University of Richmond Law Review

Volume 23 | Issue 1 Article 3

1988

A Hospital's Dilemma: The Legal Implications of Promulgating Guidelines Concerning Human Immunodeficiency Virus

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A HOSPITAL'S DILEMMA: THE LEGAL IMPLICATIONS OF PROMULGATING GUIDELINES CONCERNING HUMAN IMMUNODEFICIENCY VIRUS

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I. INTRODUCTION

Fear has struck the workplace. The source of this fear is not lack of job security, inflation, recession or a concern about the United States' trade imbalance. The source of the fear is a disease[1]—Acquired Immunodeficiency Syndrome (AIDS)—and the virus that causes AIDS, Human Immunodeficiency Virus (HIV).[2]

As of March 1987, nearly 32,000 Americans had developed AIDS and over half of them had died.[3] As many as 1.5 million others may be infected with HIV.[4] The Public Health Service estimates that by 1991 more than 270,000 people will have contracted full-blown AIDS,[5] and more than 179,000 more will have died.[6]

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* Associate, Williams, Worrell, Kelly, Greer and Frank, P.C., Newport News, Virginia. B.B.A., 1982, J.D., 1986, College of William and Mary.

I am grateful to my colleagues, Wilson B. Dodson, III and Sharon N. Baker, for their helpful comments and assistance in the preparation of his article.

I would also like to thank Phillip R. Lingafelt for his research assistance while he was a summer associate at our firm.

1. Public opinion polls indicate that AIDS has become the highest priority health concern in America, ahead of heart disease and cancer. AMERICAN MEDICAL ASSOCIATION, PREVENTION AND CONTROL OF AIDS—AN INTERIM REPORT 2 (1987) [hereinafter AMA].

2. The scientific and medical communities have given the virus the following names: Human Immunodeficiency Virus (HIV), Human T-Lymphotropic Virus Type III (HTLV-III), and Lymphadenopathy Associated Virus (LAV). This article will refer to the virus by the name proposed by the International Committee on the Taxonomy of Viruses, that is, Human Immunodeficiency Virus (HIV).

3. U. S. DEP'T OF HEALTH & HUMAN SERVICES, AIDS: INFORMATION/EDUCATION PLAN TO PREVENT AND CONTROL AIDS IN THE UNITED STATES i (1987) [hereinafter HHS INFORMATION PLAN].

4. *Id.*

5. When using the term AIDS, one must understand the full spectrum of the disease's progression. When an individual is first infected with HIV, the virus that causes AIDS, the individual may be asymptomatic; show no physically apparent symptoms of illness. However, during this stage, the infected individual can still transmit the virus to others.

The second stage of the disease is called AIDS-Related Complex (ARC). ARC patients' symptoms are often less severe than those with the disease known as classic AIDS. Signs

At present neither a cure nor a vaccine exists for HIV. The disease represents a national and international emergency[7] and a health disaster of pandemic proportions.[8] Thanks to extensive press coverage the public knows this, and out of fear and ignorance of the disease, the public has overreacted at times. Every day one hears of calls for testing for the disease.

Because HIV is extremely fragile, the virus is difficult to transmit. The virus *cannot* be transmitted by casual contact. For this reason, fears over HIV in the workplace are generally unfounded. However, one industry does provide a work environment in which HIV can be transmitted—the health-care industry.

Health-care workers are exposed daily to patients' blood and body fluids. Such exposure is potentially conducive to the transmission of HIV. Health-care workers know this and are very concerned. Some organizations have examined the medical need for testing health-care workers and patients for HIV. Most of these organizations have rejected the idea.[9] However, some hospitals may feel a need for a testing program. In addition, every hospital risk-management staff should give guidance to its employees and medical staff on how to care for HIV-infected patients and prevent the spread of the virus in the work environment.

While there has been an explosion of medical data regarding HIV, few legislative or administrative regulations have been promulgated specifically addressing issues regarding the disease. However, a substantial body of HIV case law is developing rapidly.[10] In this area, of course, the development of the law must nec-

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and symptoms of ARC include "loss of appetite, weight loss, fever, night sweats, skin rashes, diarrhea, tiredness, lack of resistance to infection, or swollen lymph nodes." SURGEON GENERAL'S REPORT ON ACQUIRED IMMUNE DEFICIENCY SYNDROME 11 (1986).

The final stage of the disease is AIDS. Some signs and symptoms of AIDS and its associated opportunistic infections may include "a persistent cough and fever associated with shortness of breath or difficult breathing and maybe the symptoms of *Pneumocystis carinii* pneumonia. Multiple purplish blotches and bumps on the skin may be a sign of *Kaposi's sarcoma*." *Id.* at 11-12.

6. HHS INFORMATION PLAN, *supra* note 3, at i.

7. *Id.*

8. *Id.* at 3.

9. AMERICAN HOSPITAL ASSOCIATION, MANAGEMENT OF HTLV-III/LAV INFECTION IN THE HOSPITAL 2 (1986) [hereinafter AHA]; AMA, *supra* note 1, at 10.

10. *See, e.g.*, Pasteur v. United States, 814 F.2d 624 (Fed. Cir. 1987) (breach of contract action for damages in connection with delivery of sample of AIDS-related virus to research personnel at the National Cancer Institute); Coffee v. Cutter Biological, 809 F.2d 191 (2d Cir. 1987) (Connecticut's "blood shield" statute precluded action for product liability claims arising out of sale of blood components contaminated with HIV); Kentucky Cent. Life Ins. Co. v. Webster, 651 F. Supp. 935 (N.D. Ala. 1986) (insured's statement on application did

essarily follow the development of the medical data on the virus. The legal analysis of any issue relating to HIV will change with the current medical knowledge of the disease, especially in the areas of transmission and its treatment.

This article examines the legal issues a hospital administrator or risk manager must address in developing an effective infection-control policy dealing with HIV. The article addresses such issues as testing and employment policies. While the article discusses testing, it is not intended to address the medical need for such testing. A decision to test patients, employees and staff must be made by each hospital according to its own circumstances. The article merely analyzes the legal implications and restrictions of imposing such a testing program.

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not defeat coverage under life insurance policy, which became effective before insured was diagnosed with *Kaposi's sarcoma*, which is associated with HIV); Powell v. Department of Corrections, 647 F. Supp. 968 (N.D. Okla. 1986) (rejecting state prisoner's 42 U.S.C. § 1983 action filed when he was segregated from the general prison population because of his positive HTLV-III antibody test); American Council of Life Ins. v. District of Columbia, 645 F. Supp. 84 (D.D.C. 1986) (upholding ordinance which prohibited discrimination against individuals on the basis of any test screening for HIV and from denying benefits because the individual develops HIV); Cordero v. Coughlin, 607 F. Supp. 9 (S.D.N.Y. 1984) (upholding HIV-infected prisoner's segregation from general prison population); *In re* Peacock, 59 Bankr. 568 (S.D. Fla. 1986) (finding no special precautions needed for courtroom procedures where one of the participants has HIV); *In re* Southern Biotech, Inc., 37 Bankr. 311 (M.D. Fla. 1983) (denying trustee's request to assume executory contract between debtor and Florida Department of Corrections allowing debtor to operate a plasma donor facility in correctional institute because of high rate of HIV in prison); Barlow v. People, 190 Cal. App. 3d 1652, 236 Cal. Rptr. 134 (1987) (invalidating search warrant issued to authorize drawing of sample of defendant's blood after he bit a police officer); Rasmussen v. South Fla. Blood Serv., Inc., 500 So. 2d 533 (Fla. 1987) (prohibiting the tracing of HIV-infected blood to blood donor); Cheney v. Bell Nat'l Life Ins. Co., 70 Md. App. 163, 520 A.2d 402, *cert. granted*, 310 Md. 144, 527 A.2d 331 (1987) (HIV-related death due to blood transfusion to a hemophiliac was not an accident covered by an accidental death policy); Board of Educ. v. Cooperman, 105 N.J. 587, 523 A.2d 655 (1987) (upholding school-board guidelines for admission of HIV-infected students to classroom); Doe v. Coughlin, 125 A.D.2d 783, 509 N.Y.S.2d 209 (1986), *aff'd*, 71 N.Y.2d 48, 518 N.E.2d 536, 523 N.Y.S.2d 782 (1987) (upholding prisoner's exclusion from conjugal visit program); District 27 Community School Bd. v. Board of Educ., 130 Misc. 2d 398, 502 N.Y.S.2d 325 (Sup. Ct. 1986) (children with HIV held handicapped, and their automatic exclusion from school violated the Rehabilitation Act and rights to equal protection of the law); City of New York v. New Saint Mark's Baths, 130 Misc. 2d 911, 497 N.Y.S.2d 979, *order aff'd*, 122 A.D.2d 747, 505 N.Y.S.2d 1015 (1986), *appeal dismissed*, 70 N.Y.2d 693, 512 N.E.2d 555 (1987) (upholding injunction closing bath house to prevent the spread of HIV); *In re* Joseph P.M. v. Boyce, 127 Misc. 2d 931, 487 N.Y.S.2d 685 (Fam. Ct. 1985) (father ordered to undergo blood test in paternity suit even though he was a correctional officer exposed to a high risk group of HIV sufferers); LaRocca v. Dalsheim, 120 Misc. 2d 697, 467 N.Y.S.2d 302 (Sup. Ct. 1983) (not ordering the testing of prisoners for HIV because a scientifically acceptable test did not exist).

The article also examines what a health-care provider can and cannot do when a patient, employee or member of the medical staff tests seropositive. Finally, the article addresses potential labor problems that may arise due to the known presence of the disease in the hospital.[11]

A. *Human Immunodeficiency Virus*

AIDS first surfaced in the United States in 1979 in urban centers, particularly New York and California.[12] It was diagnosed as a distinct disease by the United States Centers for Disease Control (CDC) in 1981.[13] Until recently CDC defined AIDS as "a reliably diagnosed disease that is at least moderately indicative of an underlying cellular immunodeficiency in a person who has had no underlying cause of cellular immunodeficiency nor any other cause of reduced resistance reported to be associated with that disease."[14] CDC has expanded the definition of AIDS to include the wasting syndrome associated with the disease and various AIDS-indicative diseases. In layman's terms, AIDS renders the human immune system incapable of defending the body from certain otherwise rare, fatal diseases.[15] AIDS has no cure and is always fatal.[16]

To understand the disease's effects, one must understand the function of the human immune system. The system works in three stages: first, it identifies foreign agents that have entered the body; second, antibodies form that are capable of rendering the foreign

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11. This article deals only with non-emergency settings. A full range of regulatory, statutory and common-law implications control HIV-related issues in emergency settings and such restraint are outside the scope of this article. For discussion of these issues, see J. HORTY, HOSPITAL LAW, Miscellaneous, Ch. 2, at 1-2.

12. McGuirl & Gee, *AIDS: An Overview of the British, Australian, and American Responses*, 14 HOFSTRA L. REV. 107, 107 (1985); Leonard, *Employment Discrimination Against Persons with AIDS*, 10 U. DAYTON L. REV. 681, 681 n.1 (1985).

13. 36 MMWR, June 5, 1981, at 250-52 (the *Morbidity and Mortality Weekly Report* is the official publication of the Centers for Disease Control). Leonard, *supra* note 12, at 681 n.1.

14. U.S. DEP'T OF HEALTH & HUMAN SERVICES, PUBLIC HEALTH SERVICE, FACTS ABOUT AIDS (1985).

15. *See Revision of the CDC Surveillance Case Definition for Acquired Immunodeficiency Syndrome*, 258 J. A.M.A. 1143 (1987); E. HOLLAND & D. WING, HOSPITAL LAW MANUAL: SPECIAL SUPPLEMENT—AIDS AND HOSPITALS—THE EMERGING LEGAL ISSUES 2 (1986).

16. Despite the medical field's best efforts, mortality of HIV continues to approach 100% thirty months after full-blown AIDS appears. Kunkel & Warner, *Human T-Cell Lymphrotropic Virus Type III (HTLV-III) Infection: How It Can Affect You, Your Patients, and Your Anesthesia Practice*, 66 ANESTHESIOLOGY 195, 199 (1987).

agents harmless; and third, the system regulates the production of these antibodies after the foreign agents are detected.[17]

Researchers believe that HIV, the virus that causes AIDS, interferes with the body's regulation of the production of antibodies. Scientists further believe that a viral agent attacks and destroys certain cells (called T-helper lymphocytes) whose normal function is to activate the production of certain antibodies. As a result, the organs which produce these antibodies are not activated, and the foreign agents are allowed to ravage the body unhindered in a variety of ways.[18]

With the body's immune defenses down, "opportunistic infections" associated with HIV occur. The most common opportunistic infections are *Kaposi's sarcoma*, a rare skin cancer, and *pneumocystis carinii* pneumonia, an uncommon lung ailment.[19] Although these opportunistic infections may hospitalize or even kill their victims, some infected individuals are treated on an outpatient basis and are physically capable of working.[20]

Persons infected with HIV may show no signs of the infection or may be affected by a variety of clinical conditions.[21] In the most severe cases, opportunistic infections or cancers attack the patient's body with a significant morbidity and high mortality rate. In less severe cases the patient may suffer from chronic generalized lymphadenopathy, chronic diarrhea, recurrent fevers, weight loss, fatigue and central nervous system complications.[22]

The natural etiology of HIV is hard to elucidate because most people exposed to the virus are unaware they have acquired it. Within six to thirteen days of exposure, the individual usually develops an illness resembling acute infectious mononucleosis with symptoms such as a sore throat, headache, fever, nausea, myalgia, macular rash, malaise, pyrexia, lymphadenopathy and diarrhea

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17. A. FETTNER & W. CHECK, THE TRUTH ABOUT AIDS 42-58 (1984); Leonard, *supra* note 12, at 684.

18. Leonard, *supra* note 12, at 684.

19. E. HOLLAND & D. WING, *supra* note 15, at 2. The tuberculosis and herpes viruses are also dangers to HIV patients. *See* CENTERS FOR DISEASE CONTROL, AIDS: RECOMMENDATIONS AND GUIDELINES—NOVEMBER 1982-NOVEMBER 1986 37 (1986) [hereinafter CDC]; Kunkel & Warner, *supra* note 16, at 197.

20. Leonard, *supra* note 12, at 684-85.

21. Studies show that the average time between infection and diagnosis of AIDS is more than 3 years; a few people have not developed AIDS even 6 years after infection. AHA, *supra* note 9, at 3-4.

22. *Id.* at 3.

persisting for up to two weeks. Shortly thereafter the individual usually returns to his or her normal medical state. The infected person may remain asymptomatic for up to six years or longer before acquiring full-blown AIDS.[23] Early medical evidence led to the conclusion that under twenty percent of HIV-infected persons converted to AIDS; however, the most recent medical data demonstrates that, without treatment advances, a much higher percentage will acquire the full-blown disease.[24]

In 1985, a test called the enzyme-linked immunosorbent assay (ELISA) and another test called the Western blot were approved for the detection of antibodies to the HIV infection.[25] The tests are presently being used to screen blood and plasma in order to prevent the transmission of HIV in blood transfusions.[26]

These tests are also used to detect the presence of antibodies to HIV in humans. The presence of antibodies only means that the individual has been infected with HIV, not that the person is still infected or will contract full-blown AIDS.[27] While the ELISA test is the least expensive of the two tests, its reliability has been questioned because it can produce false-negative and false-positive results.[28] For this reason a series of ELISA tests must be given to ensure the test's reliability. In the alternative, a seropositive ELISA result can be confirmed or rejected by the use of the Western blot. While the Western blot is fairly accurate, it is a labor-intensive test and, therefore, is much more time consuming and expensive.[29] One problem associated with both tests is that they cannot detect the presence of HIV antibodies during the virus's incubation period, which is usually three to twelve weeks after exposure but may be as long as six months.[30] During the incubation

23. Kunkel & Warner, *supra* note 16, at 196.

24. AMA, *supra* note 1, at 2.

25. CDC, *supra* note 19, at 44.

26. *Id.* With the use of these screening tests, the American Red Cross' blood supply is today considered 99.9% safe. *New Test Shows Infection Before Antibody Production*, 2 AIDS POLICY & L. Sept. 9, 1987.

27. E. HOLLAND & D. WING, *supra* note 15, at 2.

28. One study concludes that if the ELISA test were used to test the general population, more than 97% of the positive tests (results indicating the presence of the HIV virus) would be false positives. However, of the negative tests, less than .01% would be false-negatives. When testing high-risk groups, a positive test is much more likely to be a true-positive. For example, for hemophiliacs a positive test has a 99% chance of being a true-positive. *See* Sivak & Wormser, *Predictive Value of a Screening Test for Antibodies to HTLV-III*, 85 AM. J. CLINICAL PATHOLOGY 700, 702 (1986).

29. Sivak & Wormser, *supra* note 28, at 700.

30. Kunkel & Warner, *supra* note 16, at 196.

period the tests will most likely indicate that the individual tested has not been exposed to HIV when, in fact, he has been (*i.e.*, a false-negative result).

Certain groups are at an increased risk of becoming infected with HIV. Within the United States, these groups include the following: homosexual and bisexual men with multiple partners (73% of all HIV victims); present or past abusers of intravenous drugs (17%) persons with a history of prior blood transfusions (1.6%); persons with hemophilia or other coagulation disorders (0.8%); persons having heterosexual contact with someone who is infected with HIV or at risk for HIV (1%).[31]

While AIDS itself is extremely dangerous, the virus is very fragile and not easily transmitted. HIV is a blood-borne virus that is not spread by casual contact.[32] Epidemiologic data suggests that the virus can be transmitted through intimate sexual contact, sharing contaminated needles, transfusion of whole blood or blood components, or from an infected mother to her child before, at, or shortly after the time of birth.[33]

Of particular importance to health-care workers, CDC recently reported that several health-care workers have contracted HIV while performing their duties at work. Four health-care workers contracted the virus following needlestick exposures to blood from HIV-infected patients. Two workers seroconverted after having large amounts of HIV-infected blood exposed to their skin. Three other health-care workers contracted the virus by non-needlestick exposures to blood from infected patients.[34] In addition, apparently one dentist has been infected with HIV due to patient contact.[35]

HIV has been isolated from blood, semen, vaginal secretions, saliva, tears, breast milk, cerebrospinal fluid, amniotic fluid and

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31. HHS INFORMATION PLAN, *supra* note 3, at i; AHA, *supra*, note 9, at 4.

32. CDC, *supra* note 19, at 6.

33. CDC, *supra* note 19, at 2; AHA, *supra* note 9, at 4.

34. U.S. Dep't of Health & Human Services, UPDATE: HUMAN IMMUNODEFICIENCY VIRUS INFECTIONS IN HEALTH-CARE WORKERS EXPOSED TO BLOOD OF INFECTED PATIENTS, 36 MMWR, May 22, 1987, at 285-89. In addition, San Francisco General Hospital reported its first known case of an employee testing HIV positive as a result of occupational exposure (deep needlestick). *Hospital Reports First Case of Occupational Exposure*, 2 AIDS POLICY & L., Oct. 7, 1987, at 5.

35. U. S. Dep't of Health & Human Services, RECOMMENDATIONS FOR PREVENTION OF HIV TRANSMISSION IN HEALTH-CARE SETTINGS, 36 MMWR, Aug. 21, 1987, at 3S, 5S [hereinafter RECOMMENDATIONS].

urine. HIV may likely be isolated from other body fluids, secretions and excretions; however, epidemiologic evidence has implicated only blood, semen, vaginal secretions and breast milk in transmission of the disease.[36]

The HIV infection is similar to hepatitis B virus (HBV) in that it is transmitted by sexual contact, blood or blood products and perinatal transmission from mother to child.[37] However, the risk of HBV transmission in the health-care setting far exceeds that of HIV transmission.[38] For these reasons, CDC has concluded that those measures used to control the spread of HBV should also effectively control the spread of the HIV.[39]

B. *CDC Recommendations and Guidelines for Health-Care Workers and Laboratory Personnel*

Since AIDS was classified as a separate disease, CDC has published various guidelines and recommendations aimed at preventing the spread of the disease.[40] Several of these sets of guidelines and recommendations have addressed the special needs of the health-care industry. On August 21, 1987, CDC released its most current compilation of recommendations for the prevention of HIV transmission in health-care settings.[41]

In these guidelines CDC acknowledged that medical history and examination cannot reliably identify all patients infected with HIV; therefore, *all* patients should be treated as if they potentially are infected with the virus, and universal blood and body-fluid precautions should be used.[42] These detailed recommendations[43] in-

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36. *Id.* at 3S; CDC, *supra* note 19 at 7.

37. CDC, *supra* note 19, at 7.

38. *Id.* "The risk of acquiring HBV infection following a needlestick from an HBV carrier ranges from 6% to 30%, far in excess of the risk of HTLV-III/LAV infection following a needle-stick involving a source patient infected with HTLV-III/LAV, which is less than 1%." *Id.*

39. CDC, *supra* note 19, at 6-8.

40. *See* CDC *supra* note 19.

41. RECOMMENDATIONS, *supra* note 35, at 3S.

42. *Id.* at 5S.

43. 1. All health-care workers should routinely use appropriate barrier precautions to prevent skin and mucous-membrane exposure when contact with blood or other body fluids of any patient is anticipated. Gloves should be worn for touching blood and body fluids, mucous membranes, or non-intact skin of all patients, for handling items or surfaces soiled with blood or body fluids, and for performing venipuncture and other vascular access procedures. Gloves should be changed after contact with each patient. Masks and protective eyewear or face shields should be worn during proce-

clude the use of barrier precautions, such as wearing gloves, masks, protective eyewear and gowns, to prevent skin and mucous-membrane exposure when contact with blood or any other body fluids of any patient is anticipated. Other precautions include the proper handling of needles, syringes, scalpels and other sharp instruments and devices.

The August 21 recommendations also addressed special precautions to be followed in performing invasive procedures.[44] Because HIV can be transmitted by contact with infected blood, health-

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dures that are likely to generate droplets of blood or other body fluids to prevent exposure of mucous membranes of the mouth, nose, and eyes. Gowns or aprons should be worn during procedures that are likely to generate splashes of blood or other body fluids.

2. Hands and other skin surfaces should be washed immediately and thoroughly if contaminated with blood or other body fluids. Hands should be washed immediately after gloves are removed.

3. All health-care workers should take precautions to prevent injuries caused by needles, scalpels, and other sharp instruments or devices during procedures; when cleaning used instruments; during disposal of used needles; and when handling sharp instruments after procedures. To prevent needlestick injuries, needles should not be recapped, purposely bent or broken by hand, removed from disposable syringes, or otherwise manipulated by hand. After they are used, disposable syringes and needles, scalpel blades, and other sharp items should be placed in puncture-resistant containers for disposal; the puncture-resistant containers should be located as close as practical to the use area. Large-bore reusable needles should be placed in a puncture-resistant container for transport to the reprocessing area.

4. Although saliva has not been implicated in HIV transmission, to minimize the need for emergency mouth-to-mouth resuscitation, mouthpieces, resuscitation bags, or other ventilation devices should be available for use in areas in which the need for resuscitation is predictable.

5. Health-care workers who have exudative lesions or weeping dermatitis should refrain from all direct patient care and from handling patient-care equipment until the condition resolves.

6. Pregnant health-care workers are not known to be at greater risk of contracting HIV infection than health-care workers who are not pregnant; however, if a health-care worker develops HIV infection during pregnancy, the infant is at risk of infection resulting from perinatal transmission. Because of this risk, pregnant health-care workers should be especially familiar with and strictly adhere to precautions to minimize the risk of HIV transmission.

Id. at 6S.

44. *Id.* at 6SD-7S. The CDC defines "invasive procedure" as:

surgical entry into tissues, cavities, or organs or repair of major traumatic injuries (1) in an operating or delivery room, emergency department, or outpatient setting, 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.

care workers who perform or assist in invasive procedures theoretically are at a higher risk of contracting and/or transmitting HIV than other health-care workers. With this in mind, in addition to the universal blood and body-fluid precautions, CDC included separate guidelines for invasive procedures.[45]

As for clinical laboratory workers, CDC promulgated additional guidelines to be used in conjunction with the universal precautions. These recommended precautions include the use of well-constructed containers with secure lids for the collection and storage of blood and body-fluid specimens to prevent leaking during transport, and in certain situations, the use of biological safety cabinets and mechanical pipetting devices. Also recommended is the decontamination of laboratory work surfaces, contaminated materials used in laboratory tests and scientific equipment that has been contaminated with blood or other body fluids.[46]

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45. 1. All health-care workers who participate in invasive procedures must routinely use appropriate barrier precautions to prevent skin and mucous-membrane contact with blood and other body fluids of all patients. Gloves and surgical masks must be worn for all invasive procedures. Protective eyewear or face shields should be worn for procedures that commonly result in the generation of droplets, splashing of blood or other body fluids, or the generation of bone chips. Gowns or aprons made of materials that provide an effective barrier should be worn during invasive procedures that are likely to result in the splashing of blood or other body fluids. All health-care workers who perform or assist in vaginal or cesarean deliveries should wear gloves and gowns when handling the placenta or the infant until blood and amniotic fluid have been removed from the infant's skin and should wear gloves during post-delivery care of the umbilical cord.

2. If a glove is torn or a needlestick or other injury occurs, the glove should be removed and a new glove used as promptly as patient safety permits; the needle or instrument involved in the incident should also be removed from the sterile field.

Id. at 7S.

46. 1. All specimens of blood and body fluids should be put in a well-constructed container with a secure lid to prevent leaking during transport. Care should be taken when collecting each specimen to avoid contaminating the outside of the container and of the laboratory form accompanying the specimen.

2. All persons processing blood and body-fluid specimens (e.g., removing tops from vacuum tubes) should wear gloves. Masks and protective eyewear should be worn if mucous-membrane contact with blood or body fluids is anticipated. Gloves should be changed and hands washed after completion of specimen processing.

3. For routine procedures, such as histologic and pathologic studies or microbiologic culturing, a biological safety cabinet is not necessary. However, biological safety cabinets (Class I or II) should be used whenever procedures are conducted that have a high potential for generating droplets. These include activities such as blending, sonicating, and vigorous mixing.

4. Mechanical pipetting devices should be used for manipulating all liquids in the laboratory. Mouth pipetting must not be done.

5. Use of needles and syringes should be limited to situations in which there is no alternative, and the recommendations for preventing injuries with needles outlined

In addition to the above sets of precautions and recommendations, CDC's August 21 report established guidelines for dentists and morticians.[47]

Of particular interest to hospital administrators and the news media was the CDC's apparent change in policy regarding testing patients for HIV. Prior to the August 21 report, CDC did not recommend the routine testing of patients.[48] Previous CDC recommendations had emphasized the value of HIV serologic testing of patients for: (1) management of parenteral or mucous-membrane exposures of health-care workers; (2) patient diagnosis and management; (3) counseling and serologic testing to prevent and control HIV in the community; and (4) assisting state and local health departments in determining the prevalence of HIV infection among patients from age groups at highest risk of infection.[49] However, until the August 21 report, CDC's position had always been that routine serologic testing of all patients was not recommended.

The August 21 report, while not specifically advocating routine testing of patients, took a more neutral position on the issue. The report emphasized that the utility of routine HIV testing as an adjunct to the universal blood and body-fluid precautions is unknown.[50] However, acknowledging the fact that some hospitals have already instituted testing programs, the report stated that the "[d]ecisions regarding the need to establish testing programs for patients should be made by physicians of individual institutions."[51]

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under universal precautions should be followed.

6. Laboratory work surfaces should be decontaminated with an appropriate chemical germicide after a spill of blood or other body fluids and when work activities are completed.

7. Contaminated materials used in laboratory tests should be decontaminated before reprocessing or be placed in bags and disposed of in accordance with institutional policies for disposal of infective waste.

8. Scientific equipment that has been contaminated with blood or other body fluids should be decontaminated and cleaned before being repaired in the laboratory or transported to the manufacturer.

9. All persons should wash their hands after completing laboratory activities and should remove protective clothing before leaving the laboratory.

Id. at 9S.

47. *Id.* at 7S-8S.

48. CDC, *supra* note 19, at 7, 9, 21. However, CDC did recommend that serologic testing be made available to health care workers who may wish to know their HIV-infection status. *Id.* at 7. In addition, CDC acknowledged that some hospitals in certain geographic areas may deem it appropriate to initiate routine serologic testing of patients. *Id.*

49. RECOMMENDATIONS, *supra* note 35, at 14S.

50. *Id.*

51. *Id.*

If testing programs are established, CDC stressed that the following principles be followed:

> —Obtaining consent for testing.
> —Informing patients of test results, and providing counseling for seropositive patients by properly trained persons.
> —Assuring that confidentiality safeguards are in place to limit knowledge of test results to those directly involved in the care of infected patients or as required by law.
> —Assuring that identification of infected patients will not result in denial of needed care or provision of suboptimal care.
> —Evaluating prospectively 1) the efficacy of the program in reducing the incidence of parenteral, mucous-membrane, or significant cutaneous exposures of health-care workers to the blood or other body fluids of HIV-infected patients and 2) the effect of modified procedures on patients.[52]

As for testing health-care workers, CDC reported that while there have been no documented cases of transmission of HIV from infected health-care workers to patients, such transmission is theoretically possible during invasive procedures.[53] If a testing program is established for health-care workers, then in addition to the above considerations outlined for the testing of patients, a hospital must also address the frequency of testing.[54]

If a health-care worker tests seropositive, CDC recommends that the hospital determine whether the worker can continue his or her duties on an individual basis, giving due consideration to the welfare of the worker and the hospital's patients.

II. Developing An HIV-Infection Control Policy

A. *A Hospital's Need to Identify Patients, Employees and Medical Staff with HIV*[55]

A hospital may wish to identify an HIV-infected patient, employee, or medical staff member on a limited basis in order to pro-

52. *Id.* at 15S.
53. *Id.*
54. *Id.*
55. When a physician orders an HIV test, a hospital is not required to obtain a specific consent form unless required by state statute. "Otherwise, the hospital has no duty to inform the patient that the test his physician has ordered is in fact a test for exposure to the HTLV-III virus. By notifying a patient of the purpose of the test, the hospital could be unnecessarily interjecting itself into the physician-patient relationship." J. Horty, *supra* note 11, Miscellaneous, Ch. 2 at 5.

tect other employees of the hospital, other patients or perhaps even the infected individual. The key is the risk of transmission of the disease. As stated earlier, the infection can only be transmitted in limited ways and certainly not by casual contact. In most work environments the risk of transmission of HIV is non-existent. However, because of the unique services provided by hospitals, under certain circumstances the risk of transmission of HIV may be very real.[56]

However, a hospital should attempt to convince its medical staff to inform the patient that the blood test will include an HIV antibody test in addition to tests for other blood-borne diseases. While this is not required by the doctrine of informed consent (because the patient has already consented to the blood test itself), lack of specific consent to test for HIV may come back to haunt the hospital if a breach of confidentiality occurs.

For example, Mr. Smith enters the hospital for an operation to correct an old football injury to his knee. His physician orders a series of blood tests, among which is included a test for the HIV antibody. Mr. Smith consents to the blood tests, but is not informed that one of the tests is for the detection of the antibody to HIV.

Mr. Smith tests seropositive. For some reason, the test result becomes known to Mr. Smith's acquaintances, and Mr. Smith is unfairly discriminated against. Mr. Smith certainly has a cause of action against the hospital for breach of confidentiality. To make matters worse, during the jury trial of the cause of action, evidence is admitted to show that not only did the hospital negligently disclose the test results, but, in addition, neither the hospital nor Mr. Smith's attending physician ever informed him that he was being tested for HIV. Such evidence can only make the hospital's situation worse.

In addition, ethical considerations as well as legal considerations must be addressed by hospitals when instituting testing programs. Bayer, Levine and Wolf offer the following ethical guidelines for any testing program:

1. The purpose of the screening must be ethically acceptable.
2. The means to be used in the screening program and the intended use of the information must be appropriate for accomplishing the purpose.
3. High-quality laboratory services must be used.
4. Individuals must be notified that screening will take place.
5. Individuals who are screened have a right to be informed about the results.
6. Sensitive and supportive counseling programs must be available before and after screening to interpret the results, whether they are positive or negative.
7. The confidentiality of screened individuals must be protected.

Bayer, Levine, & Wolf, *HIV Antibody Screening: An Ethical Framework for Evaluating Proposed Programs*, 256 J.A.M.A. 1768, 1769-70 (1986).

56. For example, hospital personnel deal daily with patients' body fluids and tissues, which may create an opportunity for transmission of HIV. Nurses, laboratory technicians, OB-GYN staff and surgical teams all perform duties that may expose them to HIV. Such exposure may occur via a needlestick or scalpel injury or simple contact with blood of an HIV-infected patient. Granted, the likelihood of transmission of the infection is small; however, the potential transmission of the disease is a real concern and one that a hospital *must* address.

B. Testing of Patients[57]

A hospital may wish to determine whether a patient has HIV in order to insure that certain procedures are followed to prevent the transmission of the infection to others.[58] CDC has indicated that normal procedures which are followed to prevent the spread of HBV will also prevent the spread of HIV in hospital settings.[59] In addition, if the hospital adopts the guidelines suggested by CDC on August 21, 1987, the risk of transmission of the virus should be minimized.

However, without identifying which patients are infected with HIV, health-care workers must constantly remain on a high state of alert, being ever so cautious with each and every patient to insure that there is no risk of transmission of the disease. By forcing the health-care worker to remain in such a high state of alert at all times with every patient, fatigue or laxness may set in. During the daily routine, the health-care worker may begin to short circuit the extra protections imposed by the hospital and recommended by CDC because of the attitude that "this patient is probably not infected anyway."[60] The fact that a health-care worker *knows* that a particular patient is infected with HIV may be the best guarantee that the hospital guidelines imposed to prevent the transmission of the virus are followed.

In addition, an argument exists that the Occupational Safety and Health Act (OSHA) requires hospitals to identify HIV-in-

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57. This article only addresses testing of patients in non-emergency settings. In emergency settings a hospital may be obligated to follow requirements established by licensing agencies or accreditation boards. In addition, it would be legally risky to deny emergency care to anyone who has or is suspected of having HIV. *See* E. HOLLAND & D. WING, *supra* note 15, at 6.

58. Some hospitals have prescribed special surgical procedures for operating on HIV-infected patients. For example, normal procedures may be altered so that hand-to-hand exchange of sharp instruments is eliminated. Stapling instruments may be utilized instead of hand-suturing equipment. Surgeons may use electrocautery devices rather than scalpels. Finally, though uncomfortable, gowns that prevent the seepage of blood onto the skin of the surgical staff may be used. RECOMMENDATIONS, *supra* note 35, at 14S-15S.

59. *See, e.g.*, CDC, *supra* note 19, at 7; *see also supra* notes 37-39 and accompanying text.

60. A hospital must recognize this human tendency and institute enforcement mechanisms to ensure that HIV-related procedures are followed.

A good example of a department that daily comes into contact with patients in such a way as to transmit the HIV virus from the patient to the employee is the dialysis department. Given the frequent occurrence of blood spills in such centers, three writers have suggested routine screening of dialysis patients for HIV. Bayer, Levine & Wolf, *supra* note 55, at 1772.

fected patients to at least those personnel who may have contact with the patients in such a way as to acquire the virus.[61] Such personnel may include individuals in pathology, intensive care, dialysis units and ob-gyn, as well as members of surgical teams and other direct-care personnel.[62] For example, a surgeon or hospital employee may wish to take more stringent precautions than what has been recommended by CDC when performing invasive procedures on an HIV-infected patient. Before the surgeon or employee can decide to take these more stringent precautions, he or she has to know that the patient in question has HIV, *i.e.*, the patient must be tested. Health-care workers will certainly take greater precautions when dealing with a *known* recognized hazard than when dealing with a *potential* recognized hazard.[63]

Another reason for identifying infected patients is to protect HIV-infected patients from contracting contagious diseases which

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61. 29 U.S.C. § 654 (1982)(duty of hospital to its employees). In addition, a hospital owes its employees the duty of exercising reasonable care in providing a safe work environment under state law. E. HOLLAND & D. WING, *supra* note 15, at 17. Employers are further expected to know the particular hazards associated with their industry and to take measures to abate those hazards. Kenney & Schulze, *Legal Aspects of Infection Control Programs: Hepatitis B and AIDS*, 3 VA. ST. B. NEWSL., HEALTH L. SEC. 6, 11 (1986).

62. The American Medical Association has acknowledged that health-care workers, especially those who perform invasive procedures, and emergency room and laboratory personnel are at some risk when treating HIV-patients. AMA, *supra* note 1, at 9.

63. However, a hospital that does not want to implement a patient-testing program could argue that it provides a safe work environment as long as it educates its employees about the CDC guidelines for treating HIV-patients and provides its employees with the necessary training and equipment to implement the CDC recommendations. The CDC has stated that routinely following the same-infection control precautions for preventing the transmission of other blood-borne infectious diseases, such as HBV, is sufficient to prevent the transmission of HIV. E. HOLLAND & D. WING, *supra* note 15, at 18.

A hospital that does not impose routine testing of patients may run into a problem if a health-care worker complains that the workplace is unsafe because the hospital does not adequately identify the HIV-infected patients. In Hentzel v. Singer Co., 138 Cal. App. 3d 290, 188 Cal. Rptr. 159 (1982), the court, interpreting California law, held that "an employee is protected against discharge or discrimination for complaining in good faith about working conditions or practices which he reasonably believes to be unsafe, whether or not there exists at the time of the complaint an OSHA standard or order which is being violated." *Id.* at 299-300, 188 Cal. Rptr. at 165 (footnote omitted). Therefore, the hospital may face a dilemma about what it can do to the complaining employee.

In addition, the hospital may wish to identify HIV-patients in order to excuse pregnant personnel from caring for them. While the risk of transmission of the HIV infection to pregnant health-care workers is not known to be greater than the risk to those not pregnant, RECOMMENDATIONS, *supra* note 35, at 6S, at least one doctor has suggested that the prudent course of action may be to excuse pregnant personnel from caring for HIV-patients until further information is available. *See* Conte, *Infection with Human Immunodeficiency Virus in the Hospital*, 105 ANNALS OF INTERNAL MED. 730, 732 (1986).

are present in hospital settings.[64] Because an HIV-patient's immune system is weakened by the disease, the patient is much more susceptible to opportunistic infections. Because it is generally accepted that hospitals owe patients a duty of protection from infections,[65] hospitals are forced to separate HIV-infected patients from patients with other contagious diseases.

Finally, routine testing of patients in mental hospitals might be considered because of the possibility of sexual contact among patients. In settings where segregation by gender is practiced, homosexual contact, voluntary or involuntary, has been known to occur. Given the diminished capacity of these patients, it may be appropriate to screen these patients in order to protect the non-infected patients from possible HIV infection.[66]

C. *Testing of Employees and Medical Staff*[67]

Hospitals may want to test their employees and medical staff for the presence of HIV in order to prevent the transmission of the virus to patients. As stated earlier, in the normal work environment there is little need for testing employees for HIV because the virus cannot be transmitted through casual contact. However, certain hospital personnel, such as those involved in invasive procedures, may contact patients in a way that potentially could transmit the virus. While the likelihood of transmission is small, the result of such transmission would be tragic. The hospital owes a duty to protect a patient from such infection, and the only way to do so is to identify infected personnel and see that they do not take part in procedures that may transmit the disease to patients.

Hospitals may wish to test employees to protect the employees' own health. Since hospital workers are constantly exposed to infectious patients, the hospital may argue that the test is for the employees' own good. If an employee tests positive for HIV, the hospital can transfer the employee to a position where the employee will not be in danger of acquiring an opportunistic infection.[68]

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64. *See* AMA, *supra* note 1, at 15.

65. IIB HOSP. L. MANUAL *Principles of Hospital Liability* § 3-8 (1987).

66. Bayer, Levine & Wolf, *supra* note 55, at 1772.

67. A few jurisdictions have enacted legislation that specifically prohibits the use of blood tests for employment purposes to detect the presence of the HIV antibody. *See* CAL. HEALTH & SAFETY CODE § 199.21(f) (West 1988); FLA. STAT. ANN. § 381.606(5) (West 1986); MASS. GEN. L. ch. 111, § 70F (Supp. 1987); WIS. STAT. § 103.15(2) (Supp. 1986).

68. *See* Leonard, *supra* note 12, at 701.

Finally, there is no reason to test hospital employees for the protection of employees because, in the normal course of hospital procedure, employees' duties should not force them to come into contact with each other in any way that would transmit the disease.

III. Legal Implications of HIV Testing and Infection-Control Programs in Hospital Settings

While a hospital may desire to implement HIV testing and infection-control programs for patients and employees, it must ensure that the programs do not violate various federal, state and local laws. The following is a brief survey of laws that will affect the institution of such programs.

A. Handicap Antidiscrimination Laws

1. Rehabilitation Act of 1973

Section 504 of the Rehabilitation Act of 1973[69] prohibits a federally funded program[70] from discriminating against an individual on the basis of his or her handicap. The Act reads in pertinent part:

> No otherwise qualified individual with handicaps in the United States, as defined in section 706(8) of this title, shall, solely by reason of his handicap, be excluded from the participation in, denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance . . . .[71]

The Act defines "individuals with handicaps" as follows:

> [A]ny person 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 impairment, or (iii) is regarded as having such an impairment.[72]

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69. 29 U.S.C.A. § 794 (West Supp. 1987).

70. The Department of Health and Human Services (HHS) has defined "federal financial assistance" so broadly as to include almost any hospital. 45 C.F.R. § 84.3(h) (1987). For example, any hospital involved in the Medicare or Medicaid programs or receiving governmental financial assistance in the construction of its facility will be covered by the act.

The United States Supreme Court has held that the regulations promulgated by HHS provide "an important source of guidance on the meaning of § 504." School Bd. of Nassau County v. Arline, 107 S. Ct. 1123, 1126 (1987) (quoting Alexander v. Choate, 469 U.S. 287, 304 n.24 (1985)).

71. 29 U.S.C.A. § 794 (West 1987).

72. *Id.* § 706(8)(B) (West Supp. 1987).

The Act, together with the regulations promulgated by the Department of Health and Human Services (HHS),[73] defines "handicap" so broadly as to include HIV.[74]

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73. 45 C.F.R. §§ 84.1-84.61 (1987). Specifically, the regulations define "physical or mental impairment" as follows:

> (i) "Physical or mental impairment" means (A) 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; cadiovascular; reproductive, disgestive, genito-urinary; hemic and lymphatic; skin; and endocrine; or (B) any mental or psychological disorder, such as mental retardation, organic brain syndrome, emotional or mental illness, and specific learning disabilities.

Id. § 84.3(j)(2)(i). "Major life activities" is defined as "functions such as caring for one's self, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning, and working." *Id.* § 84.3(j)(2)(ii).

The phrase "is regarded as having an impairment" is defined as follows:

> (A) has a physical or mental impairment that does not substantially limit major life activities but that is treated by a recipient as constituting such a limitation; (B) has a physical or mental impairment that substantially limits major life activities only as a result of the attitudes of others toward such impairment; or (C) has none of the impairments defined in paragraph (j)(2)(i) of this section but is treated by a recipient as having such an impairment.

Id. § 84.3(j)(2)(iv). Finally, the regulations define "qualified handicapped person" as follows: "With respect to employment, a handicapped person who, with reasonable accommodation, can perform the essential functions of the job in question . . . [and] [w]ith respect to other services, a handicapped person who meets the essential eligibility requirements for the receipt of such services."

Id. § 84.3(k)(1) and (4). A hospital administrator and hospital counsel must realize that the definition of "qualified handicapped person" is different in employment contexts than in patient contexts.

74. *See* Chalk v. United States District Court, 832 F.2d 1158 (9th Cir. 1987).

An HIV-infected individual would be a handicapped person as defined by 45 C.F.R. § 84.3(j)(1)(i). Because HIV affects the hemic (blood) and lymphatic systems, the HIV victim falls into the "impairment" definition. *See* Leonard, *supra* note 12, at 691.

Because HIV-infected individuals usually have to undergo extensive medical treatment, this is enough to demonstrate that one or more of the individual's life activities have been substantially limited. *See Arline*, 107 S. Ct. at 1127. Even if the HIV sufferer has not undergone extensive medical treatment that has limited the individual's major life activities, the stigma attached to the infection probably would have such a limiting effect.

At least one HIV-infected physician has filed suit aginst a county hospital alleging that the hospital unfairly discriminated against him when it prohibited him from performing invasive procedures. The physician, reportedly a neurologist, charged that such actions violated the Vocational Rehabilitation Act of 1973 and the fourteenth amendment. Doe v. County of Cook, No. 87-C-6888 (N.D. Ill. filed Aug. 5, 1987); *see also Trial Scheduled in Case Involving Doctor's Duties*, 2 AIDS POLICY & L., 4 (Aug. 26, 1987) at 4; *see also* Letter from Marie Chretien to Charlotte Memorial Hospital in Charlotte, North Carolina (Aug. 5, 1986), *reported in* AIDS IN THE WORKPLACE 224-32 (2d ed. 1987). This Office of Civil Rights "OCR" letter ruling stated that a registered nurse infected with HIV was "handicapped" and therefore protected by the Vocational Rehabilitation Act of 1973. In this case, the hospital had relieved the nurse of all duties, even though there were positions available which he could safely perform without risk of transmitting the virus to others. The OCR held that this action violated the nurse's rights under the Vocational Rehabilitation Act of 1973 be-

The Act probably does not affect a hospital's ability to test routinely patients entering hospital facilities. However, the Act does limit how a hospital can react to a seropositive test result. Under most circumstances, a hospital cannot refuse to treat a HIV-infected individual if the individual is otherwise eligible to receive treatment. Such refusal would clearly violate HHS regulations.[75] It is less clear whether a hospital can segregate HIV-infected patients from other patients. While the HHS regulations as a general rule prohibit hospitals from providing separate benefits and services to handicapped individuals, such separate benefits and services may be provided when necessary to ensure that the handicapped individual receives benefits and services as effective as those provided for others.[76] Therefore, if a hospital is "quarantining" an HIV-infected patient to protect other patients and employees, this separation of services and benefits probably violates the regulations. However, if the separation is for the protection of the HIV-infected patient, *e.g.*, to protect the patient from opportunistic infections or to efficiently centralize services, then the separation is most likely acceptable.[77]

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cause the nurse's removal from duty was motivated solely by his condition (AIDS) and not by the transmittability of the disease (which was the basis of removing employees with other ailments).

75. HHS has promulgated a regulation specifically addressing discrimination against handicapped patients in the health-care industry. 45 C.F.R. pt. 84 (1987). The most pertinent section of the regulation states as follows:

> (a) *General.* In providing health, welfare, or other social services or benefits, a recipient may not, on the basis of handicap:
>
> (1) Deny a qualified handicapped person these benefits or services;
>
> (2) Afford a qualified handicapped person an opportunity to receive benefits or services that is not equal to that offered nonhandicapped persons;
>
> (3) Provide a qualified handicapped person with benefits or services that are not as effective (as defined in § 84.4(b)) as the benefits or services provided to others;
>
> (4) Provide benefits or services in a manner that limits or has the effect of limiting the participation of qualified handicapped persons; or
>
> (5) Provide different or separate benefits or services to handicapped persons except where necessary to provide qualified handicapped persons with benefits and services that are as effective as those provided to others.

Id. § 84.52(a).

However, these regulations do not require hospitals to provide treatment to handicapped individuals that the hospital does not provide to non-handicapped individuals. For example, a burn treatment center is not required to provide types of medical services not made available to non-handicapped individuals. The burn treatment center cannot, however, refuse to treat the burns of a deaf individual solely because of his or her deafness. *Id.* § 84 app. A, subpart F.

76. *Id.* § 84.52(a)(5) (1987).

77. The hospital's argument would be that it owes a duty to each patient to institute an effective infection-control program. *See supra* note 65 and accompanying text. In fact, HHS

The Rehabilitation Act of 1973 and HHS regulations substantially affect a hospital's right to implement an employee testing program. The regulations prohibit a hospital from making pre-employment inquiries as to whether an applicant is a handicapped person.[78] In addition, a hospital cannot use a test that screens out or tends to screen out handicapped persons unless; (1) the test score or result is shown to be job-related; and (2) no alternative tests are available that would not screen out as many handicapped individuals.[79] Hospitals may condition an offer of employment on the results of a medical examination provided that; (1) all entering employees for the particular job take the same exam; and (2) the results of the examination are used only in accordance with other related HHS regulations.[80] Therefore, the examination must be job-related and must not unduly discriminate against handicapped individuals.

What this means to a hospital is that it may test only those employees in positions where they come into contact with patients in such a way as to transmit the HIV infection to the patients, such as employees participating in invasive procedures. The hospital can show that the need to prevent such employees from performing these procedures in order to protect its patients is a job-related criterion.[81]

Recently, the United States Supreme Court addressed the issue of whether contagious handicapped individuals are protected from discriminating employment practices by the Rehabilitation Act of 1973. In *School Board of Nassau County v. Arline*,[82] an elemen-

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requires every hospital participating in the Medicare and Medicaid programs to institute infection-control programs. 42 C.F.R. § 482.42 (1987).

78. 45 C.F.R. § 84.14 (1987). An exception is granted, however, if based on ability to perform job-related functions. *Id.*

79. *Id.* § 84.13(a).

80. *Id.* § 84.14(c).

81. *See* Note, *Aids and Employment Discrimination Under the Federal Rehabilitation Act of 1973 and Virginia's Rights of Persons with Disabilities Act*, 20 U. RICH. L. REV. 425, 438 (1986).

82. 107 S. Ct. 1123 (1987). The Court in *Arline* refused to reach the question of whether an individual infected with HIV is a handicapped person under the Act. *Id.* at 1128 n.7. However, it is clear from the Court's analysis that an HIV infected person is handicapped. Other courts have come to the same conclusion. District 27 Community School Bd. v. Board of Educ., 130 Misc. 2d 398, 502 N.Y.S.2d 325 (Sup. Ct. 1986); Shuttleworth v. Broward County, No. 85-6623 (D. Fla. 1985); Cronan v. New England Tel. Co., No. 80332 (Mass. 1986), *reprinted in* AIDS IN THE WORKPLACE 233-37 (2d ed. 1987); *see also* Department of Fair Employment & Hous. v. Raytheon Co., No. FEP83-84, LI-031p, L-33676, 87-04 (Fair Employment and Hous. Comm., Cal., Feb. 5, 1987), *reprinted in* AIDS IN THE WORKPLACE 241-68 (2d ed. 1987).

tary school teacher was discharged after suffering a third relapse of tuberculosis over a two-year period. The school board informed Arline that she had been terminated not because she had done anything wrong but because of her continued bout with tuberculosis.[83] In examining the case, the Court first found that Arline was handicapped within the meaning of the Rehabilitation Act because tuberculosis was a physical impairment and also because her hospitalization for the disease limited her major life activities.[84]

The school board argued that Arline was discharged not because of her physical impairment but because of her contagiousness.[85] The Court rejected this reason for termination, stating that "[a]llowing discrimination based on the contagious effects of a physical impairment would be inconsistent with the basic purpose of Section 504, which is to ensure that handicapped individuals are not denied jobs or other benefits because of the prejudiced attitudes or the ignorance of others."[86] The Court went on to state the following:

> Congress acknowledged that society's accumulated myths and fears about disability and disease are as handicapping as are the physical limitations that flow from actual impairment. Few aspects of a handicap give rise to the same level of public fear and misapprehension as contagiousness. Even those who suffer or have recovered from such noninfectious diseases as epilepsy or cancer have faced discrimination based on the irrational fear that they might be contagious. The Act is carefully structured to replace such reflexive reactions to actual or perceived handicaps with actions based on reasoned and medically sound judgments: the definition of "handicapped individual" is broad, but only those individuals who are both handicapped *and* otherwise qualified are eligible for relief. The fact that *some* persons who have contagious diseases may pose a serious health threat to others under certain circumstances does not justify excluding from the coverage of the Act *all* persons with actual or perceived contagious diseases. Such exclusion would mean that those accused of being contagious would never have the opportunity to have their condition evaluated in light of medical evidence and a determination made as to whether they were "otherwise qualified." Rather, they would be vulnerable to discrimination on the ba-

83. *Arline*, 107 S. Ct. at 1125.
84. *Id.* at 1127-30.
85. *Id.* at 1128.
86. *Id.* at 1129.

> sis of mythology—precisely the type of injury Congress sought to prevent.[87]

The remaining issue in the case was whether Arline was otherwise qualified for the job of elementary school teacher. The Court held that a contagious person who poses a significant risk of communicating an infectious disease to others in the workplace will not be otherwise qualified for a particular job if reasonable accommodation would not eliminate that risk.[88] The Court found two conflicting interests that had to be weighed: (1) the handicapped person's right to be free from deprivations based on prejudice, stereotypes, or unfounded fear; and (2) the grantee's (school board's) concern to avoid exposure of others to significant health risks.[89] The basic factors to consider in weighing those interests include:

> "[Findings of] facts, based on reasonable medical judgments given the state of medical knowledge, about (a) the nature of the risk (how the disease is transmitted), (b) the duration of the risk (how long is the carrier infectious), (c) the severity of the risk (what is the potential harm to third parties) and (d) the probabilities the disease will be transmitted and will cause varying degrees of harm."[90]

In other words, *Arline* requires that in order to discharge or refuse to hire a handicapped person because of his contagious state, an employer must show that the particular individual poses a *real* threat of transmission of the disease to others.

On March 22, 1988, Congress, in reaction to *Arline*, amended the definition of "handicapped individual" to exclude any contagious individual whose infection or disease poses a direct threat to other individuals. This amendment is certainly consistent with the Court's rationale in *Arline*.[91]

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87. *Id.* at 1129-30 (footnotes omitted) (emphasis in original).

88. *Id.* at 1131 n.16. In other words, the "Act would not require a school board to place a teacher with active, contagious tuberculosis in a classroom with elementary school children." *Id.*

89. *Id.* at 1131.

90. *Id.* (quoting Brief for American Med. Assoc. at 19). The Court then remanded the case to the district court to determine if Arline was otherwise qualified for her position. *Id.* at 1132.

91. Act of March 22, 1988, Pub. L. No. 100-259, 102 Stat. 28 (1988). Section 7(8) of the Rehabilitation Act of 1973 is amended by adding after subparagraph (B) the following:

> (C) For the purpose of sections 503 and 504, as such sections relate to employment,

A hospital administrator must integrate the principles of the Rehabilitation Act, the HHS guidelines, and *Arline* into any HIV-related program. As for testing employees for HIV, the hospital must be able to establish the need for the testing. Each job must be evaluated to determine if persons in that job come into contact with patients in such a way as to transmit the virus. Certainly, there is no need to test administrative personnel for the virus because there is no risk of transmission of the disease to patients. However, surgical teams and members of the obstetrics and gynecology departments do come into contact with patients in such a way as to risk transmission of the virus. For this reason, a hospital should be able to test those employees. If an employee tests seropositive, then the hospital must attempt to accommodate the employee, *i.e.*, transfer the employee to a position where the risk of transmitting HIV to others is not a problem.

2. State Handicap Anti-discrimination Statutes and Local Ordinances

As of 1987, all fifty states and the District of Columbia had statutes or executive orders forbidding discrimination in the employment of handicapped individuals either in the public sector, private sector or both.[92] Some of the statutes substantially track the language of the Rehabilitation Act of 1973. Most state statutes, however, contain substantial differences which a hospital must be aware of before it decides to institute an HIV-related program. While the definitional language for "handicap," "disability" or "physical disability" varies from state to state, it appears that these statutes would apply to an HIV-infected individual.[93] Since this area has already been thoroughly covered by another author,[94] this article will not reanalyze the topic.

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such term does not include an individual who has a currently contagious disease or infection and who, by reason of such disease or infection, would constitute a direct threat to the health or safety of other individuals or who, by reason of the currently contagious disease or infection, is unable to perform the duties of the job.

Id.

92. State employment law is conveniently collected in 8A Lab. Rel. Rep. (BNA) (Fair Empl. Prac. Manual), and 3 Empl. Prac. Guide (CCH). For two excellent articles regarding state laws prohibiting discrimination against handicapped individuals see Leonard, *supra* note 12, at 689-96; Leonard, *AIDS and Employment Law Revisited*, 14 HOFSTRA L. REV. 11 (1985).

93. *See* Leonard, *supra* note 92, at 21.

94. *See* Leonard, *supra* note 12, at 689-96; Leonard, *supra* note 92, at 21-23.

Similarly, state public accommodations laws arguably cover hospital services and often prohibit discrimination based on handicap. In addition, several localities have reacted to HIV discrimination by enacting their own anti-discrimination ordinances. Such locally applicable HIV-anti-discrimination laws have been passed in Los Angeles, San Francisco and West Hollywood, California, Philadelphia and Hennepin County, Minnesota.[95]

B. *Employee Retirement Income Security Act of 1974*

The Employee Retirement Income Security Act of 1974 (ERISA)[96] has no effect on a hospital's decision on whether or not to test its employees. However, ERISA may apply when a hospital reacts to a seropositive blood test by discharging the infected employee. ERISA may provide coverage in situations where an employee participating in an employee-benefit plan is discharged because of an HIV diagnosis or a positive antibody test result.[97] Section 510 prohibits employee discharges intended to deprive the employee of benefits to which he or she is entitled under such plans.[98] Benefit plans are broadly defined and include health-care benefits, as well as pensions and life insurance.[99] Some federal courts have implied a private cause of action under this provision, allowing employees who have been discharged after being diagnosed with an expensive-to-treat ailment to enforce their rights by direct suit.[100]

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95. LOS ANGELES, CAL. MUN. CODE art. 5.8 (1985); San Francisco, Cal., Ordinance art. 38 (Nov. 20, 1985); West Hollywood, Cal., Ordinance 77U (Aug. 15, 1985); Philadelphia, Pa., Exec. Order No. 4-86 (Apr. 15, 1986). For discussion of Berkeley, Cal., and Hennepin County, Minn., ordinances, see PRACTICING LAW INSTITUTE, EMPLOYMENT PROBLEMS IN THE WORKPLACE 158 (1986). BNA's AIDS IN THE WORKPLACE (2d ed. 1987) contains numerous city ordinances relating to HIV.

96. 29 U.S.C. §§ 1001-1461 (1982).

97. Leonard, *supra* note 92, at 24. However, pursuant to the Consolidated Omnibus Budget Reconciliation Act of 1986, 29 U.S.C. § 1161 (1987), such terminated employees will have the right to continue coverage by paying a monthly premium.

98. 29 U.S.C. § 1140 (1982). The section states:

> It shall be unlawful for any person to discharge . . . suspend, expel, discipline, or discriminate against a participant or beneficiary for exercising any right to which he is entitled under the provisions of an employee benefit plan . . . or for the purpose of interfering with the attainment of any right to which such participant may become entitled under the plan. . . .

99. 29 U.S.C. § 1002(1)-(3) (1982); *see* Leonard, *supra* note 92, at 25.

100. *E.g.*, Kross v. Western Elec. Co., 701 F.2d 1238, 1243-46 (7th Cir. 1983); Amato v. Bernard, 618 F.2d 559, 566-68 (9th Cir. 1980); Folz v. Marriot Corp., 594 F. Supp. 1007, 1014-15 (W.D. Mo. 1984). The average cost of hospital care per HIV patient exceeds $147,000. Harness, *AIDS: An Emerging Crisis*, 37 LABOR L.J. 559, 560 (1986).

C. *Confidentiality*

As a general rule, health-care providers owe a duty to patients to maintain the confidentiality of their medical records. In the absence of legal process and an assortment of narrow exceptions, a health-care provider has a duty to release a patient's privileged information only to the patient, the patient's authorized representative, the attending physician and hospital staff members with a legitimate interest in the patient's care.[101] The rationale for such confidentiality is that every individual has a right to privacy regarding his or her own medical care and has a right to determine who may have access to confidential medical information.[102] In many states, disclosure of confidential medical information is a crime as well as a civil wrong.[103]

The primary objection of groups to HIV-testing programs is that the confidentiality of results will be breached thereby subjecting HIV-infected individuals to prejudice and discrimination. Their concern is not unfounded, based on past case histories.[104] A few states, such as California,[105] Florida,[106] Massachusetts,[107] and Wisconsin,[108] have enacted legislation that specifically restricts the disclosure of HIV-antibody test results.

If a health-care provider breaches its duty of confidentiality, possible causes of action include defamation, invasion of privacy, breach of contract and betrayal of professional secrets.[109] Therefore, a health-care provider should ensure the confidentiality of any patient's seropositive test result. Given the sensitive nature of HIV records, consideration should be given to additional security measures, such as maintaining test results separate and apart from

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101. E. HOLLAND & D. WING, *supra* note 15, at 6-7.

102. CATHOLIC HEALTH ASSOCIATION, AIDS: LEGAL IMPLICATIONS FOR HEALTH CARE PROVIDERS 3 (1987) [hereinafter CHA].

103. *Id.* Note, however, that some states mandate reporting of antibody-positive test results to state health officials. These states include Arizona, Colorado, Georgia, Minnesota, Nevada and South Carolina. Matthews & Neslund, *The Initial Impact of AIDS on Public Health Law in the United States-1986*, 257 J. A.M.A. 344, 344 (1987).

104. *See* PHILIPSON & WOODS, AIDS, TESTING, AND PRIVACY: AN ANALYSIS OF CASE HISTORIES (1987).

105. CAL. HEALTH & SAFETY CODE § 199.21 (West Supp. 1988).

106. FLA. STAT. § 381.606 (Supp. 1986).

107. MASS. GEN. L. ch. 11, § 70F (Supp. 1986).

108. WIS. STAT. § 103.15 (Supp. 1986).

109. E. HOLLAND & D. WING, *supra* note 15, at 7; Matthews & Neslund, *supra* note 103, at 350.

standard medical records and special coding procedures. In addition, hospital personnel should be reminded of this duty of confidentiality when treating HIV patients. Undoubtedly, the presence of an HIV patient will be a source of interest, concern and discussion among personnel.[110] Such discussion can have a devastating impact on the patient and lead to legal liability on the part of the hospital.

In no event should signs or publicly accessible records identify any patient as having tested positive for the HIV antibody. A hospital may use the general category "Blood/Body Fluid Precautions" as recommended by the CDC *Guidelines for Isolation Precautions in Hospitals* if the precautions are used for other patients with blood-borne diseases throughout the hospital.[111] However, only the precautions, not the diagnosis, should be identified.[112]

As for employees with seropositive test results, any information obtained by testing must be accorded confidentiality. In addition, HHS has promulgated specific regulations restricting disclosure of employee medical test results to the following individuals and only for the following reasons:

> 1. Supervisors and managers of the hospital may be informed regarding restrictions on the work or duties of [the HIV-infected employee] and regarding necessary accommodations;
> 2. First aid and safety personnel may be informed, where appropriate, if the condition might require emergency treatment; and
> 3. Government officials investigating compliance with the [Rehabilitation] Act of [1973] shall be provided with information upon request.[113]

Balanced with this duty of confidentiality is an obligation to protect others from the transmission of the disease. As stated earlier, OSHA may require a hospital to identify its HIV patients to those employees who may come into contact with the patients and thus risk transmission of the virus. In addition, some courts have held that health-care professionals *must* disclose confidential patient information to those individuals who are foreseeably in danger of se-

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110. E. HOLLAND & D. WING, *supra* note 15, at 7.
111. AHA, *supra* note 9, at 8.
112. *Id.*
113. 45 C.F.R. § 84.14(d) (1987).

rious harm from their patients.[114] However, before this duty to warn arises, health-care professionals must be aware of specific risks to specific persons.[115]

The issue as to whether there is a duty to warn third persons of the possible transmission of HIV arises in cases where the physician knows that a specific individual is likely to have an intimate exchange of body fluids with the infected patient. The doctor's duty in this situation is far from clear. The physician faces potential liability either way he or she decides.[116] If the physician warns the third person of the HIV-infected patient's condition, the physician has breached his duty of confidentiality to his patient. However, if the doctor fails to warn the third party, the physician has breached his duty to warn the third party. In such a situation, where there are strong clinical grounds to believe that a specific contact has not been informed of the HIV-infected patient's status and the contact is in serious danger of exposure to HIV, the physician should inform the contact of the HIV-infected patient's condition because of the virus' tragic effects.[117] The American Medical Association suggests an alternative solution of informing public health authorities if the physician thinks an infected individual has an unsuspecting sexual partner.[118] Certainly, this is an area of law ripe for legislation so that physicians may be given more definitive legal guidance.[119]

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114. Tarasoff v. Regents of Univ. of Calif., 17 Cal. 3d 425, 551 P.2d 334, 131 Cal. Rptr. 14 (1976).

115. Gammill v. United States, 727 F.2d 950 (10th Cir. 1984) (no duty to warn the general public of HBV in the community).

116. Gostin & Curran, *AIDS Screening, Confidentiality, and the Duty to Warn*, 77 PUB. HEALTH & THE L. 361, 364. Gostin and Curran recommend that the physician should first counsel the HIV-infected patient to inform his or her sexual contacts. However, if the doctor has strong evidence that a specific contact has not been informed of the patient's infection, the physician should notify the contact of the patient's seropositive test result. *Id.*

117. *Accord id.* at 364. The Canadian Medical Association voted at its annual meeting on August 25, 1987 to permit doctors to violate patient confidentiality and tell sexual partners of HIV-infected patients that they could contract the disease. *Canadian Doctors Authorize Sexual Partner Notification*, 2 AIDS POLICY & L., Sept. 9, 1987, at 4.

118. AMA, *supra* note 1, at 16-17.

119. The AMA has made the following recommendation in this area:

> Specific statutes must be drafted which, while protecting to the greatest extent possible the confidentiality of patient information, (a) provide a method for warning unsuspecting sexual partners, (b) protect physicians from liability for failure to warn the unsuspecting third party but (c) establish clear standards for when a physician should inform the public authorities . . . .

AMA, *supra* note 1, at 17. Such a recommendation is quite reasonable and should be acted upon by state legislatures.

D. *Negligence*

In a hospital setting, a hospital may be held negligent in at least two ways: (1) by improperly administering HIV antibody tests; and (2) by breaching its duty to patients, employees and other individuals to provide an effective infection-control program. Current medical information acknowledges that the present testing methods produce both false-positive and false-negative results. Such results are inherent in the available testing methods and will not create liability so long as the nature of the test, its inadequacies and the actual test results are adequately explained by an attending physician. Potential liability will exist, however, for the negligent performance of the test.

In addition, a hospital owes a duty to its patients, employees and other individuals to provide an effective infection-control program. Theoretically, a health-care facility would be subject to tort liability if a patient or visitor contracted HIV as a result of exposure to an HIV-infected employee or patient in the facility.[120] However, given the current medical information on the transmission of the disease, transmission is highly unlikely. As long as the hospital takes precautions recommended in the most current medical literature and those recommended by the CDC, the chances of tort liability should be minimized.[121] If a hospital becomes aware of a risk of transmission of the virus, it should take immediate steps to eliminate or abate the danger.

E. *Occupational Safety and Health Statutes*

Both the federal and state governments have enacted legislation to provide workers with safe working environments. The "general duty" clause[122] of the federal Occupational Safety and Health Act[123] requires employers to provide a place of employment "free from recognized hazards that are causing or are likely to cause death or serious physical harm."[124] Employers are expected to

120. CHA, *supra* note 102, at 7.

121. *But see* HOSP. L. MANUAL, *supra* note 65, at § 3-8 ("mere compliance with minimum statutory standards will not automatically establish that the hospital provided the requisite degree of care. The hospital may be held to a higher standard of care than that imposed by a statute or regulation.").

122. 29 U.S.C. § 654(a)(1) (1982).

123. *Id.* §§ 651-78.

124. *Id.* § 654(a)(1).

know the particular hazards associated with their industry or profession and to take adequate measures to abate those hazards.[125] In this regard, this act may require hospitals to identify HIV-infected patients (and perhaps infected employees)[126] to those employees who have contact with the infected individuals in a manner particularly conducive to the transmission of HIV.[127]

Various factors will determine the parameters of the hospital's general duty, including the presence of a known occupational risk, the foreseeability of harm, available means to abate or avoid the hazard and the consequences if the measures are not implemented.[128] Of particular interest is the Occupational Safety and Health Administration's determination that HBV is an occupational hazard to high-risk health-care workers. In a field instruction issued in 1983, the agency recommended that employers consider both protective work practices and vaccination as measures for abating the hazard.[129]

On October 30, 1987, the United States Departments of Labor and Health and Human Services issued a Joint Advisory Notice on HBV and HIV.[130] This notice announced that OSHA would begin a program of enforcement to insure that health care employers were providing safe work environments. Both governmental departments urged adherence to CDC's guidelines. The notice also provided certain "recommendations" to prevent the transmission of HBV and HIV. Given OSHA's broad statutory authority, these recommendations should be treated as regulations and hospital administrators should become familar with them.

The recommendation requires hospitals to divide jobs into three categories determined by the likelihood of exposure to body fluids. For those categories where exposure is possible, standard operating procedures and educational programs must be developed. Engi-

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125. Kenney & Schulze, *supra* note 61, at 11.

126. However, during the normal course of business, employees should not be coming into contact with each other in such a way as to be able to transmit HIV to each other.

127. Examples of such types of patients might include surgery patients, ob-gyn patients and dialysis patients.

Apparently, the federal Occupational Safety and Health Administration is in the process of adopting CDC's August 21, 1987 recommendations on the protection of health-care workers from HIV. *See OSHA Official Says Agency Will Adopt CDC Guidelines*, 2 AIDS POLICY & L. Oct. 21, 1987, at 5-6.

128. Kenney & Shulze, *supra* note 61, at 11.

129. OSHA Instruction CPL2-2.36 (Nov. 30, 1983).

130. 52 Fed. Reg. 41,818 (Oct. 30, 1987).

neering controls and protective equipment must also be utilized to minimize exposure to body fluids. The notice also provides for extensive record keeping for the administrative procedures used to classify jobs, standard operating procedures, training reports, surveillance reports to insure the standard operating procedures are followed, and conditions associated with each incident of potential HBV/HIV exposure. Finally the notice requires monitoring, at the employees request, for HBV and HIV antibodies after exposure to the viruses and medical counseling for those employees who test positive for the viruses.

Under these federal and state health and safety laws, an employee may lawfully refuse to work in a proven unsafe environment and may also insist on wearing protective safety gear while working.[131] This means that a health-care employee may lawfully refuse to treat an HIV patient if it is unsafe.[132] Once again, the key question is whether the health-care employee may come into contact with the patient in such a way as to risk the transmission of the virus. If the hospital has taken reasonable steps to identify the HIV-infected patient and/or has instituted other precautions such as those recommended by CDC, the treatment of HIV-infected patients should not pose a health threat to any employee. Therefore, if an employee refuses to treat HIV patients in spite of these precautions, the employee may be lawfully disciplined.[133]

A hospital should allow an employee to wear protective gear, even if the hospital thinks the gear is more than is necessary.[134] If, however, the employee's actions are disturbing to the patient, the attending physician or other hospital personnel, the hospital should investigate the employee's rationale for such actions and determine the reasonableness of the actions.[135] Educating the employee on the transmission of the disease may solve the problem. The hospital should be aware of state health and safety laws in

131. *See, e.g.*, CAL. LAB. CODE § 6310 (West Supp. 1988).

132. CHA, *supra* note 102, at 8.

133. *Id.*

134. One court has held that disciplining an employee for complaining about a health hazard, even if the hazard is not real, may constitute "wrongful termination" against public policy. In such a case, the hospital is subject to liability for compensatory and punitive damages. Hentzel v. Singer Co., 138 Cal. App. 3d 290, 299, 188 Cal. Rptr. 159, 165 (1982). Therefore, a hospital that disciplines an employee for insisting on extra reasonable precautions or for complaining about the danger of treating HIV-infected patients may risk liability under federal and state health and safety statutes and under common law wrongful termination theories. CHA, *supra* note 102, at 8-9.

135. *Id.*

this situation. Some states, such as California, prohibit discrimination against employees for complaining about health hazards, even if the hazards do not exist, as long as the employee has a reasonable belief that they exist.[136]

F. *National Labor Relations Act*

Another federal statute that protects employees who refuse to work in protest of a safety-threatening situation is the National Labor Relations Act.[137] This act prohibits an employer from discriminating against an employee who engages in concerted activity to protest an unsafe condition in the workplace so long as the method of protest is not excessive. This protection is available to non-union as well as union employees. Obviously, a refusal by a group of health-care workers to treat an HIV patient would be a concerted activity. Individual action may also constitute concerted activity as long as the alleged hazard affects other employees as well. Thus, a refusal by a group of health-care workers, or one health-care worker representing other co-workers, to treat an HIV-infected patient because of a reasonable fear of contracting the virus would be protected concerted activity under the act for which an employer may not retaliate.[138]

However, non-union employees who refuse to work because of dangerous conditions are considered to be economic strikers under the act. The hospital would be free to hire replacement workers and these replacement workers may be retained even after the striking employees return to work. The hospital is not obligated to reinstate a striking health-care worker at the end of the strike if no vacancies exist. Instead, striking employees are placed on a preferential hiring list until they are reinstated or have obtained equivalent employment elsewhere. Thus, a non-union health-care worker who exercises his or her right to refuse to perform hazard-

136. CAL. LAB. CODE §§ 6310-6311 (West Supp. 1988); *Hentzel*, 138 Cal. App. 3d at 299, 188 Cal. Rptr. at 165 (1982); *see also* Bernales v. San Francisco Dep't of Pub. Health, Nos. 11-17001-1 to -4 (Cal. Lab. Comm'r, Sept. 9, 1985) (several nurses claimed they had been unlawfully transferred because of their insistence on wearing protective gear thought unnecessary by the hospital. While the hearing officer dismissed the complaints because he found the transfers to be unrelated to the protective-gear issue, he noted that the nurses' concern was understandable and their conduct was protected under the state's labor laws).

137. 29 U.S.C. §§ 141-87 (1982). See specifically 29 U.S.C. §§ 157, 158(a)(1).

138. Kruchko, *AIDS and the Health Care Worker*, 5 VA. HOSP. A. PERSP., March 13, 1987 at 1. *See generally* Note, *AIDS and Employment: An Epidemic Strikes the Workplace and the Law*, 8 WHITTIER L. REV. 651, 674-75 (1986).

ous work under the National Labor Relations Act may be permanently replaced.[139]

The act also creates a safety-related exception to no-strike provisions in collective bargaining agreements provided the employees are acting in good faith and they have objective evidence that an abnormally dangerous condition for work exists.[140] If the employees meet their burden, employers cannot discipline or discharge them. However, if the employees' fear is unreasonable or lacks an objective basis, the employer may discipline or terminate the workers who refuse to return to work.[141] Realistically, however, a hospital's right to terminate highly-skilled personnel may be of little comfort.

Under collective bargaining agreements, some unionized employees may also have a contractual right to refuse to perform hazardous work. Most agreements contain clauses requiring the employer to provide a safe working environment. Frequently, this type of clause contains language permitting employees to refuse to perform tasks that put the employees in imminent danger.[142]

As a practical matter, the hospital may be able to avoid such labor problems by instituting effective education programs and infection-control programs. Even if the educational programs do not ease the employees' fears, workers so informed about the current state of medical knowledge regarding HIV should have a much harder time proving their fear of contracting HIV is "reasonable."[143]

G. *Worker Compensation Statutes*

If an employee does contract HIV as a result of on-the-job exposure, the employee should be eligible for benefits under a state worker compensation statute.[144] HIV would certainly be an "occu-

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139. Kruchko, *supra* note 138, at 1-2.

140. 29 U.S.C. § 143 (1982).

141. Brown, *AIDS Discrimination in the Workplace: The Legal Dilemma*, 92 CASE AND COM., May-June, 1987, at 3, 8.

142. Kruchko, *supra* note 138, at 2.

143. *Id.* at 8.

144. CHA, *supra* note 102, at 7; *Workplace Legal Disputes to Rise, Lawyer Products*, 2 AIDS POLICY & L. 8-9, Aug. 26, 1987, at 8-9. Worker compensation statutes generally are the only remedy available to employees who suffer injuries while on the job. The employee need not prove any negligence on the part of the employer. In exchange for this right, the employee waives his or her right to sue the employer for negligence. *See* LARSON, THE LAW OF WORKMEN'S COMPENSATION § 41.32 (1982).

pational disease" under most worker compensation schemes. Because HIV is difficult to transmit, a more likely source of liability is the contraction of opportunistic infections by HIV-infected employees from patients they are treating.[145]

Many states prohibit discrimination against an employee who exercises a right under their workers' compensation laws. Any adverse employment decision concerning such a person may subject a hospital to liability for unlawful discrimination or unlawful retaliation.

IV. NEED FOR EDUCATION

As stated earlier, many potential HIV-related problems can be solved through educational programs. Ignorance of the disease fosters fear, and fear in this area will inevitably lead to problems. The hospital administrator or risk management coordinator must take the lead in instituting these programs.[146] Several hospitals have developed special teams to institute educational and infection-control programs. These teams are readily available to patients, employees, medical staff and the public to answer medical questions about HIV, to give advice regarding appropriate practices and to provide support to patients and personnel. These teams usually are com-

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HBV has been recognized as an occupational disease compensable under these statutes. *See* Booker v. Duke Medical Center, 297 N.C. 458, 256 S.E.2d 189 (1979) (blood laboratory technician); Sacred Heart Medical Center v. Department of Labor, 92 Wash. 2d 631, 600 P.2d 1015 (1979) (intensive care nurse).

In certain limited circumstances, a health-care employee may be entitled to damages beyond those provided in the state workman's compensation scheme. The "dual capacity" theory provides that an employee is not limited to the workman's compensation program if the employee can demonstrate that his relationship to the hospital was that of a patient, not an employee. *See, e.g.*, Bell v. Industrial Vangas, Inc., 30 Cal. 3d 268, 276, 637 P.2d 266, 269-71, 179 Cal. Rptr. 30, 35 (1981) quoting D'Angona v. County of Los Angeles, 27 Cal. 3d 661, 666-67, 613 P.2d 238, 243-44, 166 Cal. Rptr. 177, 181 (1980)).

In some states, traditional tort damages may also be available if the employee can prove an intentional tort. *See, e.g.*, Bazley v. Tortorich, 397 So. 2d 475 (La. 1981). The Supreme Court of Ohio has held that an employee who contracts an occupational disease may sue his employer in negligence if the employee can prove that the employer was aware of the causative hazard and intentionally disregarded the problem by failing to disclose it and take protective measures. Blankenship v. Cincinnati Milacron Chem., Inc., 69 Ohio St. 2d 608, 433 N.E.2d 572, *cert. denied*, 459 U.S. 857 (1982). *See generally* Kenney & Schulze, *supra* note 61, at 12-14.

145. CHA, *supra* note 102, at 7.

146. The Board of Trustees of the American Medical Association recently published a report which stated that "[p]hysicians should assume the leadership role in educating themselves, their patients, and the public" regarding the HIV infection. AMA, *supra* note 1, at 1.

posed of an infection-control practitioner, a psychiatric social worker, a psychiatrist, a chaplain, a nursing administrator, a patient representative, an infectious disease specialist and often a public relations coordinator.[147]

In developing education, testing and infection-control programs, these teams should work closely with hospital counsel, not only seeking legal advice regarding practices and programs, but also educating counsel in the latest medical developments surrounding HIV.

In dealing with any HIV-related program, the stakes are enormous. Emotions run high when dealing with the topic. Not only is legal liability a consideration for the hospital, but so are public,[148] patient and employee relations. Planning for potential problems so they can be avoided or handled as gently as possible is of utmost importance. Certainly, in this area an ounce of prevention is worth a pound of cure.

V. Conclusion

Hospital administrators and counsel are faced today with numerous and varied legal issues surrounding HIV-related decisions. For some hospitals these decisions must be made on a daily basis. Unfortunately, the law in this area is still emerging and far from clear. A hospital administrator seeking legal guidance may feel that the hospital's counsel is leading the institution into a legal quagmire of no return.

The disease has placed federal and state laws at odds with each other. Those laws enacted for the protection of HIV-infected individuals and other handicapped individuals run contrary to those laws protecting other employees and patients. In addition, HIV represents a dilemma to hospitals because hospitals have obligations not only as health-care providers, but also as employers. This is certainly one area where the law has failed to keep pace with medical technology.

This article has examined the legal implications of HIV-related decisions in a hospital setting. The reader should keep in mind that legal implications are not the only consideration a hospital

147. AHA, *supra* note 9, at 6.

148. A recent survey revealed that 37% of a sample studied feared contracting HIV while in a hospital that treats HIV-infected patients. CHA, *supra* note 102, at 3.

should investigate in making such decisions.[149] Economics, medical feasibility and public pressure in this area may lead a hospital to the conclusion that while it may *legally* pursue certain HIV-related actions, under the circumstances, such actions are not in the best interest of the hospital.

149. One doctor wrote in response to the trend of doctors refusing to treat HIV-infected patients that physicians over time have honored their "social contract" to treat the sick even at the risk of their own personal physical detriment. As the doctor eloquently put it:

> The fear of contagion has prompted some physicians to refuse to care for AIDS patients. Fear of coming to harm as a consequence of medical practice has been of concern to physicians at least since contagion has been recognized to exist. The balance among duty, fear, and courage has been a necessary part of medical practice ever since.
>
> Physicians are not asked to risk certain death or infection. The community, however, expects us to take "reasonable" risks—reasonable, at least, within the context of our community and its situation. . . .
>
> There has been an enduring social contract intimately involving the healer with his community. This contract has been pervasive throughout diverse ages and societies, and it seems as alive today as in ages past. It is a tacit contract, and it assumes that the physician—endowed by his community with immense privileges, prerogatives, rights, and power, as well as with considerable material rewards—will merit that trust. Society assumes that the contract will be honored and the trust kept in time of need. Its expectations of "reasonable risk" necessitates courage without demanding heroism. A definition of what is reasonable is inherent within the context of the situation abroad at the time. The contract is reasonable. It has endured over the ages and has been hallowed by use. We abrogate it at our peril and at our shame. If we honor it, to that extent may we be deserving of honor; if we break it, to that degree are we worthy of shame—worthy, as de Chauliac would say, of "infamy."
>
> The current trend in our society to forget duty in pursuit of personal pleasure may explain but does not exculpate our actions in violation of that contract. We have a choice—we can contribute further to society's decay by evading our contract in pursuit of comfort, or we may contribute to a renaissance of society by salvaging that which seems valuable. A new, a compassionate, a "better" society stands in need of our help and our reconstruction. We physicians may be privileged to partake.

Loewry, *AIDS and the Physician's Fear of Contagion*, 89 CHEST 325, 325-26 (1986).