Nova Law Review

Volume 16, *Issue* 3 1992 *Article* 5

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Abstract

It is very curious how some people think legislators can write laws that give people absolute protection from certain risks or harm. Laws which are well-considered may reduce risks and offer substantial protection from harm; for example, laws prohibiting murder or requiring the wearing of a seat belt.

KEYWORDS: health, care, AIDS

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It is very curious how some people think legislators can write laws that give people absolute protection from certain risks or harm. Laws which are well-considered may reduce risks and offer substantial protection from harm; for example, laws prohibiting murder or requiring the wearing of a seat belt. Both of those laws, when obeyed, save lives and reduce risks. But, obviously many people still commit murder. Even more people do not wear seat belts and get injured in automobile accidents. While saving thousands of lives each year, these laws do not offer absolute protection.

Each year in this country, and especially in Florida, many children lose their lives by drowning. Legislation which, for example, would require all open bodies of water to be fenced might save a few lives a year. But, the high cost and impracticality associated with the implementation of such a law would make it an unwise use of resources. Resources could be better spent teaching children about water safety and how to swim.

Every year when the state Legislature meets in Tallahassee, legislators are asked to consider hundreds and hundreds of proposed bills. There are already thousands of pages of law in statute books which regulates every part of our life and death.

However, it is my opinion, one which I believe is shared by most Americans, that before government interferes in, or mandates, certain behavior of a private citizen, a particular government action should be in the greater public or state interest. And, in looking to prevent a particular harm or reduce a risk, one must weigh the significance of the risk against the cost of reducing the risk both in economic and other social consequences. So, for example, in evaluating the law which requires seat belt usage, law makers would want to assess the cost of seat belts and enforcement versus the reduction in morbidities and mortalities.

This general discussion leads nicely to the more specific issue of whether law makers should require mandatory testing of health care

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workers (HCWs) for the human immunodeficiency virus (HIV) and/or restrict in any way the practice of an HIV-infected HCW. It is truly a political dilemma because public opinion polls clearly indicate the public overwhelmingly believes that the answer to this question is yes. This article will analyze the issue and soon it will become evident that the obvious and simple answer may not be so obvious and simple after all.

First, a review of the chronology of events leading to this discussion would be in order. In July of 1990, the Center For Disease Control (CDC) reported a transmission of HIV involving a Florida dentist and a twenty-two-year-old patient. The report issued by CDC indicated that the patient had no identifiable risk behaviors or factors, the dentist had AIDS at the time of the dental procedure performed, and that there was a high degree of DNA sequence similarity between the HIV strain infecting the patient and the dentist. On September 4, 1990, the Florida Department of Health and Rehabilitative Services released a letter written by the dentist to all his patients which advised that they seek counseling and testing. Subsequently, it was announced four other patients of the dentist had tested positive for HIV and also had a high degree of DNA sequence similarity.

On February 21, 1991, the CDC had an open meeting in Atlanta, Georgia, on the risk for transmission for blood-borne pathogens for patients during invasive procedures. Representatives from eighty organizations testified. Without exception, every organization opposed mandatory HIV testing. There was a least one individual representing himself who was a proponent of mandatory testing, however, and there were various groups and individual advocates who testified that HIV-infected professionals should voluntarily restrict their practice and/or disclose their positivity to their patients.

Prior and subsequent to the February CDC meeting, the first dental patient's family and attorneys went on a media campaign calling for the mandatory HIV testing of health care workers and for the disclosure by HIV-infected health care workers to their patients of HIV status. This media avalanche brought on a flurry of proposed legislation around the country including: United States Senator Jesse Helms'[1] sponsored amendment, which imposed a criminal penalty on HIV-infected doctors who treat patients without disclosing their HIV status;[2]

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1. Helms, a Republican, is the senior United States Senator from North Carolina.

2. *See* 137 CONG. REC. S10331-01 (daily ed. July 18, 1991) (discussion of Helms amendment, No. 734).

and, Congressman Bill Dannemeyer's[3] bill which requires mandatory HIV testing for HCWs.[4]

Congress did not pass either of the foregoing proposals, but instead enacted legislation requiring states to enforce CDC recommendations or lose Title 42 funding which equates to billions of dollars for health, social service, environmental, and housing assistance from the federal government.[5] The new law read:

> (a) Notwithstanding any other provision of law, a State shall, not later than 1 year after the date of the enactment of this Act, certify to the Secretary that such State has in effect regulations, or has enacted legislation, to adopt the guidelines issued by the Centers for Disease Control concerning recommendations for preventing the transmission, by health care professionals, of the human immunodeficiency virus and the hepatitus B virus to patients during exposure prone invasive procedures. Such regulations or legislation shall apply to health professionals practicing within the State and shall be consistent with Centers for Disease Control guidelines and Federal law. Failure to comply with such guidelines, except in emergency situations when the patient's life is in danger, by a health care professional shall be considered as the basis for disciplinary action by the appropriate State licensing agent.
> (b) . . . [I]f a State does not provide the certification required . . . [w]ithin the 1-year period described . . ., such State, should be ineligible to receive assistance under the Public Health Service Act (42 U.S.C. 301 et. seq.) until such certification is provided."[6]

In other words, the pain of noncompliance to a state's budget would be unbearable.

On July 15, 1991, CDC proposed guidelines for preventing transmission of HIV or HBV[7] during exposure-prone invasive procedures. They advised: 1) all health care workers should adhere to universal precautions; 2) there was no basis for restricting the practice of health care workers from procedures not identified as exposure prone, provided universal procedures were practiced; 3) exposure prone proce-

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3. Dannemeyer is a Republican congressman from California.

4. *See* 136 CONG. REC. H3520-02 (daily ed. June 13, 1990) (consideration of House Resolution 4785).

5. *See* 137 CONG. REC. H7383-01 (daily ed. Oct. 2, 1991) (regarding 42 U.S.C. § 634).

6. *Id.*

7. Hepatitis B virus.

dures should be identified by medical/surgical/dental organizations and institutions at which these procedures are performed; 4) health care workers who perform exposure prone procedures should know their HIV antibody status; 5) health care workers who are infected with HIV should not perform exposure prone procedures unless they have sought counsel from an expert review panel and have been advised under what circumstances, if any, they may continue to perform these procedures. Such circumstances would include notifying prospective patients of the health care workers positivity before they undergo exposure prone invasive procedures.

The sixth recommendation by CDC was that mandatory testing of health care workers for the HIV antibody was not recommended. "The current assessment of risk that infected health care workers will transmit HIV to patients during exposure prone procedures does not support the diversion of resources that would be required to implement mandatory testing programs. Compliance of health care workers with the recommendations can be increased through education, training, and appropriate confidentiality safeguards."[8]

Following the release of these proposals CDC met immediate resistance. Professional organizations such as the American Dental Association said they would and could *not* publish a list of so-called risky procedures. The State of New York determined it would not cooperate; thus, risking the loss of billions of federal dollars. Even the American Medical Association, which at first had been one of the sole supporters of generating such lists, decided it could not develop such a list.

CDC again went back to the drawing board and at the time of the writing of this article stated it would be drafting yet another set of guidelines that would call for a case-by-case evaluation of HIV-infected HCWs.

It is with that backdrop that state legislatures across the country, including Florida's, must determine whether to follow CDC guidelines or give up federal public health dollars; or, to go further than federal law on the issue of testing and restriction. At least one state, Illinois, has passed a law which requires health care workers with AIDS to disclose that information to their patients. In discussing what, if any, action the Florida Legislature should take in this regard, this article will

8. Centers for Disease Control, *Recommendations for Preventing Transmission of Human Immunodeficiency Virus and Hepatitus B Virus to Patients During Exposure-Prone Invasive Procedures,* 40 MORBIDITY AND MORTALITY WEEKLY REPORT, 1 (July 12, 1991).

look separately at the two issues of mandatory testing and restriction and disclosure.

On the issue of mandatory testing, we first need to address the question of risk. What is the risk that we seek to reduce by testing health care workers? After we examine the risk, we can then address the question of how much it would cost to reduce the risk in terms of economic and other consequences.

To understand risk, one should get a feel for the relative risk. CDC estimates that a person has approximately a one in 20,000 chance of being in an airplane crash, a one in 50,000 chance of being struck by lightning and, if pregnant, a one in 15,000 chance of dying due to pregnancy or childbirth complications.

CDC tells us that a patient has about a one in 2.6 million chance of being infected with AIDS by a dentist. Ironically, there is a one in 5,200 chance of being killed in a car accident on the way to the dentist. Where, however, the risk involves a known HIV-infected HCW, the odds of infection are reduced. For example, according to CDC there is a one in 416,667 probability for transmission to a single patient by a HIV-infected surgeon. The cumulative probability that an infected surgeon will transmit HIV to at least one patient over a period of seven years is even further reduced. CDC does caution that these probabilities are based on certain models that could be affected by many variables such as whether or not universal precautions are used.

Even so, of the 200,000 AIDS cases in the United States, there have been only five documented transmissions from health care worker to patient - that being the aforementioned case of the Florida dentist. In look backs of more than 2,100 patients of six different HIV-infected physicians, researchers have found no linkage between HIV-infected workers and HIV-infected patients.

According to the scientific community, there is a lack of scientific evidence indicating that there is more than an infinitesimal risk of transmission involved even where procedures are labeled exposure prone. Of course, there are those skeptics who claim that "there is so much we do not know" about AIDS. That raises the question whether law makers pass laws based upon what we know or what we don't know.

It appears that the risk of transmission of HIV infection from a HCW to a patient is not great. However because the harm we are seeking to reduce is death, we need to look at the cost and other consequences of reducing the risk.

The estimated cost of mandatory HIV testing varies depending

upon such things as who will be tested, the number of times the test will occur, and whether there will be counseling with the testing as currently mandated by Florida law. The Florida Health and Rehabilitative Service (HRS) agency estimates that there are 250,000 health care workers in Florida whose occupations put them in situations where there could possibly be a blood-to-blood exposure between a HCW and a patient. At a hearing of the Joint Task Force on AIDS Oversight, a joint legislative committee of the Florida Legislature, an HRS representative testified that it would cost $50 million a year for all those workers to be tested on a twice-a-year basis. This figure takes into account not only the cost of a HIV test and in some instances a confirmatory test, but also the cost of counseling, increased personnel, laboratory space and equipment that would be necessitated by a deluge of new testing. That figure is more than twice what Florida currently spends on AIDS education, testing, counseling and treatment.

Should legislators during a time of recession and severe budget cuts divert so many millions of dollars to protect the public against what appears to be a minimal risk? And, there are other factors to consider.

Opponents of mandatory HIV testing claim that it would cause a false sense of security because the best and only real protection against transmission of infection is the use of universal precautions. There is an approximate six-week "window" period in which a person may be infected with AIDS but the virus will not be detected by a test. Thus, a person could be infected and show a negative test result and, obviously, a person could be infected any time subsequent to a negative AIDS test as well.

Then, there is the potential of the reduction of health care professionals willing to treat HIV-infected persons. If onerous conditions are placed on HCWs, there is justified concern many of these workers will question why they should risk their professional careers by treating HIV-infected patients. Sadly enough, a recent polling of the membership of the American Medical Association indicated only one-third of all primary care doctors believed that they had a responsibility to take care of AIDS patients.

There is the logistical problem of screening. How often should it be done, once a year, twice a year, after every blood exposure, or after every new sex partner?

There is also the concern that the initiation of mandatory testing for health care workers would just be the start of costly and questionably effective mandatory testing schemes for other groups of people. For

example, HRS estimates that the mandatory testing of all patients entering Florida hospitals in one year would cost $175 million. The Illinois experience after passing law in 1988 requiring HIV tests of all persons applying for marriage licenses turned out to be a major failure. Not only did the number of marriages in the state drop by 17,000 in the year following the passage of the law, but there was a wasteful diversion of millions of dollars. In the year following passage, 156,000 people were tested and only twenty-six were found to be HIV positive. At an estimated cost of $25 to $100 per blood test, this represented a cost of $150,000 to $600,000 to find just one infected person.

In summary, in light of CDC guidelines, the relative unsophistication of the HIV test, the high cost of a mass testing scheme, the diversion of valuable dollars and the already minimal risk, it is not likely that many state legislatures will be adopting mandatory testing laws.

The question of what to do with the HIV-infected HCW is a more difficult issue than that of mandatory testing. Some legal medical experts who concur in their opposition to mandatory testing disagree on whether or not a HCW should be obligated to reveal his or her HIV status to their patient. Larry Gostin of Harvard writes that HCWs who are infected with HIV should not perform exposure prone procedures unless they have been before an expert review panel and then notify the patient before they undergo exposure prone invasive procedures.[9]

Chai R. Feldblum of Georgetown argues that remote risks associated with a provider are completely outside of the doctrine of informed consent. She contends that if providers are required to inform a patient of HIV infection they should also be required to disclose marital problems, substance abuse problems, insomnia or any other psychological or physical factor that might in some way endanger the patient. She argues that if a provider truly poses a real risk, the only solution is a restriction. Otherwise it is an unnecessary invasion of privacy of a provider.[10]

Disclosure is most likely tantamount to an automatic restriction since most patients would probably not seek the services of an HIV

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9. Larry Gostin, *HIV-infected Health Care Professional: Public Policy Discrimination and Patient Safety*, 18 LAW, MEDICINE AND HEALTH CARE 303 (1990). *See* Larry Gostin, *HIV-infected Physicians and the Practice of Seriously Invasive Procedures*, 19 HASTINGS CENTER REP. 32 (1989).

10. *See* Chai R. Feldblum, *A Response to Gostin: HIV-infected Health Care Professional: Public Policy Discrimination and Patient Safety*, 19 LAW, MEDICINE AND HEALTH CARE 134 (1991).

infected professional. However, the cost there to society is not minimal. There are figures suggesting a loss of $1.6 billion dollars in training expenses for HIV-infected health care workers should they leave the profession.

Proponents of the now-defunct July 1991 CDC guidelines say that regardless of the minuteness of the risk, any error should be on the side of protecting the patients. This is the most popular political position to take. The correct social and health policy still remains fuzzy.

In Florida, we have elected to take an approach leaving the decision of how to handle HIV-infected health care workers to the professional regulatory boards and HRS. Under Florida Statute § 455.2224, the health-related regulatory boards are given the authority to handle, counsel and serve HIV and hepatitis-infected health care professionals under their regulations. So, for example, the Florida Board of Medicine is authorized to handle, counsel and serve any HIV or hepatitis-infected physician. A similar responsibility is given to HRS to serve, counsel or handle the health care workers that they license under Florida Statute § 381.045.

The Florida Board of Dentistry has already taken strong steps toward implementing its authority. It have strengthened infection control procedures and the penalties enforcing them. And, it proposes to refer HIV-infected dentists to the Impaired Practitioner Program which is currently used for dentists suffering from drug or alcohol abuse.

Florida law also requires AIDS education as a condition of licensing for all health care professionals under Florida Statutes §§ 455.2226, 455.2228, and 381.0034. The direction that the Florida Legislature has chosen to go on this issue is consistent with its longstanding approach to follow CDC guidelines and to avoid emotionalized legislation. Unfortunately, the recent incident of the apparent transmission of HIV infection from the Florida dentist to five of his patients has given another opportunity to right wing politicians to righteously declare that it is time to consider AIDS a public health disease and not a civil rights disease.

Such rhetoric is verbally wrong and inflammatory. In fact, we will never stop the spread of AIDS unless people feel they can come forward for testing, counseling and treatment without being punished or ostracized. Confidentiality, informed consent testing and anti-discrimination laws are not only compatible with public health but actually facilitate the fight against HIV infection.

The Florida AIDS Omnibus Bill of 1988 and Florida's subsequent AIDS legislation adopted this strategy and, therefore, the underpinning

of the Florida AIDS law is education, confidentiality and informed consent testing and strong anti-discrimination laws.

The question now is where do we go from here? If we give in to fear and hysteria and put into place what appears to be simple and obvious, but wrong, strategies, we will be wasting valuable dollars that could be used to save many lives. Unfortunately, there is no set of laws that will give the public absolute protection from HIV.

While the television talk show hosts spend hours debating whether we should test health care workers for HIV we allow hundreds of thousands of people to die from a known preventable health risk, i.e., breast cancer, infant mortality, hospital infections and even tired interns. We continue to sell tobacco and resist sex education in our schools.

As we struggle with this complex issue of testing, there are many things we know that we must do now. There must be improvements in infection control and non-stigmatized evaluation of HIV-infected health care workers. We must continue to focus on education and drug abuse treatment. And, at the top of the list is access to health care for the millions of Americans without it as vigorously recommended by the National Commission on Acquired Immune Deficiency Syndrome in its 1991 report.

Health care workers need to talk to their patients to alleviate their fears. Most importantly, politicians should not allow the issue to become political in any way. At stake are too many lives including those of our own children.