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AIDS, HIV, AND HEALTH CARE WORKERS: SOME INTERNATIONAL LEGISLATIVE PERSPECTIVES

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I. INTRODUCTION AND HISTORICAL PERSPECTIVE

In 1985 Dr. Edward N. Brandt, former United States Assistant Secretary for Health and currently President of the University of Maryland at Baltimore, commented on the need to examine the "total societal response" to the acquired immune deficiency syndrome (AIDS) epidemic.[1] Almost at the same time, the staff of the World Health Organization's (WHO's) Health Legislation Unit in Geneva recognized the need to create and maintain a clearinghouse of significant international, national, and subnational legislative texts dealing with all aspects of AIDS and infection by the human immunodeficiency virus (HIV).

Sweden was the first country to introduce legislation on AIDS. Promulgated on March 8, 1983, these regulations made mandatory the reporting of confirmed and suspected AIDS cases to the National Bacteriological Laboratory.[2] Sweden also adopted the first legal instruments dealing with protection against HIV transmission in the health care environment. In March 1985 Sweden's National Board of Occupational Safety and Health (the Board) issued general recommendations "concerning protection against AIDS in the course of the care and administration of patients" along with highly detailed recommendations which laid out "measures to be taken in work entailing a risk of infection with HTLV-III."[3] The Board ad-

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** Technical Officer, WHO, Geneva, Switzerland. The views expressed herein are solely those of the authors; they do not necessarily reflect any views WHO holds on the issues discussed. The authors wish to express their gratitude to the support provided by WHO's Global Programme on AIDS, and particularly by its Director, Dr. Jonathan M. Mann, for the unit's activities in this and allied areas.

1. Brandt, *Implications of the Acquired Immunodeficiency Syndrome for Health Policy*, 103 ANNALS INTERNAL MED. 771-73 (1985).

2. *See* World Health Organization, *Regulation No. 6 of 8 March 1983 of the National Board of Health and Welfare concerning notification of Acquired Immune Deficiency Syndrome (AIDS)*, 34 INT'L DIG. HEALTH LEGIS. 748, 748 (1983) (Sweden) (English translation).

3. *See* World Health Organization, *General Recommendations of the National Board of Occupational Safety and Health concerning protection against AIDS in the course of the care and*

dressed the latter recommendations to the staff of inpatient and outpatient services, personnel working in laboratories, dental personnel, and pathologists and other staff performing autopsies. Today, these two sets of recommendations are of historical interest only, having been repealed and superseded by a much simpler text which the same regulatory agency enacted in November 1986.[4]

The philosophy underlying this change of approach is undoubtedly the same as that which guided the United States Centers for Disease Control (CDC) in formulating their recommendation urging hospitals and other health facilities to implement "universal precautions."[5] As the United States Presidential Commission on the Human Immunodeficiency Virus Epidemic (the President's Commission) pointed out, these precautions are designed—

> to emphasize the need for all health care workers to consider the blood and blood-contaminated body fluids of *all* patients as potentially infected with HIV and/or other blood-borne pathogens and to adhere rigorously to infection control precautions for minimizing the risk of exposure to blood and body fluids of all patients.
>
> This represents a major difference in the way body substance precautions were taken in the past. Under the old system the health care worker was required to identify the patient and the specific infection in order to implement appropriate infection control procedures.
>
> . . . [D]ependence on HIV blood testing as an infection control procedure or to screen all patients for the purpose of preventing occupational transmission of HIV is not effective and in fact may interfere with other means of preventing occupational transmission. However, the use of testing for the early diagnosis, medical management, care,

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administration of patients, 36 INT'L DIG. HEALTH LEGIS. 595, 595-600 (1985) (Sweden) (English translation).

4. *See* World Health Organization, *Order No. 23 of 20 November 1986 of the National Board of Occupational Safety and Health laying down Regulations on infections of the blood and General Recommendations for the implementation of these Regulations*, 38 INT'L DIG. HEALTH LEGIS. 251, 251-52 (1987) (Sweden) (English translation).

5. Update: Universal Precautions for Prevention of Transmission of Human Immunodeficiency Virus, Hepatitis B Virus, and Other Bloodborne Pathogens in Health-Care Settings, 37 MORBIDITY & MORTALITY WEEKLY REP. 377 (1988). *See also* Centers for Disease Control, *Recommendations for Preventing HIV Transmission in Health-Care Settings*, 36 MORBIDITY & MORTALITY WEEKLY REP. 305 (1987) [hereinafter *CDC Recommendations: No. 2S*]; *Universal Precautions Updated; More Individual Decisions Allowed*, 3 AIDS ALERT 138 (1988) (comment on this version of the Centers for Disease Control's "universal precautions" guidelines).

and understanding of the patient is appropriate.[6]

As of September 1988 approximately seventy countries had introduced some form of legislation concerning AIDS and HIV infection, a significant number of which addressed issues specifically concerning health care workers (HCWs).[7] The following countries, among others, have specifically addressed hospitals or HCWs in their legislation: Australia (New South Wales), Austria, Belgium, Brazil, Canada (Alberta), Chile, China, Dominican Republic, Greece, Guatemala, Indonesia, Luxembourg, Malta, Norway, Panama, Peru, Rwanda, South Africa, Spain (two autonomous communities), Sweden, Switzerland, and Turkey.[8]

This article provides some illustrative examples of the forms that legislation has taken.[9]

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6. PRESIDENTIAL COMM'N ON THE HUMAN IMMUNODEFICIENCY VIRUS EPIDEMIC, REPORT OF THE PRESIDENTIAL COMMISSION ON THE HUMAN IMMUNODEFICIENCY VIRUS EPIDEMIC 32 (June 1988) (emphasis in original) [hereinafter PRESIDENT'S COMM'N].

7. A regularly updated, synoptic listing of legislation, which began in 1983 as a 12-page document, now contains well over 100 pages and has been widely distributed throughout the world. *See* World Health Organization, WHO/GPA/HLE/88.2, Tabular Information on Legal Instruments Dealing with AIDS and HIV Infection (Dec. 1988). No less importantly, a group at the Harvard School of Public Health, headed by Professor William J. Curran and Associate Professor Larry Gostin, has conducted an in-depth analysis of WHO's legislative database as well as other relevant documentation. *See* W. Curran, L. Gostin, International Study of Legislation Relating to the AIDS Epidemic (1988) (Harvard University School of Public Health) (unpublished), [hereinafter Harvard University Study].

8. *See* Harvard University Study, *supra* note 7, at 4 (Australia), 16-17 (Austria), 21 (Belgium), 25 (Brazil), 34 (Canada), 44-45 (Chile), 61 (Dominican Republic), 88 (Greece), 92 (Guatemala), 102 (Indonesia), 117 (Luxembourg), 121 (Malta), 132 (Norway), 135-37 (Panama), 144-45 (Peru), 154-55 (Rwanda), 161 (South Africa), 176 (Spain), 184 (Spain), 191-92 (Sweden), 197 (Switzerland), 202 (Turkey).

9. Exhaustive coverage and analysis, particularly concerning implementation of the legislation, is beyond the scope of this article. Virtually all items of legislation referred to in this article have been reported in WHO's quarterly journal, the *International Digest of Health Legislation*. Moreover, this article does not cover the United States because relevant literature is presently abundant and is increasing almost exponentially. It also does not review systematically the numerous guidelines, statements and recommendations which may have effects similar to laws or regulations elsewhere. Those guidelines, however, will occasionally be mentioned *passim*, if only to illustrate the possible legal position. *See, e.g.*, U.S. DEP'T OF HEALTH & HUMAN SERVS., *AIDS: A Public Health Challenge: State Issues, Policies and Programs*, 14 LAW, MED. & HEALTH CARE 225-302 (1986); *AIDS Law & Policy*, 15 LAW, MED. & HEALTH CARE 1-94 (1987). *See also generally* INST. OF MED., CONFRONTING AIDS UPDATE 1988 (1988) (discussion of legal issues); Spong, *AIDS and the Health Care Provider: Burgeoning Legal Issues*, 67 MICH. BAR J. 610 (1988) (a concise, well-documented review of issues at the federal level and in a particular state); PRESIDENT'S COMM'N, *supra* note 6.

The role of the WHO, especially its Global Programme on AIDS, in influencing the national process of policymaking and legislative action has been substantial and is expected to intensify in the months and years to come. *See, e.g.*, Mann, *Global AIDS: Epide-*

II. THE NATURE OF THE RISK

The CDC defined HCWs as "persons, including students and trainees, whose activities involve contact with patients or with blood or other body fluids from patients in a health-care setting."[10] The inclusion of this definition in a United Kingdom report on the subject[11] suggests that at least some measure of consensus exists concerning what should be understood by this term. The risks of HIV transmission in the health care workplace are generally considered extremely low; as one specialist pointed out:

> The combined studies of almost 1,400 health care workers and 1,300 dental personnel suggest that the risk of HIV infection even after mucous membrane exposure or parenteral inoculation of infected blood, fluids, or secretions is extremely low—probably less than one per 200 incidents. This risk is probably a *maximum* estimate, since the denominator was selected only from those persons who had sustained one or more direct accidental exposures to potentially infectious blood or other fluids. If the actual risk of HIV transmission in medical, dental and nursing settings were higher than has been estimated in the published studies, it is almost certain that the number of AIDS cases in health care workers with no other identified risk would be considerably higher than has been observed.[12]

Moreover, there are no reported cases to date which indicate the transmission of HIV from HCWs to patients. Nevertheless, the fact remains that HCWs are concerned by risks of HIV transmission in

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miology, Impact, Projections, Global Strategy, in AIDS PREVENTION & CONTROL 3 (1988) (describing WHO's influence over national policymaking); K. Kay, AIDS—A Global Concern, Presented at the Proceedings of the Third International Intensive Care Nursing Conference, Montreal, Canada (Aug. 30-Sept. 2, 1988).

Many of the principal legal considerations of AIDS, at least in developed countries, are not greatly different from those that apply in the United States. *See, e.g.*, Allen, Fox, Arras, Freedman & Annas, *AIDS: The Responsibilities of Health Professionals*, 18 HASTINGS CENTER REP. 1, 2-4, 10-32 (Apr./May 1988). *See also* ABA AIDS Coordinating Comm., AIDS: The Legal Issues (1988) (discussion draft); PRESIDENT'S COMM'N, *supra* note 6 at 102; Felix, Mueller & Schmid, *AIDS in the Long-Term Care Setting*, 7 ST. LOUIS U. PUB. L. REV. 115 (1988). United Kingdom perspectives on the subject are outlined in U.K. Health Depts., AIDS: HIV-INFECTED HEALTH CARE WORKERS (1988) [hereinafter HIV-INFECTED HEALTH CARE WORKERS].

10. *See CDC Recommendations: No. 2S*, *supra* note 5, at 305.

11. *See* HIV-INFECTED HEALTH CARE WORKERS, *supra* note 9.

12. *See* Allen, *Health Care Workers and the Risk of HIV Transmission*, 18 HASTINGS CENTER REP. 2, 4 (Apr./May 1988) (emphasis in original).

the course of their professional duties.[13] This factor certainly must be taken into account by policymakers, health administrators, hospital and laboratory managers, and those persons in similar positions.[14]

III. COMPLIANCE BY HCWs WITH GENERAL LEGISLATION ON AIDS AND HIV

HCWs probably are the key groups in any given country responsible for ensuring compliance with that country's laws and regulations concerning communicable diseases in general, and AIDS and HIV in particular.[15] Whether mandatory reporting of AIDS or HIV infection is appropriate exemplifies those issues which have raised substantial debate in different countries. Although details of this requirement's pros and cons are beyond the scope of this article, TABLE 1 provides synoptic information on approaches taken by different countries and subnational jurisdictions.

IV. EDUCATION OF HCWs

It is critically important that HCWs remain fully aware of the nature of HIV infection, the modes of transmission of the virus, and the entire spectrum of medical, ethical, and societal issues in the field of AIDS. In 1987 the Committee of Ministers of the twenty-one-member Council of Europe stated:

> Appropriate training programmes should be organised for all categories of health staff, especially for those working in the field of diagnosis, treatment, control of transmission of infections, psychological support and terminal care.
>
> Staff on the social services should be trained in the implementation of policies and regulations, as well as in patient and family assistance and psychological support.

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13. *See Health Workers Worry About AIDS Risk*, MED. & HEALTH PERSP., June 15, 1987, 1, 4.

14. Significantly, WHO convened a meeting in Geneva on January 11-13, 1989, specifically designed to facilitate the review of issues relating to HIV and HCWs. This meeting was a follow-up to a June 27-29, 1988 consultation on AIDS and the workplace held in Geneva in association with the International Labour Office. For a statement by the participants in the June 1988 consultation, see World Health Organization, *Statement by Participants*, WHO/GPA/INF/88.7, (1988).

15. *See* Fluss, *What Can Legislators Do to Combat AIDS?*, 9 WORLD HEALTH F. 365, 365-69 (1988) (description of major elements covered in such legislation); Fluss, *The AIDS Pandemic: Some Global Legislative and Legal Aspects*, in AIDS IN CHILDREN, ADOLESCENTS & HETEROSEXUAL ADULTS: INTERDISCIPLINARY APPROACH TO PREVENTION 58 (1987).

TABLE 1
SELECTED JURISDICTIONS IN WHICH AIDS AND SEROPOSITIVITY ARE SUBJECT TO MANDATORY REPORTING (based mainly on legislative instruments available to WHO, as of September 30, 1988)

JURISDICTION	AIDS	SEROPOSITIVITY
Australia	x (all States and Territories)	x (all States and Territories)
Austria	x	—
Bermuda	x	—
Brazil	x	—
Brunei Darussalam	x	—
Bulgaria	x	—
Canada	x (all Provinces and Territories)	x (seven Provinces)
Chile	x	—
China	x	x
Costa Rica	x	x
Czechoslovakia	x	x
Denmark	x	—
Dominican Republic	x	—
Ecuador	x	—
Egypt	x	—
Fed. Rep. of Germany*	—	x
Finland	x	x
France	x	—
French Polynesia	x	—
German Dem. Rep.	x	x
Greece	x	—
Guatemala	x	—
Guernsey (plus Alderney, Herm, Jethou)	x	—
Hungary	x	—
Iceland	x	x
Israel	x	—
Italy	x	—
Jordan	x	—
Liechtenstein	x	x
Luxembourg	x	—
Malaysia	x	x
Malta	x	—
Mexico	x	x
Monaco	x	—
Mozambique	x	—
New Zealand	x	—
Norway	x	x
Panama	x	—
Paraguay	x	—
Peru	x	—
Philippines	x	x
Poland	x	—
Republic of Korea	x	x
Romania	x	x
Singapore	x	x
Spain (Andalusia, Aragon, Catalonia, Madrid)	x	—
Sweden	x	x
Switzerland	x	x
Thailand	x	—
USA	x (except in American Samoa)	x (13 States)
USSR	x	x
Venezuela	x	x
Yugoslavia	x	—

* Positive confirmatory tests only.

> Staff who may have occupational exposure to infected fluids and secretions should be kept informed of sensible hygienic precautions to be taken both for themselves and for their clients.
>
> Training for teachers should be organised to allow them to integrate AIDS prevention in health education.[16]

V. MEASURES FOR THE PROTECTION OF HCWS AGAINST INFECTION

Recognizing the importance of compliance by HCWs with universal precautions,[17] a number of countries have issued regulations or guidelines designed to prevent transmission. These are directed generally at HCWs and specific categories of HCWs, or they relate to specific health care environments. Thus, texts have been issued dealing with dialysis (Portugal),[18] laboratory personnel (Austria, Chile, France, and Norway),[19] ophthalmological care (Sweden),[20] dental personnel (Chile, Norway, Sweden, and the United Kingdom),[21] health care providers working in centers and clinics caring for drug-dependent persons (France and Italy),[22] and the handling of bodies of persons who have died from AIDS (Alberta, Chile, and France).[23]

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16. *See* Council of Europe, *Disease Control and Medical Care*, 39 INT'L DIG. HEALTH LEGIS. 22, 27 (1988) (Recommendation R (87) 25 app.). In many countries, educational programs can be implemented in the absence of statutes or regulations. *See, e.g.*, Circular of August 25, 1984, issued by the Italian Ministry of Health on prophylactic measures against AIDS (containing a rubric discussing the scope and nature of information which should be provided to health personnel).

17. *See CDC Recommendations: No. 2S*, *supra* note 5 and accompanying text.

18. World Health Organization, INT'L DIG. HEALTH LEGIS. 789 (1986).

19. *See* World Health Organization, WHO/GPA/HLE/88.2, Document 4 (Austria), 14 (Chile), 22 (France), 25 (Norway) (1988).

20. *Id.* at 68.

21. *See, e.g.*, BRITISH DENTAL ASSOCIATION, GUIDE TO BLOOD BORNE VIRUSES AND THE CONTROL OF CROSS INFECTION IN DENTISTRY (1987). In the United Kingdom, the health authorities have issued guidance for the following: persons engaged in community care of AIDS patients and other HIV-positive clients; surgeons, anesthetists, dentists, and their teams; persons working in the social services; employees of health service laboratories; nurses; and obstetricians and gynecologists. A government committee has issued advice on the decontamination of equipment, linen, or other surfaces contaminated with hepatitis B (HBV) or HIV. *See, e.g.*, DEP'T OF HEALTH & SOC. SECURITY, AIDS: HIV-INFECTED HEALTH CARE WORKERS (1988) (report of the recommendations of the London Expert Advisory Group on AIDS) [hereinafter DEP'T OF HEALTH REP.].

22. *See* World Health Organization, 37 INT'L DIG. HEALTH LEGIS. 537 (1986) (France); *id.* at 542-43 (Italy).

23. *See id.* at 17 (Canada); World Health Organization, 39 INT'L DIG. HEALTH LEGIS. 622 (1988) (Canada); World Health Organization, 38 INT'L DIG. HEALTH LEGIS. 248 (1987) (France); *id.* at 762 (Chile).

VI. TESTING IN HEALTH CARE INSTITUTIONS

There have been recommendations that some or all categories of hospitalized patients be given HIV antibody testing;[24] this may also include the testing of physicians, nurses, and other HCWs, particularly those engaged in invasive procedures. In fact, this testing may possibly occur even in the absence of appropriate confidentiality safeguards.

The pre- and post-counseling which WHO, among others, has called for[25] as a precondition to this testing obviously cannot operate under these conditions. One of the most eloquent affirmations of principles in this area was formulated in October 1987 by the then French Minister of Social Affairs and Employment. The circular reads substantially as follows:

> In the first place, attention should be drawn to the fact that the test for the detection of anti-HIV antibodies must certainly not be extended generally to all patients hospitalized in or passing through [*transitant*] a public or private health establishment.
>
> Mandatory screening is limited to cases of donations of blood, organs, tissues, and cells, and in particular sperm (Order of 23 July 1985 . . .). In such cases, recourse to the tests constitutes an indispensable precaution vis-à-vis the recipient.
>
> It is quite clear that systematic screening is inappropriate [*inopérant*] and entails costs that are wholly disproportionate to the results to be anticipated.
>
> On the other hand, in certain departments, such as those of surgery and obstetrics and gynecology, or indeed in departments in which endoscopic explorations are performed, there is no objection to a test for the detection of HIV being proposed to patients admitted to the department.
>
> . . . .
>
> Finally, I would like to point out that under no circumstances should HIV screening tests be relied upon for the protection of care personnel. Strict compliance with the rules of hygiene is in actual fact the sole answer to that problem.[26]

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24. *See, e.g.*, World Health Organization, 39 INT'L DIG. HEALTH LEGIS. 31-32 (1988) (France).

25. *See, e.g.*, World Health Organization, WHO/SPA/INF/88.2, Counselling on HIV Infection and Disease at 4 (1988).

26. Circular issued by Philippe Seguin, former French Minister of Social Affairs and

Although not legislation, the following statement issued by the General Medical Council in the United Kingdom represents crucially important guidance for that nation's physicians on the issues of confidentiality and consent to investigation and treatment:

> The Council believes that the need to obtain consent should apply generally, but that it is particularly important in testing for HIV infection, not because the condition is different in kind from other infections but because of the possible serious social and financial consequences which may ensue for the patient from the mere fact of having been tested for the condition. They provide a strong argument for each patient to be given the opportunity, in advance, to consider the implications of submitting to such a test and deciding whether to accept or decline it. In the case of a patient presenting with certain symptoms which the doctor is expected to diagnose, this process should form part of the consultation. Where blood samples are taken for screening purposes, as in antenatal clinics, there will usually be no reason to suspect HIV infection, but even so the test should be carried out only where the patient has given explicit consent. Similarly, those handling blood samples in laboratories, either for specific investigation or for the purposes of research, should test for the presence of HIV only where they know the patient has given explicit consent. Only in the most exceptional circumstances, where a test is imperative to secure the safety of persons other than the patient, and where it is not possible for the prior consent of the patient to be obtained, can testing without explicit consent be justified.
>
> . . . .
>
> The Council believes that, where HIV infection or AIDS has been diagnosed, any difficulties concerning confidentiality which arise will usually be overcome if doctors are prepared to discuss openly and honestly with patients the implications of their condition, the need to secure the safety of others, and the importance for continuing medical care of ensuring that those who will be involved in their care know the nature of their condition and the particular needs which they will have. The Council takes the view that any doctor who discovers that a patient is HIV positive or suffering from AIDS has a duty to discuss these matters fully with the patient.

Employment, to the Regional and Departmental Directorates of Health and Social Affairs (Oct. 1987).

> When a patient is seen by a specialist who diagnoses HIV infection or AIDS, and a general practitioner is or may become involved in that patient's care, then the specialist should explain to the patient that the general practitioner cannot be expected to provide adequate clinical management and care without full knowledge of the patient's condition. The Council believes that the majority of such patients will readily be persuaded of the need for their general practitioners to be informed of the diagnosis.
>
> If the patient refuses consent for the general practitioner to be told, the doctor has two sets of obligations to consider: obligations to the patient to maintain confidence, and obligations to other carers whose own health may be put unnecessarily at risk. In such circumstances the patient should be counselled about the difficulties which his or her condition is likely to pose for the team responsible for providing continuing health care and about the likely consequences for the standard of care which can be provided in the future. If, having considered the matter carefully in the light of such counselling, the patient still refuses to allow the general practitioner to be informed, then the patient's request for privacy should be respected. The only exception to that general principle arises where the doctor judges that the failure to disclose would put the health of any of the health care team at serious risk. Similar principles apply to the sharing of confidential information between specialists or with any other health care professionals such as nurses, laboratory technicians, and dentists.
>
> . . . .
>
> This advice is intended as a guide for doctors and is not in any sense a code. Individual doctors must always be prepared, as a matter of good medical practice, to make their own judgments of the appropriate course of action to be followed in specific circumstances, and able to justify the decisions they make.[27]

The Royal College of Nursing in the United Kingdom also stated that

> there are no indications for, or benefits of, routine screening of health care workers . . ., health care workers who are HIV-antibody positive should not be barred from employment in the health service, nor (would they) recommend any areas where (such) personnel should not be employed

27. *See Notes and News—General Medical Council Advice on Testing for HIV Infection*, 2 LANCET 464, 464-65 (1988).

(providing that they follow good practice guidelines).[28]

In the Federal Republic of Germany, the Federal Chamber of Physicians and the German Hospital Association have issued joint recommendations on this and related issues.[29] The National AIDS Council in the Federal Republic rejected routine HIV testing of medical personnel.[30] In fact, it recently rejected compulsory testing of job applicants and workers, including those in health care, thus opposing the view that "the special risk of infection alleged by the German Hospital Association and the Federal Chamber of Physicians justifies the routine HIV testing of applicants for jobs in, and certain staff of, hospitals."[31]

VII. THE OBLIGATION TO PROVIDE CARE

Because of reported cases in which physicians, dentists, and other HCWs refused to provide treatment to people with AIDS and HIV infection, bodies in various countries have issued statements corresponding to the position of the American Medical Association's Council on Ethical and Judicial Affairs (AMA Council). The AMA Council determined that "when an epidemic prevails, the physician must continue his labors without regard to the risk to his own health. . . . [A] physician may not ethically refuse to treat a patient whose condition is within the physician's realm of competence" because the patient is HIV-infected.[32]

Corresponding statements also were issued by the General Medical Council in the United Kingdom on May 21, 1987, stating:

> The Council is seriously concerned at recent reports that, in a small number of cases, doctors have refused to provide patients who are HIV positive, or are suffering from AIDS, with necessary care and treatment. The Council expects that the profession will extend to such patients the same high standard of medical care and support which they would offer to any other patient.
>
> It is entirely proper for a doctor who has a conscien-

28. *See* Widdows, *supra* note 9.

29. GEMEINSAME HINWEISE AND EMPFEHLUNGEN DER BUNDESÄRZTEKAMMER UND DER DEUTSCHEN KRANKENHAUS ZUR HIV-INFEKTION (1988). Hirsch, *AIDS-Test bei Krankenhauspatienten*, 3 AIDS-FORSCHUNG 157 (1988) (comment on this issue as it affects Federal Republic of Germany).

30. 31 BUNDESGESUNDHEITSBLATT 358 (1988).

31. Letter from Professor Manfred Steinbach (Sept. 26, 1988) (transmitting the text of this recommendation).

32. Centers for Disease Control, *Council Says Doctors Have Obligation to Treat AIDS Patients*, CDC AIDS WEEKLY, Jan. 11, 1988, 10.

> tious objection to undertaking a particular course of treatment, or who lacks the necessary knowledge, skill or facilities to provide appropriate investigation or treatment for a patient, to refer that patient to a professional colleague.
>
> However, it is unethical for a registered medical practitioner to refuse treatment, or investigation for which there are appropriate facilities, on the ground that the patient suffers, or may suffer, from a condition which could expose the doctor to personal risk. It is equally unethical for a doctor to withhold treatment from any patient on the basis of a moral judgment that the patient's activities or lifestyle might have contributed to the condition for which treatment was being sought. Unethical behaviour of this kind may raise a question of serious professional misconduct.[33]

In France the National Council of the Association of Physicians affirmed that a hypothetical risk to a physician should never lead that physician to withhold urgent assistance from a patient.[34] The National AIDS Council in the Federal Republic of Germany previously made a somewhat similar statement, pointing out that even where a patient refuses to undergo an HIV test (for certain indications), a physician still should not exercise, on ethical grounds, his or her "right to refuse further treatment of" such a patient.[35]

In the United States and other countries, physicians employed by public hospitals generally are required to treat any patient which the hospital admits. In order to work in a public hospital, physicians necessarily waive their right to choose patients.[36]

VIII. HIV-POSITIVE HCWs

Determining how to deal with seropositive physicians, nurses, and others in close proximity with patients in the health care environment raises sensitive ethical problems. This matter has been discussed widely in the United States.[37]

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33. *See* DEP'T OF HEALTH REP., *supra* note 21 at 18-19.

34. *See Un risque hypothéthique ne doit, en aucun cas, mettre en question ou faire différer l'aide urgente que l'on doit apporter à une victime* (Jan. 28, 1988).

35. *See* 21.09 *Votum des Nationalen AIDS Beirates* 1 (1988) (English translation).

36. *See* Banks, *The Right to Medical Treatment*, in AIDS AND THE LAW: A GUIDE FOR THE PUBLIC 175, 179 (H. Dalton, S. Burris & Yale AIDS Law Project, eds. 1987).

37. *See, e.g.*, W.F. BANTA, AIDS IN THE WORKPLACE: LEGAL QUESTIONS AND PRACTICAL ANSWERS 178-79 (1988) (setting forth a sample policy for HIV-infected hospital personnel).

In the United Kingdom, the President of the General Medical Council issued the following statement on November 27, 1987:

> Considerable public anxiety has been aroused by suggestions that doctors who are themselves suffering from AIDS or who are HIV positive might endanger their patients. In the circumstances, having consulted colleagues, I am making their further statement on behalf of the Council.
>
> There is no known case anywhere in the world of the human immunodeficiency virus (HIV) having been transmitted by an infected doctor to a patient in the course of medical treatment.
>
> Nevertheless it is imperative, both in the public interest and on ethical grounds, that any doctors who consider that they may have been infected with HIV should seek appropriate diagnostic testing and counselling, and, if found to be infected, should have regular medical supervision. They should also seek specialist advice on the extent to which they should limit their professional practice in order to protect their patients. They must act upon that advice, which in some circumstances would include a requirement not to practise or to limit their practice in certain ways. No doctors should continue in clinical practice merely on the basis of their own assessment of the risk to patients.
>
> It is unethical for doctors who know or believe themselves to be infected with HIV to put patients at risk by failing to seek appropriate counselling, or to act upon it when given.
>
> The doctor who has counselled a colleague who is infected with HIV to modify his or her professional practice in order to safeguard patients, and is aware that this advice is not being followed, has a duty to inform an appropriate body that the doctor's fitness to practise may be seriously impaired. There are well-tried arrangements for dealing with such cases. They are designed to protect patients as well as to assist the sick doctor. If the circumstances so warrant the Council is empowered to take action to limit the practice of such doctors or to suspend their registration. These arrangements also safeguard the confidentiality and support which doctors when ill, like other patients, are entitled to expect.
>
> The principles underlying this advice are already familiar to the profession, which has long adopted policies and procedures designed to prevent the transmission of in-

fection from doctors to patients.[38]

On January 13, 1988, the General Dental Council in the United Kingdom stated its position in the following terms:

> 1. There has been considerable public concern about the risk of contracting AIDS and, more recently, about the possibility that patients might be infected by doctors or dentists who are themselves suffering from AIDS or are HIV positive. There is no known instance of transmission of the AIDS virus from dentist to patient in the course of treatment. The risk of cross-infection in the dental surgery has always existed. Dentists have a duty to understand the risk and the precautions which must be taken to avoid it.
>
> 2. It is the ethical responsibility of dentists who believe that they have been infected with HIV to obtain medical advice and, if found to be infected, to submit to regular medical supervision. Their medical supervision will include counselling, in particular, in respect of any changes in their practice which might be considered appropriate in the best interests of protecting their patients. It is the duty of such dentists to act upon the medical advice they have been given, which may include the necessity to cease the practice of dentistry altogether or to modify their practice in some way.
>
> 3. Dentists who know that they are, or believe that they may be, HIV positive and who might jeopardise the well being of their patients by failing to obtain appropriate medical advice or to act upon the advice that has been given to them are behaving unethically and contrary to their obligations to patients. Behaviour of this kind may raise a question of serious professional misconduct.[39]

Questions also have addressed whether asymptomatic, HIV-infected surgeons could conceivably undergo deterioration of their operating skills. In this context, the following finding is relevant:

> At present, there is no evidence for an increase of clinically significant neuropsychiatric abnormalities in CDC Groups II or Groups III HIV-1 seropositive (i.e. otherwise asymptomatic) individuals as compared to HIV-1 seronegative controls.
>
> Therefore, there is no justification for HIV-1 serological screening as a strategy for detecting such functional im-

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38. *See* DEP'T OF HEALTH REP., *supra* note 21 at 17-18.
39. *Id.* at 19.

pairment in asymptomatic persons.[40]

IX. THE ISSUE OF CONFIDENTIALITY

In its 1987 recommendation, the Committee of Ministers of the Council of Europe emphasized the need for confidentiality in reporting cases of AIDS and seropositivity.[41] This provision on confidentiality is contained in many countries' statutes and regulations, including Australia (New South Wales), Chile, China, Greece, Iceland, New Zealand, Panama, Spain (certain autonomous communities), and Sweden.[42] Nevertheless, provisions may be included which define the conditions under which confidentiality may be waived. In this field, the debate somewhat corresponds to ongoing discussions of these issues in the United States.[43]

X. CONCLUSION

This article has not dealt with other issues undoubtedly important and relevant to the concerns of HCWs. For example, the right of physicians to provide zidovudine[44] has been restricted by regulations in the Netherlands. In the Netherlands, physicians may only prescribe the drug to certain categories of patients, while in Sweden, prescribing is limited to physicians holding specific qualifications.[45] This article also has not addressed insurance issues, despite their great importance at the present juncture.[46] Nor have economic issues been discussed, although they are also relevant and

40. World Health Organization, WHO/GPA/DIR/88.1, Report of the Consultation on the Neuropsychiatric Aspects of HIV Infection 2 (Mar. 14-17, 1988).

41. *See* World Health Organization, 39 INT'L DIG. HEALTH LEGIS. 22-27 (1988) (recommendation R (87) 25.

42. *See* World Health Organization, 37 INT'L DIG. HEALTH LEGIS. 12-14 (1986) (Australia); World Health Organization, 38 INT'L DIG. HEALTH LEGIS. 465 (1987) (Australia); Harvard University Study, *supra* note 7, at 46 (Chile); World Health Organization, 39 INT'L DIG. HEALTH LEGIS. 623 (1988) (China); *id.* at 629 (Greece); World Health Organization, 38 INT'L DIG. HEALTH LEGIS. 488-89 (1987) (Iceland); World Health Organization, 37 INT'L DIG. HEALTH LEGIS. 543 (1986) (New Zealand); World Health Organization, 39 INT'L DIG. HEALTH LEGIS. 40 (1988) (Panama); World Health Organization, 38 INT'L DIG. HEALTH LEGIS. 39 (1987) (Aragon, Spain); World Health Organization, 39 INT'L DIG. HEALTH LEGIS. 368-69 (1988) (Cantabria, Spain); World Health Organization, 38 INT'L DIG. HEALTH LEGIS. 42 (1987) (Sweden).

43. *See, e.g., Hearings on S. 100-100 Before the Subcomm. on Health & the Environment of the U.S. House Comm. on Energy & Commerce on a Series of House Bills and Resolutions*, 100th Cong., 1st Sess. (1988).

44. Formerly known as AZT.

45. *See* World Health Organization, 39 INT'L DIG. HEALTH LEGIS. 695 (1988) (Netherlands).

46. *See generally* OFFICE OF TECHNOLOGY ASSESSMENT, MEDICAL TESTING AND HEALTH

important in our societies which are presently confronted with the need to carefully maintain the all-too-scarce health resources available.[47]

This article, however, has sought to draw attention to ways nations other than the United States are addressing an array of important legal and ethical problems raised by the current pandemic of AIDS and HIV. It is hoped that it has made a contribution, even if modest, to the debate.

INSURANCE (1988); OFFICE OF TECHNOLOGY ASSESSMENT, AIDS AND HEALTH INSURANCE: AN OTA SURVEY (1988).

47. Eastwood & Maynard, Treating AIDS Patients: Is it Ethical to be Efficient? (unpublished paper) (available at the Health Legislation Unit, WHO, Geneva). The authors are grateful to Mr. R. Grose for making available this important contribution.