HIV-Infected Health Care Workers Who Perform Invasive, Exposure-Prone Procedures: Defining the Risk and Balancing the Interests of Health Care Workers and Patients

INTRODUCTION

In the early 1990s, a report of a dentist who transmitted Acquired Immunodeficiency Syndrome (AIDS)[1] to a patient resulted in mass fear and confusion among the health care industry, regulatory agencies, and the public at large.[2] After conducting an extensive study, the United States Centers for Disease Control (CDC)[3] confirmed that six patients of Dr. David Acer had become infected with human immunodeficiency virus (HIV)[4] while under his care in the early 1990s.[5] This incident, known as the "Acer cluster,"[6] however, is

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[1] *See* Part I.A.2 for an explanation of AIDS and how it affects the immune system.

[2] The controversy was precipitated by a patient, Kimberly Bergalis, who was diagnosed with HIV two years after being treated by her dentist, David J. Acer, who also was HIV positive. *See* GERALD J. STINE, ACQUIRED IMMUNE DEFICIENCY SYNDROME: BIOLOGICAL, MEDICAL, SOCIAL, AND LEGAL ISSUES 194 (2d ed. 1996).

[3] The Centers for Disease Control and Prevention (CDC) is an agency of the Department of Health and Human Services (HHS) that seeks "[t]o promote health and quality of life by preventing and controlling disease, injury, and disability." *Centers for Disease Control and Prevention* (visited Oct. 20, 1997) <http://www.cdc.gov/aboutcdc.htm>.

[4] *See* WILLIAM B. RUBENSTEIN ET AL., THE RIGHTS OF PEOPLE WHO ARE HIV POSITIVE 4-6 (1996). The distinction between the two terms exists because an individual can have HIV without showing any symptoms. *See id.* at 4-5. Nonetheless, the entire range of HIV infection, which includes asymptomatic HIV infection, symptomatic HIV infection, and AIDS, is referred to as HIV disease. *See id.*

[5] *See* American Bar Association, *Calming AIDS Phobia: Legal Implications of the Low Risk of Transmitting HIV in the Health Care Setting*, 28 U. MICH. J.L. REFORM 733, 734-35 (Eric N. Richardson & Salvatore J. Russo eds., 1995) [hereinafter *Calming AIDS Phobia*] (providing the American Bar Association's AIDS Coordinating Committee's report on HIV and health care workers).

[6] "Cluster" is a CDC term that refers to a "group of patients who have been infected by exposure to a single health care worker [HCW]." *See Calming AIDS Phobia*, *supra* note 5, at 734 n.3 (citing Centers for Disease Control, *Recommendations for Preventing Transmission of Human Immunodeficiency Virus and Hepatitis B Virus to Patients During Exposure-Prone Invasive Procedures*, 40 MORBIDITY & MORTALITY WKLY. REP. 1, 2-3

the only *known* transmission of HIV from a health care worker (HCW)[7] to a patient in the United States. Because of obstacles to reporting exposures and unreliable data regarding how many physicians have been infected with AIDS, the fact that the Acer cluster is the only documented instance of transmission should not be considered dispositive.[8] Further, the CDC's confirmation of a report in

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(1991)).

[7] For CDC purposes, HCWs were defined in 1992 as "persons, who worked in health-care, clinical or HIV-laboratory settings." *Surveillance for Occupationally Acquired HIV Infection—United States, 1981-92*, 41 MORBIDITY & MORTALITY WKLY. REP. 823-25 (1992). In the recent draft guidelines from the CDC entitled *Infection Control in Health Care Personnel*, HCWs include:

> [A]ll paid and unpaid persons working in health care settings who have the potential for exposure to infectious materials, including body substances, contaminated medical supplies and equipment, contaminated environmental surfaces, or contaminated air. These personnel may include, but are not limited to, emergency medical service personnel, dental personnel, laboratory personnel, mortuary personnel, nurses, nursing assistants, physicians, technicians, students and trainees, contractual staff not employed by the health care facility, and persons not directly involved in patient care (e.g., clerical, dietary, housekeeping, maintenance, and volunteer personnel) but potentially exposed to infectious agents.

62 Fed. Reg. 47276 (1997).

[8] There is, however, significant controversy as to the events of this case. *See* Alix R. Rubin, Comment, *HIV Positive, Employment Negative? HIV Discrimination Among Health Care Workers in the United States and France*, 17 COMP. LAB. L.J. 398, 407-08 (1996). For example, although the dentist used barrier precautions, he did not comply with the CDC's universal precautions. *See id.* at 408.

In addition, the established facts made it difficult to prove the transmission of HIV from HCW to patient. *See* STINE, *supra* note 2, at 194-95. First, Bergalis's dental records demonstrate that her two extractions were not complicated, making infection less likely. *See id.* at 194. Second, interviews with Bergalis and Acer failed to elicit other risk factors even though Bergalis repeatedly asserted that she was a virgin, an issue that was disputed. *See id.* at 194-95. Third, tests of both Bergalis's and Acer's DNA strains indicated a high degree of similarity. *See id.* at 195. Fourth, the two-year interval between Bergalis's dental procedure and her development of AIDS was short—Bergalis developed oral candidadas only 17 months after being infected, which is rare considering that "1% of infected homosexual/bisexual men and 5% of infected transfusion recipients develop AIDS within two years of infection." *Id.* Reportedly, Bergalis settled her suit with Acer's insurance company for $1 million and with his estate for an undisclosed amount. *See id.* Before her death in December 1991, Bergalis testified before Congress to encourage legislation mandating HIV testing of all HCWs. *See id.* at 195-96. Ironically, after writing a blasting letter to the Florida Department of Health blaming the department for failing to do a "damn thing," she admitted on national television that she was treated by another dentist but declined to inform him of her HIV status. *See id.*

When the sixth infected patient, who did not undergo an invasive procedure, was identified in 1993, some speculated that Acer may have intentionally, rather than negligently, infected his patients. *See* Barry Sullivan, *When The Environment is Other People: An Essay on Science, Culture, and the Authoritative Allocation of Values*, 69 NOTRE DAME L. REV. 597, 628-24 (1994).

France of an orthopedic surgeon who was diagnosed with full blown AIDS in 1994 and transmitted the virus to a patient in 1992 during surgery demonstrates that the Acer cluster is not an anomaly.[9] Some infection control experts hope that the incident in France will dispel the collective belief in the health care industry that the Acer cluster was a random occurrence.[10]

Although federal disability law prohibits employers from discriminating against HIV-infected HCWs based on the contagious nature of the disease, exceptions exist if the person poses a "direct threat" or "significant risk" to others. Therefore, if a HCW suffers from a disability such as HIV and poses "a significant risk" to others while performing the essential functions of the job, that HCW is deemed not qualified for that position.[11] Consequently, some HCWs are not protected by disability law. As will be discussed in this Note, the debate surrounding protection of infected HCWs centers on a tension in the case law regarding what constitutes a "significant risk."[12]

Although many courts have concluded that HIV poses a substantial risk to patients that cannot be eliminated,[13] the American Medical and Dental Associations (AMA and ADA) have classified the risk as insufficient to warrant mandatory testing or mandatory disclosure to patients.[14] Because the informed consent doctrine is not premised on what the physician deems material but rather on what a reasonable patient considers material, the medical profession has violated the essence of informed consent by allowing physician paternalism and egotism to supersede patient autonomy.[15]

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[9] *See CDC: French HIV Surgical Case Will Not Affect U.S. Policy on Infected Providers,* HOSP. INFECTION CONTROL, Mar. 1997, at 33-34 (noting that the risk is not zero but it is very low). Yet testing was only performed on 968 of the surgeon's 2458 patients. *See id.* at 34.

[10] *See id.* (noting that some experts think the health care industry is in denial of the risk of HCW-to-patient transmission of HIV).

[11] See Part II.D of this Note for the legal analysis of whether someone who poses a "significant threat" to patients is qualified to work in the health care field.

[12] *See generally* Part II.D of this Note (discussing the inconsistent application of "significant risk" analysis by federal courts).

[13] *See* Mauro v. Borgess Med. Ctr., 886 F. Supp. 1349, 1353 (W.D. Mich 1995) (commenting that a "mere scintilla of evidence [of risk] does not alter the facts that transmission is possible and invariably lethal"); Estate of Behringer v. Medical Ctr., 249 N.J. Super. 597, 651, 592 A.2d 1251, 1279 (Law Div. 1991) (noting that the risk of transmission and the anxiety that accompanies that risk both pose a substantial risk to patients).

[14] *See* BARRY R. FURROW ET AL., HEALTH LAW: CASES, MATERIALS AND PROBLEMS 419 (3d ed. 1997).

[15] See Part III of this Note for an analysis of informed consent.

Concededly, the CDC has documented only six patients contracting HIV from a HCW. This should not end the inquiry, however, as to whether mandatory testing or mandatory disclosure of a HCW's HIV status should be required to protect patients from potential exposure. Because actual injury is required for a patient to prevail under informed consent,[16] recovery is unrealistic unless actual transmission occurs. Despite the proof problems that would hinder patients' success rates on informed consent claims, patients should not be precluded from prevailing on other tort claims such as the negligent or the intentional infliction[17] of emotional distress.[18]

This Note examines the myriad of legal issues that the Acer cluster triggered. Part I explains general information and terminology regarding HIV and AIDS. Part II examines two federal laws, section 504 of the Rehabilitation Act of 1973 (section 504)[19] and the Americans with Disabilities Act of 1990 (ADA),[20] that prohibit disability-based discrimination unless the individual poses a "significant threat" to others. Part III examines patients' claims under the informed consent doctrine and the negligent or the intentional infliction of emotional distress. Part IV proposes three recommendations for eliminating the confusion regarding the "significant threat" test to balance physicians' interests in avoiding disability-based discrimination and patients' interests in ensuring that they are not placed at unnecessary and avoidable risk of HIV transmission.[21] The proposal

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[16] *See, e.g.*, Canterbury v. Spence, 464 F.2d 772, 790 (D.C. Cir. 1972) (noting that "[a]n unrevealed risk that should have been made known must materialize, for otherwise the omission, however unpardonable, is legally without consequence.").

[17] *See, e.g.*, K.A.C. v. Benson, 527 N.W.2d 553, 560 (Minn. 1995). The intentional infliction of emotional distress requires a showing (a) of extreme and outrageous conduct, (b) of conduct that was either intentional or reckless, (c) that the defendant knew that the conduct would likely cause severe emotional distress, and (d) that severe, emotional distress did occur. *See id.*

[18] Under common-law principles, if a negligent action results in physical injury, the actor may also be liable for emotional injury that ensues. *See* RESTATEMENT (SECOND) OF TORTS § 456 (1995). Further, emotional injury may include the apprehension regarding the effects of the injury. In the HIV context, a plaintiff must demonstrate that he (1) was within a zone of danger, (2) reasonably feared for his safety, and (3) suffered severe emotional distress with accompanying physical manifestations. *See K.A.C.*, 527 N.W.2d at 557.

[19] *See* 29 U.S.C. § 706(8) (1998) (providing a definition of disability), *id.* § 794 (providing the legal framework for analyzing disability discrimination).

[20] *See* 42 U.S.C. §§ 12101-12213 (1998).

[21] This Note does not examine whether the distinction between a physician as an independent contractor or employee is relevant for ADA purposes. For a more in-depth analysis on that subject, see Michael R. Lowe, *Stirring Muddled Waters: Are Physicians with Hospital Medical Staff Privileges Considered Employees Under Title VII or the ADA Act When Alleging an Employment Discrimination Claim?*, 1 DEPAUL J. HEALTH CARE

encompasses three concepts: (1) clarification of the "significant threat"[22] test by CDC experts, the Equal Employment Opportunity Commission (EEOC), ethicists, patient advocates, physicians, and other HCWs to be codified by Congress; (2) mandatory testing of HCWs involved in exposure-prone procedures; and (3) mandatory informed consent if the HIV-positive HCW wishes to participate in exposure-prone procedures.

Indisputably, AIDS is a devastating disease that has triggered legitimate fears in the general public because, at present, there is no cure.[23] That a patient is at risk of contracting the fatal disease each time an HIV-infected physician performs an invasive, exposure-prone procedure heightens this concern. Unfortunately, dissemination of piecemeal and sometimes contradictory information about the disease has resulted in discrimination based upon unfounded fears. To

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L. 119 (1996).

[22] The terms "significant risk," "significant threat," and "direct threat" are used interchangeably throughout this Note.

[23] *See* RUBENSTEIN ET AL., *supra* note 4, at 3. Although there are no vaccines or cures, a group of 50 doctors volunteered to test the efficacy of an AIDS vaccine. *See* Ronald Kotulak, *Doctors Volunteer for Live HIV Tests: Physicians Push For Potentially Risky AIDS Vaccine Experiments on Humans*, AUSTIN AMERICAN-STATESMAN, Nov. 12, 1997, at A1. Although there is no cure, treatments involving protease inhibitors have been somewhat effective at slowing the replication of HIV within the body. *See* Martin Markowitz, M.D., *Protease Inhibitors: What They Are, How They Work, When to Use Them* (visited Sept. 23, 1997) <http://www.iapac.org/consumer/proinbk.html>. Protease inhibitors prevent one of HIV's enzymes, protease, from replicating in such a way that furthers the HIV infection. *See id.* Although protease inhibitors do not rid a body of the HIV infection, they reduce the amount of the virus by almost 99%. *See id.* Consequently, fewer helper cells are infected and subsequently destroyed, resulting in an HIV-infected individual being able to fight off other infections, thereby lengthening his lifespan. *See id.* Protease inhibitors differ from other anti-HIV drugs, such as azidothymidine (AZT), a form of a reverse transcriptase inhibitor, in their target and their strength. *See id.* While reverse transcriptase inhibitors halt the duplication of HIV's genetic material by protecting a cell's nucleus, protease inhibitors result in defective HIV replicas that cannot infect new cells. *See id.* By combining these two types of inhibitors, physicians enable HIV-infected patients to battle the disease more effectively. *See id.*

Protease inhibitors, however, are not a cure for HIV infection. *See id.* In fact, researchers have recently confirmed that protease inhibitors and reverse transcriptase inhibitors do not actually eliminate the AIDS virus from the human body. *See* Christine Gorman, *The Odds Grow Longer: Doctors Had Hoped by Now to Have Eliminated the AIDS Virus from Some Patients. No Such Luck*, TIME, Nov. 24, 1997, at 84. Rather, researchers such as Dr. David Ho, a pioneer in AIDS research, have discovered in three studies that HIV merely lurks in the memory T-cells. *See id.* Researchers speculate that HIV could hide in T-cells during a resisting phase without replicating themselves for decades. *See id.* Although people living with HIV can survive the infection for an extended period of time due to the combinations of inhibitors, the next step is to find a way to lure the dormant virus out of the T-cells and immediately attack the infected T-cells. *See id.*

balance those considerations, the aforementioned recommendations seek to (1) relieve HCWs of the burden of making the highly subjective decision as to whether they should voluntarily remove themselves from procedures and (2) reassure patients that they are not being exposed to HIV. In short, although HCWs should not be discriminated against for having HIV, their interests should not supersede patient protection.[24]

I. BACKGROUND INFORMATION REGARDING HIV AND AIDS

A. *The AIDS Epidemic—Generally*

1. Statistics

AIDS was first identified in the United States in 1981,[25] and in 1993, it became the leading cause of death in the United States for people between the ages of twenty-five and forty-four, "surpassing all other diseases, automobile accidents, and gun violence."[26] In February 1998, a CDC expert reported a 44% drop in AIDS deaths during the first half of 1997, due in large part to the development of new treatments.[27] Within the past two years, the World Health Organization (WHO) reported that as of 1995, twenty million people were infected with HIV—1.5 million are located in the United States.[28] In 1997, however, the United Nations Commission on AIDS (UNAIDS) and the WHO acknowledged that their earlier figures underestimated the scope of the epidemic by thirty percent.[29] The 1997 report concluded that 30.6 million people are actually infected with HIV.[30]

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[24] *See* Michael L. Closen, *HIV-AIDS, Infected Surgeons and Dentists, and the Medical Profession's Betrayal of Its Responsibility to Patients*, 41 N.Y.L. SCH. L. REV. 57, 58 (1996).

[25] *See* NATIONAL HEALTH LAWYERS ASS'N, HEALTH LAW PRACTICE GUIDE § 10:3 (1997).

[26] *Calming AIDS Phobia*, *supra* note 5, at 738. As of June 30, 1997, 612,078 people have been reported with AIDS in the United States. *See Centers for Disease Control AIDS Information* (visited Feb. 17, 1998) <http://www.cdc.gov/nchstp/hiv_aids/hiv_info/vfax/260230htm>.

[27] *See* Daniel Q. Haney, *Doctors Hail 44% Drop in AIDS Deaths*, STAR-LEDGER, Feb. 3, 1998, at 9; *see also Update: Trends in AIDS Incidence—United States, 1996*, 46 MORBIDITY & MORTALITY WKLY. REP. 37, 37 (1997) (attributing the decline to the success of antiretroviral therapies).

[28] *See* RUBENSTEIN ET AL., *supra* note 4, at 5.

[29] *See Global AIDS Picture Darker Than Thought, U.N. Study Says*, ASBURY PARK PRESS, Nov. 27, 1997, at A9.

[30] *See id.*

2. The Nature of the Disease and How Transmission Occurs

HIV annihilates the immune system by disengaging T-lymphocyte helper cells, rather than T-lymphocyte suppressor cells, the former of which are responsible for attacking infectious agents.[31] Immediately upon infection, the T-lymphocyte helper cells activate the immune system by multiplying and outnumbering the T-lymphocyte suppressor cells.[32] Eventually, however, HIV disengages the helper cells' ability to multiply and outnumber the suppressor cells,[33] leaving the helper cells ineffective in protecting the body from disease.[34] AIDS is the combination of conditions and illnesses that manifest themselves during the later stages of HIV infection after the immune system is disarmed.[35]

Although exposure to the virus does not necessarily result in infection, there are specific types of behavior and conditions that increase the likelihood of viral transmission: sexual contact, blood-to-blood contact, and perinatal contact.[36] For purposes of this Note, blood-to-blood contact is of primary concern. Such contact can occur through needle-sharing, transfusion of tainted blood product, transplantation of infectious tissue, and "exposure of mucous membranes and non-intact skin to infectious blood or bodily fluids."[37] One cannot be infected, however, by donating blood or coming into contact with tears, saliva, or urine, even though viral particles have been found in these secretions.[38] To prevent transmission of the virus, three primary harm-reduction techniques exist: (1) practicing safer sex, (2) declining to share needles or equipment used to disinfect drugs or syringes, and (3) following universal precautions in the health care setting.[39] The final harm-reduction technique seeks to protect both HCWs and patients from transmission of HIV, which is the focus of this Note.

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[31] *See* RUBENSTEIN ET AL., *supra* note 4, at 10.
[32] *See id.* at 10-11.
[33] *See id.*
[34] *See id.*
[35] *See id.* at 4.
[36] *See id.* at 6-7.
[37] RUBENSTEIN ET AL., *supra* note 4, at 6-7.
[38] *See id.* at 7.
[39] *See id.* at 8.

B. *AIDS and Health Care Workers*

Of the approximately 9,269,000 people employed by the health care industry,[40] 19,638 HCWs have been reported to be HIV-positive as of June 30, 1997.[41] Although HCWs are in a high-risk profession, as of mid-1997, only fifty-two HCWs were infected with HIV by a patient.[42] These figures demonstrate that the risk of a physician being infected by a patient is greater than the risk of a physician or other HCW infecting a patient.[43] The difference becomes relevant because a patient may refuse consent to treatment by an HIV-infected HCW, but a HCW may not refuse a person treatment solely because of his HIV-positive status.[44] As will be discussed in Part III, the distinction is premised on the notion that the physician has a fiduciary duty to his patient whereas the patient does not have a corresponding ethical duty to the physician.[45] The Supreme Court's grant of certiorari in the case of *Abbott v. Bragdon*[46] may signify that the Court will explain the foundation for this distinction.

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[40] *See* NATIONAL HEALTH LAWYERS ASS'N, *supra* note 25, § 10:1. The CDC, however, estimates that 8.8 million people work in the health care field and 6 million people work in more than 6000 hospitals. *See* 62 Fed. Reg. 47276 (1997).

[41] *See* Telephone Interview with CDC PH Guideline Information Center at 888-232-3228 (Nov. 25, 1997) (on file with the *Seton Hall Law Review*). Of those 19,638 HCWs who are HIV positive, the occupations of 18,588 are known: 1591 physicians, 105 surgeons, 4378 nurses, 428 dental workers, 376 paramedics, 2616 technicians, 932 therapists, and 4082 health aides. *See id.* As of June 30, 1997, 76% have died. *See id.* The breakdown by profession: 1258 physicians, 80 surgeons, 3329 nurses, 338 dental workers, and 263 paramedics. *See id.*

[42] *See* Telephone Interview with CDC PH Guideline Information Center at 888-232-3228 (Nov. 25, 1997) (on file with the *Seton Hall Law Review*). Of the 52 infected employees the breakdown is as follows: 19 laboratory technicians, 21 nurses, 6 physicians and surgeons, 2 surgical technicians, 1 dialysis technician, 1 respiratory therapist, 1 health aide, and 1 housekeeper. *See id.* Forty-five were infected by puncture or cut transmission (percutaneous), 5 by mucous membrane or skin transmission (mucotaneous), 1 both, and 1 unknown. *See id.* Twenty-four have since died. *See id.*

[43] *See Human Immunodeficiency Virus*, 8 OCCUPATIONAL MED. DIG. 7 (1996) (noting that the likelihood of acquiring HIV on the job depends on the prevalence of HIV among patients, the "efficiency of transmission after a single contact with blood," and the nature and frequency of occupational blood contact).

[44] *See* 42 U.S.C. § 12182(a), (b)(1)(A)(i) (1998) (providing that no individual may deny persons equal enjoyment of the opportunity to obtain services from any place of public accommodation, which has been interpreted to include clinics, hospitals, and doctors).

[45] *See* Closen, *supra* note 24, at 119-20.

[46] 107 F.3d 934 (1st Cir. 1997) (holding that a dentist may not limit the dental services he is willing to provide to an asymptomatic, HIV-infected patient at a hospital), *cert. granted*, 118 S. Ct. 554 (1997). The Supreme Court granted certiorari to determine whether (1) reproduction is a major life activity within the purview of the

1. The Nature and Likelihood of the Risk

Experts have speculated that HIV transmission from HCW to patient can occur only if two elements exist.[47] First, transmission requires an intense trauma situation "that would provide a portal of entry for the virus" into the human body, that would usually exist during an invasive procedure.[48] Second, blood or some other bodily fluid from the HCW's open tissue that would most likely manifest itself subsequent to a needle stick or scalpel injury during the invasive procedure must come into contact with the patient's "portal of entry."[49]

In response to the Acer cluster, the CDC conducted approximately seventy look-back studies to determine whether patients of HIV-infected dentists, surgeons, and physicians were infected.[50] At present, no patients have tested positive.[51] These results are misleading, however, because testing was voluntary and that variable raises the possibility "that included selection bias may have influenced the results."[52] While these studies demonstrate that the Acer cluster is the only *known* transmission in the United States, these studies do not discount the possibility that patients have contracted and died of AIDS after being exposed to an infected HCW. Given that almost 20,000 HCWs have contracted HIV out of a potential nine million, the aforementioned studies are less than persuasive considering the limited cross section of patients tested.[53]

In addition, although the CDC estimated in the early 1990s that the probability of a surgeon infecting a patient is 8.1%,[54] several obstacles hinder confirmation of that estimate. Specifically, the fact that over 15,000 HCWs have died of AIDS is not conclusive as to the number of HCWs who have contracted the disease. Uncertainty as to the actual number of HIV-infected HCWs plagues these studies be-

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ADA, (2) asymptomatic HIV is a per se disability under the ADA, and (3) a physician must perform invasive procedures on an HIV-infected individual. Oral argument is scheduled for March 30, 1998.

[47] *See Calming AIDS Phobia, supra* note 5, at 739-40.

[48] *Id.*

[49] *Id.* at 740.

[50] *See id.* at 743-44.

[51] *See id.*

[52] *See* LAWRENCE MIIKE & JULIA OSTROWSKY, OFFICE OF TECHNOLOGY ASSESSMENT, HIV IN THE HEALTH CARE WORKPLACE 1 (1991) (on file with the *Seton Hall Law Review*).

[53] The number of HCWs who have contracted HIV does not reflect precisely how many perform invasive procedures. *See supra* notes 41-42.

[54] *See* Closen, *supra* note 24, at 73 (noting that the estimate was based on a seven-year period assumed to be the work expectancy of an HIV-infected surgeon).

cause no disclosure requirements or mandatory testing exists for HCWs.[55] Thus, the report of only one incident of HCW-to-patient transmission in the United States is not a reliable indicator of actual transmission; after all, if we do not know the HIV status of HCWs, how can we trace transmission of the disease?[56] In short, the health care industry has failed to implement a systemic approach for determining which HCWs are HIV-positive.[57]

Further, look-back studies are not the most effective surveillance method for identifying clusters of HCW-to-patient transmission.[58] Look-back studies are only relevant and helpful in those instances where a HCW's HIV status has been detected or volunteered. Therefore, some infection control experts advocate tracing a patient with no identified risk factors (NIR) back to an infected HCW rather than looking backwards from HCW to patient.[59]

In addition to the problems attendant to look-back studies, documentation of actual exposure in surgeries is hindered for several reasons. First, in complex surgical procedures it is difficult to identify whether exposure has occurred based on the number of people present and the instruments involved.[60] Second, patients are not in a position to make such reports if they are unconscious.[61] Third, subordinates are unlikely to report a potential exposure incident,[62] and reporting would be impossible if the HIV statuses of the surgeon and other participating HCWs are unknown. Finally, it is unlikely that HCWs would voluntarily disclose an incident of actual exposure because it would compromise their self-interests in avoid-

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[55] *See id.* at 79-80. Closen criticizes experts who discount the real threat of HCW-to-patient transmission, commenting that

> Advocates of the medical profession's version of the "Don't Ask, Don't Tell" policy with respect to HIV infection among surgeons and dentists depend heavily upon the fact that [only one] documented case of accidental transmission [exists]. They conclude that because of this absence there is either no risk at all of HIV transmission to patients or that the risk is so slight as to be irrelevant and immaterial. This school of thought represents fragmented thinking. Assuming transmissions have occurred but have not been documented, this shortsighted and stubborn policy is killing people.

Id. (footnotes omitted).

[56] *See id.* at 85.

[57] *See id.*

[58] *See Paris Surgeon Probably Transmitted HIV to Patient*, HOSP. INFECTION CONTROL, (American Health Consultants), Feb. 1997, at 20.

[59] *See id.*

[60] *See* Closen, *supra* note 24, at 80.

[61] *See id.*

[62] *See id.*

ing discharge and malpractice suits.[63] Thus, accounts that the Acer cluster is the only known incident of physician to patient exposure in the United States should not be considered dispositive on the subject.

Some critics attempt to downplay the risk associated with HCW-patient transmission by comparing the risk of dying from HIV exposure by a HCW and the probability of a patient dying from other risks.[64] For example, one medical expert commented that "a patient's chances of dying in an airplane flight or crossing the road to get the mail are greater" than the likelihood of a HCW-to-patient infection.[65] Another doctor argued that a patient's risk of HIV transmission by a HCW is less than the hazards associated with hospital staph infections, anesthetic complications, or incompetence.[66] The primary distinction between the aforementioned risks and HIV transmission is that a patient, if properly informed, could avoid infection.[67] Although physicians cannot generally be held liable for physician-specific risks, such as fatigue and depression, HIV should not be classified within the physician-specific category, as will be discussed in Part III.

2. How CDC Guidelines Seek to Reduce the Risk

On July 12, 1991, after documentation of the Acer cluster, the CDC published *Recommendations for Preventing Transmission of Human Immunodeficiency Virus and Hepatitis-B Virus to Patients During Exposure-Prone Invasive Procedures* (CDC Recommendations).[68] In the 1991 report, the CDC acknowledged that adherence to universal precautions was not fool-proof given the nature of certain invasive procedures[69] that are exposure-prone.[70]

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[63] *See id.* at 81.

[64] *See* Rubin, *supra* note 8, at 408-09. Rubin notes that experts have suggested that HCW-to-patient transmission of HIV is as likely to happen as lightning striking or winning the lottery. *See id.*

[65] *Id.* at 409.

[66] *See id.* at 489-90.

[67] *See* FURROW ET AL., *supra* note 14, at 417-18 (observing the difference between risk of disease infection and risks stemming from physicians' performance).

[68] Centers for Disease Control, *Recommendations for Preventing Transmission of Human Immunodeficiency Virus and Hepatitis-B Virus to Patients During Exposure-Prone Invasive Procedures*, 40 MORBIDITY & MORTALITY WKLY. REP. 1 (1991) [hereinafter *CDC Recommendations*].

[69] *See id.* at 2. An invasive procedure is the

> "[s]urgical entry into tissues, cavities, or organs or repair of major traumatic injuries" associated with any of the following: "(1) an operating or delivery room, emergency department or outpatient setting,

Although the CDC stated that the risk of HIV transmission from HCW-to-patient was smaller than Hepatitis B (HBV) transmission, the CDC sought to minimize the risk of both HIV and HBV transmissions by recommending the following measures. First, "[a]ll HCWs *should* adhere to universal precautions" that include protective barriers, appropriate handwashing, and special care in the use and disposal of needles.[71] Further, HCWs *should* comply with disinfection and sterilization techniques for reusing devices in invasive procedures; any HCW who has "exudative lesions or weeping dermatitis *should* refrain from" engaging in direct patient care or performing invasive techniques until the condition dissipates.[72] Second, if a HCW participates in an invasive procedure that is not classified as exposure-prone, there is no scientific evidence warranting restriction of that HCW's participation.[73] Third, medical, surgical, and dental organizations and institutions *should* identify the exposure-prone procedures at their respective facilities.[74] Fourth, HCWs who perform invasive exposure-prone procedures are responsible for knowing their HIV status.[75] Fifth, HCWs who are HIV-positive *should not* participate in exposure-prone procedures without approval from an

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

Id. app.

[70] *See id.* at 4. The CDC defined exposure-prone invasive procedures as "certain oral, cardiothoracic, colorectal . . . and obstetric/gynecologic procedures." *Id.* The CDC also included "[p]ercutaneous exposure of the patient to the HCW's blood [during general surgery, gynecology, orthopedic, cardiac, and trauma events when a] sharp object causing the injury recontacted the patient's wound." *Id.* According to the CDC,

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

Id. Where an invasive procedure does not have the above characteristics, the risk of HIV transmission is substantially lower. *See id.*

[71] *Id.* at 5 (emphasis added).

[72] *Id.* (emphasis added).

[73] *See id.*

[74] *See CDC Recommendations, supra* note 68, at 5 (emphasis added).

[75] *See id.* (noting requirements for HCWs who do not have serological evidence of immunity from hepatitis).

expert panel.[76] That panel would decide whether the HIV-infected HCW should be permitted to continue working and whether his patients should be informed of his HIV status.[77] Finally, the CDC does not recommend mandatory testing of all HCWs given a cost-benefit analysis of the risk that infected HCWs will transmit HIV or HBV and the economic resources that mandatory testing would require.[78] Although the CDC Recommendations provide a framework for preventing HIV transmission and determining whether a HCW should be permitted to participate in exposure-prone procedures, they did not provide any legal consequences for a physician, hospital, or medical organization's failure to comply with these precautionary measures.[79]

a. Increasing the Force of the Guidelines

As a result of the Acer cluster, Congress sought to prevent additional instances of HCW-to-patient HIV transmission by increasing incentives for complying with the CDC Recommendations.[80] The first significant proposal from Congress, the Helms Disclosure Proposal,[81] passed in the Senate and would have required HCWs to disclose their HIV status or be subject to a $10,000 fine and no less than a ten-year prison term.[82] The second proposal, the Kimberly Bergalis Patient and Health Provider Protection Act of 1991, also referred to as the Dannemeyer Proposal,[83] mandated HIV testing of HCWs who perform exposure-prone procedures, mandatory disclosure of those

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[76] *See id.* (emphasis added). The CDC also encourages career counseling and job retraining if a HCW becomes infected with HIV or HBV. *See id.* at 6. In addition, the CDC advocates periodic reevaluation to determine whether a HCW's antibody status has changed because of treatment. *See id.* In determining whether a patient should be informed of exposure by an infected HCW, the CDC recommends proceeding on a case-by-case basis. *See id.* To that end, the CDC recommends consulting with state and local public health officials to determine whether patients should be notified and, further, whether a follow-up study should be conducted. *See id.*

[77] *See id.*

[78] *See id.* at 6 (noting that the efficacy of the CDC's Recommendations can be increased through education, training, and appropriate confidentiality safeguards); *see also infra*, note 94 (commenting that the mandatory approach to monitoring HCWs would require downstream liability).

[79] *See generally CDC Recommendations*, *supra* note 68 and accompanying text (declining to provide any penalties for non-compliance).

[80] *See* Rubin, *supra* note 8, at 411.

[81] H.R. 2622, 102d Cong. (1991).

[82] *See id.*

[83] H.R. 2788, 102d Cong. (1991).

test results, and nonconsensual testing of patients.[84] Neither of these proposals passed both houses of Congress.

Ultimately, Congress enacted the Treasury, Postal and General Government Appropriations Act of 1992, which included the Dole/CDC Amendment (the Act).[85] Within one year of its enactment, the Act required that each territory's and state's top public health official certify to the Secretary of Health and Human Services that the state's policy for adhering to the CDC Recommendations was consistent with federal law.[86] In furtherance of that goal, the Act required that each state articulate the process for determining disciplinary sanctions for failure to comply with the CDC Recommendations.[87] If a state failed to articulate a policy to ensure compliance with the CDC Recommendations by October 28, 1992,[88] that state became "ineligible to receive assistance under the Public Health Service Act."[89] By October 1992, twenty-three states and territories had complied with the Act, twenty-nine had applied for an extension, and seven states and territories had adopted the CDC Recommendations.[90] Although all states and territories have complied with the mandate,[91] approaches vary as evidenced by the existence of both voluntary and mandatory guidelines.[92]

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[84] *See id.*

[85] *See* 42 U.S.C. § 300ee-2 (1998) (effective Oct. 28, 1991).

[86] *See id.*

[87] *See id.*

[88] Pursuant to the Act, however, the Secretary may extend the deadline when a state requires additional time to comply with the CDC Recommendations. *See id.*

[89] *Id.*

[90] *See* Rubin, *supra* note 8, at 412.

[91] *See Centers for Disease Control and Prevention Draft Guideline for Infection Control in Health Care Personnel, 1997*, 62 Fed. Reg. 47276, 47279 (Sept. 8, 1997).

[92] *See* NATIONAL HEALTH LAWYERS ASS'N, *supra* note 25, § 10:14. In 1992, the Hawaii Governor's Committee on AIDS prepared two scenarios for implementing the CDC Recommendations: the voluntary approach and the mandatory approach. *See id.* Under the voluntary approach, HCWs should adhere to universal precautions, should know their status and receive voluntary counseling, and state and institutional panels should advise the HIV-infected HCWs as to whether they should refrain from procedures. *See supra* notes 68-79 and accompanying text (discussing CDC Recommendations). Under Hawaii's voluntary approach, the infected HCW would not be required to cease treating patients, would be able to maintain confidentiality, and would be required to disclose her HIV status only upon written consent. *See* NATIONAL HEALTH LAWYERS ASS'N, *supra* note 25, § 10:15. Any proposal related to notifying a patient or reassigning a HCW would be purely advisory and subject to the HCW's final approval, unless there is evidence that the HCW is functionally impaired. *See id.* Hawaii, Illinois, Missouri, New York, Oklahoma, and Texas follow this approach. *See id.* Essentially, under the voluntary approach HCWs exercise wide discretion in determining whether they should restrict their job activities.

b. Why Universal Precautions Do Not Ensure Universal Compliance or Universal Protection

Both the CDC Recommendations and the Act do not ensure universal compliance with universal precautions for several reasons. First, the CDC Recommendations are not mandatory as indicated by the language of the Act, which consistently uses "should" rather than "shall."[93] Consequently, there is "no unwavering obedience" of HCWs to adhere to the universal precautions.[94] Second, the CDC Recommendations and the Act do not dictate any legal consequences for HCWs, health care institutions, or licensing boards for failing to adhere to them. They merely punish states financially for declining either to adopt the CDC Recommendations or devise their

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Similar to the voluntary approach, the mandatory approach requires adherence to universal precautions and recommends refraining from invasive procedures if the HCW is infected with dermatitis or lesions. *See id.* § 10:16. Contrary to the voluntary approach, the mandatory approach would require (1) HCWs to submit to routine mandatory testing as enforced by the state health department and licensing board, (2) panel review procedures to be established by the State Department of Health (DOH), (3) HCWs to comply with the DOH's decisions, or be disciplined, and (4) HIV-infected HCWs to report their status. *See id.* HCWs' reassignments would occur based on protocols established by professional organizations, employers, or facilities. *See id.* Liability could be imposed on members of review panels or professional organizations. *See id.* In addition, "downstream liability" could be imposed on institutions, facilities, employers, and agencies for failure to comply. *See id.*

In August 1991, the American Hospital Association (AHA) advocated adhering to CDC Recommendations and following a more voluntary-oriented approach. *See id.* § 10:17. The AHA criticized mandatory routine testing of those HCWs who adhere to universal precautions and who do not perform exposure-prone invasive procedures. *See id.* The AHA, however, acknowledged that the testing of patients or HCWs "should occur only after consideration of legal and ethical issues, and only with informed consent, notification of test results, counseling, and the maintenance of confidentiality of information . . . ." *Id.* (enumerating situations where testing for HIV may be appropriate). Further, the AHA provided some guidance for assembling an expert review panel. *See id.* In addition, the AHA delineated the appropriate criteria for evaluating infected HCWs' "fitness for duty." *See id.* Overall, the AHA sought to balance the confidentiality of HCWs while providing patients with appropriate information to comprehend the implication of exposure. *See id.*

[93] *See CDC Recommendations, supra* note 68, at 5.

[94] *See* Kenneth R. Courington et al., *Universal Precautions Are Not Universally Followed*, 126 ARCH. SURG. 93, 94-95 (1991) (noting an overall infraction rate of 57% in one study and 58% in another and documenting the observed infraction rates by area: 75% occurring in the operating room, 75% occurring in the surgical intensive care unit (ICU), and 30% occurring in the surgical ward). The study revealed that in the surgical context infractions stemmed from the failure of HCWs to use gloves. *See id.* at 95. The second infraction rate (58%) occurred even though researchers informed the participants of the initial infraction rate. *See id.* at 93 (noting the participants believed that study was a one-time intervention).

own policies.[95] Third, states' recommendations can actually be less stringent than the federal guidelines because the CDC Recommendations are not a requirement but rather a suggestion, leaving patients with even less protection.[96] Fourth, as the CDC acknowledges and as evidenced by over fifty HCWs contracting HIV on the job, latex barriers are not foolproof.[97] As will be discussed in Parts III and IV, the CDC Recommendations do not encourage compliance; indeed, physicians continue to perform invasive, exposure-prone procedures despite their HIV status.

No clear mandates to prevent HCW-to-patient transmission have been promulgated by the CDC since its 1991 Recommendations. In September 1997, however, the CDC published a notice of its draft of guidelines for infection control in HCWs and requested comments.[98] The revised infection control guidelines are scheduled for publication in February 1998.[99] The draft indicated that the CDC is currently "in the process of reviewing relevant data" regarding HCW-to-patient transmission policies.[100] In the interim, Part IV of this Note recommends more specific guidelines to prevent HCWs from transmitting HIV to patients.

II. ANTI-DISCRIMINATION LAW AND HIV-INFECTED HEALTH CARE WORKERS

Since the onset of AIDS in the United States in 1981, discrimination that accompanies the negative stereotypes surrounding the disease has harmed those who are HIV-infected as well as the public at large.[101] For example, the CDC's first report of AIDS noted that

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[95] *See* 42 U.S.C. § 300ee-2 (1998) (effective Oct. 28, 1991).

[96] *See generally supra* notes 71-79 (discussing the CDC Recommendations and the decision by the CDC not to make the CDC Recommendations mandatory); *CDC Recommendations, supra* note 68.

[97] *See* Closen, *supra* note 24, at 83 (noting that "universal precautions did not prevent the transmission to 50 to 100 or more health care workers who have contracted HIV from patients."). *See* Part I.B of this Note (providing statistics of number of infected HCWs).

[98] *See* 62 Fed. Reg. 47276 (1997) (requesting comments by October 17, 1997).

[99] *See CDC Issuing New HCW Infection Control Guidelines to Protect Staff and Patients,* HOSP. INFECTION CONTROL, (American Health Consultants), Jan. 1998, at 1 (noting that the report will be published in both the *American Journal of Infection Control* and *Infection Control and Hospital Epidemiology*).

[100] 62 Fed. Reg. at 47279.

[101] *See* Wendy E. Parmet & Daniel J. Jackson, *No Longer Disabled: The Legal Impact of the New Social Construction of HIV,* 23 AM. J.L. & MED. 7, 10-11 (1997) (discussing how public perceptions or "social constructions" define societal, medical, and legal reactions regarding the disease). The hysteria that accompanied the HIV epidemic limited rational public health strategies. *See id.* at 10. The negative stereotypes that

the disease had afflicted five men, all of whom were gay,[102] leading to the misnomer of the "gay plague."[103] In the mid-1980s the high-risk group status expanded to Haitians and intravenous drug users, solidifying negative stereotypes associated with both groups and implying that the disease affected only immigrants or addicts.[104] When it was discovered that the disease was sexually transmitted, the public dismissed the disease as one that afflicted moral outcasts who engaged in deviant behavior.[105] Finally, in 1985, Ryan White, a school-aged hemophiliac who was infected after a blood transfusion, humanized AIDS as the world watched his school district deny him entry to the classroom based on his infection.[106]

Nonetheless, anyone with HIV remained stigmatized and at risk of being discriminated against based on unfounded fears regarding HIV transmission. HIV-positive children were excluded from attending schools and HIV-positive employees were terminated from their jobs.[107] For recourse from this type of discrimination, victims looked to two federal acts[108]—the Rehabilitation Act of 1973[109] and the Americans with Disabilities Act of 1990.[110]

A. *Section 504 of the Rehabilitation Act and the Americans with Disabilities Act*

Both section 504 of the Rehabilitation Act and the ADA protect one who "(i) has a physical or mental impairment which substantially limits one or more of such person's major life activities, (ii) has a record of such an impairment, or (iii) is regarded as having such an impairment."[111] These statutes differ, however, in that section 504

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accompanied HIV and the fears regarding transmission deterred people from being tested and, if infected, counseled for the disease. *See id.*

[102] *See id.* at 9.

[103] *Id.*

[104] *See id.* (citing Janet L. Dolgin, *AIDS: Social Meanings and Legal Ramifications*, 14 HOFSTRA L. REV. 193, 197 (1985)).

[105] *See id.*

[106] *See id.* at 10.

[107] *See* Parmet & Jackson, *supra* note 101, at 10.

[108] *See* discussion *infra* Part II.A. HIV-infected victims also employed state anti-discrimination laws, which are not addressed in this Note. *See, e.g.*, N.J. STAT. ANN. § 10:5-1 *et seq.* (West 1998).

[109] *See* 29 U.S.C. §§ 706(8), 794 (1998).

[110] *See* 42 U.S.C. §§ 12101-12213 (1998).

[111] 29 U.S.C. § 706(8)(B) (1998); *see also* 42 U.S.C. § 12102(2). The second category, which protects individuals who have a *record* of an impairment, reflects the Act's goal of protecting people from fears and stereotypes. *See* 29 U.S.C. § 706(8)(B); 42 U.S.C. § 12102(2)(B). The third category, which protects those who are *regarded as* having a substantially limiting impairment, also protects a person

restricts only those entities that receive *federal* financial assistance[112] from discriminating against a "qualified individual with handicaps . . . solely by reason of her or his handicap."[113] In addition, the ADA is significantly more expansive because it applies to both public and private employers.[114] Of particular relevance to this Note, Title I of the ADA addresses employment rights.[115]

After a disability has been established, the next step is premised on whether the disability "substantially impairs"[116] or "substantially limits"[117] a major life activity[118] based on an individualized inquiry.[119] In conducting this analysis, however, both the ADA and section 504 provide an exception that allows people to make disability-based determinations if the impairment poses a "significant threat" to others.[120] Specifically, employers are permitted to exclude employees

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from fears and stereotypes based on misperceptions, even if the person has no impairment. *See* 29 U.S.C. § 706(8)(B); 42 U.S.C. § 12102(2)(C).

[112] *Compare* 29 U.S.C. § 794 (limiting the dictates of the Act to "program[s] or activit[ies] receiving Federal financial assistance) *with* 42 U.S.C. § 12111(5) (applying the ADA to employers "engaged in an industry affecting commerce").

[113] 29 U.S.C. § 794. Under the ADA, a qualified individual is one "who, with or without a reasonable accommodation, can perform the essential functions" of the current or desired job. 42 U.S.C. § 12111(8).

[114] *See* 42 U.S.C. § 12111(5). There are two employers exempted from the ADA's reach. *See id.* An exception is made for corporations wholly owned by the United States or an Indian Tribe. *See id.* The statute also does not extend to bona fide private membership clubs, which are tax exempt labor organizations. *See id.*

[115] *See* 42 U.S.C. §§ 12101-12117, *et seq.* Title II covers public transportation and other state and local government services that include licensing boards. *See* 42 U.S.C. §§ 12131-12150. Title III includes public accommodations and services operated by private entities such as hotels and movie theaters. *See* 42 U.S.C. §§ 12181-12189. Title IV addresses telecommunications, *see* 47 U.S.C. § 225 (1998), and Title V addresses miscellaneous issues such as the EEOC guidelines. *See* 42 U.S.C. §§ 12201-12213.

[116] 42 U.S.C. § 12102(2)(A).

[117] 29 U.S.C. § 706(8)(B). In its interpretative guidelines, the EEOC defines a substantial limitation as one that precludes an individual from performing any major life activity that an average person would be capable of performing, or one that significantly restricts the "condition, manner or duration under which an individual can perform a particular major life activity as compared to the" average person. 29 C.F.R. § 1630.2(j)(1)(i), (ii) (1998).

[118] *See* 42 U.S.C. § 12102(2)(A); 29 U.S.C. § 706(8)(B). The EEOC guidelines define a major life activity to include "caring for oneself, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning, and working." 29 C.F.R. § 1630.2(i) (1998).

[119] In determining individualized injury, courts should review both the nature and the severity of the condition, the expected duration of existence, and the long-term significance of the limitation. *See* 29 C.F.R. § 1630.2(j)(2)(iii) (1998).

[120] *See* 42 U.S.C. § 12113(b); 29 U.S.C. § 706(D); *see also* EEOC Regulations, 29 C.F.R. § 1630.2(r) (1998) (recommending the four-part balancing test adopted in *School Board of Nassau County v. Arline*, 480 U.S. 273 (1987)).

who "pose a direct threat to the health or safety of other individuals in the workplace."[121] In such a case, employees are deemed not "otherwise qualified" under section 504 and further they cannot "perform the essential functions of the employment" regardless of reasonable accommodation as required under the ADA.[122] Under both statutes, however, the EEOC requires that the disability pose a "significant risk of substantial harm."[123] Courts' interpretations of whether HIV risks meet this standard have varied, as will be demonstrated in Part II.D. Before addressing whether HIV constitutes a significant threat, Part II.B will address whether contagious diseases are protected disabilities.

B. Contagious Diseases as Disabilities

In 1987, the United States Supreme Court decided in *School Board v. Arline*[124] that a teacher who suffered from tuberculosis, a contagious disease, was a handicapped individual within the meaning of the Rehabilitation Act.[125] Gene Arline had taught in New York's Nassau County public school system from 1966 until 1979; the school district discharged her after her third relapse of tuberculosis within two years.[126] In analyzing Arline's claim under section 504 of the Act, the Court reviewed the regulations promulgated by the Department of Health and Human Services (HHS) to determine whether Arline suffered a physical impairment.[127] Because Arline had tuberculosis that required hospitalization in 1957, the Court concluded that she had a record of impairment, placing her within a protected class under section 504.[128]

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[121] 42 U.S.C. § 12113(b).

[122] 42 U.S.C. § 12111(8). An employer may be excused from providing a reasonable accommodation by transferring the employee or restructuring the job. *See* 42 U.S.C. § 12111(9). This exception applies only when making a reasonable accommodation would impose an undue hardship on the employer's normal business operations. *See* 42 U.S.C. § 12111(10).

[123] 29 C.F.R. § 1630.2(r) (1998) (noting that there must be a substantial harm that has a high probability of occurring).

[124] 480 U.S. 273 (1987).

[125] *See id.* at 289.

[126] *See id.* at 276.

[127] *See id.* at 280. HHS defines physical impairment as

> any physiological disorder or condition, cosmetic disfigurement, or anatomical loss affecting one or more of the following body systems: neurological; musculoskeletal; special sense organs; respiratory, including speech organs; cardiovascular; reproductive; digestive; genitourinary; hemic and lymphatic; skin; and endocrine.

45 C.F.R. § 84.3(j)(2)(i)(a) (1998).

[128] *See Arline*, 480 U.S. at 281.

In remanding to the district court, the Court articulated the appropriate individualized inquiry for determining whether Arline was "otherwise qualified" for her job as an elementary school teacher.[129] The Court sought to balance legitimate concerns regarding Arline's contagiousness against section 504's goal of protecting handicapped individuals from "deprivations based on prejudice, stereotypes or unfounded fear . . . ."[130]

Based on the AMA's amicus curiae brief, the Court articulated a four-prong test.[131] The test, based on reasonable medical opinions given current medical information, considered (1) the type of risk or how transmission occurs, (2) the duration or term of that risk or how long a person is infectious, (3) the severity of the risk based on the potential harm to others, and (4) the probability that transmission will occur causing a myriad of harms.[132]

After determining whether the person poses significant health and safety risks, the Court required an evaluation of whether the individual was "otherwise qualified."[133] In the analysis, the Court recognized that an individual who does pose a "significant risk" of transmitting an infectious disease to others in the workplace is not "otherwise qualified . . . if reasonable accommodation will not eliminate that risk."[134] Therefore, under *Arline*'s four-part balancing test, discrimination against an individual with a contagious disease does not constitute disability discrimination if a reasonable accommodation will not protect others from the significant health and safety risks.[135] On remand, the district court concluded that Arline did not pose a "significant risk" or "direct threat" of transmitting tuberculosis to the children in the Nassau County elementary schools because she did not have active, contagious tuberculosis.[136] The court deemed Arline "otherwise qualified" and ordered reinstatement.[137]

In dicta, the Supreme Court explained the importance of protecting handicapped individuals from disability discrimination, emphasizing Congress's recognition that "society's accumulated myths and fears about disability and disease are as handicapping as are the

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[129] *See id.* at 287.
[130] *Id.*
[131] *See id.* at 288.
[132] *See id.* (relying on the standard articulated in the AMA's amicus curiae brief).
[133] *See id.* at 287.
[134] *Arline*, 480 U.S. at 287 n.16.
[135] *See id.*
[136] *See* Rubin, *supra* note 8, at 419-20.
[137] *See id.*

physical limitations that flow from actual impairment."[138] In addition, the Court noted that few conditions of handicap cause as much public fear and apprehension as contagious diseases.[139] Although the Court explicitly discussed how contagious diseases give rise to discrimination, it declined to examine the question of whether someone who carries the HIV virus is physically impaired.[140] Generally, however, courts have concluded that HIV constitutes a disability under section 504.[141] In addition, in 1988, the United States Department of Justice declared that individuals who are HIV-infected are disabled under section 504 because the disease manifests itself in physical impairments that substantially limit major life activities such as breathing, talking, seeing, or walking.[142] Based on those conclusions, various states have classified AIDS and HIV as protected disabilities in antidiscrimination statutes.[143] The challenge is for the HIV-infected individual to rebut a defendant's defense that the plaintiff posed a "significant threat" to the health and safety of others.

In 1987, Congress passed the Civil Rights Restoration Act,[144] which sought to codify the "significant risk" test articulated in *Arline*.[145] Specifically, Congress "added a provision to section 504 of the Rehabilitation Act stating that persons with 'contagious diseases or infections' are not covered under section 504 if they pose a '*direct threat* to the health or safety of other individuals.'"[146] Thus, if an employer cannot eliminate the "significant risk" by reasonable accommodation, the employee will not be "otherwise qualified."[147] Although codification of the *Arline* standard did not provide a

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[138] *Arline*, 480 U.S. at 284.

[139] *See id.*

[140] *See id.* at 282 n.7; *see also* Chalk v. United States, 840 F.2d 701, 704, 711 (9th Cir. 1988) (finding an AIDS-infected teacher qualified to teach hearing-impaired children because there was no evidence of a "significant risk" to children and because to hold otherwise would defeat the purpose of section 504 that seeks to dispel unfounded prejudices).

[141] *See* Rubin, *supra* note 8, at 417-18 n.167 (citing Ray v. Desoto County Sch. Dist., 666 F. Supp. 1524, 1538 (M.D. Fla. 1987) (finding three hemophiliac brothers protected under the Rehabilitation Act and requiring their readmission to the Desoto County schools)).

[142] *See id.* at 418; *see also* 28 C.F.R. Pt. 35 App. A § 35.104 (1998).

[143] *See* Rubin, *supra* note 8, at 418 (citing statutes from Florida, New Jersey, and West Virginia).

[144] *See* 29 U.S.C. § 794 (1998).

[145] *See Calming AIDS Phobia*, *supra* note 5, at 752.

[146] *Id.* (emphasis added). Despite this mandate, section 504 does not provide a definition of "direct threat." *See id.* at 754.

[147] *See id.* at 753.

definition of "direct threat," the ADA defines "direct threat" as one that poses a "significant risk to the health or safety of others that cannot be eliminated by reasonable accommodation."[148] As will be discussed in Part II.D, much of the debate in disability case law regarding HIV revolves around how precisely to quantify and qualify what constitutes a "significant risk." Before parsing out those concepts, the next section addresses whether asymptomatic, rather than symptomatic, HIV constitutes a disability.

C. *Whether Asymptomatic HIV Constitutes a Disability*

Although the legislative history of the ADA demonstrates that AIDS is a protected disability, a debate has emerged as to whether *asymptomatic* HIV constitutes a disability. This controversy has only recently evolved because of technological advances such as protease inhibitors,[149] which reduce traces of HIV to undetectable levels. Consequently, an individual with HIV can live for years without exhibiting symptoms.[150]

In 1997, decisions from the United States Courts of Appeals for the First and Fourth Circuits demonstrated that the circuits are divided regarding the issue. In March, the United States Court of Appeals for the First Circuit held in *Abbott v. Bragdon*[151] that a woman's asymptomatic, HIV status constituted a physical impairment that substantially limited a major life activity—the ability to reproduce.[152] Five months later in *Runnebaum v. NationsBank*,[153] the United States Court of Appeals for the Fourth Circuit held in an eight to four decision that an asymptomatic, HIV-positive man was not physically impaired because reproduction did not constitute a major life activity.[154] Further, the Fourth Circuit commented that the plaintiff failed to demonstrate that he declined to engage in a major life activity.[155] Essentially, the different outcomes are premised on the courts' analyses

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[148] 42 U.S.C. § 12111(3) (1998).

[149] *See supra* note 23 and accompanying text (describing protease inhibitors).

[150] *See* RUBENSTEIN ET AL., *supra* note 4, at 11 (noting that, although individuals may remain symptom free for two to ten years, such individuals are contagious during the latency period).

[151] 107 F.3d 934 (1st Cir. 1997), *cert. granted*, 118 S. Ct. 554 (1997).

[152] *See id.* at 949.

[153] 123 F.3d 156 (4th Cir. 1997) (en banc).

[154] *See id.* at 172 (noting that "nothing inherent in the infection actually prevents either procreation or intimate sexual relations for the purposes of the ADA"). The Fourth Circuit noted that the statute specifically addressed the physical impairment itself—not the individual's response to the impairment. *See id.*

[155] *See id.*

of whether reproduction is a major life activity and whether that activity's impairment is based on the existence of HIV or merely one's reaction to the disease.

In *Abbott*, the First Circuit acknowledged that reproduction is not mentioned specifically in the EEOC Regulations, which enumerate functions such as walking, seeing, hearing, learning, and working.[156] Nonetheless, the court concluded that reproduction "fits comfortably within its sweep" because it is one of the most natural major life functions.[157] In contrast, based on *Webster's Dictionary*'s definition of "major,"[158] the Fourth Circuit concluded that reproduction was not the type of activity contemplated by Congress, even though the court acknowledged that procreation and intimate sexual relations are affected by HIV and that procreation constitutes a fundamental human activity.[159] Consequently, the *Runnebaum* dissent

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[156] *See Abbott*, 107 F.3d at 940 (citing 28 C.F.R. § 36.104 (1998)).

[157] *Id.* The decision in *Abbott* is consistent with the EEOC Guidelines, which state that if reproduction is impaired then the reproductive system is impaired. *See* Gary D. Friedman & Joyce Phillips, *Is Fertility an ADA 'Disability'? If Reproduction is Deemed a Major Life Activity, Employers' Insurance Costs May Escalate*, NAT'L L.J., Feb. 24, 1997, 3. *Abbott*, however, does not signify that the inability to conceive constitutes a per se disability, but rather that HIV impairs the reproductive system because of the contagious nature of the disease. *See id.* This interpretation is also consistent with case law. *See id. Compare* Erickson v. Board of Governors, 911 F. Supp. 316, 322-23 (N.D. Ill. 1995) (finding that plaintiff with a reproductive disability stated a claim under the ADA and holding that discharge for missing workdays while she pursued lengthy infertility treatments violated the ADA) *and* Pacourek v. Inland Steel Co., 858 F. Supp. 1393, 1396-97, 1405 (N.D. Ill. 1994) (same) *with* Krauel v. Iowa Methodist Med. Ctr., 95 F.3d 674, 677 (8th Cir. 1996) (holding in part that employer's denial of insurance coverage for infertility treatments did not violate ADA because plaintiff's inability to conceive did not prevent her from performing duties as a respiratory therapist and because employer did not disparately treat plaintiff based on her gender) *and* Zatarain v. WDSU-Television, Inc., 881 F. Supp. 240, 243 (E.D. La. 1995), *aff'd*, 79 F.3d 1143 (5th Cir. 1996) (holding that, because television anchor's inability to conceive does not constitute a disability, employer is not required to accommodate in the absence of a disability). The Department of Justice also supports the conclusion that asymptomatic and symptomatic HIV limit the major life activity of reproduction based on the fear of transmitting HIV to a fetus and discourages people from engaging in intimate sexual relations. *See* Department of Justice Guidelines, 29 C.F.R. Pt. 36 App. § 36.104 (1998).

[158] *See Runnebaum*, 123 F.3d at 170 (noting that *Webster's Dictionary* defines major as "demanding great attention or concern . . . greater in dignity, rank, importance or interest").

[159] *See id.* at 170-71 (citing *Krauel*, 95 F.3d at 677). The *Runnebaum* court also compared *Krauel* with *Abbott*, 107 F.3d at 941 (concluding that procreation is covered under the ADA); McWright v. Alexander, 982 F.2d 222, 226-27 (7th Cir. 1992) (holding, under the Rehabilitation Act, that an employer failed to make a reasonable accommodation for employee to pursue fertility treatments that interfered with her work schedule); and *Zatarain*, 881 F. Supp. at 243 (holding that plaintiff did not have impairment of the reproductive system).

vehemently rebuked the majority's conclusion that procreation was not a major life activity and classified it as "perhaps the most important life activity, since we would cease to exist as a species if we no longer reproduced."[160] Chastising the majority for creating a per se rule that asymptomatic HIV is never protected under the ADA, the dissent reiterated that the majority's conclusion was inapposite to the statutory text, medical findings, legislative history, administrative regulations, and the Fourth Circuit's earlier decision in *Ennis v. National Association of Business & Educational Radio, Inc.*,[161] which required a case-by-case analysis.[162] Consequently, the dissent concluded that the majority's decision constituted an inappropriate, outright repeal of the ADA, which Congress enacted to curb discrimination against people who suffer from asymptomatic HIV.[163]

The circuits also differed as to whether reproduction was substantially impaired by HIV. Relying on EEOC regulations[164] and judicial authority,[165] the First Circuit concluded that HIV substantially impaired one of Abbott's major life activities because the disease had a profound effect on her ability to engage in intimate sexual relations, gestation, childbearing, child rearing, and nurturing familial relations.[166] Rejecting the assertion that the plaintiff's reproductive system was impaired because of her choice not to procreate or engage in sexual relations,[167] the court concluded that HIV substantially

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[160] *Runnebaum*, 123 F.3d at 184 (Michael, C.J., dissenting) (citing *Abbott*, 107 F.3d at 940).

[161] 53 F.3d 55, 60, 61-62 (4th Cir. 1995) (finding that an employee did not establish a prima facie case of discrimination under the ADA based on her son's HIV status and fear of medical treatment being too costly because the court rejected a per se rule that HIV-infected individuals are disabled and evidence in the record that indicated her job performance justified her termination).

[162] *See Runnebaum*, 123 F.3d at 186 (Michael, C.J., dissenting).

[163] *See id.*

[164] *See* 28 C.F.R. § 36.104 (1998).

[165] *See* Gates v. Rowland, 39 F.3d 1439, 1446 (9th Cir. 1994) (noting that classification of asymptomatic and symptomatic HIV as a disability is consistent with the holdings of *School Board of Nassau County v. Arline* and *Chalk v. United States*).

[166] *See* Abbott v. Bragdon, 107 F.3d 934, 942 (1st Cir. 1997), *cert. granted*, 118 S. Ct. 554 (1997).

[167] *See id.*; *see also* Pacourek v. Inland Steel Co., 858 F. Supp. 1393, 1405 (N.D. Ill. 1994) (holding that reproduction is a major life activity and finding that reproductive disorders qualify as physical impairments under the Rehabilitation Act). *But see* Krauel v. Iowa Methodist Med. Ctr., 95 F.3d 674, 677 (8th Cir. 1996) (holding that choices governing reproduction and sexual relations are lifestyle choices and are distinguishable from breathing, walking, and other major life activities described in the EEOC Guidelines); Zatarain v. WDSU-Television, Inc., 881 F. Supp. 240, 243 (E.D. La. 1995), *aff'd*, 79 F.3d 1143 (5th Cir. 1996) (holding that the analyses governing physical impairments and major life activities are analytically distinct com-

limits a "fecund woman's major life activity of reproduction,"[168] making Abbott disabled under the ADA.[169] Consequently, the First Circuit held that Bragdon's refusal to provide routine dental care to Abbott violated the ADA.[170]

In contrast, the Fourth Circuit refused to acknowledge that a person's reaction to his impairment, which leads to behavior modifications pertaining to major life activities, serves to create a statutory disability.[171] Although the court recognized that asymptomatic, HIV-infected individuals may refrain from engaging in procreation or sexual relations because of the fear that offspring or a partner may become infected, the court concluded that there was "nothing inherent in the virus [that] substantially limits procreation or intimate sexual relations."[172] Consequently, the court concluded that Runnebaum failed to demonstrate that he was disabled under the ADA.[173]

Both decisions are flawed.[174] The Fourth Circuit decision is troubling because it disregarded legal findings based on medical evidence that the actual physical impairment of the individual is not the primary issue, but "rather the issue is the contagious effect of the

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ponents of the ADA' s definition of disability).

[168] *Abbott*, 107 F.3d at 942. The court also rejected the respondent's assertion that Abbott's reproductive activity was not substantially limited, given that if she took AZT there would be only an 8% chance of transmission. *See id.*

[169] *See id.* As to the "direct threat" exception, the court concluded that Bragdon could not seek shelter under this safe-harbor provision. *See id.* at 943, 949. Recognizing that these cases are fact sensitive, the court noted that because Abbott required only a simple procedure, Bragdon failed to provide evidence of a direct threat of physician to patient transmission. *See id.* at 949. The court, however, prefaced its conclusion with the disclaimer that its holding did not "eschew[ ] a blanket rule" and that the ADA analysis continues to require a case-by-case inquiry. *See id.*

[170] *See id.* (noting that impartial observers have reason to empathize with Abbott and Bragdon).

[171] *See* Runnebaum v. NationsBank, 123 F.3d 156, 172 (4th Cir. 1997) (en banc).

[172] *Id.*

[173] *See id.* at 174. The court also concluded that Runnebaum failed to demonstrate that the employer discriminated against him because of his disability, particularly because of his performance deficiencies. *See id.* at 175. In addition to failing on his ADA claim, Runnebaum's ERISA claim failed even though he asserted that by firing him the bank interfered with his ability to pay for AZT, which had been covered under the employer's health insurance plan. *See id.* at 163, 175. Consequently, the court affirmed the district court's grant of summary judgment in favor of NationsBank. *See id.* at 176.

[174] Despite their shortcomings, the dispositions in *Runnebaum* and *Abbott* are relevant to the issue of whether asymptomatic HIV-positive individuals are protected under the ADA. One hopes that the Supreme Court will settle the dispute in the circuits regarding HIV as a disability. *See supra* note 46. Although the issue of whether asymptomatic HIV constitutes a disability is pertinent to individuals who are HIV-positive, the debate regarding HIV-infected HCWs centers upon whether they pose a "significant risk" to others despite being asymptomatic.

HIV virus."[175] At the onset, HIV is a retrovirus that penetrates the individual's immune system and leads to a gradual but inevitable disarmament of the immunological defenses.[176] Because individuals are impaired immediately upon infection and because potential transmission is the basis of disability, there is no distinction for purposes of disability law between asymptomatic and symptomatic individuals—both categories are protected under the ADA.[177] In short, because of the Fourth Circuit's misinterpretation of the ADA, misplaced reliance on factually distinct case law, and disregard of prior case law and EEOC guidelines, *Runnebaum* should not be afforded significant weight when analyzing disability law.

In comparison, however, *Abbott* is flawed because the court's conclusion—that the plaintiff decided not to have children because of her HIV status—protects only women who have the capacity to reproduce.[178] For example, *Abbott* does not protect homosexual men who can never reproduce with their partners or post-menopausal women who cannot conceive a child.[179] Although the *Abbott* court conducted the prerequisite individualized analysis and concluded that Abbott was protected "based in large part on the fortuity of her own fertility,"[180] the First Circuit's decision does not provide broad protection under the ADA. Consequently, to protect the widest range of disabled people, courts should recognize that asymptomatic HIV substantially impairs the ability to engage in reproductive activities because of the risk of transmission, rather than limiting protection to those individuals with specific intentions to reproduce.[181]

As noted earlier, the United States Supreme Court granted certiorari to *Abbott* in November 1997.[182] Therefore, the Court has the opportunity to address whether asymptomatic HIV constitutes a disability and whether a physician must treat an HIV patient.[183] As to

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[175] Gates v. Rowland, 39 F.3d 1439, 1446 (9th Cir. 1994).

[176] *See id.* (citing Chalk v. United States, 840 F.2d 701, 706 (9th Cir. 1988)); *see also Runnebaum*, 123 F.3d at 180-81 (Michael, C.J., dissenting) (noting that in asymptomatic stages of HIV infection the disease attacks the lymph system).

[177] *See Gates*, 39 F.3d at 1446 (citing 28 C.F.R. § 35.104(4)(1)(ii) (1998)).

[178] *Cf.* International Union v. Johnson Controls, Inc., 499 U.S. 187, 211 (1991) (holding that a gender-specific fetal protection policy in the workplace violated Title VII because (1) it only protected women and (2) the employer did not offer a bona fide occupational qualification as a defense).

[179] *See* Parmet & Jackson, *supra* note 101, at 35-36.

[180] *Id.* at 35.

[181] *See Runnebaum*, 123 F.3d at 185 (Michael, C.J., dissenting).

[182] 118 S. Ct. 554 (1997).

[183] *See supra* note 46 (stating the issues for which the Supreme Court granted certiorari).

the second issue, the Court's disposition could have a profound effect on patients' rights in terms of the duty to treat and informed consent. On one hand, patients' rights could be restricted if the Court concludes that physicians do not have a duty to treat HIV-infected patients or that patients must disclose their HIV status.[184] On the other hand, patients' rights could be expanded if the Court decides that physicians should be required to disclose their HIV status to patients.

D. Why the "Significant Risk" or "Direct Threat" Test Has Been Inconsistently Applied to Individuals with HIV

According to the EEOC,[185] the legal standard for determining whether an individual should be discharged because of a disability is premised upon whether a worker or employer has a "reasonable belief based on objective evidence that (1) leads to a suspicion that a worker might pose a direct threat in the workplace; or (2) arises because of suspicion that the worker cannot perform the essential functions of a job."[186]

As to the first consideration, whether HIV-infected persons pose a "significant risk" or "direct threat" to others, courts have retreated from the *Arline* balancing test[187] and recently have employed a more stringent test, which requires individuals to demonstrate that they do not pose *any* risk of transmitting the virus.[188] Two waves of cases exemplify the shift.[189] The first set of cases involves courts granting protection to HIV-infected individuals because the risk posed to others was characterized as minimal.[190] These cases, however, occurred be-

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[184] *See supra* note 93 (noting that AHA recommends HIV testing of patients in certain condition but rejects mandatory testing of HCWs).

[185] *See* Fair Employment Practice (123) (Oct. 16, 1997) (on file with the *Seton Hall Law Review*).

[186] *Id.*

[187] *See* Sullivan, *supra* note 8, at 599-600.

[188] *See id.*

[189] *See id.* at 618-43.

[190] *See id.* at 627-39. The first wave is characterized by four cases. *See id.* at 627; *see also* Martinez v. School Bd., 861 F.2d 1502, 1504 (11th Cir. 1988) (acknowledging lower court's finding that the risk of a child transmitting HIV in the educational setting was a "remote theoretical possibility"); Chalk v. United States, 840 F.2d 701, 707 (9th Cir. 1988) (holding that school teacher who had AIDS posed a "minimal risk" to children); Doe v. Dolton Elementary Sch. Dist. No. 148, 694 F. Supp. 440, 445 (N.D. Ill. 1988) (holding that HIV-infected child did not pose a "significant risk" to other children); Glover v. Eastern Nebraska Community Office of Retardation, 686 F. Supp. 243, 351 (D. Neb. 1988), *aff'd*, 867 F.2d 461, 464 (8th Cir. 1989) (holding that mandatory HIV testing was unnecessary because the risk of transmission to residents was "trivial," "extremely low," and "theoretical"). There was also a

fore the "remote" possibility of HIV transmission from HCW to patient became a reality with the Acer cluster.[191] Four of the five cases within the second wave involved HCWs, but none required a showing of a "significant risk."[192] Rather, the courts equated *any* risk of transmission as a "significant risk" given that AIDS is fatal.

In 1990, the second wave of cases began with *Leckelt v. Board of Commissioners*.[193] In *Leckelt*, the United States Court of Appeals for the Fifth Circuit upheld the discharge of a nurse who refused to submit results of an HIV test, thereby preventing the hospital from determining how best to comply with the CDC Recommendations.[194] In addition to concluding that the hospital did not discriminate against Leckelt solely because of his handicap,[195] the court found that he was not "otherwise qualified" to perform his duties because he failed to comply with the hospital's policy for monitoring HIV and other infectious diseases.[196] Emphasizing that high-risk employees often fail to comply with the CDC Recommendations, the court held that the opportunity for infection "far outweighed" the employee's privacy interests.[197] Consequently, the Fifth Circuit held that the hospital did not violate section 504.[198]

HCW case in 1988 in which a consent decree in the Illinois District Court provided that an HIV-infected neurologist whose privileges were suspended could be "reasonably accommodated" by requiring added precautions, namely that he wear double gloves. *See* Rubin, *supra* note 8, at 420-21.

[191] *See supra* notes 6-10 and accompanying text (discussing Acer cluster).

[192] See *infra* notes 193-228 and accompanying text for a discussion of the second wave of cases.

[193] 714 F. Supp. 1377, 1389 (E.D. La. 1989), *aff'd*, 909 F.2d 820, 821 (5th Cir. 1990).

[194] The hospital infection control practitioner investigated Leckelt after his roommate of eight years died of AIDS and reports began circulating that an unidentified, gay nurse was HIV-positive. *See Leckelt*, 909 F.2d at 822. After the practitioner suspected Leckelt and requested that he submit to an HIV test, Leckelt informed the practitioner that he was awaiting results of an HIV test. *See id.* at 822-23. Leckelt agreed to provide the practitioner with his results when he received them. *See id.* at 823. During that conversation, Leckelt informed the infection control staff person of his draining lesion. *See id.* In response, the practitioner forbade Leckelt from returning to work until he secured a medical clearance from his doctor. *See id.* Later, the practitioner also learned of Leckelt's status as a HBV carrier who had a history of syphilis. *See id.* After two weeks of trying to acquire Leckelt's test results, the hospital discharged Leckelt for his "failure to comply with hospital policies—namely failure to submit the test results" and failure to inform the practitioner of his refusal. *Id.* at 824. The court supported the hospital's conduct and reiterated that "a hospital has the right to require such testing . . . in order to fulfill an obligation to its employees and to the public." *Id.*

[195] *See id.* at 826.

[196] *See id.* at 830.

[197] *See id.* at 832.

[198] *See id.* at 833 (holding in part that the hospital did not violate the Louisiana

In 1991, a New Jersey court held in *Estate of Behringer v. Medical Center*[199] that an HIV-infected otolaryngologist/plastic surgeon posed a "reasonable probability of substantial harm" because he performed invasive procedures.[200] Further, the court acknowledged that actual exposure was not the only concern because patients would also suffer the stress of post-exposure testing.[201]

Later that year, in *Doe v. Washington University*,[202] the United States District Court for the Eastern District of Missouri found, given the frequency of self-injury and the potential for subsequent exposure to patients, a dental student was not "otherwise qualified" because he could not meet his credential requirements without performing invasive procedures.[203] Relying on CDC studies regarding the Acer cluster and the likelihood of injury,[204] the court concluded that substantial deference should be given to the academic decision that the probability of harm was too great.[205]

Relying on the *Washington University* analysis, a Pennsylvania court decided *In re Milton S. Hershey Medical Center*.[206] The court determined that the hospital's decision to reveal the HIV status of an obstetrics/gynecology surgical resident was appropriate after the resident admitted exposing a patient to HIV when he accidentally

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Civil Rights for Handicapped Act, the Equal Protection Clause of the Fourteenth Amendment, or Leckelt's right to privacy under both the Fourth and Fourteenth Amendments). As to the search and seizure analysis, the court concluded that the government's strong interest in maintaining a safe workplace outweighed the limited invasion of Leckelt's privacy, in part because of the hospital's compelling interest in protecting its employees and patients from HIV. *See id.* at 831-32 (citing National Treasury Employees Union v. Von Raab, 489 U.S. 656, 679 (1989) (holding that suspicionless drug testing of United States Customs Service employees is reasonable under the Fourth Amendment because they intercept drugs, carry firearms, and access sensitive information)).

[199] 249 N.J. Super. 597, 592 A.2d 1251 (Law Div. 1991). For a discussion of this case in the informed consent context, see Part III of this Note.

[200] *Estate of Behringer*, 249 N.J. Super at 657, 658, 592 A.2d at 1283 (noting that where the ultimate harm is death the low possibility of transmission suffices to preclude a surgeon from performing invasive procedures if there is *any* risk of transmission).

[201] *See id.* at 651, 592 A.2d at 1279.

[202] 780 F. Supp. 628 (E.D. Mo. 1991).

[203] *See id.* at 633. The hospital offered a reasonable accommodation by allowing the student to perform his requirements at an AIDS clinic and offering him opportunities in other medical programs at the university that did not require performing invasive procedures. *See id.* at 630.

[204] *See id.* at 633.

[205] *See id.* at 631.

[206] 595 A.2d 1290 (Pa. Super. Ct. 1991), *aff'd*, 634 A.2d 159 (Pa. 1993). For a discussion of this case in the informed consent context, see Part III of this Note.

cut his surgical glove during an invasive procedure.[207] Because he performed invasive procedures and a potential for actual transmission existed,[208] the court concluded that the resident presented a health risk to his patients.[209] Although this decision is not addressed specifically in the second wave of cases, it is consistent with the shift from a "significant risk" to an "any risk" analysis.

In 1993, in *Bradley v. University of Texas M.D. Anderson Cancer Center*,[210] the United States Court of Appeals for the Fifth Circuit found an HIV-positive surgical technician not "otherwise qualified."[211] The court also held that the hospital's reassignment of the technician to the purchasing department did not constitute disability-based discrimination.[212] Under the *Arline* analysis, the court focused on the probability that Bradley could transmit the disease and cause harm[213] even though the risk was small.[214] The court stated that "[a] cognizable risk of permanent duration with lethal consequences suffices to make a surgical technician not 'otherwise qualified.'"[215] The court further noted that the hospital could not make "'reasonable accommodation' to eliminate the risks connected with the 'essential functions'" of being a surgical technician because only removal would eliminate the risk.[216] Therefore, the court found reassignment appropriate, noting that the hospital had no duty to reassign Bradley to a particular position.[217]

Similarly, in *Scoles v. Mercy Health Corp.*,[218] the United States District Court for the Eastern District of Pennsylvania held in 1994 that a hospital's refusal to allow an HIV-positive surgeon to treat patients did not violate the Rehabilitation Act.[219] The court explained that

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[207] *See id.* at 1296; *see also* Doe v. University of Maryland Med. Sys. Corp., 50 F.3d 1261, 1266 (4th Cir. 1995) (holding that HIV-infected neurosurgical resident posed a "significant risk to the health and safety of patients" given the exposure-prone procedures he performed).

[208] *See Hershey*, 595 A.2d at 1296.

[209] *See id.* at 1298 (noting that the resident posed a risk to other surgeons' patients as well).

[210] 3 F.3d 922 (5th Cir. 1993) (per curiam).

[211] *See id.* at 925.

[212] *See id.* at 923.

[213] *See id.* at 924.

[214] *See id.* (focusing on the "catastrophic consequences" of transmission).

[215] *Id.* (citations omitted).

[216] *Bradley*, 3 F.3d at 925.

[217] *See id.*

[218] 887 F. Supp. 765 (E.D. Pa. 1994).

[219] *See id.* at 772. The surgeon also brought suit under the ADA. *See id.* This claim failed for the same reasons. *See id.* It should be noted, however, that Dr.

the surgeon posed a "significant risk" to his patients for three reasons. First, no cure for AIDS exists.[220] Second, each time he performs an invasive procedure, the patient is at risk.[221] Third, although people may live for years after exposure, death is inevitable.[222] Consequently, an HIV-infected surgeon cannot be "otherwise qualified" under either of the federal disability statutes or present medical standards. Although this case is not classified specifically within the second wave of cases, *Scoles* demonstrates that, given the fatal nature of AIDS, any risk of transmission is significant.

The second wave of cases reflects the ambiguity in the statutory definition of "significant risk."[223] This uncertainty is based upon the conflict between an analysis based on scientific facts, which show that HIV transmission is unlikely, and a normative values approach, which reflects real concerns that transmission results in fatality.[224] In this context, "significant risk" is a relative term. Therefore, the quantification or qualification of what constitutes a "significant risk" is actually premised on acceptable risks, which are defined according to both facts and values.[225] As such, a "significant threat" is measured by scientific evidence of whether the risk is likely to cause harm and whether individuals view the potential for actual harm as significant.

Concededly, this "any risk" formulation may deprive people with contagious diseases of the rights secured in *Arline*.[226] Although current case law may not be wholly consistent with Congress's intent to protect people with HIV from discrimination, patients' rights should not be compromised simply because Congress has declined to provide additional guidance.[227] Resolution of this conflict should come from Congress rather than the courts,[228] and if Congress is unable to devise a solution due to a lack of technical expertise, it should delegate a clear mandate to the CDC.

Because there is no cure for AIDS, any judicial miscalculation regarding what constitutes a "significant risk" could be fatal. Thus, courts cannot rely blindly on scientific evidence without regard to

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Scoles could have performed invasive procedures if he obtained documentation of informed consent from all of his patients. *See id.* The issue of informed consent is discussed in further detail in Part III of this Note.

220 *See id.*

221 *See id.*

222 *See id.*

223 *See* Sullivan, *supra* note 8, at 643.

224 *See id.* at 648-49.

225 *See id.* at 659.

226 *See id.* at 668.

227 *See id.*

228 *See id.* at 688. For further discussion of this view, see Part IV of this Note.

normative values of what people consider to be a "significant risk."[229] Public opinion polls suggests that any risk is a "significant risk."[230] Therefore, until Congress articulates a more tangible test or clarifies "significant risk" analysis, HIV-infected HCWs who perform invasive and exposure-prone procedures should be suspended or terminated if a reasonable accommodation is not feasible.

III. PATIENT CONCERNS REGARDING INVASIVE, EXPOSURE-PRONE PROCEDURES: WHY THE RISK OF HIV INFECTION IS MATERIAL AND THE FEAR OF TRANSMISSION IS REASONABLE

Employees, including HCWs, should be protected from disability discrimination caused by their HIV status. Nonetheless, as indicated by the "direct threat" and "significant risk" language under the Rehabilitation Act and the ADA, a HCW's right to be free from discrimination is not absolute. As stated in Part I, there is only one *known* incident of HIV transmission from a physician or dentist to a patient in the United States. Nonetheless, most people would like to know whether their treating physicians are HIV-positive.[231] The dilemma, however, is premised upon whether a physician has a legal duty to disclose that information to a patient.[232] Although a large portion of this Note speaks generally of statistics involving HCWs, Part III specifically focuses on physicians, including dentists and surgeons, and discusses whether a patient should be informed of his physician's HIV status. The intentional and negligent infliction of emotional distress torts provides additional areas of debate.

A. *Informed Consent*

The doctrine of informed consent is premised on a patient's right to autonomy and self-determination.[233] Specifically, the doc-

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[229] *See* Sullivan, *supra* note 8, at 647-67.

[230] *See* Closen, *supra* note 24, at 97-98. Studies indicate that 78% of survey respondents "would either discontinue all treatment with [the] infected [HCW] or would continue treatment but exclude surgery or other invasive procedures." *Id.* at 99. Most survey participants believed that HCWs should reveal their HIV status to patients before treatment. *See id.* at 98-99. As such data is clearly available, it could and should be used to provide normative guidance as to what types of risk are acceptable. *See* Sullivan, *supra* note 8, at 655.

[231] *See* Closen, *supra* note 24, at 97-100 (citing various opinion polls indicating that between 80-90% of the public believes that physicians should disclose their HIV status given the risk of harm to patients).

[232] *See* FURROW ET AL., *supra* note 14, at 407.

[233] *See* Schloendorff v. Society of New York Hosp., 105 N.E. 92, 93 (N.Y. 1914). *Schloendorff* was one of the first cases to address the issue of informed consent.

trine recognizes that an individual has "a right to be free from nonconsensual interference with his or her business."[234] Generally, informed consent seeks to "protect individual autonomy; protect the patient's status as a human being; avoid fraud or duress . . . and involve the public generally in medicine."[235]

As stated in 1972, in one of the most significant informed consent cases, *Canterbury v. Spence*,[236] the doctrine is based on the notion that a physician should divulge information that he objectively, not subjectively, considers to be "material" according to what information a prudent patient would want to make a decision.[237] In *Canterbury*, the court defined a risk as being material "'when a reasonable person, in what the physician *knows or should know* to be the patient's position, would be likely to attach significance to the risk or cluster of risks'" when deciding whether to undergo a specific procedure.[238] In addition to demonstrating that (1) a specific risk was material, a patient must demonstrate that (2) a reasonably prudent patient would have foregone the procedure if informed of the significant dangers and (3) those risks manifested an actual injury.[239]

As to the first element, the issue of whether a physician's HIV status is material to the patient's medical decisionmaking is somewhat unusual because the risks are based upon the physician's own characteristics that, as a general rule, are not considered in the analysis.[240] The inherent dilemma permeating the issue is whether physician-risk information, rather than procedure-specific risks, can be considered.[241] HIV-infected HCWs should be classified within the

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[234] FURROW ET AL., *supra* note 14, at 397.

[235] *Id.* (citing Alexander Morgan Capron, *Informed Consent in Catastrophic Disease Research and Treatment*, 123 U. PA. L. REV. 340, 365-76 (1974)).

[236] 464 F.2d 772 (D.C. Cir. 1972).

[237] *See id.* at 787.

[238] *Id.* (quoting Jon R. Waltz & Thomas W. Scheuneman, *Informed Consent to Therapy*, 64 N.W. U. L. REV. 628, 640 (1970)). In addition to the *Canterbury* reasonable patient standard, there is also a professional disclosure standard. *See* FURROW ET AL., *supra* note 14, at 406. The professional disclosure standard assesses whether there is a duty to disclose based on a "reasonable medical practitioner similarly situated." *Id.* Although states are divided between these standards a "slight majority" has adopted the professional standard even though the patient standard has secured increased approval. *See id.*

[239] *Id.* at 790-91.

[240] *See* FURROW ET AL., *supra* note 14, at 418 (discussing the role performance risks play in determining the risk an HIV-infected physician poses to his patients).

[241] *See id.* at 417 (citing Kennedy v. St. Charles Gen. Hosp. Auxiliary, 630 So. 2d 888, 892 (La. Ct. App. 1993)). *Compare* Hales v. Pittman, 576 P.2d 493 (Ariz. 1979) (holding that defendant doctor's lack of experience and procedure's high risk were material and should have been disclosed) *and* Hidding v. Williams, 578 So. 2d 1192,

physician-specific category of facts subject to disclosure for three reasons. First, HIV is a contagious and fatal disease that causes irreparable harm.[242] Second, the lethal risk depends upon the physician's HIV status *and* the procedure involved.[243] Third, in contrast to fatigue or depression, an HIV-infected physician who performs an invasive procedure places a patient at risk of contracting the disease each time the physician makes an incision, punctures the skin, or places his hands into a patient's body cavity.[244]

Further, HIV is contagious and the risk associated with invasive procedures make the disease a hybrid between physician-specific and procedure-specific risks. Specifically, if the physician performs a non-invasive procedure, there is no material risk in the procedure despite the physician's HIV status. In contrast, if a physician performs an invasive procedure, his HIV status should be considered a procedure-specific risk given that the invasive procedure would not be risky but-for the physician's HIV status, whereas the risk of a physician causing harm based on fatigue or depression exists in every procedure. Further, as stated by the court in *Mauro v. Borgess Medical Center*,[245] the appropriate test is whether the risk is avoidable, in the sense that it could be eliminated by the particular physician foregoing the procedure.[246] Accordingly, because HIV transmission necessarily results in death, the HIV status of a physician should be con-

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1196, 1198 (La. Ct. App. 1991) (holding that physician's failure to disclose alcoholism violated informed consent statute) *and* Johnson v. Kokemor, 545 N.W.2d 495, 506 (Wis. 1996) (noting that the combination of the procedure's risks and the doctor's inexperience was material and thus disclosure was required) *with* Ornelas v. Fry, 727 P.2d 819, 823 (Ariz. Ct. App. 1986) (refusing to allow evidence of alcoholism to prove that anesthesiologist was impaired during procedure that resulted in negligence).

One example of a physician-specific risk is the aging process, which may result in diminished motor skills decreasing a surgeon's survival rate. *See* FURROW ET AL., *supra* note 14, at 417. The informed consent issue concerns whether the surgeon should be required to disclose his diminishing motor skills even though his record remains excellent. *See id.* Typically, institutional peer review and a surgeon's own integrity would result in an institution declining to credential the surgeon or the surgeon would voluntarily step down if incompetence existed. *See id.* at 417-18. Institutional peer review has not been successful, however, in protecting patients from being exposed to HIV-infected HCWs because of the lack of mandatory testing. *See* discussion *supra* Part II.D and *infra* Part IV.

[242] *See supra* notes 218-222 and accompanying text (highlighting concerns that HIV is fatal).

[243] *See supra* notes 218-222 and accompanying text. *But see* FURROW ET AL., *supra* note 14, at 418 (positing that disclosing physicians' contagious diseases is different from performance based or procedure specific risks).

[244] *See* Mauro v. Borgess Med. Ctr., 886 F. Supp. 1349, 1353 (W.D. Mich. 1995).

[245] 886 F. Supp. 1349 (W.D. Mich. 1995).

[246] *See id.* at 1353.

sidered material if that physician performs exposure-prone, invasive procedures.

As to the second element required for an informed consent claim, people often classify the risk of HIV transmission from a HCW to be material.[247] For instance, ninety percent of those surveyed in one poll,[248] and eighty percent surveyed in another poll,[249] stated that physicians who are HIV-positive should inform patients of their HIV status. The respondents in one poll admitted that they would forego treatment with that physician, or at the least, refuse to permit that physician to perform any invasive, exposure-prone procedures.[250] Although a patient's refusal would likely result in de facto termination,[251] the issue is distinct from whether the risk is material to the patient. Indeed, termination is an unfortunate consequence for a physician. Nonetheless, it is the patient's prerogative to refuse treatment from that physician because patient choice and autonomy are the essence of the informed consent doctrine.[252] Further, the risk of transmission is material as exemplified by the disposition of the second wave of HIV-disability discrimination cases that classified any risk of transmission as significant.[253]

The patient-physician relationship exists to serve and protect the patient's interests,[254] not those of the physician.[255] Further, the physician owes a fiduciary duty to the patient, whereas the patient does not owe a reciprocal ethical duty to the physician.[256] Given the

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[247] *See* Closen, *supra* note 24, at 69.

[248] *See id.* at 98. That poll also provided evidence that 94% of respondents believed that dentists should inform their patients that they are infected with the HIV virus. *See id.* at 97-98.

[249] *See id.* at 98.

[250] *See id.* at 99.

[251] *See* Estate of Behringer v. Medical Ctr., 249 N.J. Super. 597, 613, 592 A.2d 1251, 1258 (Law Div. 1991).

[252] *See supra* notes 233-235 and accompanying text. As the *Estate of Behringer* court commented:

> 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. . . . If there is to be an ultimate arbiter of whether the patient is to be treated invasively by an AIDS-positive surgeon, the arbiter will be the fully-informed patient.

Estate of Behringer, 249 N.J. Super. at 657, 592 A.2d at 1283.

[253] *See* discussion *supra* Part II.D.

[254] *See* Closen, *supra* note 24, at 119 (commenting that doctors' elevation of "self-interest above patient autonomy" must end).

[255] *See id.* at 59.

[256] *See id.* at 119.

unequal positions in a patient-physician relationship, it is preposterous to place the onus on the patient to ask whether the physician is HIV-positive, given the inequality of medical knowledge.[257]

The medical profession's promulgation of a "Don't Ask-Don't Tell" policy[258] constitutes an industry-wide breach of the duty of care.[259] As demonstrated in the famous tugboat radio equipment case, *The T.J. Hooper v. Northern Badge Corp.*,[260] that an entire industry requires a certain standard does not automatically signify that the requirement does not lag behind in the adoption of new standards.[261] After Judge Learned Hand conducted an economic analysis as to whether the probability of loss or harm outweighed the benefit of requiring radios on tugboats, Judge Hand concluded that the absence of radio equipment was an avoidable risk.[262] Although the CDC does not mandate testing unless it is proven cost-effective,[263] a cost-benefit analysis should not be dispositive as to whether a reasonable patient considers that information to be material.

Further, several cases have concluded that the HIV status of a physician who practices invasive, exposure-prone procedures is material under the informed consent doctrine. In 1991, a New Jersey court was the first to address that issue in *Estate of Behringer v. Medical Center*.[264] After the hospital suspended Behringer's privileges, he filed suit alleging that the hospital had violated the state's anti-discrimination statute by suspending his privileges and by failing to maintain confidentiality of his diagnosis and test results.[265] The court

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[257] *See id.*

[258] *See id.* at 79 (analogizing the regulatory scheme to the military's homosexual reporting policy).

[259] *See id.* at 119.

[260] 60 F.2d 737 (2d Cir. 1932).

[261] *See* Closen, *supra* note 24, at 118-19 (citing *T.J. Hooper*, 60 F.2d at 740).

[262] *See T.J. Hooper*, 60 F.2d at 740.

[263] *See* discussion *supra* Part I.B.2 (discussing CDC Recommendations); *see also* Kathryn A. Phillips et al., *The Cost-effectiveness of HIV Testing of Physicians and Dentists in the United States*, 271 JAMA 851, 851 (1994) (noting the substantial benefits of mandatory HIV testing of surgeons and dentists). Phillips explained:

> [U]nder a medium seroprevalence and transmission risk scenario, mandatory testing of all surgeons might avert 25 infections at a total cost of $27.9 million or $1115000 per infection averted and an incremental cost of $291,000 compared with current testing; however, the incremental cost-effectiveness per patient averted ranges from $29807000 under a low-risk scenario to a savings of $81000 under a high risk scenario.

Id.

[264] 249 N.J. Super. 597, 657, 592 A.2d 1251, 1283 (Law Div. 1991).

[265] *See id.* at 605, 592 A.2d at 1254. The physician was rushed to the hospital's

held the hospital liable for the unauthorized disclosure of his test results,[266] but concluded that suspension was appropriate.[267] Although the court noted that at the time Behringer acquired the disease no physician had transmitted HIV to his patient,[268] the court agreed that the patient should be the "ultimate arbiter" in assessing the potential for harm.[269]

Similarly, that same year, in *In re Milton S. Hershey Medical Center*[270] the Pennsylvania Supreme Court upheld the hospital's disclosure of a resident's HIV status to over 400 patients and colleagues to whom the resident provided assistance during invasive procedures.[271] The court concluded that the hospital acted reasonably in revealing the resident's HIV status to patients because of the strong likelihood that the resident may have exposed a patient to HIV after cutting his surgical glove during an invasive, internal procedure.[272] The resident, who eventually voluntarily withdrew from invasive procedures, argued that his right to privacy, as defined by a state statute, outweighed the compelling need to disclose his HIV status to patients.[273] The court rejected this argument because his name was kept confidential and because the notification form to patients stated only that they had been exposed to an HIV-positive physician and that the hospital would provide HIV testing and counseling.[274] Consequently, the court held that the public's right to be informed of a highly contagious and inevitably fatal disease outweighed the physician's right to maintain confidentiality regarding his HIV status.[275]

Three years later in *Scoles v. Mercy Health Corp.*[276] the United States District Court for the Eastern District of Pennsylvania held that the hospital did not violate an HIV-positive surgeon's rights

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emergency room—where he worked—and was diagnosed with AIDS. *See id.* at 607-08, 592 A.2d at 1255-56.

[266] *See id.* at 641-42, 592 A.2d at 1273-74.

[267] *See id.* at 658, 592 A.2d at 1283. The court noted that all parties recognized that the informed consent requirement was actually a form of "de facto prohibition" from surgical privileges because no patients would likely consent. *See id.* at 613, 592 A.2d at 1258.

[268] *See id.* at 647, 592 A.2d at 1276-77.

[269] *See id.* at 657-58, 592 A.2d at 1283.

[270] 634 A.2d 159 (Pa. 1993).

[271] *See id.* The number of patients informed includes those at Harrisburg Hospital, for which the resident also worked. *See id.*

[272] *See id. But see id.* at 162 n.2 (commenting that the hospital could not establish if the resident had nicked his surgical glove).

[273] *See id.* at 162.

[274] *See id.*

[275] *See id.*

[276] 887 F. Supp. 765 (E.D. Pa. 1994).

when the hospital threatened suspension of surgical privileges unless the physician obtained informed consent.[277] The court also concluded that the hospital appropriately informed 1000 patients of their potential exposure to HIV.[278] Therefore, cases since *Hershey* and *Estate of Behringer* have concluded that a physician who performs invasive, exposure-prone procedures poses a material risk.

Although a patient is likely to prove that the risk of HIV transmission is material and would result in his foregoing a procedure, proving causation is often insurmountable in a strict informed consent case seeking recovery; transmission has been documented in the United States only on six occasions, by a single doctor, Dr. David Acer, and once in France, by an orthopedic surgeon.[279] Because the causation element is impossible to prove, the disposition of a traditional informed consent claim is predetermined in favor of the physician.[280] That strict informed consent is not possible unless someone contracts the disease from an HIV-infected physician should not preclude the possibility of a patient recovering for the emotional distress associated with learning of a physician's HIV status.

B. The Negligent and Intentional Infliction of Emotional Distress

In *Faya v. Almaraz*,[281] Maryland's highest court recognized recovery for two patients' emotional distress subsequent to learning that their oncologist died of AIDS.[282] The court rejected the strict, traditional requirement of actual exposure.[283] Essentially, the court permitted recovery upon a showing that the patients suffered from emotional distress that was manifested by physical symptoms.[284] The court, however, limited the reasonable time frame for recovery as the period between when they learned of their surgeon's HIV status and when they learned that they were not HIV-positive.[285] Essentially, the

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[277] *See id.* at 771-72.

[278] *See id.* at 767.

[279] *See* discussion, *supra*, introduction of this Note.

[280] *See* Closen, *supra* note 24, at 96.

[281] 620 A.2d 327 (Md. Ct. App. 1993).

[282] *See id.* at 329, 339 (holding that summary judgment in favor of hospital and physician should be reversed and remanded to determine (1) whether physician negligently inflicted emotional distress on patient by failing to notify the patient of his HIV status and (2) whether the hospital was liable for physician's failure to disclose that information based on agency principles).

[283] *See id.* at 336.

[284] *See id.* at 334, 338-39.

[285] *See id.* at 339 (noting that six months is the appropriate window of reasonableness in measuring the anxiety that resulted because six months, as opposed to twelve months, is the period of time necessary to confirm whether one has HIV).

court applied a negligence standard and concluded that because the physician knew his HIV status, and the emotional distress was reasonably foreseeable, he had a duty to warn his patients.[286]

The majority of state court cases, however, requires actual injury, placing *Faya* in the minority.[287] In *Marchica v. Long Island Railroad*,[288] however, the United States Court of Appeals for the Second Circuit held in the employment context that actual exposure constitutes actual injury.[289] The court permitted Marchica, a railroad worker, to prevail on a claim for the negligent infliction of emotional distress for the railroad's failure to provide Marchica with a reasonably safe work environment.[290]

The Second Circuit relied in part on the Supreme Court's decision in *Consolidated Rail Corp. v. Gottshall*,[291] which permits recovery for plaintiffs "'who sustain a physical impact as a result of a defendant's negligent conduct, or who are placed in immediate *risk* of physical harm by that conduct.'"[292] Under a zone of danger test, the Court concluded that employees can recover for both physical and emotional injuries if an employer's negligent conduct threatens the employee with imminent, physical impact.[293] Consequently, the Second Circuit recognized a claim for the negligent infliction of emotional distress based on Marchica's possible contraction of HIV after

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[286] *See id.* at 337. The court also noted that the case should be remanded on an ostensible agency claim to determine whether the hospital was vicariously liable. *See id.* at 338-39 (holding that dismissal of all complaints was inappropriate).

[287] *See, e.g.*, Kerins v. Hartley, 33 Cal. Rptr. 2d 172, 174, 181 (Cal. 1994) (holding that patient's emotional distress claim failed due to a lack of actual exposure and because it is more probable than not that the patient would not contract the disease); Brzoska v. Olson, 668 A.2d 1355, 1357 (Del. 1995) (requiring actual exposure to the virus by the dentist to prevail on fraudulent misrepresentation claim, which would only provide damages for economic harm and not mental anguish, and holding that a battery claim based on informed consent was not recognized). Although the *Kerins* court noted that it had earlier followed *Faya*, which did not require actual injury, the *Kerins* court required actual injury. *See id.* at 174; *see also* K.A.C. v. Benson, 527 N.W.2d 553, 557 (Minn. 1995) (requiring actual exposure by an ob-gyn to prevail on claim for negligent infliction of emotional distress and rejecting the "zone of danger" test).

[288] 31 F.3d 1197 (2d Cir. 1994).

[289] *See id.* at 1206.

[290] *See id.* After being pricked by a hypodermic needle while working in a railroad station, the court held that emotional distress did ensue as evidenced by physical manifestations of nightmares, sleeping difficulties, general irritability, crying, vomiting, weight loss, and the need for psychiatric care. *See id.* at 1201, 1206.

[291] 512 U.S. 532 (1994).

[292] *Marchica*, 31 F.3d at 1203 (quoting *Gottshall*, 512 U.S. at 547-48).

[293] *See id.* (citing *Gottshall*, 512 U.S. at 554-55).

a needle prick and his subsequent emotional distress while waiting for his HIV test results.[294]

Although *Marchica* held employers liable for the negligent infliction of emotional distress based on the fear of AIDS, recovery should be permitted for patients who are exposed to HIV during an invasive procedure by an HIV-positive physician. As stated earlier, the physician owes a fiduciary duty to his patients.[295] In fact, physicians owe a comparable or greater duty to patients than employers owe to employees.[296] Consequently, the *Marchica* decision, which does not require a showing of actual exposure and infection to HIV, provides support for *Faya* and for a patient's claim for emotional distress upon being exposed to HIV by a physician.

Admittedly, however, there are reporting problems because of the complexity of invasive procedures as well as the disinclination of HCWs to report needle pricks or other exposures during such a procedure.[297] Nonetheless, courts should permit a patient to recover for being operated upon by an HIV-infected physician based on the negligent or intentional infliction of emotional distress, even without a breach of universal precautions or other actual exposures. The distinction between the negligent and intentional infliction of emotional distress should be based in part on whether the physician knows of his HIV status. Regardless, an employer's failure to remove hypodermic needles from the workplace is far less egregious than an HIV-positive physician's invasion into a patient's body with a scalpel or other sharp instrument.[298]

In short, under both section 504 and the ADA, courts perceive the risk of a physician transmitting HIV to patients as material.[299] In addition, patients classify HIV-infected HCWs as a material risk as demonstrated by various public opinion polls.[300] Therefore, HIV-infected HCWs who perform invasive, exposure-prone procedures should be required to disclose that information to patients. If they fail to provide patients with that information, those patients should be permitted to recover for the infliction of emotional distress without being required to show that actual transmission has occurred.

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[294] *See id.* at 1206.

[295] *See* Closen, *supra* note 24, at 119. For a discussion of the fiduciary duty owed to patients by doctors see Part III.A of this Note.

[296] *See* Closen, *supra* note 24, at 129-31.

[297] *See* discussion, *supra*, Part I.B.

[298] *See supra* notes 60-63 (discussing reporting problems).

[299] *See generally* Part III.D of this Note.

[300] *See supra* notes 248-250.

To prevent the patient from suffering emotional distress, however, more efficient solutions exist, such as implementing a policy of mandatory testing.[301] If mandatory testing were required, physicians would be removed from performing invasive procedures before potential exposure and consequential emotional damage occurred. The challenge, however, is that the CDC,[302] the AMA, and the ADA[303] only require that the HCW know his seropositive status and that he voluntarily abstain from risky procedures; these groups also maintain that mandatory testing is unnecessary given the cost-benefit analysis.[304] Part II.D of this Note, however, illustrates why voluntary abstention is useless and ineffective because physicians who know they are HIV positive and realize that they *should* abstain from procedures often disregard the risk. Nonetheless, threshold screening procedures and credentialing provide their own unique set of problems.

IV. RECOMMENDATIONS: CLEARER GUIDELINES, MANDATORY SCREENING OF HCWS, AND INFORMED CONSENT

A. *Background: Statutory and Constitutional Considerations*

Generally, the ADA prohibits medical exams and inquiries before a conditional offer has been made to an applicant.[305] A conditional offer, however, may hinge on the result of an HIV test if the employer meets the following requirements: (1) all offerees in the same category are required to submit to exams or inquiries even though they may not have a disability, (2) all information collected in that inquiry must be kept on separate forms and be protected by confidentiality, and (3) the subsequent use of the results of the inquiry or exam must be consistent with the general requirements of the ADA.[306] For an employer to use the results of an HIV test to screen out an applicant, the employer must demonstrate that the applicant was excluded for job-related concerns and the inability to perform the essential functions of the job, even with a reasonable accommodation.[307] Health care is usually the easiest field in which to

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[301] *See* Closen, *supra* note 24, at 132-33.

[302] *See supra* Part I.B.2 of this Note (enumerating CDC Recommendations, which provide that a HCW should know his HIV status and should consult with an expert panel to determine whether disclosure is appropriate).

[303] *See* FURROW ET AL., *supra* note 14, at 418-19.

[304] *See* discussion, *supra* Part I.B of this Note.

[305] *See* 29 C.F.R. § 1630.14 (1998).

[306] *See id.*

[307] *See id.* § 1630.14(b)(3).

meet these requirements, in part, because the CDC guidelines address the issue.[308]

Upon securing employment, an HCW may be required to submit to an HIV test if and only if it is a job-related concern and consistent with a business necessity.[309] Again, these requirements are easy to satisfy within the health care field.[310] As stated in Part I.B, the CDC recommends that HCWs be aware of their HIV antibody status, that they voluntarily be tested for HIV, and that they decline participation in exposure-prone procedures unless expert panels have reviewed their situations and provided recommendations.[311] Although the ADA permits HIV testing of applicants and employees in the health care context provided that employers adhere to the aforementioned requirements, the constitutional ramifications have not yet been addressed in high-risk employment areas such as health care.[312]

Generally, the Fourth Amendment's Search and Seizure Clause[313] of the United States Constitution controls the analysis. The United States Supreme Court has employed a balancing test in this context to weigh the intrusion on the individual's privacy interest against the state's legitimate or compelling interests.[314] In the context of HIV testing, courts have upheld mandatory testing programs (1) for prisoners, because the government interest in preventing HIV transmission outweighs prisoners' diminished expectations of privacy;[315] (2) for foreign service exams, because HIV testing impacts

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[308] *See* AMERICANS WITH DISABILITIES ACT: EMPLOYEE RIGHTS AND EMPLOYER OBLIGATIONS § 5.04(7) (Jonathan R. Mook et al. eds., 1997).

[309] *See* 42 U.S.C. § 12112(d)(4) (1998), 29 C.F.R. § 1630.14(c) (1998).

[310] *See* AMERICANS WITH DISABILITIES ACT, *supra* note 308, § 5.04(7).

[311] *See supra* notes 68-79 and accompanying text (discussing CDC Recommendations).

[312] *See* Mark D. Johnson, Comment, *HIV Testing of Health Care Workers: Conflict Between the Common Law and the Centers for Disease Control*, 42 AM. U. L. REV. 479, 502 (1993).

[313] The Search and Seizure Clause provides: "The right of the people to be secure in their persons, houses, papers, and effects, against unreasonable searches and seizures, shall not be violated . . . ." U.S. CONST. amend. IV.

[314] *See* Skinner v. Railway Labor Executives' Ass'n, 489 U.S. 602, 633 (1989) (holding that Federal Railroad Administration was permitted to obtain employee blood and urine samples to test for presence of drugs or alcohol absent particularized suspicion of drug or alcohol use); National Treasury Employees Union v. Von Raab, 489 U.S. 656, 679 (1989) (holding that United States Customs Service could require employees to submit to urinalysis without particularized suspicion of drug use before being promoted to more sensitive positions that involve firearms).

[315] *See* Dunn v. White, 880 F.2d 1188, 1194 (10th Cir. 1989) (relying in large part on *Von Raab*).

general fitness for duty;[316] (3) for both fire and police personnel, because they respond to medical emergencies;[317] and (4) even for professional boxers, because they may pose a risk to their opponents.[318] Although courts have upheld mandatory HIV testing in these contexts, mandatory testing has been struck down where the evidence failed to demonstrate that casual contact posed a risk of HIV transmission.[319] The health care industry, by its very nature, is distinguishable from these casual contact scenarios because HCWs engage in invasive, exposure-prone procedures.

Although Congress declined to enact mandatory testing laws even amidst the Acer cluster incident,[320] a statutorily-based duty may eliminate litigation in the area of informed consent and the infliction of emotional distress. In addition, mandatory testing would eliminate the burden on the judiciary of making a medical and legal determination of what constitutes a "significant risk," given the CDC's failure to articulate more specific guidelines regarding questions of who, how, and when a HCW should not partake in patient care.[321]

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[316] Local 1812, Am. Fed'n of Gov't Employees v. United States Dep't of State, 662 F. Supp. 50, 54-55 (D.D.C. 1987).

[317] *See* Closen, *supra* note 24, at 97 n.231 (comparing Anonymous Fireman v. City of Willoughby, 779 F. Supp. 402, 418 (N.D. Ohio 1991) (holding that mandatory HIV testing of firefighters is reasonable under the Fourth Amendment) with Doe v. District of Columbia, 796 F. Supp. 559, 573 (D.D.C. 1992) (holding that HIV-positive firefighter could not be denied employment based solely on his seropositive status)).

[318] *See id.* at 137-38 n.435.

[319] *See* Glover v. Eastern Neb. Community Office of Retardation, 867 F.2d 461, 464 (8th Cir. 1989). *Glover* is disturbing because two patients tested positive for HIV after an employee died from AIDS. *See* Glover v. Eastern Neb. Community Office of Retardation, 686 F. Supp. 243, 247 (D. Neb. 1988).

[320] *See* discussion *supra* Part I.B.2.

[321] *See* Chai R. Feldblum, *A Response to Gostin, The HIV-Infected Health Care Professional: Public Policy, Discrimination, and Patient Safety*, 19 LAW MED. & HEALTH CARE 134, 136 (1991) (expressing a fear that voluntary self-deferral could lead to mandatory testing). Feldblum also notes that voluntary deferral by physicians provides little or no incentive for hospitals to monitor HCWs because the standard of care as articulated by the CDC does not exclude HIV-infected HCWs who perform invasive procedures. *See id.* at 137; *see also* Larry Gostin, *CDC Guidelines on HIV or HBV-Positive Health Care Professionals Performing Exposure-Prone Invasive Procedures*, 19:1-2 LAW MED. & HEALTH CARE 140, 142 (1991) (noting that CDC Recommendations provide an appropriate balance—treating HIV-infected HCWs with respect while still providing procedural safeguards to protect patients from HIV exposure).

B. Recommendations

This Note proposes three recommendations to clarify the ambiguity surrounding whether HIV-positive HCWs pose a "significant risk" to patients and whether a patient should be informed of a HCW's HIV status. First, the CDC should revise its recommendations to identify an exhaustive list of those invasive, exposure-prone procedures that could result in potential transmission of HIV and those that do not pose a risk.[322] At the same time, the CDC should identify high-risk positions in the health care field. Second, Congress should implement a mandatory testing regime for those HCWs who perform invasive, exposure-prone procedures.[323] Third, if a HCW wishes to participate in such procedures upon learning of his HIV status, written informed consent should be required.[324]

As to the first recommendation, Congress should delegate to the CDC the specific task of assembling specialists from the various fields identified in the 1991 report, including cardiology, obstetrics and gynecology, trauma and emergency room, orthopedics, dentistry, and surgery.[325] After reviewing both approved and experimental procedures, the committee should make recommendations regarding which procedures could result in percutaneous[326] or mucotaneous[327] exposure. Each year, the committee should review any additional procedures that may have been developed. Subsequently, a more diverse committee of CDC and EEOC experts, the AMA, the ADA, HCWs, ethicists, and patient representatives should assemble to determine what constitutes a "significant risk" in the sense of being an acceptable risk.[328] Finally, Congress should codify what precisely constitutes a "significant risk" so that the judiciary has guidance to ensure more consistent applications of the "significant risk" test.[329]

Until Congress and the CDC clearly articulate a test to quantify and qualify what constitutes a "significant risk" with HIV-infected HCWs, this Note also recommends that a mandatory HIV testing re-

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[322] *See* Sullivan, *supra* note 8, at 689 (noting that if Congress is unable to formulate suitable guidelines the task should be delegated to an agency).

[323] *See* Closen, *supra* note 24, at 133-34.

[324] Estate of Behringer v. Medical Ctr., 249 N.J. Super. 597, 657-58, 592 A.2d 1251, 1283 (Law Div. 1991).

[325] *See supra* notes 69-70 (providing a definition of high risk procedures).

[326] *See supra* note 42.

[327] *See supra* note 42.

[328] *See* Sullivan, *supra* note 8, at 689 (recommending that Congress delegate the task of clarifying "significant risk" if necessary).

[329] *See id.*

gime be implemented.[350] Recognizing that a testing plan that reaches all HCWs would be overbroad and unnecessary, testing should be limited to those HCWs who participate in invasive, exposure-prone procedures.[351] These tests should be imposed every three to six months, depending on the current state of medical knowledge and how early one's seropositive status can be detected in the blood.[352] The cost of testing should be incurred by the hospital or managed care organization for general HCWs, or by physicians, who should consider the fee as a credentialing requirement for staff privileges.[353] In exchange for implementing testing, hospitals, managed care organizations, and all HCWs should be afforded immunity from liability for any claims related to emotional distress, but not for general negligence claims regarding malpractice.

Further, recognizing that HCWs' personal lives should not be invaded, hospitals should implement strict confidentiality and reporting procedures to ensure that the results of these tests are not disseminated.[354] If a HCW tests positive for HIV, patients who were treated by the HCW since the HCW was last tested should be contacted.[355] Any look-back contact, however, should not disclose the name of the HIV-infected HCW.[356] As illustrated in Part II.D and as feared by experts, the CDC Recommendations do not provide enough force or incentive for physicians to know their HIV status or to abstain voluntarily from invasive procedures if they are HIV-positive.[357]

Third, this Note recommends that an HIV-infected HCW be permitted to participate in an invasive, exposure-prone procedure *only if* he has obtained written informed consent from his patient regarding the likelihood of the risk and the harm that could ensue.[358] If a HCW continues to defy the mandate, he should be reported to

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[350] *See* Closen, *supra* note 24, at 132.

[351] *See id.* at 132-33.

[352] *See* Faya v. Almaraz, 620 A.2d 327, 339 (Ct. App. Md. 1993) (limiting recovery to the period of reasonable anxiety).

[353] *See* Lowe, *supra* note 21, at 160 (using the control test to determine whether a managed care organization, hospital, or health plan employs a doctor as an employee or an independent contractor).

[354] In re Milton S. Hershey Med. Ctr., 634 A.2d 159, 162 (Pa. 1993) (protecting the identity of an HIV-infected HCW).

[355] *See id.*

[356] *See id.*

[357] *See generally* Feldblum, *supra* note 321, at 137; Closen, *supra* note 24, at 132.

[358] Estate of Behringer v. Medical Ctr., 249 N.J. Super. 597, 657-58, 592 A.2d 1251, 1283 (Law Div. 1991) (requiring informed consent but not specifying whether written consent is necessary).

the local licensing agency, which should revoke that HCW's license and should be permitted to impose administrative, civil, and criminal sanctions. Finally, if the HCW's employer also fails to comply with these recommendations, it should be held liable for corporate negligence.[339]

CONCLUSION

Despite tremendous medical advances over the past two decades, HIV continues to challenge the scientific and medical communities, demonstrating that there is no certainty regarding HIV—except that it remains fatal.[340] Nonetheless, a balance must be struck between an HIV-infected HCWs' right to be free from disability discrimination and patients' rights to be free from unnecessary risks. Unfortunately, physicians and other HCWs have failed to heed the CDC Recommendations that HCWs know their HIV status and abstain from invasive procedures. Thus, the burden should be placed on hospitals, managed care organizations, or other providers to know their employees' HIV statuses.

Although the issue of HIV-infected HCWs remains sensitive, mandatory testing should be implemented as the most effective way to achieve an equilibrium between HCWs' and patients' interests. It seems absurd that emergency fire and police personnel, professional boxers, and foreign service personnel can be required to submit to mandatory HIV testing,[341] but that HCWs, who owe a fiduciary duty to their patients, have continued to evade such a requirement. Although the probability of transmission is remote, HIV is lethal. Further, HCWs owe their patients unique responsibilities. These overriding considerations justify mandatory HIV testing.

Mara E. Zazzali

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[339] *See* Lowe, *supra* note 21, at 160-61 (asserting that the employment relationship between the doctor and the hospital or the doctor and the health plan, including managed care organizations, depends on the degree of control the employer has over the doctor); *see also supra* note 98 (recommending downstream liability).

[340] *See* Closen, *supra* note 24, at 101-04.

[341] *See* Closen, *supra* note 24, at 96-97.