain from doing them if they are HIV positive. And in one case a United States Court of Appeals upheld a hospital's right to demand the results of a nurse's HIV test where a reasonable suspicion existed that the nurse had been exposed to HIV. The hospital argued that under the CDC guidelines they were required to determine the HIV status of employees potentially exposed to the virus to ascertain whether they posed a risk to the hospital community.[34] The CDC is now instructing state health departments to determine on a case by case basis whether doctors, dentists and other health care workers with AIDS, HIV

virus or hepatitis B are a threat to patients.[35] State health departments are to consider the skill and physical health of the infected workers and whether they are performing "exposure-prone" procedures where the health worker could be injured and bleed into an opening in a patient.

Health care workers who perform procedures regarded as "exposure prone" encompass a variety of positions in addition to that of doctors, dentists and nurses. Physical therapists, for example, perform the type of invasive and high risk procedures which may be deemed "exposure prone" pursuant to a state health department assessment. Physical therapists frequently treat patients with open wounds and chemical burns. The debridement and whirlpool therapies utilized expose both patient and therapist to a risk of HIV transmission. Physical therapists treating postoperative patients are exposed to many types of bodily fluids, as are cardiopulmonary therapists who are exposed to airborne particles which include blood and sputum. Moreover, in a few states needle insertion electromyography (EMG) is performed by physical therapists. These invasive procedures engaged in by physical therapists underscore the need for adherence to universal precautions and a recognition that such procedures pose a risk of HIV to either the patient or the therapist, and that an HIV infected physical therapist could potentially be regarded as a threat to patients under CDC analysis.

Mandatory HIV Testing for Patients

In addressing the question of mandatory testing of individuals for exposure to the AIDS virus, the competing interests of the health care worker's right to know of potential exposure to HIV infection and the long recognized constitutional right to privacy must be balanced. Testing at first was not encouraged due to lack of effective treatment when diagnoses were made late in the course of the disease, and due to the potential negative manner in which such test results might be utilized. Today, however, early medical intervention has produced dramatic benefits in delaying or preventing opportunistic infection, progressive immunodeficiency and neurologic disease.[36] Thus, the call for HIV testing to detect HIV in the early, asymptomatic stages becomes a more compelling issue than heretofore regarded.

The major advisory bodies, including CDC and the Presidential Commission on AIDS advise against HIV blood screening for patients (and employees).[37] Many states also prohibit testing unless the subject gives an informed consent.[38] Both federal and state statutes require that an individual's HIV status remain confidential. Although health care workers are at somewhat

higher risk of contracting AIDS in the work place than other employees, (the CDC has documented 46 cases of health care workers being infected with the AIDS virus on the job) the posture of the CDC and Department of Health and Human Services is one of strict adherence to what are deemed "universal precautions" with respect to all patients irrespective of infection status. In cases where a health worker experiences a needle stick or exposure to bodily fluids or blood, the CDC recommends seeking consent from the patient to test for HIV. Confronted with a refusal, it is suggested by the CDC that such workers seek medical evaluation and be retested at several times after exposure.[39] Some states, such as Connecticut have sought further protection for the safety of health care workers, recognizing a "right to know" among health care workers who have been potentially exposed to HIV infection. These statutes under certain circumstances, authorize the testing of patients even without their consent and disclosure of test results to those health care providers significantly exposed to the HIV infection.[40]

Mandatory Testing of Health Care Workers

While recognizing that transmission of HIV to patients can occur and has occurred in the health care setting of Dr. David Acer's Florida dental office, the official guidelines set forth by the CDC do not support mandatory HIV testing of health care workers. The risk of transmission is highest where health care workers perform invasive procedures, and in these instances the CDC recommends that the infected worker's physician and the institution's medical director determine whether changes in work assignments are advisable.[41] And, as noted earlier, the CDC is directing all state health departments to decide on a case by case basis which health care workers pose a risk to patients. Again the CDC has assumed the position that full implementation of "universal precautions" will minimize the risk of transmission of the virus to patients. The AMA has adopted a stronger stance in advocating that a physician who knows he or she is HIV positive should not engage in any activity that creates a risk of transmission of the disease to others.[42] In contrast, the Presidential Commission on AIDS asserts that there is no medical or scientific basis for restricting the practice of AIDS infected health care professionals. The Commission contends that strict adherence to infection control procedures should prevent transmission of the virus.[43] Although the law is not clear in this area, mandatory testing of health care workers will probably only be mandated where the worker has been exposed to the AIDS virus and/or if it is limited to those who engage in the type of invasive procedures where the risk of transmission is the greatest.

Duty to Warn Third Parties About the AIDS Status of a Patient

The issue is currently being debated as to whether a health care worker has a duty to warn foreseeable third parties who are engaged in high risk behavior with an AIDS patient. Many courts have imposed a duty upon physicians, psychotherapists and psychiatrists to warn family members, other health care workers and those perceived to lie within a foreseeable zone of risk about the contagious condition of a patient (such as scarlet fever or tuberculosis)[44] or of a mental condition of a patient that created a threat of physical harm to third parties.[45] In these cases the disclosure of confidential information was deemed necessary to protect the interests of innocent parties, and hence was viewed as a more significant factor than the concomitant loss of privacy of the individual patient. One court, in particular, stressed that the privacy right in an individual's medical condition is not absolute and can he invaded to satisfy compelling governmental interests.[46] The rationale for applying this legal reasoning to the AIDS epidemic would urge that such notification could prevent the transmission of the virus, and would aid the early detection, treatment and retardation of the progression of the disease, public health protections which some commentators suggest support an infringement to the right to privacy and physican-patient confidentiality.

In response to this perceived need for limited disclosure of the status of an HIV patient, and breach of the physician-patient privilege, some states have enacted laws affording immunity from liability for breach of confidentiality lawsuits, to physicians who disclose a patient's AIDS status to the patient's spouse or sexual partner.[47] In fact, some states such as Colorado, Georgia, Idaho, Illinois and Wisconsin require physicians and other health care providers to report the HIV status of their patients (with identifiers) to state health authorities within a short period after treating them. Some commentators have urged that inasmuch as AIDS is incurable, the physician's legal and ethical duty to warn foreseeable third parties of the risk of infection becomes a more compelling case than exists with other contagious or sexually transmitted diseases.[48] Such proposals invoke vehement opposition from public interest groups who argue that the institution of such a requirement will only serve to further burden and discriminate against AIDS victims.

Liability for Transmission of AIDS Through Transfusion

It has been estimated by the CDC that 29,000 transfusion recipients received HIV infected blood during the period between 1978 and 1984.[49] The 1980's witnessed but a small number of these cases being litigated; now several hundred transfusion associated AIDS cases have been filed. During that period a marked change in the posture of the courts with respect to the liability of blood banks has been observed. Historically blood banks bave been afforded virtual immunity from suit premised on the belief that the adequacy of the blood supply must be maintained and that blood donor organizations adhered to strict notions of safety precautions in screening donors and blood. Blood donor organizations were consistently construed as providing a service, and not a sale of goods, and hence theories of liability such as warranty and product liability were viewed as inapplicable. Moreover, "blood shield" statutes (which were written with liability for hepatitis in mind) codified this philosophy in every state except New Jersey.[50] Thus, the only avenue of recovery for a plaintiff was to ground its case in negligence, and under the "blood shield" statutes these were generally unsuccessful.

Today the negligence theory of recovery has been utilized successfully against blood banks wberein the blood bank failed to use surrogate tests to eliminate AIDS tainted blood prior to 1985, failed to use the ELISA test (enzyme linked immunosorbent assay) when it became available in 1985 or failed to employ an adequate screening process for donors. Plaintiffs have prevailed against physicians and hospitals where they could demonstrate that negligent treatment caused the need for transfusions (a tonsillectomy, for example, was negligently handled, prompting the need for transfusions) or that negligent failure to use the patient's blood existed (plaintiffs specifically requested that their own blood be used to avoid AIDS; tainted donor blood was used instead).[51]

Conclusion

AIDS constitutes a tragedy for those who are afflicted with this contagious, incurable and fatal disease. It further constitutes a worldwide public bealth problem which has been termed by one court as the modern day equivalent of leprosy.[52] As the rate of reported AIDS cases continues to escalate so too will the burgeoning AIDS related litigation. The unique questions that it raises for health care providers with regard to issues of ethical and legal duties, privacy, responsibility and the balancing of competing private and public interests are ones that should be of significance to all health care professionals.

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LIABILITY WITHOUT PRIVITY: DEVELOPMENTS IN THE IMPLIED WARRANTY OF HABITABILITY

by

Patricia M. Pattison*
Daniel J. Herron**

"The assault upon the citadel of privity is proceeding in these days apace."[1] This statement, originally made by Cardozo, has been widely quoted, especially by William Prosser. Concerning products liability, Prosser noted in 1960 that the assault was well developed;[2] in 1966 he concluded that the citadel had fallen.[3]

The citadel of privity is again under assault. This time it relates to liability for defective housing. Specifically, this paper will (I.) review the background and origin of the implied warranty of habitability, (II.) identify seven factors which court decisions have weighed and utilized in defining and refining the warranty, (III.) analyze the heart of the implied warranty development--the privity issue, (IV.) compare the application of the warranty with the development of products liability, and conclude by speculating on possible new directions for the development of the warranty.

* Professor, College of Business Administration, University of Wyoming, Laramie, Wyoming.

** Associate Professor, Richard T. Farmer School of Business Administration, Miami University, Oxford, Ohio.