Risk and Rationality: The Centers for Disease Control and the Regulation of HIV-Infected Health Care Workers

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ARTICLES

RISK AND RATIONALITY: THE CENTERS FOR DISEASE CONTROL AND THE REGULATION OF HIV-INFECTED HEALTH CARE WORKERS

MARY ANNE BOBINSKI

AIDS is a terrible disease that we must take seriously. I didn't do anything wrong, but I'm being made to suffer like this. My life has been taken away. Please enact legislation so other patients and health care providers don't have to go through the hell that I have. Thank you.

Kimberly Bergalis
Congressional Testimony

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Readers of articles on HIV-related issues are often concerned with the timeliness of research. This article was completed and accepted for publication in October 1991. After publication delays, it was substantially revised in late March 1992. Developments occurring through June 1992 are referenced in footnotes.

I am angry that our Government will criminalize health-care workers instead of allowing them to do their jobs. They will test patients instead of providing care. They will collect names instead of providing treatments that could save our lives, yours and mine.

David Barr
Congressional Testimony

I. INTRODUCTION

Rock Hudson, Ryan White, Kimberly Bergalis. Each person has become a symbol in the evolution of our perceptions of Acquired Immunodeficiency Syndrome ("AIDS"), each represents a focal point of public attention and fear. The sickness and death of Rock Hudson, a leading romantic film actor, is widely credited with first galvanizing public attention toward AIDS. Yet, Hudson's death possessed the elements of a Hollywood film featuring an interesting but foreign locale; it was safely removed from the reality of everyday heterosexual life.

Ryan White's struggle against fear and discrimination carried two more immediate messages for the general public. First, Ryan was a child who acquired AIDS through his treatment for hemophilia. He was innocent in a way that many could understand, without the overlay of sexual or drug morality. The second message also concerned this public perception of innocence. For many, this innocence highlighted the reprehensible nature of the discrimination suffered by Ryan, clearly demonstrating the needless suffering caused by fear and ignorance.

through dental treatment by an HIV-infected dentist, testified before Congress in support of a bill introduced by Representative William E. Dannemeyer. Id. Dannemeyer's bill would have required HIV-antibody testing of health care workers and would have permitted non-consensual testing of patients. Id.; H.R. 2788, 102d Cong., 1st Sess., 137 CONG. REC. 2376 (daily ed. June 26, 1991).


5. Despite the best efforts of public health spokes-persons, academicians and activists, many people continue to label some persons with HIV infection "innocent," thus wrongly imputing guilt to others living with the effects of the same viral infection. See Berke, AIDS Battle Reverting to "Us Against Them," N.Y. Times, Oct. 6, 1991, §4, at 4. (citing Bergalis' congressional testimony).
The meaning of Kimberly Bergalis' life and death is still contested.\(^6\) To her, to her family, and to the politicians and people who supported them, she also symbolized innocent suffering. To them, the suffering resulted from the political power of AIDS activists and/or gays, and political indifference toward protecting public health.\(^7\) To others, however, the Bergalis case, while tragic, merely represented the triumph of irrational fear over reasoned public policy.

The Bergalis case represents a pivotal point in our treatment of the Human Immunodeficiency Virus (HIV) as a public health issue. It may mark the beginning of the short descent into politically driven public health policies that divert us from AIDS prevention into the never-ending battle of fear prevention. That diversion could ultimately exact a high price. First, these policies treat risk irrationally, fostering public fear of minuscule risks without appreciably benefiting public health. Second, such policies help perpetuate the erroneous notion that HIV prevention simply involves identification and control of infected individuals. Third, these policies actually increase the risk of illness; they decrease incentives for voluntary testing and increase incentives for health care providers to refuse to treat the ill.

The publicity surrounding the Bergalis case has created a new and powerful fear for some—the fear of contracting a fatal disease while obtaining medical or dental care.\(^8\) Following Bergalis' congressional testimony, Congress passed a bill requiring states to regulate HIV-infected health care workers (HCWs).\(^9\) Responding to constituents' fears, state legislatures had already been debating a wide range of bills designed to confront the risk of HIV transmission in health care settings.

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\(^7\) Her father, George Bergalis, testified that "It's time for Congress to get off their duffs and treat AIDS as a disease rather than a 'civil rights issue.'" Hilts, supra note 1, at A8.

\(^8\) Public attention has recently focused on the risk of transmission from health care workers to patients because of Kimberly Bergalis. Yet the concern is not new; public opinion surveys have consistently revealed the public's concern with the issue of HIV infection in health care workers and others. See, e.g., Gentile, Doctors and AIDS, NEWSWEEK, July 1, 1991, at 48, 51 (reporting results of Newsweek-Gallup poll); Marshall, O'Keefe, Fisher, Caruso & Surdukowski, Patients' Fear of Contracting the Acquired Immunodeficiency Syndrome From Physicians, 150 ARCHIVES INTERNAL MED. 1501 (1990); Gerbert, Maguire & Spitzer, Patients' Attitudes Toward Dentistry and AIDS, 1989 J. AM. DENTAL ASS'N 16S; Gerbert, Maguire, Hulley & Coates, Physicians and Acquired Immunodeficiency Syndrome, 262 JAMA 1969 (1989).

\(^9\) See H.R. 2788, supra note 1.
Private actors, such as hospitals and insurers, feared litigation or loss of business if the public perceived them to be ignoring the problem of HIV infection among HCWs. As a result, they also began restricting the practices of such workers or requiring disclosure of HIV status to patients.

The validity of this public and private activity must be evaluated in the context of the actual risk of transmission posed by HIV-infected HCWs. All agree that this risk is minute, even for the most intrusive and complex surgical procedures. The courts ultimately will be forced to determine which, if any, privacy invasions and practice restrictions imposed on HCWs are legally justified by this real albeit minimal risk.

Courts and legislatures considering HCW regulation must confront medical assessments of the risk. Part II of this article examines the evolution of public health policy toward HIV-infected HCWs, primarily as expressed by the federal Centers for Disease Control (the CDC). Objective assessments of the public health risk may be used to measure the legality of public and private discrimination designed to reduce that risk. Part III considers the legitimacy of public and private efforts to reduce the risk of transmission by restricting the practice of infected HCWs. Part IV analyzes the legality of HIV testing programs. Finally, Part V describes the components of a sensible state policy toward HIV-infected HCWs.

II. THE CDC AND RISK REGULATION: PUBLIC HEALTH AND PUBLIC TRUST

The CDC, part of the federal government's public health arm, has been deeply involved in issuing guidelines and recommendations for reducing the risk of HIV transmission in a wide variety of contexts. In this role, it has been perched on the uneasy fault line between scientific and political understandings of risk. The CDC has long minimized the risk of HIV transmission in most workplaces and has advocated the use of standard infection control procedures, known as universal precautions, to reduce the risks posed in the health care setting. In July 1991, the CDC finally released its long promised, updated guidelines on HIV-infected health care workers. The new guidelines continued to support universal precautions as the primary technique for preventing HIV transmission, but also suggested that HCWs who perform certain "exposure-prone" procedures should determine their own HIV status and, if HIV-infected, should refrain from performing those procedures.

These recommendations have been widely attacked as deeply flawed. Nevertheless, these guidelines are extremely important because they mark the first battleline in the fight to implement rational public
and private health policies. The CDC's recommendations, or policies based on them, might be attacked as irrational because of the extremely low risk posed by HIV-infected HCWs.10 If the recommendations survive, perhaps in a revised form, they should serve two purposes: (1) to limit inappropriate public/private regulation; and (2) to guide effective policy-making.

First, the CDC's current and proposed revised guidelines might be used to mark the outer line of legally permissible state regulation of infected HCWs.11 Based on the CDC's risk assessment, new state laws requiring HIV-antibody testing of all HCWs, or laws unduly restricting the practice of infected HCWs, could be successfully challenged as irrational or discriminatory. Private organizations might be similarly limited in their ability to identify and discriminate against HIV-positive HCWs.

Second, the CDC's revised guidelines may be interpreted as supporting sensible state policies that reduce HIV risks in the health care setting without unnecessarily infringing on the rights of HCWs or patients.12 States implementing the CDC approach should improve their policies by elaborating on several issues not fully considered in the CDC recommendations.

A. The Emphasis on Universal Precautions

The CDC has developed guidelines and recommendations through either staff efforts or consultations with medical or other experts.13 The CDC's conclusions provide an unusually authoritative source of information about risk and help determine the medically appropriate standard of care.14 Over the past ten years, the CDC has issued several sets of guidelines or recommendations relevant to the problems of HIV-infected HCWs. A brief review of those guidelines will put the CDC's current recommendations into context.

10. See infra notes 119-23 and accompanying text (discussing the irrationality of CDC guidelines).
11. See infra notes 91-294 and accompanying text (Parts III and IV).
12. See infra notes 295-345 and accompanying text (Part V).
In 1981, the first reports of what later came to be understood as HIV infection appeared in the CDC’s *Morbidity and Mortality Weekly Report (MMWR)*. The CDC issued the first precautionary recommendations seventeen months later in a 1982 publication designed to protect clinical and laboratory workers from potential infection. In the fall of 1983, the CDC issued recommendations to minimize the risk of transmission to certain health care workers and morticians.
Researchers did not identify HIV, the virus associated with the development of AIDS, until 1983. A screening test for antibodies to the virus became commercially available in 1985. These developments created new opportunities for implementing effective public health measures, but they also created the potential for discrimination and infringements on individual liberty.

The availability of HIV antibody testing brought no significant changes to the CDC's assessment of HIV risks in the health care setting. The CDC's 1985 workplace guidelines discounted the risk of transmission in most workplace or school settings and emphasized reducing the small risk of transmission in health care, particularly the risk of transmission from patient to HCW. The CDC did recognize that HIV-infected HCWs could pose a danger to their patients

[W]here there is both (1) a high degree of trauma to the patient that

later public health determinations.


20. The CDC's subsequent guidelines on HIV in the workplace and in schools seemed conscious of the social and legal implications of public health information. The CDC encouraged participation by a wide range of groups as it developed these new guidelines:

Because the settings addressed in these guidelines [workplaces and schools] were more specific than in previous guidelines, more input was sought from the groups affected by the recommendations and from individuals with particular expertise . . . . In addition to various public health, medical, and dental professionals, the developers of the workplace and invasive-procedure guidelines consulted with restaurant professionals, morticians, hairdressers and cosmetologists, gay rights advocates, labor union representatives, and emergency medical technicians.

Neslund, Matthews & Curran, supra note 13, at 75; see also CDC, Summary: Recommendations for Preventing Transmission of Infection with Human T-Lymphotropic Virus Type III/Lymphadenopathy-Associated Virus in the Workplace, 34 MORBIDITY & MORTALITY WEEKLY REP. 681, 689 (1985) [hereinafter CDC, Workplace Guidelines] (identifying consultants on workplace guidelines). The consultants' criticisms of CDC draft guidelines occasionally resulted in revisions. Neslund, Matthews & Curran, supra note 13, at 76.

21. CDC, Workplace Guidelines, supra note 20, at 681. In the health care environment, the CDC recommended universal precautions: using barriers and proper infection control procedures to reduce the risk of transmission. However, it did not recommend routine serologic testing of patients, although it noted that hospitals in high incidence areas might adopt such testing. Id. at 685.
would provide a portal of entry for the virus (e.g., during invasive procedures) and (2) access of blood or serous fluid from the infected HCW to the open tissue of a patient, as could occur if the HCW sustains a needlestick or scalpel injury during an invasive procedure.\(^\text{22}\)

The key factor, then, was the nature of the procedure being performed by the HCW. HIV infection alone was not a basis for restricting the practice of HCWs who did not perform invasive procedures.\(^\text{23}\) In subsequent guidelines, the CDC would address potential restrictions on the practice of HIV-infected HCWs who perform invasive procedures.

Five months later, the CDC issued recommendations specifically designed to reduce the risk of HIV transmission during invasive procedures.\(^\text{24}\) These 1986 health care guidelines once again recommended stringent adherence to universal precautions, which provided reciprocal protection for both health care workers and patients.\(^\text{25}\) The CDC reject-

\(^{22}\) Id. at 686.

\(^{23}\) Id.

\(^{24}\) CENTERS FOR DISEASE CONTROL, U.S. DEP’T HEALTH & HUMAN SERV., Recommendations for Preventing Transmission of Infection with Human T-Lymphotropic Virus Type III/ Lymphadenopathy-Associated Virus During Invasive Procedures, 35 MORBIDITY & MORTALITY WEEKLY REP. 221 (1986) [hereinafter CDC, Health Care Recommendations — I]. The guidelines resulted from another protracted consultation process between the CDC, infectious disease experts and representatives of various professional groups. Id. at 221. The controversial nature of the guidelines and the need to validate their content was obvious: this time, a description of the guideline development process could be found in the document’s first paragraph, rather than the last. Compare CDC, Health Care Recommendations—I with CDC, Workplace Guidelines, supra note 20, at 689 (last paragraph of guidelines devoted to methodology).

\(^{25}\) Universal precautions, also called universal blood and body-fluid precautions, require consistent use of certain techniques to reduce the risk of exposure to blood or other body fluids. “Since medical history and examination cannot reliably identify all patients infected with HIV or other blood-borne pathogens, blood and body-fluid precautions should be consistently used for all patients” whenever exposure to blood or body fluids is possible. CENTERS FOR DISEASE CONTROL, U.S. DEP’T HEALTH & HUMAN SERV., Recommendations for Prevention of HIV Transmission in Health-Care Settings, 36 MORBIDITY & MORTALITY WEEKLY REP. (SUPP. NO. 2) 3S, 5S (1987) [hereinafter CDC, Health Care Recommendations—II] (emphasis in original); See also CENTERS FOR DISEASE CONTROL, U.S. DEP’T HEALTH & HUMAN SERV., Update: Universal Precautions for Prevention of Transmission of Human Immunodeficiency Virus, Hepatitis B Virus, and Other Bloodborne Pathogens in Health-Care Settings, 37 MORBIDITY & MORTALITY WEEKLY REP. 377 (1988) [hereinafter CDC, Health Care Recommendations—III] (clarifying the meaning of universal precautions). HCWs exercise care in using and disposing of sharp instruments that could be contaminated with blood, and they wear latex gloves, goggles, masks, and other equipment to create a barrier that will prevent exposure to blood or other body fluids.
ed routine HIV screening for HCWs who perform invasive procedures, because "the risk of transmission in this setting is so low." Similarly, the CDC rejected global restrictions on the practice of invasive procedures by infected HCWs, instead favoring a more ambiguous general standard: "All HCWs with evidence of any illness that may compromise their ability to adequately and safely perform invasive procedures should be evaluated medically to determine whether they are physically and mentally competent to perform invasive procedures." Patients were to be informed if exposed to a HCW's blood in the course of an invasive procedure; the HCW might be asked to voluntarily undergo HIV-antibody testing in order to determine the risk to the patient.

The CDC's next installment, the 1987 health care guidelines, again emphasized universal precautions as the primary technique for minimizing HIV transmission. Health care workers performing invasive procedures were to stringently adhere to universal blood and body-fluid precautions, while health care employers were to provide education pro-

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27. Id. at 222. This ambiguous standard does not clearly indicate whether HIV infection is a condition that might compromise a HCW's "ability to adequately and safely perform invasive procedures." Id. In addition, the standard does not establish whether HIV-infected HCWs have a duty to notify health care institutions of their status.
28. Id.; see also, CDC, Workplace Guidelines, supra note 20, at 686.
30. CDC, Health Care Recommendations — II, supra note 25, at 6S-7S. The CDC defined HCWs broadly, "as persons, including students and trainees, whose activities involve contact with patients or with blood or other body fluids from patients in a health-care setting." Id. at 3S. The CDC also used a broad definition for invasive procedures, with specific examples of settings or procedures:

In this document, an invasive procedure is defined 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.
grams, proper equipment and appropriate monitoring programs. The CDC did not recommend universal screening for patients; instead, individual physicians and institutions were to determine whether such testing programs were needed. Similarly, the CDC did not directly advocate HCW testing programs, "since transmission of HIV from infected health-care workers performing invasive procedures to their patients has not been reported and would be expected to occur only very rarely, if at all, the utility of routine testing of such health-care workers to prevent transmission of HIV cannot be assessed." Nor did the CDC directly advocate restrictions on the practice of HIV-infected HCWs:

The question of whether workers infected with HIV—especially those who perform invasive procedures—can adequately and safely be allowed to perform patient-care duties or whether their work assignments should be changed must be determined on an individual basis. These decisions should be made by the health-care worker's personal physician(s) in conjunction with the medical directors and personnel health service staff of the employing institution or hospital.

Patients exposed to a HCW's blood or body fluid were to be informed of the event and to receive appropriate counseling. The CDC guidelines remained consistent for the next four years. In its subsequent statements, the CDC did not advocate testing to identify HIV-infected HCWs or impose restrictions on their practice. The guidelines were also consistent with the ethical or policy recommendations

Id. at 6S-7S.

31. Id. at 12S.

32. Id. at 14S. The CDC noted that any testing programs implemented "should" include counseling, informed consent, and confidentiality safeguards. Id. at 15S.

33. The CDC also evinced a concern for the social and legal implications of such a testing program: "If consideration is given to developing a serologic testing program for health-care workers who perform invasive procedures, the frequency of testing, as well as the issues of consent, confidentiality, and consequences of test results . . . must be addressed." CDC, Health Care Recommendations—II, supra note 25, at 15S.

34. Id. at 16S.

35. Id. at 17S.

promulgated by most other professional groups. The American Medical Association (the AMA) and the American Hospital Association (the AHA), for example, also noted the low risk of HIV transmission during invasive procedures and advocated individualized assessment of an infected HCW's activities. However, some policies conflicted. The AMA Ethics Council, for example, advocated a “zero risk” policy, requiring HIV-infected physicians to refrain from engaging in any procedure that could pose any risk to the patient, no matter how minute. Other groups favored disclosing the risk to patients as an alternative to direct practice restrictions.

B. Public Health and Politics: The Acer Tragedy

In 1990, the CDC began to investigate a case of HIV infection that suggested a dentist, David Acer, had transmitted HIV to a dental patient,

37. Of the professional organizations, the AMA had taken the most risk adverse approach to HIV-infected health care workers. See Council on Ethical & Judicial Affairs, Am. Med. Ass'n, Ethical Issues Involved in the Growing AIDS Crisis, 259 JAMA 1360, 1361 [hereinafter Ethical Issues] (“A physician who knows that he or she is seropositive should not engage in any activity that creates a risk of transmission of the disease to others . . . [and] should consult colleagues as to which activities the physician can pursue without creating a risk to patients.”). Even this approach stops short of mandatory testing and global practice restrictions. Before 1990, other groups had emphasized the low risk of transmission and the ability to protect patients through the use of universal precautions. See, e.g., Health and Pub. Policy Comm’n, Am. College of Physicians and the Infectious Diseases Soc’y of Am., The Acquired Immunodeficiency Syndrome (AIDS) and Infection with the Human Immunodeficiency Virus (HIV), 108 ANNALS INTERNAL MED. 460, 464-65 (rejecting routine screening of HCWs and asserting that HIV-infected physicians generally “present virtually no risk of” transmission to patients); AMERICAN HOSP. ASS’N, MANAGEMENT OF HIV INFECTION IN THE HOSPITAL (1988); GMC Warns Doctors Infected with HIV or Suffering from AIDS, 295 BRITISH MED. J. 1500 (1987) (General Medical Counsel concludes that infected physicians must consult with others to determine whether restrictions on practice are necessary). See also Barnes, Rango, Burke & Chiarello, The HIV-Infected Health Care Professional: Employment Policies and Public Health, 18 LAW, MED. & HEALTH CARE 311, 314-16 (1990) (discussing professional positions); Isaacman, The Other Side of the Coin: HIV-Infected Health Care Workers, 9 ST. LOUIS U. PUB. L. REV. 439, 490-92 (1990) (discussion of professional recommendations). The tone of professional recommendations changed somewhat after the Acer case. See infra notes 46-47 and accompanying text.

38. Ethical Issues, supra note 37, at 1361.

Kimberly Bergalis. The CDC issued preliminary findings in July 1990, concluding that the Florida dentist might have transmitted HIV to one of his patients. Subsequent investigation revealed five patients who might have acquired HIV infection in the same dental practice.

Concerned about identifying the mode of transmission and anxious to ease the public’s fears, the CDC considered further modifying its guidelines governing HIV-infected HCWs. In February 1991, the CDC held a public meeting at which a variety of professional and advocacy groups expressed their opposition to both mandatory testing and restrictions on the professional practices of HIV-infected HCWs.

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40. See infra note 43.


43. CENTERS FOR DISEASE CONTROL, U.S. DEP’T OF HEALTH & HUMAN SERV., Update: Transmission of HIV Infection during an Invasive Dental Procedure—Florida, 40 MORBIDITY & MORTALITY WEEKLY REP. 21 (1991); CENTERS FOR DISEASE CONTROL, U.S. DEP’T OF HEALTH & HUMAN SERV., Update: Transmission of HIV Infection During Invasive Dental Procedures, 40 MORBIDITY & MORTALITY WEEKLY REP. 377 (1990); See also Smith and Waterman, The Continuing Case of the Florida Dentist, 256 SCIENCE 1155 (1992); and Ou and Ciesielski, Molecular Epidemiology of HIV Transmission in a Dental Practice, 256 SCIENCE 1165 (1992). These scientific conclusions about the probable transmission between Acer and one of his patients will be a key issue in a Florida suit to be heard in Spring 1992. Palca, The Case of the Florida Dentist, 255 SCIENCE 392, 392 (1992). The suit revolves around Richard Driskill’s claim that Acer was the source of his infection and that CIGNA Dental Health of Florida violated its duty to protect participants in its dental services program. Id. CIGNA has refused to settle the case, in part because of a dispute over causation. CIGNA’s lawyers reportedly argue that:

[T]here is reasonable doubt about whether Driskill got the virus from his dentist. Not only could his lifestyle have made him vulnerable to infection from other sources, . . . but the CDC has not conclusively established that the virus that infected Acer and Driskill can be distinguished from others in south Florida.

Id.

continued to work on new guidelines through the spring of 1991, reportedly attempting to overcome the mandatory testing position supported by some members of the Bush Administration.45

At the same time, professional groups continued to discuss the issue, now in the context of heightened public concern with patient safety. These groups began to emphasize eliminating the risk to patients from HIV-infected HCWs, yet most continued to reject mandatory HIV testing for HCWs.46 Professional groups also continued to grapple with whether infected HCWs should be required to disclose their status to patients.47

Public and professional concern about the risk of transmission seemed to open the door to new testing programs, new regulatory mechanisms governing the range of practice for health care professionals, and new pressures on the overall system for dealing with HIV infection in the health care setting. State legislators, seeking to eliminate any possible risk of HIV transmission, introduced a number of proposals designed to reassure the public. The proposed laws attempted to eliminate the risk through mandatory testing programs for HCWs, restrictions on HIV-infected HCWs’ practices, and mandatory disclosure requirements imposed on HIV-infected HCWs, and, sometimes, on infected patients.48


47. See, e.g., AMA Statement on HIV Infected Physicians, supra note 46; Association for Practitioners in Infection Control & Soc’y of Hosp. Epidemiol., Position Paper: The HIV-Infected Healthcare Worker, 11 INFECTION CONTROL HOSP. EPIDEMIOL. 647, 652-53 (1990). At the same time, employers and education programs were also being forced to make practical determinations about responding to HIV-infected health care workers. See, e.g., Comer, Myers, Steadman, Carter, Rissing & Tedesco, Management Considerations for an HIV Positive Dental Student, 55 J. DENTAL EDUC. 187 (1991) (discussing the University of Georgia School of Dentistry’s response to an HIV-positive dental student).

48. See, e.g., Hermann, State Legislatures Consider Bills Dealing With HIV-Infected Health Care Providers in Face of CDC Inaction, 24 J. HEALTH & HOSP. L. 215, 215-17 (1991) (brief survey of bills pending in state legislatures as of June 1991). Contrary to this trend, the New York State Health Department issued regula-
Some of the state proposals demonstrated only dubious rationality, akin to attempting to kill a mosquito with a cannon. In Delaware, for example, two Senate bills would have required HIV-positive health care professionals to disclose their HIV status to their patients, regardless of the nature of the proposed treatment or the risk of transmission. Legislation in several states would have restricted the ability of infected HCWs to perform certain broadly defined ‘dangerous procedures’; passage of these measures would have barred infected HCWs from performing nearly any medical procedure. The CDC’s delay in responding to the Acer case may have hampered the ability of some legislatures to react responsibly.

C. The New CDC Guidelines: The Evaporating Standard

1. The CDC’s July 1991 Guidelines

The CDC finally released its promised new health care guidelines in July 1991. The new approach established similar standards for HIV-infected and Hepatitis B Virus (HBV) infected HCWs. The CDC reconfirmed that HIV-infected HCWs posed no risk to patients unless they performed certain invasive procedures. However, the CDC noted


50. For example, a Hawaii Senate bill required patient notification before performing “invasive procedures that utilizesharp instruments,” which could include giving a shot. See, Hermann, supra note 48, at 216 (citing S. 1143, 16th Haw. Leg., Reg. Sess. (1991)). A Delaware House bill would require all HIV-positive HCWs to “cease performing any operation or surgical procedure which will bring the professional into contact with human blood or plasma.” Hermann, supra note 48, at 215 (citing H. 191, 136th Del. Gen. Assembly (1991)).


52. The CDC again noted that, although both viruses were transmitted through similar kinds of contacts, HBV was much more easily transmissible than HIV. Id. at 1-3. This article will not consider the implications of HBV infection for health care workers. See Note, Hepatitis B and Dentistry: Medico-Legal Implications of Dentist to Patient Transmission, 62 WASH. U. L.Q. 261 (1984) (focusing on liability issues).

53. CDC, Health Care Recommendations—IV supra note 51, at 1.
that universal precautions had failed to completely prevent hepatitis transmission from HCWs to patients during "exposure-prone" procedures, which the CDC defined as a special subset of invasive procedures. Although HIV is more difficult to transmit than HBV, the guidelines concluded that "until further data are available, additional precautions are prudent to prevent HIV and HBV transmission during procedures that have been linked to HCW-to-patient HBV transmission or that are considered exposure-prone."

The guidelines recommended continued strict adherence to universal precautions. They also changed three important areas: (1) the definition of risky procedures; (2) the testing of HCWs; and (3) the imposition of restrictions on the practice of HIV-infected HCWs. Generally, the CDC recommendations can be viewed as suggesting particular approaches to these three issues, while leaving others to battle over the specifics. The CDC's initial skeletal approach might be used to limit some public or private attempts to identify and discriminate against HIV-infected HCWs. Yet, these guidelines allow states to determine the important specifics of a rational health policy.

The problem of defining risky procedures provides a good example of the CDC's skeletal framework of limitations, which is combined with an opportunity for elaboration. After reviewing the data on hepatitis transmission, the CDC generally defined "exposure-prone" procedures as those in which the HCW manipulates sharp instruments within confined spaces or without full view of the area. The guidelines also listed a number of procedures that could be classified as exposure-prone based on past association with HBV transmission. Health care workers performing these procedures might sustain cuts or needlesticks, which could expose the patient to the HCW's blood. However, the CDC stopped

54. Id.
55. Id.
56. Id. at 4.
57. The guidelines noted that, "[d]espite adherence to the principles of universal precaution, certain invasive surgical and dental procedures have been implicated in the transmission of HBV from infected HCWs to patients, and should be considered exposure-prone. Reported examples include certain oral, cardiothoracic, colorectal, and obstetric/gynecologic procedures." CDC, Health Care Recommendations—IV, supra note 51, at 4.
58. In emphasizing certain characteristics of procedures that might create a risk of transmission, the CDC was adopting an apparently sensible approach that, nonetheless, deviated from at least some empirical research. See, Wright, McGeer, Chyatte & Ransohoff, Mechanisms of Glove Tears and Sharp Injuries Among Surgical Personnel, 266 JAMA 1668 (1991) (study of breaches of barriers during surgery, focusing on problems presented by positioning of hands and instruments).
short of providing a detailed list of risky procedures. Instead, the guidelines recommended that "exposure-prone procedures should be identified by medical/surgical/dental organizations and institutions at which the procedures are performed."\(^{59}\) The CDC subsequently indicated its willingness to assist in developing a list of exposure-prone procedures.\(^{60}\)

The CDC's treatment of the testing issue follows the same pattern of general guidance. The CDC guidelines explicitly rejected mandatory testing.\(^{61}\) At the same time, they encouraged voluntary testing by recommending that "HCWs who perform exposure-prone procedures should know their HIV antibody status."\(^{62}\) Perhaps because such testing was theoretically voluntary, the CDC guidelines did not specify any particular mechanisms or safeguards for testing and confidentiality.

Finally, the new guidelines recommended restrictions on the practice of HIV-infected HCWs (along with certain HBV-infected HCWs), but left the determination of the nature of the restrictions to others. Contrary to AMA and American Dental Association ethical advisory opinions, the guidelines did not restrict HCWs from performing any procedure that might pose any risk to a patient. The CDC position was more limited: HIV- or HBV-infected workers "should not perform exposure-prone procedures unless they have sought counsel from an expert review panel."\(^{63}\) These expert review panels would be comprised of physicians, some of whom would be local or state health officials.\(^{64}\) The panel

59. CDC, Health Care Recommendations — IV, supra, note 51, at 5.

60. A month after issuing its new guidelines, the CDC issued a notice indicating that it was establishing a centralized process for issuing a national reference list of exposure-prone procedures. The CDC anticipated that a list would be available by November 1991. CENTERS FOR DISEASE CONTROL, U.S. DEP'T OF HEALTH & HUMAN SERV., Process for Identifying Exposure-Prone Invasive Procedures, 40 MORBIDITY & MORTALITY WEEKLY REP. 565 (1991). This optimism proved unwarranted. See infra notes 77-82 and accompanying text.

61. “Mandatory testing of HCWs for HIV antibody . . . [or evidence of HBV infection] is not recommended. The current assessment of the risk that infected HCWs will transmit HIV or HBV to patients during exposure-prone procedures does not support the diversion of resources that would be required to implement mandatory testing programs.” CDC, Health Care Recommendations—IV, supra note 51, at 6 (emphasis omitted).

62. Id. at 5.

63. Id.

64. The guidelines specified that:

The review panel should include experts who represent a balanced perspective. Such experts might include all of the following: a) the HCW's personal physician(s), b) an infectious disease specialist with expertise in the epidemiology of HIV and HBV transmission, c) a health professional with expertise in the procedures performed by the HCW, and d) state or local
would determine whether, and under what conditions, an infected HCW might continue to perform risky procedures. As one condition of continued practice of "exposure-prone" procedures, the guidelines required that patients be notified of the risk of HIV transmission.\textsuperscript{65}

The new guidelines suggested that the risk of HIV transmission from HCW to patient—previously viewed as too small to require HCW testing and practice restrictions—had gained a new salience after the Acer case. The guidelines were not premised on new information about previously unknown risks of transmission. Instead, they merely stated that, "until further data are available, additional precautions are prudent."\textsuperscript{66} At the very least, the CDC's new recommendations represented an extremely risk averse approach, advocating the elimination of even minute risks.\textsuperscript{67}

The appearance of the CDC's guidelines in July 1991 coincided with the continuing decline in the health of Kimberly Bergalis, who was reported to be near death.\textsuperscript{68} Bergalis' plight won the sympathies of

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\textsuperscript{65} "Such circumstances would include notifying prospective patients of the HCW's seropositivity before they undergo exposure-prone invasive procedures." CDC, \textit{Health Care Recommendations—IV}, supra note 51, at 5.

\textsuperscript{66} \textit{Id.} at 1. The CDC's investigation into the Acer case has failed to determine how HIV transmission occurred. Altman, \textit{An AIDS Puzzle: What Went Wrong in Dentist's Office}, N.Y. Times, July 30, 1991, at C3, col. 1. The dentist clearly did not follow appropriate infection control procedures, but investigators have even considered intentional transmission as a possible mechanism. \textit{Id.}

\textsuperscript{67} Arguably, the absence of new risk information, and the excessive response to the known risk information, demonstrates the irrationality of the new guidelines. See infra notes 120-23 and accompanying text (discussing rationality of CDC guidelines). These guidelines might lie outside the limits of a rational response to the risk presented by HIV-infected health care workers.

Of course, a purely objective or rational public health paradigm might be illusory, since scientific consensus often requires the balancing of individual and group interests, as does political consensus process. Thus, the CDC's critics may contend that its decisions resulted from political compromise rather than scientific revelations. If true, however, this position would tend to confirm the conclusion that the CDC's approach represents the outer limits of permissible decision-making about the risks of HIV-infected health care workers. Even more restrictive policies should certainly be deemed irrational and medically unnecessary.

\textsuperscript{68} Gentile, \textit{supra} note 8, at 49. Though greatly weakened and debilitated, Bergalis traveled to Washington to address Congress on behalf of Representative
many, including prominent politicians who wished to heed her plea to prevent future cases of HCW-to-patient transmission. After the CDC recommendations appeared, the United States Senate considered and passed two pieces of legislation designed to confront the issue. Some states also acted quickly, adopting the new CDC guidelines or some other, more stringent approaches. Private entities also reacted, forcing the resignations of infected health care workers.

After lengthy consideration and dispute, the Senate and House eventually compromised on a new federal law that requires state public health officials to certify that the state has adopted CDC guidelines or “guidelines which are equivalent.” This new law, signed by the Presi-


71. As of April 1992, California, Maryland, Florida, Louisiana, Texas and Hawaii had passed HIV-infected HCW legislation. 1991 Cal Adv. Legis. Serv. 1190 (Deering)(October 1991 legislation requiring education programs on use of universal precautions, investigation and disciplinary actions against health care providers who fail to follow universal precautions, and requiring the State Dep’t of Health Services to “develop guidelines and regulations as necessary to minimize the risk of transmission of blood-borne infectious diseases from health care worker to patient.”); 1991 Cal. Adv. Legis. Serv. 639 (Deering) (October 1991 statute encouraging development and use of medical devices designed to reduce occupational exposure to bloodborne diseases); TEX. HEALTH & SAFETY CODE ANN. § 85.201 (Vernon 1992) (adopting CDC guidelines); and 1991 I11. Legis. Serv. 87-763 (West) (law requiring contact tracing of patients who have had an invasive (not necessarily “exposure-prone”) procedure performed by an HIV-infected HCW; also requiring HCWs to follow CDC guidelines or face disciplinary action). See also, Hermann, supra note 48 (discussing state legislative initiatives); Yang, Illinois Gov. Adds to HIV Hysteria, GAY COMMUNITY NEWS Oct. 13, 1991, at 1.


73. The final amendment, tacked onto the Treasury and Postal Service Appropriations Bill, provided:
dent on October 28, 1991, will play an important role in increasing state regulation of HIV-infected HCWs. However, in the midst of all of this legislative activity, the CDC's July guidelines were coming under increasingly heavy attack by both professional medical groups and activists. The CDC approach, tacitly approved by Congress and actually codified by some state legislatures, may eventually be revised.

2. The CDC's Evaporating Standard

The CDC's July 1991 guidelines contained two important elements: (1) a standard and (2) a process. The standard could be found in the attempt to carve out particular risky procedures, called exposure-prone, which HIV-infected HCWs should not perform. The process entailed the creation of expert review panels that would determine whether, and

Notwithstanding any other provision of law, each State Public Health Official shall, not later than one year after the date of enactment of this Act, certify to the Secretary of Health and Human Services that guidelines issued by the Centers for Disease Control, or guidelines which are equivalent to those promulgated by the Centers for Disease Control concerning recommendations for preventing the transmission of the human immunodeficiency virus and the hepatitis B virus during exposure prone invasive procedures, except for emergency situations when the patient's life or limb is in danger, have been instituted in the State.

Treasury, Postal Service and General Government Appropriations Act of 1992, Pub. L. No. 102-141, § 633, 105 Stat. 834, 876 (1991) (to be codified at 42 U.S.C. § 300ee-2). The state public health officials were responsible for monitoring compliance with the guidelines and determining appropriate disciplinary or other sanctions for violations. Id. Failure to adopt the CDC or equivalent guidelines could result in the termination of the state's federal public health funds. Id.

Significantly, the new federal statute requires that "state guidelines shall apply to health professionals practicing within the State and shall be consistent with Federal law." Id. (emphasis added). This provision may indicate congressional intent to regulate HIV-infected HCWs within the existent framework of federal anti-discrimination law, such as the Rehabilitation Act of 1973 (the "Rehab Act") and the recently enacted Americans with Disabilities Act (the "ADA"). See infra notes 152-166 and accompanying text (discussing Rehab Act) and notes 167-175 (discussing ADA). It certainly does not support the conclusion that this federal law was meant to preempt the protections afforded by the disability discrimination statutes.


74. See infra notes 78-79.
under what conditions, infected HCWs could perform those exposure-prone procedures. Of these two elements, the standard has sustained the most damaging criticism thus far.

The standard required that medical associations or health care facilities determine what procedures were exposure-prone. The CDC stated that it would assist in developing such a list of risky procedures, to be released in November 1991. But the CDC's efforts to achieve medical consensus on the contents of such a list were more than merely unsuccessful. In a spectacular failure for the CDC, numerous professional medical groups and others simply refused to participate in developing the "exposure-prone" procedures list.

The medical community overtly expressed two reasons for rejecting the CDC approach. Some groups contended that the low risk of HIV transmission did not justify the CDC's policy. Additionally, others contended that it was impossible to rationally distinguish between various invasive procedures, all of which carried a very low risk of transmission.

The CDC initially seemed unswayed by the criticism. In October

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75. See supra note 59 and accompanying text.
76. See supra note 60 and accompanying text.
77. See, e.g., Centers for Disease Control Called Upon to Scrap Plan to List Invasive Procedures, 6 AIDS POL'Y & L. 1 (Nov. 14, 1991).

It is not hard to imagine that CDC officials might have been surprised by these objections, given some of the zero-risk language that groups such as the AMA had earlier espoused. Yet the medical community's response to the exposure-prone standard was nonetheless predictable. First, the zero-risk policy did not have unanimous support; many had argued that it was a special rule created for HIV-infected physicians, which could not realistically be applied to all physicians who might pose some risk to their patients in some circumstances. Second, the zero-risk policy had been promulgated as an ethical constraint, not as an explicit and legally binding guideline. Third, the risks posed by HIV-infected physicians might have been deemed to be "near zero." Finally, the exposure-prone standard did not seem narrowly tailored to the actual risks presented by HIV-infected health care workers.

79. See Altman, supra note 78, at A3, Col. 6.
80. Some entities supported the CDC's July 1991 guidelines. The AMA and other groups initially expressed their support:
1991, CDC officials indicated their intent to release a list of exposure-prone procedures even without the assistance of some other medical groups. This optimism proved unwarranted; the exposure-prone list’s expected release date came and went without action. In early December, news reports indicated that the CDC was reformulating its approach.

The current revision of the CDC guidelines, which as of April 1992 had not yet been officially released, contains two important changes. First, the CDC seems to have abandoned the exposure-prone standard in favor of an expert review panel’s individualized assessment of a practitioner’s ability to perform a specific invasive procedure. Second,

Some professional organizations supported restrictions on HIV-infected health care workers. The American Academy of Orthopaedic Surgeons recommended that seropositive surgeons not perform procedures involving internal fixation devices, implanted wires, and blind probing. The Federation of State Medical Boards, which represents licensing and disciplinary boards, said that it would be professional misconduct for health care workers who perform invasive procedures identified by the CDC as exposure-prone not to know their HIV status. Furthermore, the federation recommended that boards require that the names of HIV-infected health care workers be reported to them.


83. The revised guidelines state:

The new recommendations recognize that the risk to patients during invasive procedures depends upon the skill and technique of the individual infected health care worker and the health care worker’s physical condition, as well as on the specific invasive procedure being performed. Accordingly, a precise list of exposure-prone procedures will not be developed.

These new CDC draft guidelines also clarify that some common medical procedures do not pose a risk to patients:

Routine health-care procedures such as physical examinations; blood pressure checks, eye examinations; oral, rectal or vaginal exams are not considered invasive procedures. In addition, many invasive procedures pose no risk to the patients of exposure to the health care worker’s blood, when performed using standard infection control techniques, including universal precautions.
the CDC appears to have modified its prior requirement that a patient be notified before an infected HCW performs a risky procedure on the patient. The primary effect of these revisions is to invest substantially more power and discretion in the expert review panels. The demise of

Id. at 2-3.

Although perhaps indicating the existence of multiple CDC drafts, other newly published reports support this description of the CDC’s new approach. A December 1991 New York Times article described the changes in the new draft guidelines as follows:

The draft guidelines, like the previous ones, oppose mandatory testing of health workers for HIV. Instead they call for voluntary tests (sic) those people found to be infected are advised to seek counsel from a local committee of experts before performing procedures in which their hands or instruments enter a body cavity or touch mucus membranes.

The guidelines instruct such committees to focus on three factors in determining whether infected health workers should continue to perform invasive procedures and under what circumstances.

One factor is an evaluation of the type of procedures that the health worker performs and the likelihood that drops of the worker’s blood could pose a significant risk to the patient. Among the considerations are operations in which an infected doctor or nurse cannot see his or her hands while cutting a body or putting sutures into it.

A second factor is how well the health worker complies with standard infection-control procedures.

A third factor is the medical condition of the infected health worker...

A local committee could restrict the practice of infected health workers if it judged that one or more of the three factors would increase the risk of such a worker’s transmitting the virus to a patient. It is left to each committee to determine whether periodic reassessments of each infected health worker are needed, and how often.

Altman, supra note 82, at A1, col. 5; see also Glantz, Mariner & Annas, Risky Business: Setting Public Health Policy for HIV-infected Health Care Professionals, 70 Milbank Q. 43, 53-55 (1992) (discussing possible revisions); and Lo & Steinbrook, supra note 80, at 1102 (same).

84. The new draft guidelines are singularly unclear on this point. CDC, Proposed Health Care Recommendations, supra, note 83, at 2. The new draft guidelines provide that:

In some circumstances, the panel may recommend modifying procedures to eliminate or substantially decrease the risk. When the panel is uncertain whether the procedure may pose a small risk, it may recommend that the procedures be performed only after the health care worker has informed the patient of the health care worker’s infection status.

Id. This phrasing might constitute an indirect suggestion that patients need not be notified when the expert panel issues recommendations to the infected HCW that will “eliminate or substantially decrease the risk” posed by that worker. In this draft, the CDC has also used “may” instead of “must.” Id.
the exposure-prone standard may result in these unregulated panels rendering even more “standardless” or arbitrary decisions.\(^\text{85}\)

While widely reported, the proposed changes to the July 1991 guidelines are not final unless and until the CDC releases its formal revisions.\(^\text{86}\) All that seems clear in April 1992 is that the CDC has rendered the already contested and contradictory legal and policy implications of the July 1991 pronouncements even more equivocal. This uncertainty is a problem for the large number of public and private actors concerned with providing health care.\(^\text{87}\) States continue to consider a

\(^{85}\) See, e.g., Lo & Steinbrook, \textit{supra} note 80, at 1103.

\(^{86}\) As of April 1992, reports indicated that the revised recommendations were “under review at the U.S. Department of Health and Human Services.” \textit{Id}. at 1105. Politically, the proposed guidelines required approval from the Secretary of HHS, Dr. Louis Sullivan. Altman, \textit{supra} note 82, at A1, col. 1. Under the Administrative Procedure Act, revisions to the guidelines might require formal notice and comment procedures. 5 U.S.C. § 553 (1988); see \textit{infra} note 116. The proposed revisions have received less criticism than the July 1991 guidelines. Even the AMA, long the lone supporter of the exposure-prone approach, signed on to the proposed revisions. See, e.g., Leary, \textit{A.M.A. Backs Off on an AIDS Risk List}, N.Y. Times, Dec. 15, 1991, at 1, col. 1.

The medical establishment’s apparent acceptance of the revisions, however, may not be sufficient to override other, perhaps political considerations. As this article goes to press in June 1992, news reports indicate that the CDC may avoid formally revising its position:

\[\text{T]he CDC said local boards would be better able to decide whether doctors, dentists and other medical professionals with AIDS or hepatitis B are a risk to patients.}\]

The CDC said it is drafting a letter to all state health departments, telling them they may judge on a case-by-case basis, but recommending that local health officials abide by AIDS guidelines issued by the CDC in July 1991. \textit{Issue of Medical Workers With AIDS Is Left to States}, Wall St. J., June 17, 1992, at A11, col. 2.

The CDC thus has managed to make relevant both lines of analyses followed in the remainder of this article. The analysis of the CDC’s July 1991 guidelines will remain pertinent into the foreseeable future because the CDC has refused to rescind them and because Congress has required state adoption of the CDC approach. The proposed revisions to the guidelines — while formally spurned in favor of the original July 1991 approach — are actually represented in the CDC’s suggestion that state officials determine risk on a “case-by-case” basis. In essence, the CDC is suggesting that both the July 1991 and the proposed revisions be implemented.

\(^{87}\) Nearly as importantly, it can create difficulties for law professors attempting to update their articles through the publication process. This article was completed and accepted for publication in October 1991. As it wound its way through the publication process, it underwent substantial revisions in late March 1992. Developments occurring through June 1992 are reflected in footnotes.
wide range of legislative initiatives designed to either protect patients or minimize public fear. Private entities, such as medical societies, hospitals, and health maintenance organizations, may continue their efforts to remove HIV-infected HCWs from patient care. Insurance companies may continue to attempt to restrict malpractice coverage for infected HCWs. Health care workers themselves may be concerned about their legal duties to undergo testing and, if HIV-positive, to restrict their practices or to inform their patients or employer.

Courts will use the yardstick of medical rationality to evaluate these legislative and private responses to the risks presented by HIV-infected HCWs. If found to be rational, the CDC guidelines' risk assessments


89. One medical society has already sponsored an "expert review panel." Nation's First AIDS Expert Review Panel Established by Texas County Medical Group, 6 AIDS POL'Y & L. 1 (Dec. 12, 1992). See also, Connecticut Urges At-Risk Workers to Volunteer for HIV Screening, 7 AIDS POL'Y & L. 4 (Feb. 6, 1992)(discussing Dept. of Health Services recommendations); 16 Tex. Reg. 6636 (proposed regulation issued by Texas State Board of Dental Examiners establishing disciplinary procedures for HIV-infected dental HCWs).

90. One of the difficulties in analyzing the CDC guidelines' legal implications is that they keep changing. This troublesome propensity has already been explored in
will play an important role in limiting public and private discrimination. Courts may strike down actions exceeding the guidelines which inappropriately restrict HCWs or which intrude on their privacy. Importantly, state and private actors will determine the actual mechanics of many issues that the CDC left undetermined. States should also consider confidentiality and patient concerns not even addressed in the recommendations. The following sections will analyze the implications of the CDC’s current and likely future approaches.

III. REASONING ABOUT RISK: LIMITING THE PRACTICE OF HIV-INFECTED HEALTH CARE WORKERS

A. Estimates of Risk

First and foremost, government officials and private groups are concerned with reducing the risk of HIV transmission in the health care setting and with easing the public’s fears. Both groups have been grappling with at least the following three problems: 1) identifying the procedures where patients might be at risk; 2) identifying HCWs who, in performing those procedures, might pose a risk to patients; and (3) determining whether to reduce the risk of transmission in these procedures through practice prohibitions or through disclosure of HIV-status. The CDC historically has provided important standards for understanding the actual risks presented and for appropriately reducing such risks.

As the CDC and others have consistently declared, there is only a small risk of transmission from HCW to patient. The Acer case rep-
represents the first documented set of potential transmissions from HCW to patients in the ten year history of the epidemic. The extent of HIV infection among HCWs approximately equals that of the general population; there are nearly 7,000 HCWs with AIDS and an estimated 50,000 with HIV infection. Most studies estimate the risk of HCW-to-patient transmission through one of three approaches: (1) epidemiologic studies of the patients of HIV-infected practitioners; (2) estimates based on the risk of HBV transmission from HCW to patient, or (3) estimates estimation), 454 (risk evaluation).


95. A number of studies of the HIV status of patients of surgeons or other HIV-infected health care professionals, completed prior to the Acer case, failed to find a case of HIV transmission from HCW to patient. See, e.g., No Positive HIV Tests Found Among Former Dentist's Patients, 7 AIDS POL'Y & L. 6 (March 5, 1992); Danila, MacDonald, Rhame, Moen, Reier, LeTrouneau, Sheehan, Armstrong, Bender, Osterholm & the Investigation Team, A Look-Back Investigation of Patients of an HIV-Infected Physician: Public Health Implications, 325 NEW ENG. J. MED. 1406 (1991) (investigation of serostatus of patients of HIV-infected family physician who had performed invasive procedures, such as vaginal deliveries, while suffering from open sores on his hands; no confirmed HIV-positive patients discovered); OFFICE OF TECHNOLOGY ASSESSMENT, U.S. CONGRESS, HIV IN THE HEALTH CARE WORKPLACE 5-10 [hereinafter HIV IN THE HEALTH CARE WORKPLACE] (collecting and discussing data from a number of sources); Look-Back at Dentist's Patients Reveals No Transmission of HIV, 6 AIDS POL'Y & L. 8 (Oct. 16, 1991) (thus far, 400 patients tested negative; tests of 1300 continuing); Hilt, Experts Oppose AIDS Tests for Doctors, N.Y. Times, Sept. 20, 1991, at A11, col. 1 (study of 8000 patients of 60 infected HCWs revealed no cases of HIV infection); Mishu, Schaffner, Horan, Wood, Hutcheson & McNabb, A Surgeon With AIDS: Lack of Evidence of Transmission to Patients, 264 JAMA 467, 469-70 (1990) (study of slightly less than half the patients of surgeon with AIDS reveals no cases of HIV transmission); Armstrong, Miner & Wolfe, Investigation of a Health Care Worker with Symptomatic Human Immunodeficiency Virus Infection: An Epidemiologic Approach, 152 MILITARY MED. 414 (1987) (no HIV infection reported in 75 surgical patients of a physician with AIDS).

96. The CDC favored this approach in its July 1991 guidelines. CDC, Health Care Recommendations — IV, supra note 51, at 2-4. Studies have consistently demonstrated a less than one percent risk of transmission from an HBV-infected HCW to a patient. See LaBreque, Muhs, Lutwock, Woodson & Hierholzer, The Risk of Hepatitis B Transmission from Health Care Workers to Patients in a Hospital Setting—A Pro-
based on the risk of HIV transmission from patients to HCWs. Each of these methods leads to the conclusion that the risk of HIV transmission from an infected HCW to a patient is very small, ranging from 1/40,000 to 1/400,000. The cumulative risk of transmission for an HCW engaged in a particularly risky type of procedure is much higher.

As is often the case in statistical work of this kind, the probabilities are based on a series of premises that are subject to some dispute. Changes in one or more of the underlying assumptions easily could lead to changes of an order of magnitude, in either direction. See, e.g., HIV IN THE HEALTH CARE WORKPLACE supra note 95, at 9 (analyzing CDC's statistical conclusions).
For example, over the course of his or her professional career, an infected surgeon could perform thousands of operations.99

In its July 1991 guidelines, the CDC did not quantify the risk of HIV transmission. Instead, the CDC noted that the risk was smaller than the risk of HBV transmission.100 Given this small risk, the CDC's 1991 and proposed guidelines both suggest that voluntary testing and the restriction of some activities by HIV-infected HCWs are the medically appropriate risk reduction methods. The two guidelines merely disagree about the application of the restrictions.101

Although originally intended as merely advisory, the CDC's attempts to define medically rational policy possess great practical and legal significance. Congress now requires states to adopt either the CDC approach or its equivalent.102 Some states and private actors rely upon the guidelines as they act to reduce risk.103 Courts will look to the CDC guidelines as they attempt to assess the significance of the risk created by HIV-infected HCWs and the rationality of the response to this risk.

A legal analysis of the problems presented by HIV-infected HCWs requires: 1) an assessment of the rationality and persuasiveness of the CDC's suggested policies; and, assuming a positive determination, 2) an evaluation of the constitutional and statutory framework governing state or private attempts to reduce risk, in which the CDC guidelines will serve as an important measure of medical rationality.104 Public or pri-

99. See Gostin, supra note 98, at 141 (concluding that, depending on the assumptions chosen, the cumulative risk could be as low as 1/40).
100. The CDC notes difficulties with attempts to quantify the risk, and concludes:

   The limited number of participants and the differences in procedures associated with these five investigations limit the ability to generalize from them and to define precisely the risk of HIV transmission from HIV-infected HCWs to patients. A precise estimate of the risk of HIV transmission from infected HCWs to patients can be determined only after careful evaluation of a substantially larger number of patients whose exposure-prone procedures have been performed by HIV-infected HCWs.

101. See CDC, Health Care Recommendations — IV, supra note 51 at 5-6; and CDC, Proposed Health Care Recommendations, supra note 83.
102. See supra note 73 and accompanying text.
103. See supra notes 71-72 and accompanying text.
104. The guidelines cannot, and do not, answer all questions, legal or otherwise.
Private attempts to reduce the risk will be measured against several legal constraints: the Constitution and federal or state laws prohibiting discrimination against persons with disabilities. The CDC recommendations will play an important role in applying each of these legal standards to public or private attempts to restrict the activities of HIV-infected health care workers.

B. Constitutional Challenges to Practice Restrictions

Constitutional challenges to public attempts to regulate HIV-infected HCWs will require an exploration of the limits to a state’s ability to subject some citizens to restrictions designed to protect the health of others. The state’s power to protect the public health is undoubtedly broad, though not much better defined than when the Supreme Court decided Jacobson v. Massachusetts in 1905.\(^\text{105}\)

Although this court has refrained from any attempt to define the limits of that [police] power, yet it has distinctly recognized the authority of a state to enact quarantine laws and “health laws of every description”\ldots\ldots\ldots\ldots\ldots According to settled principles, the police power of a state must be held to embrace, at least, such reasonable regulations established directly by legislative enactment as will protect the public health and the public safety.\(^\text{106}\)

The gaps in the CDC recommendations provide the possibility of conflicting determinations and overly restrictive institutional regulations. The failure to identify “exposure-prone” procedures in the July 1991 guidelines, and the rejection of such definition in the proposed revision to those guidelines, provide examples of this problem. The CDC has not established explicit standards for professional organizations or institutions to distinguish between acceptable and unacceptable minute risks to patients. Furthermore, most professional groups have already decided not to participate in the risk assessment process. See Altman, supra, note 82, at A1. Even participating professional groups are unlikely to immediately evaluate the whole range of possible procedures. Thus, institutions and individual practitioners will be left without precise guidelines, when restricting the practice of HIV-infected health care workers. Under the threat of patient litigation, private health care entities, like hospitals and insurers, may be driven to restrict HCWs from performing even virtually riskless procedures. The CDC has noted that non-exposure-prone procedures “would be expected to pose substantially lower risk, if any.” CDC, Health Care Recommendations — IV, supra note 51, at 4. But some risk will remain, and institutions may want to eliminate any public perception that they are placing patients at risk.


\(^\text{106}\) Id. In Jacobson, the Court confronted and rejected the claim that a city’s mandatory vaccination order, backed by criminal penalties, violated a citizen’s constitutional right to liberty. For the last century, the Court’s statement of the scope of the police power has been repeated in both federal and state cases. K. Wing, The Law and the Public’s Health 22 (2d ed. 1985) (Jacobson is the “archetypal case
However, even with this broad conception of police power, the state is still limited by the requirement that its action be rational and not arbitrarily applied. The exercise of the police power is constrained by the constitutional requirements of equal protection and due process.

1. Constitutional Rationality

The Equal Protection Clause of the United States Constitution, along with similar provisions in state constitutions, requires that differential treatment of persons be rationally related to a permissible state purpose. Further, despite the traditionally deferential nature of rationality review under the Due Process Clause, courts scrutinizing the "rationality" of public health legislation tend to require some evidence of medical rationality. Courts that have considered the validity of HIV-related state regulations have relied heavily upon the presence or absence of a medical justification for the challenged state provisions.

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that illustrates the scope of the states' powers in matters affecting health"). See also Sullivan & Field, AIDS and the Coercive Power of the State, 23 HARV. C.R.-C.L. L. REV. 139, 143-56 (1988) (discussing constitutional bars to state's exercise of police power to quarantine HIV-infected persons).

107. Heightened scrutiny will not be applied because a fundamental right is not implicated; for example, there is no fundamental right to work. See, Keyes, Health Care Professionals with AIDS: The Risk of Transmission Balanced Against the Interests of Professionals and Institutions, 16 J. C. & U. L., 589, 599 (1990). Thus, differential treatment of HIV-positive and HIV-negative HCWs by some government actor need only be rationally related to some legitimate governmental objective. LAURENCE H. TRIBE, AMERICAN CONSTITUTIONAL LAW 1439-43, 1454 (2d ed. 1988). See also Note, Mandatory HIV Testing of Public Employees for Human Immunodeficiency Virus: The Fourth Amendment and Medical Reasonableness, 90 COLUM. L. REV. 720, 752-58 (1990).

108. U.S. CONST. amend. XIV.

109. Id.

110. Id.

111. State discrimination against HIV-infected HCWs need only meet the rational review standard, since the differential treatment does not rest upon any suspect or quasi-suspect classification scheme. L. TRIBE, supra note 107, at 1454.

112. U.S. CONST. amend. XIV.

113. Scott Burris makes this point quite forcefully in an important article. Burris, Rationality Review and the Politics of Public Health, 34 VILL. L. REV. 933 (1989); see also Keyes, supra note 107, at 597-98 (equal protection analysis turns on medical risk).

For example, school district attempts to segregate HIV-infected students have been rejected, in part because they constitute irrational discrimination, that is, differential treatment without medical justification.\textsuperscript{115}

The federal government has given the CDC guidelines legal effect by requiring that states adopt them as a condition of continued receipt of some federal funds. Some states have already independently adopted statutory or regulatory approaches based in part on the CDC guidelines. States considering regulatory measures are likely to adopt one of three approaches: (1) the CDC’s July 1991 guidelines’ exposure-prone procedures approach; (2) the individualized determination method, suggested in the most recent CDC proposed revisions; or (3) a complete ban on practice, an even more risk averse method. The validity of any federal or state action depends, at least in part, on the CDC guidelines’ medical rationality.\textsuperscript{116}

The CDC recommendations ordinarily would receive a presumption of medical rationality, because they represent the consensus judgment of public health officials and others charged with the duty of protecting the


\textsuperscript{116} One could also argue that the guidelines are invalid because they constitute improper rule-making by the CDC. The CDC, arguing that it did not have rule-making authority and contending that its guidelines were merely advisory, did not follow formal notice and comment procedures required by the Administrative Procedures Act. CDC Plans, supra note 81, at 11-12; and 5 U.S.C. § 553 (1988) (rulemaking under the APA). If the guidelines are viewed as administrative rules, then they would clearly be illegal. Of course, this argument would be rendered moot by subsequent congressional or state statutory adoption of the CDC standard. However, the APA argument may be applied to restrict the CDC’s ability to amend its guidelines. For example, AIDS activist groups have argued that the CDC now is required to follow notice and comment procedures in defining the list of exposure-prone procedures under the guidelines. CDC Plans, supra, at 11-12 (noting congressional intent that CDC update guidelines to reflect medical progress, and implicitly arguing that this gives the CDC rule-making authority and requires adherence to APA). A similar argument could present difficulties for the CDC as it now attempts to revise the July 1991 guidelines. Such revisions could require adherence to formal notice and comment procedures. This may explain the CDC’s June 1992 end run around formally revising its July 1992 guidelines. See supra note 86 (discussion of CDC policy as of June 1992).
public’s health.\textsuperscript{117} This presumption may be tattered with respect to the much criticized July 1991 guidelines, but may apply with greater force to the proposed revisions to the 1991 guidelines, which states may eventually implement in whole or in part. If adopted, the CDC’s proposed recommendations may carry greater authority than the more restrictive ethical guidelines previously disseminated by professional groups.\textsuperscript{118}

Arguably, the CDC’s July 1991 guidelines are irrationally restrictive. The CDC has admitted that the risk to patients is very, very small and has not supported its assertion that some procedures, the “exposure-prone” ones, pose greater risks than others.\textsuperscript{119} The history of the CDC’s prior guidelines and the nearly uniform medical rejection of the exposure-prone approach arguably demonstrates that such restrictions are not justified from a public health standpoint.\textsuperscript{120} Instead, the current guidelines could be viewed as essentially a political proclamation, designed to soothe the public’s irrational fears.\textsuperscript{121} This is bolstered by the widespread criticism of the CDC’s approach offered by some medical organizations and state public health officials, and by the CDC’s own well-publicized inability to define exposure-prone procedures.\textsuperscript{122}

\textsuperscript{117} For example, in School Bd. of Nassau County v. Arline, 480 U.S. 273, 288 (1987), the Supreme Court exhibited this very presumption, holding that “courts normally should defer to the reasonable medical judgments of public health officials” when making determinations about whether individuals pose a significant health risk to others under the Rehab Act.

\textsuperscript{118} See supra notes 37-39, 46-47 and accompanying text. The ethical guidelines, for example, can be viewed as aspirational and as efforts to secure patient trust. In contrast, the CDC approach constitutes a more rigorous and detailed examination of the degree of risk presented by HIV transmission in specific kinds of procedures. Undoubtedly, however, the stance taken by the AMA, the American Dental Association, and other groups cannot be viewed as simply irrational. Instead, by advocating a “zero risk” policy, these groups have seemingly applied an inconsistent and unattainable standard for HIV, one that they do not apply to a host of other risks presented in the HCW-patient relationship.

\textsuperscript{119} See supra note 26 and accompanying text.

\textsuperscript{120} Several times in the past 10 years, the CDC considered the risks posed by HIV-infected HCWs and rejected blanket restrictions on practice. The current guidelines are not the result of any new medical discoveries about the risk of transmission. See supra note 66 and accompanying text.

\textsuperscript{121} See City of Cleburne v. Cleburne Living Center, 473 U.S. 432 (1985) (striking down a zoning ordinance under an equal protection challenge after finding the provision irrational under a heightened rational basis review); Note, supra note 107, at 745 n.142 (discussing possible impact of political control over CDC’s guidelines).

\textsuperscript{122} As noted supra at notes 77-79, criticism of the CDC approach flourished
Courts are likely to consider the CDC’s July 1991 exposure-prone approach irrational. For example, state statutes that follow these guidelines and restrict the ability of HIV-infected HCWs to perform exposure-prone procedures would probably be held invalid, even under the lenient rational basis standard of review for public health regulations.123

However, a different result is possible with respect to the CDC’s proposed revised recommendations. These new guidelines would eliminate the much criticized emphasis on producing a list of exposure-prone procedures, and instead focus on the abilities and condition of individual practitioners. This individualized approach has not yet encountered the medical revolt that greeted the July 1991 guidelines. The revised approach would presumably benefit from the assumption that it represents a new consensus, tested by the firestorm of controversy surrounding its throughout the fall and winter of 1991. Medical groups refused to participate in the process of defining these procedures, contending that the actual risk of transmission is too insignificant to warrant regulation and/or that, without individualized determinations, there is no rational way to distinguish between exposure-prone and non-exposure-prone procedures. California Medical Groups Reject CDC Request for Lists, supra note 78 (“coalition of California medical groups said there is no scientific evidence that any medical or surgical procedure threatens patients of HIV-infected health care workers if proper infection control procedures are in place”); Surgeons’ Group Opposes CDC Plan for Listing Invasive Procedures, supra note 78; Surgeons Rebuff U.S. AIDS Request, supra, note 78 (American College of Surgeons noted no documented case of surgeon to patient transmission and concluded “there is no scientific basis for suggesting that a particular surgical procedure carried a high risk.”); Altman, supra note 78 (“‘The [American Dental Association] says there is no scientific data to allow us to begin to list procedures, and to agree to participate in something of this nature is not scientifically valid and not helpful to the profession or public.’”); see also Koop, supra note 78, at 2; Bull, supra note 78, at 28. The CDC has apparently retreated from this approach by encouraging states to use individualized determinations of risk, unfortunately leaving in its wake at least one state with “exposure-prone” as the standard codified into state law. TEX. HEALTH & SAFETY CODE ANN. § 85.201 (Vernon 1992); and supra note 86.

Some states have explicitly refused to adopt the CDC guidelines. For example, the New York State Health Department has proposed to permit HIV-infected physicians to continue performing procedures unless there is a “significant risk.” New York State Policy Would Protect HCWs From Forced Disclosure of HIV Status, 6 AIDS POL’Y & L. 1 (Oct. 16, 1991) [hereinafter New York State Policy]; Sack, Albany Supports Medical Practice Despite AIDS Virus, N.Y. Times, Oct. 9, 1991, at A16, col. 1; When Your Doctor Has AIDS, TIME, Oct. 21, 1991, at 83 (discussing N.Y. policy).

123. Thus, state efforts to restrict the practice of particular procedures, such as “certain oral, cardiothoracic, colorectal . . . and obstetric/gynecological procedures,” would be without a current medical basis. CDC, Health Care Recommendations — IV, supra note 51, at 4.
predecessor.

Courts will probably find the new revisions rational because they will continue to view public health officials as objective sources of risk data.\textsuperscript{124} Public health officials have long recognized that a risk of HIV transmission exists in the health care context, and even the CDC's critics tend to agree that some HIV transmission risk exists in the health care setting.\textsuperscript{125} Once the risk has been determined, courts deciding

\begin{footnotesize}
\textsuperscript{124} Cf. Arline, 480 U.S. at 288 (under the Rehab Act, in making determinations about whether individuals pose a significant health risk to others, "courts normally should defer to the reasonable medical judgments of public health officials"); see also Closen, A Call for Mandatory HIV Testing and Restrictions of Certain Health Care Professionals, 9 ST. LOUIS U. PUB. L. REV. 421, 431 (1990); Keyes, supra note 107, at 595; Note, supra note 107, at 751 n.171 (dismissing the problem of conflicting public health advice in constitutional cases).

\textsuperscript{125} Individualized restrictions on the practice of HIV-infected HCWs could be bolstered by the practice recommendations issued by other professional groups, such as the AMA. See supra notes 38-39 and accompanying text.

The risk of HIV transmission may be compared to a host of other risks, some subject to stricter state regulation than others. Many health care professionals and activists regularly note that the risk of acquiring HIV in the course of receiving medical care is less than the risk of having a car accident on the way to treatment. See, e.g., Daniels, HIV-Infected Professionals, Patient Rights, and the "Switching Dilemma," 267 JAMA 1368, 1369 (1992) (discussing, but ultimately rejecting, the relevance of numerous interesting risk comparisons); Lowenfels & Wormser, supra note 98 at 889. On the other hand, chemicals having a 1/1,000,000 lifetime cancer risk are banned from the marketplace.

To some extent, these anomalous results can be superficially explained by the specific statutory language governing risk reduction, which might require the "elimination of risk" or might instead merely provide for the elimination of "significant risks." Compare Food Additives Amendment, Federal Food, Drug and Cosmetic Act, § 409(c)(3)(A), 21 U.S.C. § 348(c)(3)(A) (no food additive will be considered safe if it is found to induce cancer) with Industrial Union Dept. v. American Petrol. Inst., 448 U.S. 607, 652-53 (1980) (plurality opinion) (under OSHA statute, a safe workplace need not be a "risk-free" workplace). However, this only brings the level of inquiry back one step, for we can legitimately wonder about the basis for differential legislative treatment of risk. Commentators often contend that the degree of risk found legally acceptable is the result of a complex interaction of factors, including: public salience of the risk; the identity and number of those who will be restricted by risk reduction efforts; and the general perception of the activity involved as "necessary" or "normal." See, e.g., Zeckhauser & Viscusi, Risk Within Reason, 248 SCIENCE 559 (1990) (discussing difficult intersection between risk assessment and risk reduction); JOHN J. COHRSSEN & VINCENT T. COVELLO, RISK ANALYSIS: A GUIDE TO PRINCIPLES AND METHODS FOR ANALYZING HEALTH AND ENVIRONMENTAL RISKS (1989); Weinstein, Optimistic Biases About Personal Risks, 246 SCIENCE 1232 (1989); MARY DOUGLAS & AARON WILDAVSKY, RISK AND CULTURE: AN ESSAY ON THE SELECTION OF TECHNICAL AND ENVIRONMENTAL DANGERS (1983). A full discussion
\end{footnotesize}
constitutional challenges to state or federal regulations will defer to rational medical or governmental policies. 126

In fact, rather than falling to a constitutional challenge, the revised CDC guidelines could more likely provide an effective basis for evaluating legal challenges to excessive state regulation. 127 Some states may choose to exceed the CDC’s current or proposed recommendations, perhaps by imposing blanket practice restrictions on HIV-infected HCWs. Courts will likely emphasize the CDC’s pronouncements as they investigate the rationality of the challenged state regulation. The recommendations represent the federal government’s assessment of the public health risks posed by HIV-infected HCWs and advise medically justifiable restrictions designed to reduce these risks. 128 Absent some other showing of medical rationality, statutes exceeding the CDC’s current or proposed guidelines are constitutionally vulnerable, even under rational basis review. Thus, state legislation completely prohibiting the medical practices of HIV-infected physicians would be medically unjustifiable and might be found irrational. 129

of these interesting questions exceeds the scope of this article.

126. The CDC’s critics tend to argue, often quite persuasively, that the risk does not justify the imposition of restrictive policies. But this does not negate the finding of risk itself. See, e.g., Feldblum, supra note 44, at 135-36 (noting that existence of unquantifiable risk may not justify precautionary public health restrictions).

From the rationality perspective, the difficult problem concerns whether individualized determinations of risk can be any more rational that the “exposure-prone” approach. If the CDC and assorted medical organizations were unable to define a list of exposure-prone procedures, how are expert panels to rationally determine whether an infected HCW will pose an unacceptable risk to patients? Rationality might be divined from the contextualized individual approach: the objective presence of risk created by the invasive nature of the procedure considered in the light of the practitioner’s skills, experience, and condition. It might also be a mirage.

127. In this sense, the proposed CDC guidelines could represent the outer limit of rational responses to the risks posed by HIV-infected health care workers. More restrictive policies might be deemed irrational. The CDC approach might also be used to restrict private risk reduction policies, under the “significant risk” standard imposed by federal and state statutes prohibiting discrimination against people with disabilities. See infra notes 159-164 and accompanying text.

128. For example, as a method of risk reduction, the proposed CDC approach provides the opportunity for medically appropriate determinations that will maximize patient safety and permit the evolution of standards as knowledge is gained about risk. Yet the CDC’s proposed revisions cannot stand alone, without additional state regulation, lest determinations about HIV-infected HCWs be made on an ad hoc basis, potentially resulting in even greater restrictions because of the fear of litigation.

129. One could argue, however, that more stringent practice limitations are supportable under “zero risk” guidelines, such as those previously promulgated by the AMA. See supra notes 37-39 and accompanying text. Also, under a traditional ratio-
The closer question concerns possible state attempts to prohibit the performance of all invasive procedures. States attempting such policies would exceed the CDC recommendations and would conflict with the pronouncements of most medical and professional groups.\(^{130}\) Even the CDC's July 1991 recommendations suggest that courts could find these statutes irrational:

> Currently available data provide no basis for recommendations to restrict the practice of HCWs infected with HIV . . . who perform invasive procedures not identified as exposure-prone, provided the infected HCWs practice recommended surgical or dental technique and comply with universal precautions and current recommendations for sterilization/disinfection.\(^{131}\)

The CDC suggests that, from a public health standpoint, there is no basis for wider practice restrictions on HIV-infected health care workers. Performance of invasive (but not exposure-prone) procedures might nonetheless create a theoretical risk of transmission, providing the thin reed upon which courts could hold state regulation rational. Invasive procedures pose difficult legal questions because the presence of risk, no matter how minute, may justify legislative action. Rationality review has long suggested that legislatures must be given the freedom to selectively regulate risk. Under the “one step at a time” approach sanctioned in *Williamson v. Lee Optical of Oklahoma*,\(^{132}\) the Supreme Court has refused to second guess legislatures that identify and attempt to reduce problems or risks.\(^{133}\) In general, states may use the presence of real risk to legitimize any state policy that might rationally be thought to reduce that risk.\(^{134}\)

\(^{130}\) See *supra* notes 37-39, 46-47 and accompanying text.  
\(^{131}\) CDC, *Health Care Recommendations — IV*, *supra* note 51, at 5.  
\(^{133}\) On the other hand, one court has noted that, in the context of communicable disease, “the adoption of a step-by-step approach, if not necessarily impermissible, at least suggests that the Board did not regard its own evidence of risk as particularly convincing.” New York State Ass’n for Retarded Children v. Carey, 612 F.2d 644, 650 (2d Cir. 1979) (discussing Board of Education policy regarding mentally retarded children with HBV infection).  
\(^{134}\) There has been only one recent analogous judicial decision. In *Doe v. Washington University*, an HIV-infected dental student contested his dismissal from
Only one recent case, *City of Cleburne v. Cleburne Living Center*, suggests that the Supreme Court might carefully examine proffered risk explanations. In *Cleburne*, the Court confronted the application of a zoning provision that effectively barred the placement of group homes for mentally disabled persons. The Court rejected the contention that the zoning regulation should be measured under heightened or strict scrutiny because the provision did not create suspect or quasi-suspect classifications. Nonetheless, the Court struck down the application of the state provision under what has been described as a "heightened rational basis" standard.

The city denied the Cleburne Living Center a special use permit for a number of reasons, including the "negative attitudes" and fears of neighbors, the city's fear that local schoolchildren would harass the residents, and its concern about crowding and congestion. The Court carefully examined the city's asserted interests and determined that "the record does not reveal any rational basis for believing that the home would pose any special threat to the city's legitimate interests." The Court noted that some of the city's asserted interests were simply not legitimate; "mere negative attitudes, or fear, unsubstantiated by factors which are properly cognizable in a zoning proceeding, are not permissible bases for treating a home for the mentally retarded differently from apartment houses, multiple dwellings, and the like." Other interests, while legitimate, were irrationally pursued. For example, there was no evidence in the record explaining why the group home would pose any greater threat of crowding and congestion than apartment under federal and state provisions prohibiting discrimination against persons with disabilities. Although the court did not decide the case on constitutional grounds, it did apply a rationality analysis to the dispute because it believed that academic cases required such a standard. 780 F. Supp. 628, 631 (E.D. Mo. 1991). After reviewing the medical evidence, much of which came from CDC reports, the court found that the dental student's dismissal was rational because of the existence of a real, if statistically small, risk of serious harm. *Id.* at 634. This kind of reasoning could support most practice restrictions applied to infected HCWs who perform invasive procedures.

136. *Id.* at 446, 447-48. The zoning regulation requiring a special use permit for the construction of "[h]ospitals for the insane or feeble-minded," had been deemed applicable by the city. *Id.* at 436.
137. *Id.* at 442-447.
139. 473 U.S. at 448-50.
140. *Id.* at 448.
141. *Id.*
ment houses or hospitals, which were not required to secure a per-
mit.\textsuperscript{142}

Under \textit{Cleburne}'s heightened rational basis scrutiny, practice prohib-
bitions covering all or most invasive procedures might be invalid.\textsuperscript{143} Such regulations could be based more on fear and prejudice than on rational consideration of risk. Yet, most courts have stubbornly resisted litigators' attempts to make \textit{Cleburne} the wedge of a new approach to judicial review of legislation affecting stigmatized, but not "suspect," groups.\textsuperscript{144} A court is unlikely to apply a \textit{Cleburne} analysis in the ab-
sence of Supreme Court guidance indicating when and how such height-
ened rational scrutiny is appropriate.

Under established constitutional principles, the CDC's July 1991 guidelines are extremely vulnerable to a rationality attack. On the other hand, the CDC's proposed revised guidelines may prove very important to courts concerned with the rationality of state attempts to regulate HIV-infected health care workers. If ever officially enacted, courts may use the proposed guidelines to affirm the rationality of measured state responses to the risks posed by infected HCWs performing exposure-prone procedures. The proposed guidelines might also provide some basis for challenging state actions exceeding those deemed medically appropriate. Yet, the CDC guidelines offer weak protection to HCWs, since courts will rarely declare a legislature's actions irrational, especially when faced with conflicting medical opinions.

2. Procedural Protection under the Constitution

Thus far, the discussion has focused on the substantive legitimacy of state efforts to regulate HIV-infected health care workers. Procedural protections may prove even more important, particularly if the CDC adopts its proposed revised guidelines. Under both the CDC's current and proposed guidelines, entities called "expert review panels" will make

\begin{itemize}
  \item \textsuperscript{142} \textit{Id.} at 449-50.
  \item \textsuperscript{143} \textit{See Keyes, supra} note 107, at 599.
  \item \textsuperscript{144} One such case involved a nurse who was fired after refusing to divulge his HIV-antibody test result to his hospital employer. Leckelt \textit{v. Board of Comm'r of Hosp. Dist. No. 1}, 909 F.2d 820, 831-32 (5th Cir. 1990). The court expressed doubt about the level of scrutiny to be applied to classifications based on handicap, but nonetheless decided that no equal protection claim had been established. \textit{Id.} (hospital had a reasonable and compelling interest in enforcing its infection control policies). \textit{But see Pruitt v. Cheney, 1992 U.S. App. LEXIS 9812} (9th Cir. 1992) (Army's policy of discharging homosexuals might violate the Equal Protection Clause under rationality review, relying in part on City of \textit{Cleburne} \textit{v. Cleburne Living Center}, 473 U.S. 432 (1985)).
\end{itemize}
individualized determinations of the risks created by an infected HCW and will impose appropriate practice restrictions on that worker. The problem with this system is that it does not clearly identify the appropriate decision-makers, or define the decision standards or the burdens of proof. If conducted by private decision-makers, there might be few legal grounds for attacking the expert review panel process.

State involvement in the expert system, such as through incorporation into a professional licensure system, could implicate the procedural due process protections of the United States or state constitutions. State professional licensure and disciplinary systems must satisfy procedural due process. To satisfy this constitutional requirement, systems must provide appropriate notice and an opportunity to be heard. The nature of the process due can vary depending on the nature of the individual’s interest, the government’s interest, and the risk of erroneous deprivation of the individual’s interest in the absence of additional procedural safeguards.

A state’s adoption of an expert review panel system may put an infected HCW’s license at risk. A state must devise a system that answers some of the many questions left unaddressed in the CDC’s current and proposed revised guidelines. Failure to do so could result in

145. See supra notes 64 and 83.
146. Accord Lo & Steinbrook, supra note 80, at 1103.
148. See, e.g., L. TRIBE, supra note 107, at 685-94, 705-06; and F. GRAD, PUBLIC HEALTH LAW MANUAL 99-103 (2d ed. 1990). This constitutional requirement is often also supplemented by the requirements under a state’s own statutory or regulatory scheme, which may provide additional grounds for relief that will not be discussed herein. See, e.g., In re Guess, 327 N.C. 46, 393 S.E.2d 833 (N.C. 1990) (homeopathic physician challenged license revocation).
150. Id. at 334-35; see also L. TRIBE, supra note 107 at 714-18.
151. This possibility creates both a burden and an opportunity. Imposing additional procedural safeguards to prevent arbitrary or capricious licensure restrictions, such as those based on irrational risk estimates, may be a burden, but it is also an opportunity. If expert review panels are to be employed within a particular state, they will likely be more stringently regulated if they are conducted under state auspices.

States that incorporate the expert review panel approach might fold it within their current system of license regulation. Almost all states require that licensed professionals be mentally and physically competent to provide care; many state statutes already provide for the examination and discipline of HCWs suspected of having mental or physical conditions posing patient risks. See, e.g., CAL. BUS. & PROF. CODE § 820 (West 1990) (provision for requiring a physical examination of physician). A few states already specifically establish that it is unprofessional conduct to
procedural due process challenges to any subsequent license limitation or revocation.

C. Federal and State Statutes Prohibiting Disability Discrimination

1. Federal Law

The CDC's recommendations are likely to be even more important to claims of civil rights violations. Federal and state laws protecting people with disabilities from discrimination typically cover both public and private entities. Thus, infected HCWs would have a basis for challenging both state statutes and the actions of public or private hospitals or other health care entities.

The CDC's recommendations will play a critical role in determining whether federal laws protecting persons with disabilities are also applicable to HIV-infected health care workers. Two statutes are of particular importance: the Rehabilitation Act of 1973\(^{152}\) (the "Rehab Act") and the Americans with Disabilities Act\(^{153}\) (the "ADA").

The Rehab Act prohibits federal employers, federal grantees, and federal government contractors from employment discrimination against individuals with handicaps.\(^{154}\) The Rehab Act protects any 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

engage in professional activities "while suffering from a contagious or infectious disease involving serious risk to public health." WASH. REV. CODE ANN. § 18.130.180 (1991). The individualized determination approach, suggested by the CDC, might fit within the framework of these state regulations; in some states, the regulatory agency might be deemed to already have the authority to pursue such a plan without further statutory authorization.


impairment, or (iii) is regarded as having such impairment.155 In School Board of Nassau County v. Arline,156 the Supreme Court held that the Rehab Act applies to persons whose impairment arises from a contagious disease. Congress explicitly adopted this approach in the Civil Rights Restoration Act of 1988 (the "Restoration Act"),157 amending the Rehab Act to provide that an individual with handicaps does not include a person 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.158

That is, the Rehab Act protects persons with contagious diseases unless they pose a significant health or safety risk that cannot be eliminated through reasonable accommodation.159

Defining reasonable accommodation under the Rehab Act is somewhat difficult.160 Generally, employers must make some job and sched-

158. Id.
160. The Department of Health and Human Services (HHS) regulations implementing § 504, provide that federal fund recipients should "make reasonable accommodations" for individuals with handicaps, "unless the recipient can demonstrate that the accommodation would impose an undue hardship on the operation of the program." 45 C.F.R. § 84.12 (1990); see also Alexander v. Choate, 469 U.S. 287 (1985) (discussing relationship between reasonable accommodation and requirement that the individual be able to perform essential duties of job).

The Second Circuit Court of Appeals has recently held that a plaintiff has the burden of making a prima facie showing that either no reasonable accommodation was required, or that some reasonable accommodation was possible. Gilbert v. Frank, 949 F.2d 637, 642 (2d Cir. 1991). Contra Mantoodle v. Bolger, 767 F.2d 1416, 1423-24 (9th Cir. 1985) (employer has burden of showing no reasonable accommodation possible, but plaintiff may rebut this proof); Prewitt v. United States Postal Service, 662 F.2d 292, 308 (5th Cir. 1981) (employer must show reasonable accommodation is not possible).

Under the recently enacted Civil Rights Act of 1991, additional compensa-
uling adjustments, unless to do so would impose an undue burden on the employer. Employers need not create or find new jobs for an affected employee.

Courts applying this provision have held that HIV-infected persons should be considered handicapped under the Rehab Act so long as, given reasonable accommodations, they do not pose a direct health or safety threat to others and so long as they can still perform their jobs. The critical aspect of this analysis lies in determining when an

tory and punitive damages will not be available where a defendant has made "good faith efforts" to provide reasonable accommodations. Pub. L. No. 102-166, § 1977A, 105 Stat. 1072-1073.

161. 45 C.F.R. § 84.12 (1990). Undue hardship is determined by examining several factors, including number of employees and the type of accommodation needed. Id.

162. Id.

163. Almost every court considering the issue has held that HIV infection is a handicap. Many, but not all, of these cases represent determinations at the preliminary injunction stage of litigation, where a court is considering the plaintiff's probability of success on the merits.

Six cases involved patients or workers in health care settings. Doe v. Attorney General, 941 F.2d 780, 797 (9th Cir. 1991) (physician with AIDS clearly handicapped); Severino v. North Fort Myers Fire Control, 935 F.2d 1179, 1182 n.4 (11th Cir. 1991) (HIV-infected firefighter who had to perform "rescue" duties was handicapped); Leckelt v. Bd. of Comm'rs of Hosp. Dist. No. 1, 909 F.2d 820, 820 (5th Cir. 1990)(seropositivity as a handicap is assumed for purposes of appeal); Doe v. Washington Univ., 780 F. Supp. 628, 631-32 (E.D. Mo. 1991) (HIV-infected dental student is handicapped despite contagious character of disease, no analysis of impairment or perception); Glanz v. Vernick, 756 F. Supp. 632 (D. Mass. 1991) (with regard to a patient, the status of being HIV positive as a handicap not disputed); Doe v. Centinela Hosp., 57 U.S.L.W. 2034 (C.D. Cal. 1988) (No. CV87-2514 PAR (PX)) (patient with HIV infection is handicapped).


In one recent case, the Eleventh Circuit revisited the issue of whether HIV infection alone could be considered a handicap, when the only physical impairment was the state of contagiousness. Harris v. Thigpen, 941 F.2d 1495 (11th Cir. 1991) (discussing the application of the Rehab Act to prison's segregation of HIV-infected prisoners). The court questioned whether HIV infection would qualify as a physical impairment based on contagiousness alone. Id. at 1523 n.42. Ultimately, the court held that the HIV infected prisoners were handicapped under the "regarded as" provi-
individual poses a “direct threat” that cannot be “eliminated” through reasonable accommodations.

In Arline, the Supreme Court suggested that courts could measure the risk to others by an individualized determination 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.164

The Court also noted that “courts normally should defer to the reasonable medical judgments of public health officials.” 165 The Restoration Act amendments to the Rehab Act apparently codified the Court’s approach in Arline. 166 As the statement of public health officials, the CDC guidelines will be particularly important as courts struggle to determine whether infected HCWs pose a direct threat to their patients.

A similar standard will apply to most private employers under the soon-to-be-effective federal ADA. 167 Employers will be prohibited from


165. Id.


The chief difference between the ADA and the Rehab Act lies in the
discriminating against qualified individuals with disabilities based upon their disabilities. \textsuperscript{168} The ADA's language mirrors that found in the Rehab Act: persons with disabilities are those who have an impairment which substantially limits a major life activity, who have a record of such an impairment, or who are regarded as having such an impairment. \textsuperscript{169} Employers may not discriminate against a qualified individual with a disability, one who "with or without reasonable accommodation, can perform the essential functions of the employment position." \textsuperscript{170}

ADA's greater coverage of employers and employees. The Rehab Act staggers implementation so that employers with 25 or more employees will be covered first, starting in July 1992, while employers with between 15 and 25 employees will not be covered until after July 1994. 42 U.S.C. § 12111(5)(A) (Supp. 1988). The United States and certain other private groups are excluded from coverage. \textit{id.} at § 12111(5)(B); \textit{see also} 42 U.S.C. § 12209 (Supp. 1988) (discussing coverage of Congress and agencies of the legislative branch). The executive agencies of the United States will continue to be governed under the provisions of the Rehab Act. \textit{See supra} note 154 and accompanying text. Senate and certain other government employees (such as presidential appointees and certain previously exempt state employees) are protected from disability-based discrimination under the Civil Rights Act of 1991. Pub. L. No. 102-166, §§ 302, 320, 105 Stat. 1088, 1096-97.

Notably, the ADA contains extensive provisions prohibiting discrimination against persons with disabilities, in places of public accommodation. 42 U.S.C. § 12181 (Supp. 1988). Places of public accommodation include an "insurance office, professional office of a health care provider, hospital, or other service establishment." \textit{Id.} This provision could be used to challenge discriminatory actions, taken against non-employee physicians, under the theory that such actions constitute discrimination "on the basis of disability in the full and equal enjoyment of the goods, services, facilities, privileges, advantages, or accommodations" of a hospital or other health care entity. \textit{Id.} at § 12182(a). \textit{Cf. Estate of Behringer v. Medical Center at Princeton}, 592 A.2d 1251 (N.J. Super. Ct. Law Div. 1991) (state statute prohibiting discrimination in places of public accommodation covers physician privileges at hospital).

\textsuperscript{168} 42 U.S.C. § 12112(a) (Supp. 1988). Discrimination is broadly defined and is prohibited at any point in employment, from the application process to the determination of compensation or the terms, conditions, and privileges of employment. \textit{Id.} at § 12112(a) \& (b).


\textsuperscript{170} 42 U.S.C. § 12111(8) (1988). Congress specifically excluded current abusers of illegal drugs from the definition of qualified individuals with disabilities, thus permitting employers to take discriminatory actions based on drug abuse. \textit{Id.} at § 12114(a).
Reasonable accommodation includes some forms of job restructuring, at least where the accommodation would not impose an undue hardship on the employer.171

Under the ADA, employers generally may determine a position's "essential" functions172 and may require that an individual "not pose a direct threat to the health or safety of other individuals in the workplace."173 The ADA defines "direct threat" as "a significant risk to the health or safety of others that cannot be eliminated by reasonable accommodation,"174 a duplication of the Rehab Act standard adopted in Arline.175

171. 42 U.S.C. § 12111(9) (Supp. 1988). Congress attempted to ease some of the interpretive problems associated with determining reasonable accommodations by including a provision requiring consideration of various factors in evaluating "undue hardship." Id. at § 12111(10). These factors resemble those implied under the Rehab Act regulations. See 45 C.F.R. § 84.12 (1990). However, the civil rights factors focus more precisely on the employer's economic burdens. Yet, it can be anticipated that the scope of the undue hardship limit to the reasonable accommodation requirement will remain murky. See 56 Fed. Reg. 35,735-36 (July 26, 1991) (EEOC regulations governing reasonable accommodation and undue hardship). See generally Crespi, Efficiency Rejected: Evaluating "Undue Hardship" Claims Under the Americans With Disabilities Act, 26 TULSA L.J. 1 (1990); Note, Undue Hardship: Title I of the Americans with Disabilities Act 59 FORDHAM L. REV. 113 (1990).


173. Employers may utilize qualification standards that have a discriminatory impact on individuals with disabilities if the standards are "job-related and consistent with business necessity." 42 U.S.C. § 12113(a) (Supp. 1988). The statute specifically provides that "[t]he term 'qualification standards' may include a requirement that an individual shall not pose a direct threat to the health or safety of other individuals in the workplace." Id. at § 12113(b). The EEOC's implementing regulations also allow employers to discriminate when a job threatens the health or safety of the individual with disabilities. "Direct Threat means a significant risk of substantial harm to the health or safety of the individual or others." 56 Fed. Reg. 35,736 (July 26, 1991) (to be codified at 29 C.F.R. § 1630.2(r)) (emphasis added, in part).


175. See supra note 148 and accompanying text. The ADA regulations clearly adopt the Arline standard, by incorporating consideration of virtually the same factors. According to the ADA,

[i]t]he determination that an individual poses a "direct threat" shall be based on an individualized assessment of the individual's present ability to safely perform the essential functions of the job. This assessment shall be based on a reasonable medical judgment that relies on the most current medical knowledge and/or on the best available objective evidence. In determining whether an individual would pose a direct threat, the factors to be considered include:

(1) The duration of the risk;
The Rehab Act and the ADA employ similar standards for determining whether a person will be protected from discrimination. First, there must be a claim that a covered entity committed a discriminatory act. Entities currently covered under the Rehab Act include federal government employers, federal contractors, and federal funds recipients (including Medicare reimbursement recipients). This includes most health care institutions; any remaining entities with fifteen or more employees will eventually be covered under the ADA.

The discrimination requirement creates a more difficult problem. In the health care context, this usually simple determination is complicated by the variety of employment and non-employment relationships possible between health care institutions and health care professionals. The federal acts certainly provide coverage when a health care institution discriminates against an employee who is a nurse, doctor, aide, dietician, pharmacist, or other worker. But physicians with hospital staff privileges are not traditional employees. Nevertheless, they should be protected under two different approaches.

First, when a health care entity receives federal funds, the Rehab Act defines discrimination quite broadly: exclusion from participation in, denial of benefits, or subject to discrimination under the covered program or activity. Denying or reducing staff privileges of non-employee physicians would appear to violate this standard. Second, if necessary, courts interpreting the Rehab Act and the ADA could apply an expansive definition of employment developed in a line of cases interpreting Title VII under the Civil Rights Act of 1964.

(2) The nature and severity of the potential harm;
(3) The likelihood that the potential harm will occur; and
(4) The imminence of the potential harm.


176. See supra note 154 and accompanying text (employer coverage); United States v. Baylor Univ. Medical Center, 736 F.2d 1039 (5th Cir. 1984), cert. denied, 469 U.S. 1189 (1985) (Medicare and Medicaid funds are federal financial assistance requiring adherence to § 504 of the Rehab Act); and Glanz v. Vernick, 756 F. Supp. 632 (D. Mass. 1991) (hospital ear, nose and throat clinic is covered as a recipient of Medicare and Medicaid payments).


178. In Title VII cases, courts struggled to apply its anti-discrimination provisions to physicians challenging the denial or loss of admitting privileges. See, e.g., Zaklama v. Mt. Sinai Medical Center, 842 F.2d 291 (11th Cir. 1988); accord Rothenberg, The AIDS Project: Creating a Public Health Policy—Rights and Obligations of Health Care Workers, 48 MD. L. REV. 93, 124-26 (arguing that Title VII
The next stage of analysis shifts the focus from the employer and the employer's discriminatory action to the individual. First, the individual must be deemed to have a disability under the statutes; several courts have held that HIV infection or AIDS are disabilities.179 Second, the individual must be otherwise qualified for the position: she must be capable of performing the essential job requirements and must not pose a threat to others.180

Courts considering discrimination against HIV-infected HCWs must determine whether and under what circumstances HIV-infected HCWs pose a "significant risk" or "direct threat" to others. The "significant" risk standard provides greater opportunity for judicial oversight of the risk reduction efforts of public and private entities than under constitutional review alone.181 Under the Rehab Act, courts defining the sig-

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179. See supra note 163.

180. The defendant must also have discriminated against the plaintiff "solely" on the basis of her handicap. 29 U.S.C. § 794(a) (1988). Courts have not interpreted this provision restrictively; plaintiffs' actions have generally succeeded where the discriminatory "motive was the most significant factor in or was a 'but for' cause of discriminatory conduct." Severino v. North Fort Myers Fire Control Dist., 935 F.2d 1179, 1183-84 (11th Cir. 1991) (Kravitch, J., dissenting); But see, id. at 1182 (majority opinion implicitly adopts a more restrictive view without discussion).

181. See supra notes 164-65 and accompanying text. Prior to Arline, some courts held that individuals would be considered "otherwise qualified" unless their handicaps posed a "reasonable probability of substantial harm." Mantolete v. Bolger, 767 F.2d 1416, 1422 (9th Cir. 1985); Dlexler v. Tisch, 660 F. Supp. 1418 (D. Conn. 1987) (discussion of nature of safety concerns in dicta); See also Stahlhe v. Department of Transp., 716 F.2d 227 (3d Cir. 1983) (court determined whether a hearing-impaired bus driver posed an "appreciable risk" to public safety). Employers would be required to determine whether the employee was a potential risk, on a "case-by-case analysis of the applicant and the particular job," using "all relevant information re-
nificance of the risk should defer to the judgment of public health officials and under the ADA, should base their determinations “on the most current medical knowledge and/or on the best available objective evidence.”

The CDC’s pronouncements might become pivotal. A court might use the CDC’s current or proposed guidelines to determine whether an infected HCW poses a “significant risk” of HIV transmission to patients. As under constitutional analysis, this risk might be eval-

garding the applicant’s work history and medical history “[to] independently assess both the probability and severity of potential injury.” Mantolete, 767 F.2d at 1422-23.

The Second Circuit apparently adopted a less stringent risk requirement, at least in the academic context. In Doe v. New York University, the court upheld a medical school’s rejection of a student with borderline personality disorder, finding:

In our view she would not be qualified for readmission if there is a significant risk of such recurrence. It would be unreasonable to infer that Congress intended to force institutions to accept or readmit persons who pose a significant risk of harm to themselves or others, even if the chances of harm were less than 50%. Indeed, even if she presents any appreciable risk of such harm, this factor could properly be taken into account in deciding whether, among qualified applicants, it rendered her less qualified than others for the limited number of places available. In view of the seriousness of the harm inflicted in prior episodes, NYU is not required to give preference to her over other qualified applicants who do not pose any such appreciable risk at all.

666 F.2d 761, 777 (2d Cir. 1981). See also Hentoff, supra note 159, at 597-601. This approach appears to be inconsistent with that adopted by the Arline Court. An employer or institution often chooses among competing applicants. If “any appreciable risk of harm” may be considered in making determinations, then individuals with disabilities would be practically excluded from many positions. Arline requires that discriminatory actions be taken only if there is a “significant risk” that cannot be eliminated through reasonable accommodations. But see, School Bd. of Nassau County v. Arline, 480 U.S. 273, 285 n.14 (1987); and Doe v. Washington Univ., 780 F. Supp. 628 (E.D. Mo. 1991) (court applies less stringent Rehab Act analysis in academic setting, finding that decision merely must not be arbitrary or irrational).

182. See supra note 165 and accompanying text.


184. Courts have already heavily relied on the CDC’s previous pronouncements about the risk of HIV transmission in health care settings. See, e.g., Leckelt v. Board of Comm’rs of Hosp. Dist. No. 1, 909 F.2d 820, 826-30 (5th Cir. 1990) (discussing CDC and other medical guidelines). But see Severino, 935 F.2d 1179 (firefighter case, neither majority nor dissent noted existence of CDC guidelines regarding the potential transmission of HIV by rescue personnel). To date, no court has specifically discussed the CDC’s July 1991 guidelines (or its proposed revisions for that matter). In the most recent reported decision, a district court discussed previous CDC health care
uated in the context of attempts to prevent HCWs from performing: (1) exposure-prone procedures; (2) individually identified risky procedures; or (3) all invasive procedures.

Under the current July 1991 CDC guidelines, exposure-prone procedures are key to the significance of the risk posed by an infected HCW. These guidelines suggest that performing exposure-prone procedures might pose a significant risk of HIV transmission to patients, which cannot be eliminated through the reasonable accommodation of universal precautions.\footnote{186}

However, this statement collapses several stages of judicial analysis under Arline and the ADA regulations.\footnote{187} First, a court might use the guidelines to determine whether there is a significant risk of HIV transmission from HCW to patient during exposure-prone procedures by considering the duration of the risk, the nature and severity of the potential harm, the likelihood that the potential harm will occur and the imminence of the potential harm.\footnote{188} As a second stage, the court guidelines and the CDC's report of the Acer case, but did not refer to the current guidelines. Doe v. Washington Univ., 780 F. Supp. at 629-634 (alleged acts of discrimination occurred before CDC's July 1991 guidelines were released). The court used the older CDC statements to support its determination that dismissal of an HIV-infected dental student was not arbitrary or irrational, given the established (though small) risk of transmission. \textit{Id.} at 633.


185. \textit{See supra} notes 110-151 and accompanying text.

186. \textit{See supra} note 62 and accompanying text.


might then turn to the guidelines to determine whether the significant risk could be eliminated through reasonable accommodation, that is, through the use of universal precautions or other procedures. This analysis requires consideration of medical risk indicators, discussed in the CDC guidelines, along with consideration of the economic or administrative burden that would be imposed by the accommodation.

This scenario assumes that the current CDC approach represents the public health authorities' determination that there are "significant" risks posed by infected HCWs performing exposure-prone procedures. Arguably, the CDC guidelines are not really based upon a finding of "significant risk." The CDC, along with other medical groups, has repeatedly noted that the risk of HIV transmission from provider to patient is in fact very, very small.

Furthermore, the CDC has been unable to devise a list of exposure-prone procedures that, in and of themselves,
present greater risks to patients. A court unwilling to hold the current guidelines irrational would remain free to find that they are not based on a determination of significant risk, as required under the federal disability discrimination statutes. In other words, "exposure-prone" procedures are not distinguishable from other invasive procedures performed by HCWs.

Discrimination against infected HCWs grounded upon the July 1991 CDC guidelines could violate the significant risk requirement of either the Rehab Act or the ADA. The principal drawback to this argument is that courts may ignore the frailties of the exposure-prone definition in favor of focusing on the possibility of risk in the contested procedures. Thus, it may be impossible to avoid the larger question raised by the CDC's proposed revisions of the 1991 guidelines: when do HIV-infected HCWs pose a significant risk to their patients in performing invasive procedures?

The CDC's proposed revisions to the July 1991 guidelines seem overtly to support the individualized inquiry that is favored by statutes prohibiting discrimination based on disability. This individualized approach will presumably lead to a more accurate determination of the significance of risk: expert review panels will individually assess a practitioner's skills, adherence to universal precautions, and medical condition. Reviews truly conforming to the proposed approach might actually be based on medical assessments of significant risk.

192. See supra note 83.

193. Congress clearly did not intend to preempt the effect of these laws by requiring adoption of the CDC guidelines, since it required states to adopt guidelines that "shall be consistent with federal law." Pub. L. No. 102-141, § 633, 105 Stat. 834, 876 (1992).

194. This possibility raises a difficult procedural and conceptual issue created by the existence of CDC guidelines outside of a statutory or regulatory scheme. In the absence of specific statutes or regulations, the CDC guidelines might serve as a basis for decision-making, without being directly contestable in court. That is, private actors might rely on the existence of the guidelines in deciding to discriminate. However, a plaintiff challenging the discriminatory act would, of course, challenge the defendant's action directly and could only contest the validity of the CDC's approach insofar as the defendant relied upon it. Direct challenges to the CDC guidelines themselves would be only possible where they have been incorporated into a statutory or regulatory scheme. See, e.g., TEX. HEALTH & SAFETY CODE ANN. § 85.201 (Vernon 1992) (codifying the CDC's 1991 Guidelines). The failure of the CDC or HHS to follow notice and comment procedures in promulgating the guidelines could also be challenged. See supra note 116.

195. See supra note 83.

196. This is particularly so because of the proposed guideline's attempt to exclude some clearly non-risky procedures from the definition of invasive. This should
Yet, the proposed guidelines may be implicitly based on the assumption — or perhaps merely used to support the conclusion — that invasive procedures generally pose significant patient risks. The proposed recommendations should not shield essentially arbitrary or standardless decision making. Courts confronted with an expert review panel’s individualized determinations must independently determine whether the discrimination was justified by a significant risk that could not be eliminated through reasonable accommodation. 197

Arguably, HIV-infected HCWs simply do not pose legally “significant” risks. The CDC has admitted that only a very small transmission risk exists. 198 Independent assessments by other organizations and researchers support this conclusion. 199 Courts could also consider the CDC’s previous rejection of practice restrictions to support the conclusion that the risk of transmission is legally insignificant. 200

reduce some inappropriate decision making. See Doe v. Westchester County Medical Center, discussed in, Arguments scheduled June 25 Before HHS on Westchester County Medical Center Decision, 7 AIDS POL’Y & L. 1 (June 12, 1992) (hospital contends that pharmacist should be barred from preparing IV solutions).

197. This is not a situation in which the application of a general exclusionary rule is permissible. See Traynor, 485 U.S. 535; Ward v. Skinner, 943 F.2d 157 (1st Cir. 1991). See also supra note 188. Here, there is no general rule suggesting that all HIV-infected HCWs should refrain from performing all invasive procedures; the nearly unanimous medical recommendations, in fact, require an individualized inquiry.

198. See supra note 93.

199. See supra notes 93-99.

200. There are two problems with this conclusion. First, courts might focus on a wider conception of risk — one that includes more than the risk of HIV transmission. See Estate of Behringer v. Princeton Medical Center, 592 A.2d 1251 (N.J. Super. Ct. Law Div. 1991) (focusing on broader conception of risk, in holding that, under New Jersey law, a hospital could limit an HIV-infected surgeon’s privileges by requiring that he obtain the informed consent of his patients).

Second, courts have been cautioned not to rely too heavily on public health authority determinations. See Kohl v. Woodhaven Learning Center, 865 F.2d 930 (8th Cir.), cert. denied, 493 U.S. 892 (1989). In Kohl, the court of appeals chastised the district court for committing just such an error. The court noted that a public health authority’s testimony is not determinative, especially where the authority may not be familiar with the program at issue or where there is conflicting public health testimony. Id. at 938-39. Where a public health authority has general knowledge of the risks presented, a court “may be called upon to balance deference to health authorities with the deference due to the reasonable judgments of the administrators most familiar with the program under examination.” Id. at 939. Evidence of inconsistent practices by public health authorities may undermine the force of any single conclusion. Id. Others have noted the importance of official public health pronouncements. See ‘Medical, Not Legal’ Ruling Given in Maryland Prison Controversy, 6 AIDS POL’Y & L. 3 (July 10, 1991) (Maryland Attorney General rules that seropositive HCWs can be barred
Additionally, relying on the CDC's previous guidelines, a court considering restrictions on invasive practices could find that even if the risk of HIV transmission is "significant" in invasive procedures, it may be "eliminated" through the use of reasonable accommodations. Laws already impose duties on health care entities and professionals to use proper techniques, universal precautions, and proper sterilization. Therefore, those duties cannot be viewed as unduly burdening health care providers.\(^\text{201}\)

Despite these arguments, some courts will likely uphold some of these practice restrictions, whether imposed by expert review panels or others.\(^\text{202}\) Courts may use two paths to reach this result. First, a court could consider risks beyond those created by HIV transmission. A New Jersey state court adopted this approach in upholding a mandatory disclosure rule for a surgeon with AIDS.\(^\text{203}\) In *Estate of Behringer v. Princeton Medical Center*,\(^\text{204}\) the court noted that the risk of exposure to an infected HCW's blood exceeded the risk of HIV transmission. The risk of exposure created its own harms: (1) the psychological injuries created by the fear of transmission; and (2) the need to undergo periodic testing.\(^\text{205}\)

While superficially appealing, this analysis seems to violate the

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\(^\text{201}\) Cf. *Kohl*, 865 F.2d at 937-98 (discussing the undue burden placed on facility through accommodations designed to eliminate the risk of HBV transmission). Additional accommodations, not required by law, might be made by employers or educational institutions.

\(^\text{202}\) Discrimination will be permissible if courts find that HCWs pose significant risks to their patients in performing some group of procedures. Infected HCWs will not be "otherwise qualified" to perform those procedures. A HCW might legally be denied employment or refused privileges where performing those procedures is an essential aspect of the position. See *supra* note 163 (under Rehab Act) and notes 172-73 (under ADA) and accompanying text. See also *Doherty v. Southern College of Optometry*, 862 F.2d 570, 574-75 (6th Cir. 1988), *cert. denied*, 493 U.S. 810, 110 S. Ct. 53 (1989) (school's requirement of proficiency with four clinical instruments was reasonable); *Strathie v. Department of Transp.*, 716 F.2d 227, 232-33 (3d Cir. 1983) (discussing the essential nature of bus driver licensure program).

\(^\text{203}\) This case was not decided under the federal statutes prohibiting discrimination against people with disabilities; however, it does provide a possible mode of analysis under those statutes. *Estate of Behringer*, 592 A.2d at 1283 (court finds "reasonable probability of substantial harm").

\(^\text{204}\) Id. at 1251.

\(^\text{205}\) Id. at 1279 (considering the materiality of the risks presented by the surgeon under informed consent doctrine).
fundamental purpose of anti-discrimination statutes: to protect persons with disabilities from the general public's irrational fears. As the Supreme Court has noted, “few aspects of a handicap give rise to the same level of public fear and misapprehension as contagiousness.” If there is actually an insignificant risk of HIV transmission, then it would seem impermissible to load people's fears about an insignificant risk onto the scales in order to tip the balance in favor of the risk.

Second, although there is actually only a small risk of transmission, a court could find that the degree of harm transforms the risk into a significant risk. A federal court adopted this approach in *Doe v. Washington University.* In *Doe,* the court considered a Rehab Act claim brought by an HIV-infected dental student who was dismissed from his academic program. As part of the program, the student was required to complete over 1,000 hours of clinical procedures on patients. The dental school dismissed the student, concerned that he posed a risk of HIV transmission during these procedures.

The district court deviated from traditional disability analysis in two respects. First, because of the academic setting of the discrimination, it applied a “rational basis” analysis to the dental school's decision to dismiss the HIV-infected student. Second, the court focused on the existence of “some risk” of transmission, in finding that the plaintiff was

207. The Court's decision in *Arlene* supports this analysis. What if fears about exposure to tuberculosis and the potential for periodic tuberculosis screening had been weighed in the balance? 480 U.S. at 287-88.
209. *Id.* at 629.
210. *Id.* at 633. The invasive procedures would have been performed using universal precautions. *Id.*
211. *Id.* at 634.
212. *Id.* at 631. The court held that “[t]raditionally, in cases involving academic dismissal, educational institutions have the right to receive summary judgment unless there is evidence from which a jury could conclude that there was no rational basis for the decision or that it was motivated by bad faith or ill will unrelated to academic performance.” *Doe v. Washington Univ.,* 780 F. Supp. at 631. This restrictive analysis would seem to undercut the purposes of the Rehab Act, insofar as it truncates the court's analysis of whether or not the student in fact posed a significant risk to his clinical patients. This permits a school's reasonable, but wrong, interpretation of the significant risk requirement to replace an independent judicial analysis of the question. It is inconsistent with other applications of the Rehab Act in academic settings. *Cf.* Southeastern Community College v. Davis, 442 U.S. 397 (1979) (Rehab Act requirements applied to nursing school decision not to admit a deaf applicant). *But see* *Doe v. New York Univ.,* 666 F.2d 761 (2d Cir. 1981) (educational institution entitled to prefer applicants who posed less risk to themselves or others).
not otherwise qualified. Though the court's use of a special academic standard complicates the analysis, the court was apparently willing to find that a slight risk of a high degree of harm could be "significant" and render an individual not "otherwise qualified."

The Doe court's determination of the risk's significance seems flawed, much like that proposed by the Behringer court. The court failed to analyze the nature and risks of the specific procedures to be performed by the student. It did not thoroughly examine the risk reductions created by the use of universal precautions. It did not rely upon the plaintiff's lack of training and skill. Instead, it seemed willing to find that a "low but existent risk, not now capable of precise measure" was significant when coupled with a severe harm. This reasoning could eviscerate the protections afforded by the significant risk standard: the risk will be significant if the severity of harm is great, even when the probability of harm is vanishingly small.

In summary, the CDC's risk estimations will probably be used by public and private actors to impose practice restrictions on HIV-infected HCWs. Federal statutes prohibiting discrimination against people with

214. Id. at 634-36 (discussing the existence of a slight, but real risk, and emphasizing the disease's fatal character and the duty of physicians and educational institutions to do no harm).
215. It noted that the use of such precautions could not completely eliminate the risk. Id. at 633.
216. Id. at 633-34.
217. See supra notes 181-83. Commentators have been divided on the propriety of such an analysis. Compare Gostin, The HIV-Infected Health Care Professional: Public Policy, Discrimination, and Patient Safety, 19 LAW, MED. & HEALTH CARE 303, 308 (significant risk can be established by a very low risk of a high degree of harm) with Feldblum, supra note 44, at 138 (must show "significant probability of substantial harm"). The ADA regulations appear to require that the risk to others be probable:

An employer, however, is not permitted to deny an employment opportunity to an individual with a disability merely because of a slightly increased risk. The risk can only be considered when it poses a significant risk, i.e., high probability, of substantial harm; a speculative or remote risk is insufficient.


Alternatively, Congress has arguably concluded, as a matter of legislative judgment, that the risks are significant because they require state implementation of the CDC guidelines. See supra note 73 and accompanying text (discussing effect of provision in CDC guidelines statute, requiring states to conform to federal law).
disabilities might protect HIV-infected HCWs from some attempts to restrict their practice, if there is no significant risk or if the risk can be eliminated through reasonable accommodation. The legal result will depend on the nature of the restriction.

Practice restrictions based on "exposure-prone" procedures — those that attempt to follow the CDC's July 1991 guidelines — will violate these statutes because exposure-prone procedures cannot be meaningfully distinguished from other invasive procedures. Courts are likely to invalidate blanket bans on performing invasive procedures because of the exceedingly small risk of HIV transmission in most procedures. However, it is possible that the courts will uphold such prohibitions by either: 1) adding the existence of other risks (beyond the risk of HIV transmission itself); or 2) emphasizing the existence of a high degree of harm, should the risk materialize. Courts will uphold individualized determinations of the risks presented by particular providers performing particular invasive procedures, so long as they are based on significant risks. Discrimination will be barred where the risk to patients is not significant, even though hospitals and others may be afraid of losing patients who are irrationally concerned about the risk of transmission.\(^{218}\)

If a court finds significant risks of HIV transmission, it must still determine whether such risks can be reduced or eliminated through reasonable accommodations. For invasive procedures that are not exposure-prone, the CDC guidelines seem to establish that reasonable accommodation may be achieved through universal precautions and appropriate sterilization techniques.\(^{219}\) For some HCWs who perform risky invasive procedures, reasonable accommodation might be possible through job restructuring. However, reasonable accommodation would not affect the position of HCWs who must perform such procedures as an essential aspect of their jobs; discrimination against these workers would be legally permissible.\(^{220}\)


\(^{219}\) See supra notes 53 (current guidelines) and 83 (proposed revisions).

\(^{220}\) See supra notes 159-63 and accompanying text (Rehab Act). Claims brought under the ADA might be more successful because of the more comprehensive definition of reasonable accommodation, which can include job changes or job restructuring. See supra notes 170-73 and accompanying text.
2. State Law

The federal anti-discrimination statutes do not preempt state laws providing equal or greater protection for persons with disabilities.\(^{221}\) Every state has enacted some statutory protection for persons with disabilities. These statutes vary in two important ways: the type of employers covered and the type of conditions deemed protected disabilities.\(^{222}\) Some state statutes apply only to public employers or to large employers.\(^{223}\) Others cover even relatively small employers who might not be covered under the ADA until 1994, and a few cover very small employers who will never be subject to the ADA.\(^{224}\) State anti-discrimination laws will continue to be an important source of protection for individuals.\(^{225}\)

State statutes define protected conditions differently. Many states simply follow the definitional approach represented in the Rehab Act.\(^{226}\) Some states have actually adopted the Rehab Act’s approach to

\(^{221}\) 42 U.S.C. § 12201(b) (1991) (allowing state or federal laws that provide greater protection). However, Congress arguably intended to preempt state law by requiring that states adopt CDC-like guidelines to maintain their eligibility for public health funding. See supra note 73.


State statutes prohibiting discrimination in places of public accommodation might also apply in some cases. See also Estate of Behringer, 592 A.2d 1251 (holding that New Jersey statute applies to physician who has admitting privileges at a hospital, even though he is not technically an employee, because the hospital is a place of public accommodation).

\(^{223}\) See, e.g., DEL. CODE ANN. tit. 19, §722(2) (1990) (state covered; other covered employers must have 20 or more employees); and Texas Commission on Human Rights Act, TEX. REV. CIV. STAT. ANN. art. 5221k § 2.01(7) (Vernon 1992) (state covered; other covered employers must have fifteen or more employees).

\(^{224}\) See, e.g., COLO. REV. STAT. ANN. § 24-34-401(3) (1988) (employer means state and “every other person employing persons within the state”); MllN. STAT. ANN. § 363.01 subdiv. 17 (West 1991) (employer means a person who has one or more employees); WISC. STAT. ANN. § 111.32(6)(a) (West 1988) (employer includes any person “engaging in any activity, enterprise or business employing at least one individual”).

\(^{225}\) State anti-discrimination statutes might also provide procedural or remedial advantages over federal causes of action. See generally, L. ROTHSTEIN, supra note 222, at § 4.20.

\(^{226}\) See, e.g., COLO. REV. STAT. ANN. § 24-34-301 (1990); DEL. CODE ANN., tit. 19, § 722(4) (1990); LA. REV. STAT. ANN. § 46:2253(1) (West 1982); MINN. STAT. ANN. § 363.01 subdiv. 13 (West 1991) (defining “disabilities” as something which “materially limits” rather than “substantially limits”); OR. REV. STAT. § 659.400(2), (3) (1989); W. VA. CODE § 5-11-3(t) (1990) (defining a “handicapped
contagious disease, represented in the “direct threat” or “significant risk” language.\footnote{227} Other states have more restrictive definitions of disability, for example, denying protection to persons who are merely “regarded as” being impaired.\footnote{228} A number of states take a completely different approach, defining handicapping conditions by attempting to list common disabling characteristics.\footnote{229} Finally, a few states have enacted HIV-specific anti-discrimination legislation; most such legislation limits employee protection if there is a health or safety threat to others.\footnote{230}

Given the welter of different state treatments of disability issues, accurately predicting the outcome for HIV-infected HCWs in each state becomes difficult. However, some general conclusions are possible. First, states with statutes mirroring the Rehab Act language are likely to find HIV infection to be a handicapping condition.\footnote{231} Those with provisions

\begin{footnotes}
\footnote{227} See, e.g., TEX. REV. CIV. STAT. ANN. art. 5221k §2.01(4)(B) (Vernon 1991).
\footnote{228} See, e.g., TEX. REV. CIV. STAT. ANN. art. 5221k §2.01(4) (Vernon 1992); VA. CODE ANN. § 51.5-3 (1991) (definition of person with a disability).
\footnote{229} See, e.g., KAN. STAT. ANN. § 44-1002 (1986) (includes disease, but must be unrelated to person’s ability to perform job); MD. ANN. CODE OF 1957 art. 49B, § 15(g) (Michie 1991) (includes illness); MONT. CODE ANN. § 49-2-101 (1991) (includes illness); NEB. REV. STAT. § 48-1102(8) (1988) (includes illness, but must be unrelated to ability to engage in occupation); N.H. REV. STAT. ANN. § 354-A:3 (1984) (excludes illness); N.J. STAT. ANN. § 10:5-5 (West 1991) (includes illness); N.Y. EXEC. LAW § 292(21) (McKinney 1991) (includes medical impairments); OHIO REV. CODE ANN. § 4112.01(13) (Anderson 1991) (medically diagnosable condition which can reasonably be expected to limit the person’s functional ability).
\footnote{230} See, e.g., IOWA CODE ANN. § 601A.2(4) (West 1991); KY. REV. STAT. ANN. § 207.135 (Michie/Bobbs-Merrill 1991) (HIV-based discrimination prohibited unless a Bona Fide Occupational Qualification (“BFOQ”)); MO. ANN. STAT. § 191.665 (Vernon 1991) (state disability discrimination statute shall apply to persons with HIV unless individual has a contagious disease or infection that poses a direct health or safety threat to others or unless she is unable to perform her job duties); N.C. GEN. STAT. § 130A-148 (1990) (HIV-specific employment protections); R.I. GEN. LAWS § 23-6-22 (1990) (discrimination unlawful unless clear and present danger to others); VT. STAT. ANN. tit. 21, § 495 (1990) (prohibiting discrimination based on HIV test result); WASH. REV. CODE ANN. § 49.60.172 (1990) (HIV-based discrimination unlawful unless BFOQ, based on significant risk as defined by health department).
specifically covering persons with contagious diseases and/or HIV will certainly protect HIV-infected HCWs, absent a direct threat or serious risk to others. Finally, states with idiosyncratic disability definitions may not adequately cover persons with HIV infection and, therefore, may not serve as a legal source for resolving disputes involving HIV-infected health care workers.

D. Permissible Practice Restrictions

The anti-discrimination analysis first suggests that implementing the practice restrictions advocated in the CDC's current and proposed guidelines might provoke legal challenges because of the statutory "significant" risk requirement. Also, claimants will certainly argue that
courts should strike down additional restrictions — those exceeding CDC recommendations — as constitutionally deficient or as unlawful discrimination under the Rehab Act, the ADA, or the state statutes protecting individuals with disabilities from discrimination. Courts could find the CDC's proposed guidelines to be public health authorities' persuasive judgment that there is no "significant" risk of HIV transmission from HCWs to patients in many, if not most, invasive procedures.

The CDC guidelines present a framework within which to analyze public and private attempts to reduce risk by restricting HIV-infected HCWs. As will be discussed in Part V, states retain a substantial role; they may reject the CDC's July 1991 guidelines and may codify the individualized determination approach represented in the CDC's proposed revisions. Appropriate state regulation can prevent inadequate or, more likely, excessive restrictions on the professional practices of HIV-infected health care workers.

IV. IDENTIFYING INFECTED HEALTH CARE WORKERS

A. General Considerations

The privacy rights of HCWs have been left aside in all this discussion of risk identification and reduction. Public and private actors seeking to reduce the perceived risk of transmission often advocate either a mandatory HIV-antibody testing program or a voluntary program coupled with mandatory disclosure of HIV-positive status. Either of these approaches would involve serious invasions of HCWs' reasonable expectations of privacy.

The programs would infringe on several kinds of privacy interests. First, mandatory testing programs currently require a physical intrusion into an individual's body to obtain a blood sample.235 Second, analyz-
ing blood samples to obtain personal information about the individual represents a further privacy invasion. Third, this private information may then be retained or disclosed to others. The information itself may be used to support discriminatory actions that could result in economic and psychological injury to the tested individual.

In both its July 1991 guidelines and in its proposed revisions of those guidelines, the CDC responded to the debate by shifting away from sole reliance on universal precautions, which are infection control procedures to be used by all HCWs on all patients. For some HCWs, universal precautions have been supplemented with an additional duty: those HCWs engaging in either exposure-prone or risky procedures should know their HIV status and should refrain from participating in those procedures. The guidelines may provide a basis for legal challenges to state imposed mandatory testing regimes and to testing imposed by private entities. However, the legal rules governing state or privately imposed testing provide somewhat less protection than the pure anti-discrimination statutes discussed above.

Once again, public or private attempts at risk reduction will be measured against several legal constraints: the Constitution, and federal or state laws protecting persons with disabilities from discrimination. In addition, many states have specific HIV-antibody testing statutes. The CDC recommendations will play an important role in applying some of

236. Skinner, 109 S. Ct. at 1412. The Skinner Court also noted that it might be possible to characterize the taking of blood "as a Fourth Amendment seizure, since it may be viewed as a meaningful interference with the employee's possessory interest in his bodily fluids." Id. at 1413 n.4 (dicta).

237. The Court has recognized that disclosure of information to others raises informational privacy concerns. Whalen v. Roe, 429 U.S. 589 (1977) (state that collected personal information about individuals was required to guard confidentiality of information to prevent additional serious intrusions into privacy interests). See also United States v. Westinghouse Elec. Corp., 638 F.2d 570 (3d Cir. 1980) (employee medical records protected under constitutional privacy analysis); Samar, Privacy and AIDS, 22 U. WEST L.A. L. REV. 1 (1991) (discussing right to privacy in context of HIV information); Note, The Constitutional Protection of Informational Privacy, 71 B. U. L. REV. 133 (1991) (analyzing informational privacy cases and advocating continued protection under due process liberty and property rights); and Note, supra note 107, at 732.

Even disclosing a test result to the tested individual might implicate constitutional liberty or privacy concerns. Closen, Mandatory Disclosure of HIV Blood Test Results to the Individuals Tested: A Matter of Personal Choice Neglected, 22 LOY. U. CHI. L.J. 445, 454-57 (1991). For example, an individual might suffer psychological injury from the unwanted knowledge that he or she has a currently fatal condition. Id. at 456.
these legal standards to public or private attempts to impose testing or to require disclosure of HIV-antibody test results.

Testing proposals vary along two different dimensions: the source of the testing mandate and the scope of its application. Political pressure will force some states to adopt a testing requirement as part of the licensure process for some or all HCWs, or as a requirement for hospital staff or employees. Even where the legislature remains silent, public hospitals or other public entities might impose mandatory testing programs. Finally, private entities, such as hospitals or insurers, might require HIV-antibody testing. Testing might be required of all HCWs with patient contact, those who participate in invasive procedures, or only those who will perform "exposure-prone" procedures.

B. Testing and the Constitution

Public testing programs will face constitutional challenges under the fourth amendment's prohibition against unreasonable searches and seizures. Most states already have licensing provisions which require that certain licensees submit to medical examinations to ensure provider competence and/or patient safety. These provisions cover dentists, physicians, nurses, and others. California, for example, has a general provision providing for the examination of licensed health care providers:

Whenever it appears that any person holding a license, certificate or permit under this division [the healing arts] or under any initiative act referred to in this division may be unable to practice his or her profession safely because the licentiate's ability to practice is impaired due to . . . physical illness affecting competency, the licensing agency may order the licentiate to be examined by one or more physicians and surgeons or psychologists designated by the agency.

CAL. BUS. & PROF. CODE § 822 (West 1990). Failure to comply with an examination order constitutes grounds for license suspension or revocation. Id. at § 821.

Applicants for professional licensure typically will be deemed unqualified if they have a physical condition that poses a risk to patient safety or that affects their competence. Similarly, current license holders may be subject to license suspension or revocation if they have a physical or mental condition that affects their competence and/or their patients' safety. See, e.g., N.Y. EDUC. LAW § 6509 (McKinney 1985) (professional misconduct includes practicing the profession while the "ability to practice is impaired by . . . physical disability or mental disability").

239. See, e.g., Ritterband v. Axelrod, 149 Misc. 2d 135, 562 N.Y.S.2d 605 (N.Y. Sup.Ct. 1990) (court upholds state law requiring hospitals to conduct medical exams on employees, staff, students and volunteers, to protect hospital patients and personnel).

240. "The right of the people to be secure in their persons, houses, papers, and effects, against unreasonable searches and seizures, shall not be violated and no War-
warrantless search.241 Once again, the legal issue concerns reasonableness. Warrantless searches and seizures will be upheld in the civil context if a court concludes that the invasion of the individual’s legitimate privacy interest is outweighed by the governmental interests asserted to justify the search.242

Previous fourth amendment constitutional challenges to HIV-antibody testing have yielded mixed results. In Glover v. Eastern Nebraska Community Office of Retardation,243 (ENCOR) the court considered the validity of a mandatory testing program imposed on HCWs who worked with physically aggressive, mentally disabled clients. The state agency’s

rants shall issue but upon probable cause, supported by Oath or affirmation, and particularly describing the place to be searched, and the persons or things to be seized.” U.S. CONST. amend. IV; see also U.S. CONST. amend. XIV, § 1 (“nor shall any State deprive any person of life, liberty, or property, without due process of law”).

Additional constitutional arguments might arise out of a right to privacy, located somewhere within the Fifth and Fourteenth Amendments to the United States Constitution. See, e.g., Whalen v. Roe, 429 U.S. 589. These arguments will be considered in connection with the disclosure requirements that often go hand in hand with testing. See infra, notes 338-39 and accompanying text.


242. As the Skinner Court noted:

"The Fourth Amendment does not proscribe all searches and seizures, but only those that are unreasonable . . . . What is reasonable, of course, “depends on all the circumstances surrounding the search or seizure and the nature of the search and seizure itself.” . . . Thus, the permissibility of a particular practice “is judged by balancing its intrusion on the individual’s Fourth Amendment interests against its promotion of legitimate governmental interests.”"

489 U.S. at 618-19 (citations omitted) (upholding drug and alcohol testing of railroad employees despite lack of warrant or even individualized suspicion). See also National Treasury Employees Union v. Von Raab, 489 U.S. 656 (1989) (upholding warrantless drug testing of Customs Service employees).

243. 686 F. Supp. 243 (D. Neb. 1988), aff’d 867 F.2d 461 (8th Cir.), cert. denied, 492 U.S. 916 (1989). The testing policy was to be applied to applicants for, or holders of, certain jobs. Id. at 247 (home teacher, residential associate, residential assistants, vocational program manager, registered nurse, and licensed practical nurse). The court observed that workers in other job categories had also been attacked by clients. Id.

For another legal commentary on the Glover case, see Isaacman, supra note 37, at 467-69 (arguing that the Glover analysis should be applied to the problem of HIV-antibody testing for HCWs).
policy contained three parts: 1) mandatory testing for certain communicable diseases (including tuberculosis, HBV and HIV); 2) mandatory reporting of some communicable diseases; and (3) mandatory disclosure of treatment for chronic infectious diseases. The court held that the testing requirements intruded on HCWs' reasonable expectations of privacy.

The state agency argued that the policy served the important governmental objective of protecting its clients' health and safety. The policy was premised on the need to protect patients from potential infection because many patients exhibited "violent and aggressive behavior," including "biting, scratching, throwing of objects, hitting, violent outbursts, and pinching." The court conducted an extensive review to determine the testing program's medical basis, and noted that HIV-antibody testing was medically required in a narrow range of circumstances, none of which were implicated by the agency's testing policies. Further, the court noted the CDC's then apparent preference for the use of universal precautions to reduce the risk of transmission:

It is procedures of this kind that are recommended by the CDC which has published recommendations and guidelines to help battle the spread of this disease. These recommendations and guidelines do not include, nor is there any evidence that health care workers, either generally or in select groups, are routinely screened for the presence

244. Glover, 686 F. Supp. at 244-45. While the plaintiffs challenged the HIV and HBV policies, they apparently did not contest the imposition of tuberculosis testing. Id. at 244 n.1. Nor did the plaintiffs directly challenge the reporting and treatment disclosure provisions of the policy.

245. Id. at 250 (noting physical intrusion of search and "reasonable expectation of privacy in the personal information their body fluids contain"). In addition, the court noted that receipt of positive test results could constitute an injury to some employees, "[b]ecause of the foreboding message that accompanies a positive HIV test result, some people simply do not want to know if they are infected." Id. at 248. The reporting requirements of the policy were not challenged. Id.


247. Id. at 246-49. See also Note, supra note 107, at 737-39 (discussing Glover's emphasis on medical reasonableness).

248. According to the court,

[T]he medically indicated reasons for HIV testing are: (a) as an adjunct to the medical workup of a patient who may be infected, (b) for epidemiological purposes to establish the level of infection in a community, and (c) as a device used in conjunction with counseling those in high-risk groups to stimulate them to change their high-risk behaviors. Testing in isolation as provided in ENCOR's policy does not serve these purposes.

of HIV. 249

The court concluded that there was no realistic threat of HIV transmis-
sion from worker to patient. 250

This conclusion then drove the court to hold the HIV testing provi-
sion unconstitutional under the fourth amendment. The court found the
HIV-antibody testing program to be an unreasonable search and seizure:

The risk of transmission of the disease from the staff to the clients at
ENCOR is minuscule, trivial, extremely low, extraordinarily low,
theoretical, and approaches zero. Such a risk does not justify the
implementation of such a sweeping policy which ignores and violates
the staff members’ constitutional rights. 251

249. Id. at 249.

250. Id. The court’s discussion of medical risks is unusually forceful and un-
equivocal:

The evidence establishes that the risk of transmission of the AIDS
virus from staff to client, assuming a staff member is infected with HIV, in
the ENCOR environment is extremely low, approaching zero. The medical
evidence is undisputed that the disease is not contracted by casual contact.
The risk of transmission of the disease to clients as a result of a client bit-
ing or scratching a staff member, and potentially drawing blood, is extraor-
dinarily low, also approaching zero. The risk of transmission of the virus
from staff to client due to the staff member attending to a client’s personal
hygiene needs is zero . . . .

In short, the evidence in this cases establishes that the risk of
transmission of the HIV virus at ENCOR is minuscule at best and will
have little, if any, effect in preventing the spread of HIV or in protecting
the clients. Further, from a medical viewpoint, this policy is not necessary
to protect clients from any medical risks.

Glover, 686 F. Supp. at 249. But see, Anonymous Fireman v. City of Willoughby,
firefighters and paramedics).

251. Glover, 686 F. Supp. at 251. The court also struck down the mandatory
HBV testing provision on similar grounds. Here, however, the court noted that there
might be some slight risk of HBV transmission. The court rejected the assertion that
testing was a reasonable solution to such a risk:

Even if there were evidence of such a risk, the policy would not be justi-
fied as other measures exist to promote ENCOR’s interests in protecting its
clients. Specifically, ENCOR could administer the HBV immunization to its
clients, and be prepared to administer the hepatitis B immune globulin to
an unimmunized client who was exposed to the disease. In addition, unlike
testing, these measures are effective in preventing the spread of HBV and
protecting the health of ENCOR’s clients.

Id.

One court has recently permitted the imposition of mandatory HIV screening
for firefighters and paramedics. Anonymous Fireman, 779 F. Supp. at 418. The court’s
This result is inevitable once the medical justification for testing is removed.

Yet, HIV-antibody screening has been upheld as a measure designed to protect the health of those tested. In *Local 1812, American Federation of Government Employees v. United States Department of State*, the court considered the validity of the State Department's HIV-antibody testing program in the context of a motion for a preliminary injunction barring its implementation. The State Department had added HIV screening to the Department's employee medical fitness program, which already required drawing blood samples.

The government argued that it needed the program to implement the congressional mandate that foreign service officers be capable of "undertak[ing] worldwide duty." The court noted that, after a period of decision provides an interesting counterpoint to the *Glover* analysis.

First, the *Anonymous Fireman* court was forced to analyze the effect of a collective bargaining agreement which permitted testing. *Id.* at 415. The court held that the plaintiff retained his constitutional right to be free from unreasonable searches and seizures despite the existence of the collective bargaining agreement. *Id.; but see, Bolden v. Southeastern Pennsylvania Transp. Auth.*, 953 F.2d 807, 826-29 (3d Cir. 1991), cert. denied, 112 S. Ct. 2281 (1992) (union agreement to drug testing can have preclusive effect unless union has breached its duty of fair representation). The court did note the reduced expectation of privacy held by firefighters, who were members of a highly regulated industry. *Anonymous Fireman*, 779 F. Supp. at 415-16.

Second, the court found that "the risk of HIV transmission in the performance of the duties of a firefighter paramedic is high." *Anonymous Fireman*, 779 F. Supp. at 417. The risk of transmission could be reduced through transferring HIV-infected workers or through emphasizing the use of universal precautions by such workers. *Id.* The City thus had a compelling interest in learning the HIV status of its firefighters. *Id.* at 417-18.

Third, this compelling interest was held to outweigh the limited privacy interest of the firefighters. *Id.* at 418. This decision has obvious implications for health care workers, who are also members of a highly regulated industry. The question is whether other courts will find a high risk of HIV transmission in the health care context. *See infra* note 264 and accompanying text.


253. The court observed that the medical examination process "ha[d] long included a variety of laboratory tests, including a number of tests done on blood extracted from each person subject to the examination. This blood testing has provided a wide range of general information about a person's health and has also allowed detection of a variety of diseases, both infectious and non-infectious, such as hepatitis, syphilis, sickle-cell anemia, and various forms of cancer." *Id.*

254. *Id.* at 51 (relying, in part, on 22 U.S.C. § 3984(a)). The court also noted that Congress had specifically authorized the use of medical examinations for employment and health maintenance. *Id.* at 51.
of considerable study, the Department had concluded:

HIV-infected persons are impaired and medically unfit for worldwide service because such persons would be put at serious hazard by service at many posts where medical care is wholly inadequate to deal with HIV-related infection, and health and sanitary conditions are particularly hazardous to carriers of the virus.\textsuperscript{255}

Furthermore, the Department "presented substantial medical evidence supporting its view" of "significant and progressively serious medical risk."\textsuperscript{256}

The court balanced this important governmental interest against the asserted privacy interests of Department employees. However, the court suggested that these privacy interests were not particularly potent in light of the minimal additional intrusion imposed by adding HIV-antibody testing to the battery of tests already being performed.\textsuperscript{257} Nor was the court impressed with the psychological injury suffered by those informed of a positive test result; such injuries already occurred when employees were notified of other dangerous conditions.\textsuperscript{258}

Under the court's balancing analysis, the minimal intrusion of performing an additional medical test on collected blood samples was outweighed by the Department's medically justifiable concern that medical care be available for HIV-positive employees.\textsuperscript{259} The HIV-antibody testing "appear[ed] rational and closely related to fitness for duty."\textsuperscript{260} The court concluded that the plaintiffs were unlikely to succeed on their fourth amendment claims and, thus, refused to enter a preliminary injunction barring implementation of the testing program.

\textit{Glover} and \textit{Local 1812}, read together, indicate that the validity of a mandatory HIV screening program may depend on the degree of intrusion into the privacy rights of HCWs and on the medical rationality of the program's asserted justification.\textsuperscript{261} Therefore, the current and pro-

\begin{itemize}
\item \textsuperscript{255} \textit{Local 1812}, 662 F. Supp. at 52. In deciding the motion, the court did not consider other proffered justifications, including the need to protect against HIV transmission in emergency blood transfusions and the foreign policy implications of stationing HIV-infected persons overseas. \textit{Id}.
\item \textsuperscript{256} \textit{Id.} \textit{See also} \textit{Note}, \textit{supra} note 107, at 735-36 (noting the importance of the court's analysis of the medical record justifying the testing program).
\item \textsuperscript{257} \textit{Local 1812}, 662 F. Supp. at 53.
\item \textsuperscript{258} \textit{Id}.
\item \textsuperscript{259} \textit{Id.} (testing program is "rational and closely related to fitness for duty").
\item \textsuperscript{260} \textit{Id}.
\item \textsuperscript{261} This is so at least where the asserted basis for the testing program is medical: the protection of the public health. One student commentator has argued that courts might have a special obligation to carefully consider the medical justifications
\end{itemize}
posed CDC guidelines might be relevant to a court considering the medical basis for any testing program.262

Both the July 1991 and proposed revised recommendations reject mandatory testing programs. Instead, the CDC has suggested that some individual HCWs have a duty to know their HIV status. The difference between the current and proposed guidelines lies in the range of HCWs subject to this new individual duty. Whatever their other flaws, the July 1991 guidelines did restrict this duty to a subset of workers engaged in an ill-defined subset of medical procedures, known as “exposure-prone.” In contrast, the CDC’s proposed revisions impose this duty on HCWs performing any invasive procedures.263 As a result, under the proposed new guidelines, more HCWs might have a duty to know their HIV status.

Based on the CDC’s continued reliance on voluntary individual testing, a court considering the CDC’s current or proposed approach might conclude that any mandatory screening program would be medically unjustifiable. However, this conclusion is not certain, particularly because the CDC’s rejection of mandatory testing seems to be based at least as much on economic efficiency as on risk assessment: “the current assessment of the risk that infected HCWs will transmit HIV or HBV to patients during exposure-prone procedures does not support the diversion of resources that would be required to implement mandatory testing programs.”264 Arguably, a state might rationally come to a different conclusion after weighing the cost of testing against the degree of risk reduction achieved through testing. Since there is some risk of transmission in the health care context, some sort of mandatory testing program might be deemed reasonable.

262. Accord Note, supra note 107, at 743-48 (discussing the importance of CDC guidelines in determining fourth amendment reasonableness).

263. The CDC does attempt to restrict the definition of “invasive,” noting that many ordinary examination procedures, including oral, rectal, and vaginal exams, are not to be considered invasive. See supra note 83.

264. CDC, Health Care Recommendations — IV, supra note 51, at 6; see also CDC, Proposed Health Care Recommendations, supra note 83, at 3 (“The current assessment of the risk that infected [HCWs] will transmit HIV . . . to patients during invasive procedures does not justify mandatory testing.”).
This conclusion is strengthened by considering the nature of the asserted privacy interests in these cases and the Supreme Court's treatment of drug and alcohol screening in other regulated industries. The Supreme Court has upheld drug and alcohol testing of employees in safety-sensitive positions, noting the minimal intrusion on privacy and emphasizing the government's need to promote safety.\textsuperscript{265} Health care is highly regulated and its employees have traditionally been subjected to medical screening for diseases like tuberculosis. Therefore, courts might view HIV testing of HCWs who engage in invasive procedures as a minimal additional intrusion, necessary to maintain patient safety.\textsuperscript{266}

While overtly rejecting even limited mandatory testing, the CDC guidelines could actually be used to uphold such programs in the face of some constitutional attacks. On the other hand, the CDC guidelines


In a recent case, the Fifth Circuit rejected a fourth amendment claim brought by a nurse discharged for his failure to disclose the results of a voluntarily-taken HIV-antibody test. Leckelt v. Board of Comm's of Hosp. Dist. No. 1, 909 F.2d 820 (5th Cir. 1990). After the court noted that the hospital had a long-standing infectious disease policy that required reporting of diseases such as HIV and that Leckelt had voluntarily taken the test, it held that "[u]nder the circumstances, Leckelt had a significantly diminished expectation of privacy in the results of his HIV antibody test." \textit{Id.} at 833.

The court found that the hospital had a particularly strong interest in knowing Leckelt's HIV status, given the hospital's desire to prevent the spread of infectious disease, the significant basis of the hospital's suspicions about Leckelt's HIV-status, and the nature of Leckelt's job duties. \textit{Id.} The court found that the hospital's "strong interest in maintaining a safe workplace through infection control outweighed the limited intrusion on any privacy interest of Leckelt in the results of his HIV antibody test." \textit{Id.} at 833.

This case is not directly applicable to the hospital's direct imposition of HIV-antibody testing. Yet, it indicates a mode of analysis that could support the imposition of testing programs and would, at the very least, support required disclosure of test results. If HCWs who perform invasive procedures already have a duty to know their HIV status, then releasing the results for patient protection would not pose an undue burden. \textit{See also, Anonymous Fireman,} 779 F. Supp. at 418 (firefighters required to undergo HIV tests).

\textsuperscript{266.} Passage of criminal statutes might complicate the analysis because testing programs could provide evidence of felonious conduct. For example, under the Helms amendment, HCWs who performed exposure-prone procedures without informing patients of their HIV-positive status would have been subject to severe criminal penalties. \textit{See supra} note 70 and accompanying text. Under these circumstances, testing programs place HIV-infected HCWs at risk for criminal prosecution.
would certainly support a HCW’s constitutional attack on expanded testing programs, such as on attempts to impose HIV-antibody testing on all HCWs, even those who do not perform invasive procedures. The widespread intrusion on the privacy of HCWs would not be justified by any substantial medical benefits.

C. Federal and State Regulation of Employee Testing

The CDC guidelines reject mandatory testing, instead imposing a duty on certain HCWs to know their HIV status. Yet, realistically, hospitals, HMOs, or other health care entities will be under great pressure to administer or oversee HIV-antibody testing in order to calm public fears. Fear of litigation makes it unlikely that testing will remain a matter of individual duty, unsupervised by others. The CDC guide-

267. Of course, mixed approaches are possible and even likely. Hospitals are not likely to rely upon whatever testing provision is incorporated into a state’s licensure laws. Further, entities such as insurance companies are likely to be quite interested in HIV-antibody test results.

Health care entities and insurers are likely to be worried about the potential for tort liability should a patient or co-worker claim exposure to HIV. See, e.g., Wolgemuth v. Milton S. Hershey Medical Center, Dauphin Cnty. Ct., Docket No. 2694. S. 1991 (June 24, 1991) (discussed in Class Action Filed Against Hospitals After Ob/Gyn Reported HIV Positive, 6 AIDS POLICY AND LAW 4-5 (1991)) (suit filed alleging hospital breached its duties to patients by failing to test members of residency program); In re Application of the Milton S. Hershey Medical Center, 595 A.2d 1290 (Pa. Super. 1991) (court considers propriety of release of HIV-infected resident’s name to selected entities).


Of course, plaintiffs would have to show that a hospital breached its duty of care in failing to appropriately test and restrict the practice of infected HCWs, and that this breach led to cognizable injuries. For example, in Taaje v. St. Olaf Hosp., a hospital was found liable for the death of infant from tuberculosis after receiving care from a nurse with tuberculosis. 199 Minn. 113, 271 N.W. 109 (1937). The court noted that it was a nursing supervisor’s “duty to exercise due care to assure that her nurses were free from communicable disease.” Id. But the duty of care will be governed in large part by the standards established by medical organizations. Therefore,
lines might help limit both public and private entities’ attempts to implement testing programs or to use test results to discriminate against infected health care workers.

There are potentially three different sources of statutory law establishing standards for employer use of HIV-antibody testing: (1) federal disability law; (2) state disability law; and (3) state HIV-antibody testing statutes. Federal and state disability statutes may prohibit testing in some circumstances, but more often these statutes merely restrict an employer’s use of test results. In contrast, state HIV-antibody testing statutes often impose substantive restrictions on an employer’s ability to test for HIV and limit the use of results obtained from other sources.

Federal and state statutes prohibiting discrimination against persons with disabilities generally prohibit the use of certain test results to restrict employment opportunities, without specifically limiting the employer’s actual ability to test employees or applicants. The Rehab Act does not, by its terms, regulate employer-mandated tests or screening devices by executive agencies, federal contractors, or federal funds recipients. State disability discrimination statutes tend to follow the Rehab Act, failing to specifically consider the use of employment screening or testing. The only possible testing constraint derived from the Rehab Act is found in Health and Human Services (HHS) regulations, restricting the use of pre-employment screening tests:

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the CDC guidelines will serve as an important potential defense in any such action. In addition, plaintiffs might have to prove actual HIV transmission to recover. See Ordway v. Suffolk Cnty., 60 U.S.L.W. 2726 (N.Y. Sup. Ct. 1992) (claim of negligent infliction of emotional distress barred—where no specific event and where no tangible injury); Rossi v. Almaraz, Baltimore City Cir. Ct. Nos. 90344028 CL123396; 90345011 CL123459 (May 23, 1991) (discussed in Charges Against Surgeon Dropped; Patients Claimed Exposure Fears, 6 AIDS POLICY AND LAW 2 (June 12, 1991)) (judge dismissed claims of plaintiffs who were treated by HIV-infected surgeon and held that their exposure fears were not a compensable injury in the absence of evidence of actual exposure). But see Johnson v. West Virginia Univ. Hosp., 413 S.E.2d 889 (W. Va. 1991) (emotional distress damages recoverable for reasonable fear of exposure to HIV); Castro v. New York Life Ins. Co, N.Y.L.J., Aug. 5, 1991, at 23-24 (court holds that woman has cause of action for mental and physical distress in aftermath of needlestick injury, even though she refuses to disclose the results of her HIV-antibody tests).

268. The Rehab Act does, of course, prohibit discrimination against qualified individuals with handicaps. Thus, covered entities would not be permitted to use their knowledge of HIV status to discriminate, unless HIV-infected employees were not “otherwise qualified.”

269. See supra note 226 and accompanying text.

270. HHS issues regulations under § 504 of the Rehab Act.
A recipient [of federal funds] may not make use of any employment test or other selection criterion that screens out or tends to screen out handicapped persons or any class of handicapped persons unless: (1) the test score or other selection criterion, as used by the recipient, is shown to be job-related for the position in question, and (2) alternative job-related tests or criteria that do not screen out or tend to screen out as many handicapped persons are not shown by the Director to be available.

The Rehab Act provides no other protections from imposed screening.

The new ADA does specifically regulate employer use of employment qualifications and medical examinations. Employers may not use an employment test that tends to screen out individuals with disabilities, unless the test is “job-related for the position in question and is consistent with business necessity.” The statute also establishes three different time-specific rules for medical examinations and inquiries. Generally, a covered entity is only permitted to make pre-employment inquiries into an applicant’s ability to perform the job’s duties. But an offer of employment may be conditioned on an applicant’s successful completion of a medical examination which does not have to be job-related. The Equal Employment Opportunity Commission (EEOC) regulations implementing this section of the ADA provide that post-offer but pre-employment examinations do not have to be job-related and consistent with business necessity.


275. 42 U.S.C. § 12112(c)(3) (Supp. 1991). This procedural device increases an applicant’s ability to demonstrate that an employer discriminated because of disability. But some employers might still discriminate in a less detectable way, by using stereotypes or suspicion to screen out unwanted, disabled applicants.

The statute permits the use of medical examinations if they are required of all entering employees. 42 U.S.C. § 12112(c)(3)(A) (Supp. 1991). In addition, the ADA imposes certain record keeping and confidentiality requirements on employers, with respect to the results of these exams. Id. at § 12112(c)(3)(B). See also 56 Fed. Reg. 35,737-38 (1991) (to be codified at 29 C.F.R § 1630.14(b)).

276. 56 Fed. Reg. 35,738 (1991) (to be codified at 29 C.F.R § 1630.14(b)(3) (exams must be imposed on everyone within a particular job classification)).
Employment has begun, medical examinations and inquiries must be job-related and consistent with business necessity. 277

Finally, several states have specifically regulated the use of HIV-antibody tests. These statutes typically prohibit mandatory testing imposed by employers unless HIV-negative status is a bona fide occupational qualification ("BFOQ").278 At least one state completely prohibits the use of HIV testing in employment. 279

The complex web of statutory provisions governing the employment of persons with disabilities conceals some gaping holes. First, in many circumstances, an employer’s imposition of HIV-antibody testing may be wholly unregulated.280 Second, the statutory constraints most often merely require that the test be job-related and consistent with business necessity. The CDC recommendations could be used to help determine whether a testing program is necessary and job-related.

The CDC’s rejection of mandatory testing might prevent private or public entities from testing even those HCWs who engage in invasive procedures. Arguably, courts might find that public health assessments of risk do not outweigh the intrusion of testing. Yet the CDC’s imposition of a duty to know HIV status, and its development of practice restrictions for some HIV-infected HCWs, fractures this fragile conclusion. If it is permissible to restrict the practice of HIV-infected HCWs who might pose a significant risk to patients, it is probably permissible to employ testing schemes to determine whose practices should be restricted. Thus, HIV-testing might be directly related to a BFOQ for HCWs who perform at least some risk-identified procedures.

In Leckelt v. Board of Commissioners of Hospital District No.

277. 42 U.S.C. § 12112(c)(4) (Supp. 1991). The statute also permits “voluntary medical examinations,” but requires that the results remain confidential and that they be used only in accordance with the non-discrimination duties established under the Rehab Act. Id. at § 12112(c)(4)(B),(C). See also 56 Fed. Reg. 35,738 (1991) (to be codified at 29 C.F.R § 1630.14(c),(d)).

278. See, e.g., KY. REV. STAT. ANN. § 207.135 (1991) (testing prohibited unless a BFOQ); N.C. GEN. STAT. § 130A-148(i) (1990) (employers generally prohibited from imposing HIV-antibody testing on employees) (subsequently amended); TEX. HEALTH & SAFETY CODE ANN. § 81.102 (Vernon 1992) (including amendments) (employers may not impose HIV-antibody testing unless it is a BFOQ and there is no less discriminatory means of satisfying the occupational qualification).


280. Testing may be unregulated for private employers not covered by the Rehab Act, before the implementation of the ADA, and absent a specific state testing statute. Of course, such an employer might still be prevented from discriminating based on the HIV status of an applicant or employee under federal or state statutes prohibiting discrimination against people with disabilities.
the Fifth Circuit demonstrated this “do as I do, not as I say” approach to interpreting CDC guidelines. The court considered the discrimination claim of a nurse fired for refusing to disclose his HIV-antibody test results. Leckelt claimed that his firing violated the Rehab Act, which covered him as an “otherwise qualified” person with a handicap. The court rejected this contention. Assuming that Leckelt was handicapped, the court nonetheless held that he was not discriminated against “solely” because of his handicap and, in addition, held that he was not “otherwise qualified.”

First, the court of appeals upheld the district court’s factual determination that Leckelt had been fired for failing to follow the hospital’s infection control procedures, rather than for his perceived seropositivity. Second, the court used the prior CDC guidelines—which merely

281. 909 F.2d 820 (5th Cir. 1990).
282. Accord Barnes, Rango, Burke & Chiarello, supra note 37, at 317-19 (discussing problems with ambiguous CDC guidelines in context of Leckelt).
283. Leckelt, 909 F.2d 820. The hospital had become concerned about Leckelt’s HIV status after it learned that his roommate and assumed-lover had AIDS. Id. at 822. The hospital’s executive director and its Board considered the matter and determined that they needed to know Leckelt’s HIV status in order to comply with CDC guidelines. Id. Shortly thereafter, the hospital’s infection control officer requested that Leckelt consent to an HIV-antibody test. Leckelt revealed that he had already gone for testing, but had not yet picked up his result. He initially agreed to bring his result to the infection control officer, but then consistently refused to do so. Id. at 822-23. The hospital refused to let him return to work until he submitted the test results. Id. Eventually, the hospital’s executive director decided to terminate Leckelt for failure to comply with hospital policies—namely, failure to submit the test results to . . . [the infection control official] and failure to call her before each time that he was scheduled for work and tell her that he could not work because he was not going to submit the test results.
284. Leckelt, 909 F.2d at 825 (“For the purposes of this appeal, we assume that seropositivity to HIV antibodies is an impairment protected under section 504 and that [the hospital] officials treated Leckelt as though he had such an impairment.”) (emphasis in original).
285. Id.
286. Id. at 826. Leckelt had pointed to the different treatment accorded to another nurse, who had suffered a needlestick and was permitted to continue working while awaiting her test results, as indicative of the pre-textual basis of the hospital’s action. Id. at 826-27. There is some indication that Leckelt’s claim had merit. Leon-
suggested that individualized fitness determinations be made for HIV-infected HCWs who performed invasive procedures—to support its finding that Leckelt was not otherwise qualified for employment, because he failed to follow the hospital's infection control policies.\textsuperscript{287}

The court noted that the CDC's written guidelines, while not overtly supporting mandatory testing and/or notification, nonetheless could only realistically be carried out if a HCW disclosed her HIV status; only then could a hospital determine whether there should be any practice restrictions.\textsuperscript{288} Although partly relying on the CDC approach, the court of appeals ignored the CDC's risk assessments and determined that Leckelt could be a potential danger to patients.\textsuperscript{289} Further, the court rejected Leckelt's assertion that he would have been entitled to reasonable accommodations by noting that, since he had failed to disclose his HIV status, he had never given the hospital the opportunity to determine what accommodations were needed.\textsuperscript{290}

Given the Leckelt court's reasoning, the CDC's rejection of mandatory screening in its July 1991 and proposed guidelines could prove meaningless in practice. Instead, the new guidelines could support the imposition of routine HIV screening programs by hospitals or other health care entities.\textsuperscript{291} The July 1991 recommendations go farther than those applied by the Leckelt court: HCWs who perform exposure-prone procedures must know their antibody status and must either refrain from some procedures or seek an expert panel's approval. The proposed

\begin{footnotesize}
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  \item<sup>287</sup> "Ethical Challenges of HIV Infection in the Workplace, 5 NOTRE DAME J. L., ETHICS & PUB. POL'Y 53, 58-59 (1990) (discussing other information indicating motivation of hospital)."
  \item<sup>288</sup> Leckelt, 909 F.2d at 827-29.
  \item<sup>289</sup> Leckelt, 909 F.2d at 828.
  \item<sup>289</sup> Leckelt had contended that the district court erroneously found that he engaged in invasive procedures because he started "IVs." \textit{See} Leckelt, 714 F. Supp. 1377, 1382 (E.D. La. 1989). The court of appeals sidestepped this problem, noting that "[a]lthough none of Leckelt's duties apparently fell within the technical definition of an invasive procedure, at least some of these duties provided potential opportunities for HIV transmission to patients." \textit{Leckelt}, 909 F.2d at 829. Furthermore, although "Leckelt and the defendants stipulated that Leckelt generally complied with [the hospital's] policies concerning universal precautions" there was evidence that Leckelt might have failed to observe precautions on one occasion, and there was testimony regarding the general failure of HCWs to observe precautions on occasion. \textit{Id.} at 829-30. Finally, the court noted that there was evidence that Leckelt had failed to follow infection control procedures with regard to other diseases. \textit{Id.} at 830.
  \item<sup>290</sup> Leckelt, 909 F.2d at 830.
  \item<sup>291</sup> \textit{Cf.} Feldblum, \textit{supra} note 44, at 137 (pre-CDC guidelines commentary predicting this effect).
\end{itemize}
\end{footnotesize}
guideline revisions would create an even broader duty, one that would apply to all HCWs who perform invasive procedures. These CDC guidelines will support employers' assertions that seronegative status is a BFOQ for some health care jobs.

Nonetheless, the CDC guidelines could limit attempts by the state or others to impose screening programs for HCWs who do not participate in invasive procedures. Public or private entities might attempt to impose broader testing programs. For example, states might impose broad licensure screening, on the theory that a license to practice medicine permits the holder to perform many procedures, including risky ones.\(^{292}\) They could require that hospitals perform HIV-antibody testing.\(^{293}\) At the institutional level, hospitals and other health care entities might argue that general screening is required because they need a flexible workforce, whose members are able to perform risky procedures when called upon to do so.

The CDC guidelines indicate that such programs are medically unjustifiable. The CDC has clearly rejected broad testing of all HCWs, although it is seemingly ambiguous on testing workers who engage in exposure-prone or invasive procedures. Furthermore, the CDC has given the individual practitioner the responsibility for determining her need to

\(^{292}\) On the other hand, HIV-negativity is arguably an absolute requirement for some classes of HCWs—like dentists—who are nearly always involved in risky procedures. Southeastern Community College v. Davis, 442 U.S. 397 (1979) (deaf nursing school applicant not "otherwise qualified" under the Rehab Act because she was unable to perform a student nurse's essential duties).

\(^{293}\) In a recent case, a New York court considered a state regulation that required hospitals to "provide physical examinations and record medical histories for 'all employees, members of the medical staff, students, and volunteers whose activities are such that a health impairment would pose a potential risk to patients or personnel .. . or which might interfere with the performance of his/her duties.'" Ritterband v. Axelrod, 149 Misc.2d 135, 562 N.Y.S.2d 605, 607 (N.Y. Sup. Ct. 1990). The court held that the regulations were not arbitrary and capricious to the extent that they permitted individual hospitals to establish different mental and physical qualifications. \textit{Id}. at 608.

The court also rejected the petitioner's contention that the regulations violated his right to privacy because they failed to detail adequate confidentiality standards. \textit{Id}. at 611 (relying in part on Whalen v. Roe, 429 U.S. 589 (1977)). The court first found that physicians have "no constitutionally protected privacy interest in the results of a physical examination required as a condition for obtaining or retaining hospital privileges." \textit{Id}. Absent such an interest, the regulation could be upheld under a rational basis review; intermediate scrutiny would only apply if physicians had a protected privacy interest. Yet, the regulation could also be upheld under intermediate scrutiny because the state has a compelling interest in reducing malpractice and protecting the health and safety of hospital patients and personnel. \textit{Id}. at 611-12.
undergo testing; the HCW need only undergo testing if exposure-prone or invasive procedures are contemplated. Under these approaches, there is no need for broader testing programs, whether public or private.\(^{294}\)

V. STATE POLICY: TOWARD RATIONAL RISK REDUCTION

Whatever their final form, the CDC guidelines are likely to establish the practice standard in health care, whether imposed by Congress, state legislatures, or institutions driven by the fear of tort liability. The current guidelines do represent a definite shift in the public health perception of the risk of HIV transmission by HCWs. This shift in public health strategy must still be translated into sensible public policy. The best solution would be state legislation designed to achieve the objective of HIV risk reduction, while also minimizing other potential risks to individuals and society.\(^{295}\) This state legislation could be incorporated into licensure provisions for health professionals or health care institutions. The remainder of this article will consider a number of potential state solutions, some based on current proposals or enactments.

A. Practice Restrictions: Reducing the Risks of Uncertainty

The CDC's current and proposed recommendations do not provide an explicit standard for all state or private risk regulation. States, in particular, still have a significant opportunity to eliminate some of the uncertainty surrounding the practical implementation of the guidelines.\(^{296}\) State action will ease the process for HCWs, patients and hospitals by reducing the uncertainty that breeds fear of litigation. There are three primary areas of uncertainty: 1) identifying procedures that

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294. The lack of necessity is not the only basis for rejecting such programs. Another basis is the harm that mandatory testing will bring, including increasing pressure for mandatory patient testing and injuries caused by the inevitable breaches of confidentiality. See infra notes 332-35 and accompanying text (patient testing and confidentiality).

295. There have been two excellent projects developing model legislation for HIV issues. The Harvard Model AIDS Legislation Project, 16 AM. J. L. & MED. 1-247 (1990) (individual authors); Rothenberg, supra note 178. See also Fluss & Zeegers, AIDS, HIV, and Health Care Workers: Some International Legal Perspectives, 48 MD. L. REV. 77 (1989).

296. See, e.g., Rothenberg, supra note 178, at 121-28 (rejecting broad practice restrictions imposed on infected HCWs).

297. This discussion is limited to the risks posed by the threat of HIV transmission. Institutions may wish to restrict the practice of HIV-infected HCWs for other reasons as well. The CDC guidelines recommend notifying any patient who has been exposed to a HCW's blood or body fluids. If the HCW refuses HIV-antibody testing, or consents and is found to be infected, the patient may undergo testing for one year.
pose a significant risk to patients; 2) defining the substantive and pro-
cedural mechanics of the "expert panel" which will review infected
HCWs' requests to perform risky procedures; and 3) determining when
institutions may discriminate against infected HCWs based on risks other
than the risk of HIV transmission.

The CDC's failure to develop a list cataloging all exposure-prone
or risky procedures indicates the difficulties of the first task. Yet,
even abandoning the "exposure-prone" concept will not resolve the prob-
lem. Health care workers and other decision makers must somehow be
able to determine which procedures put patients at risk. Thus, public and
private actors will have an important role in determining what proce-
dures pose significant risks to patients.

The current, beleaguered guidelines suggest that professional groups
and individual institutions should define exposure-prone procedures. The
proposed guidelines suggest that decision makers focus on risky invasive
procedures. In either case, there are several problems: 1) defining the
standard for deciding what procedures might pose unacceptable risks to
patients; 2) determining who will apply that standard; and 3) determin-
ing how to apply the standard.

States adhering to the current CDC approach may wish to establish
standards for determining which procedures are "exposure-prone."
States that abandon the "exposure-prone" concept might nonetheless wish to limit decision makers' discretion by defining broad categories of procedures that do not pose undue risks to patients.

Several sources can guide or limit the identification of risky or low-risk procedures. First, states could profit from the CDC's failed attempt to focus on the particular characteristics of procedures that might put patients at risk. The ordinary practices of health care workers, including their use of universal precautions, must be factored into any standard. Second, and more importantly, identifying risky procedures will be limited by the rationality and significant risk requirements imposed under constitutional and anti-discrimination law.

States may substantially reduce the uncertainty involved in this process by establishing standards for determining when HIV-infected HCWs do not pose a significant risk to patients. Individual practitioners, health care institutions and insurers should not be left to speculate about the kind of procedures that warrant practice restrictions, particularly since this speculation might prove irrationally risk averse. These statu-

mance of a particular job can be shown to present a significant risk, as defined by the board of health by rule, of transmitting HIV infection to other persons." WASH. REV. CODE ANN. § 49.60.172 (1990) (emphasis in original). For example, a bill considered by the Texas Legislature would have required the state Boards of Medicine and Dentistry to define "exposure-prone" by rule. Tex. H.R. 7 (August 1991). As eventually enacted, the Texas statute defines "exposure-prone" through reference to the designations of professional associations or health facilities. TEX. HEALTH & SAFETY CODE ANN. § 85.202(1) (Vernon 1992).

States disagreeing with the CDC's focus on either "exposure-prone" or "risky" procedures might have an opportunity to implement other mechanisms to protect patients, even if the CDC never formally revises its recommendations. Congress has required that states adopt the CDC guidelines or their "equivalent." See supra note 73. Presumably, states have some latitude to adopt other measures designed to protect patients from the risk of HIV transmission. For example, in a draft proposal that still requires legislative action, New York has rejected the mandatory patient notification aspect of the CDC approach. New York State Policy Would Protect HCWs From Forced Disclosure of HIV Status, 6 AIDS POL'Y & L. 1, 2 (Oct. 16, 1991). Instead, the New York State Health Department favors expert review panels individually determining practice restrictions, without notifying patients. Id.

300. CDC, Health Care Recommendations — IV, supra note 51, at 4. "Characteristics of exposure-prone procedures include digital palpation of a needle tip in a body cavity or the simultaneous presence of the HCW's fingers and a needle or other sharp instrument or object in a poorly visualized or highly confined anatomic site." Id.

301. For example, in determining what procedures are more or less risky, a state might at least assume that universal precautions are followed and that the provider is of average competence.
tory provisions should protect public health while ensuring that the pressure of potential litigation does not impermissibly restrict HCWs from non-hazardous procedures.

The second area ripe for state action is the substantive and procedural mechanism for individualized decision making about health care workers. Under the current CDC guidelines, expert review panels will have authority to make important determinations about a HCW’s right to continue to practice. These expert review panels gain even more power under the CDC’s proposed revisions to the July 1991 guidelines. Without state legislation, the composition, authority and potential liability of these panels will remain undefined. The panel decisions may be arbitrary and irremediable. Further, in the absence of some central coordinating authority, the process may be undermined by inconsistent decisions about the nature of the risk posed by some procedures. States might grant decision-making power to licensing boards, state health departments, new regional entities, professional societies or health care institutions.

The current CDC guidelines describe the membership of such panels and provide for substantial involvement by public health officials. One possible approach would be to establish regional panels in which the infected HCW’s personal physician(s) and institutional representatives (if any) could join to hear a particular case. This mechanism could increase the consistency of decisions because of the panel’s accumulated expertise. In addition, state involvement provides the opportunity to establish tort immunity for panel members. Reducing litigation fears might improve the decision-making process. For ex-

302. Accord Lo & Steinbrook, supra note 80, at 1103 (discussing uncertainties surrounding expert review panels).
303. See supra note 64.
304. For example, the New York State Health Department’s recent proposal includes the “development of a set of criteria for determining whether practice limitations are warranted, but the process is based on case-by-case reviews.” New York State Policy Would Protect HCWs From Forced Disclosure of HIV Status, 6 AIDS POL’Y & L. 1, 2 (Oct. 16, 1991).
ample, some states already establish employer immunity for transmission of HIV in the workplace in the same statutory sections prohibiting employer discrimination against HIV-positive applicants or employees.\footnote{306}

Finally, states and institutions must confront fears that HIV-infected HCWs present risks other than the transmission of HIV itself. Focusing on the risk of HIV transmission alone can be misleading.\footnote{307} The CDC guidelines do not discuss whether an infected HCW might be at risk for injury to his or her own health through occupationally acquired disease.\footnote{308} The proposed CDC revisions do suggest that expert review panels evaluate an infected HCW’s physical condition.\footnote{309} However, they do not specifically discuss the potential risks to others posed by secondary infections,\footnote{310} or the potential competency problems created


Under the HCQIA, a “professional review action” which comes within the protection of the act is one which is taken or made in the conduct of professional review activity, which is based on the competence or professional conduct of an individual physician (which conduct affects or could affect adversely the health or welfare of a patient or patients) and which affects (or may affect) adversely the clinical privileges . . . of the physician.

42 U.S.C. § 11151(9) (Supp. 1991). A hospital would argue that a privileges decision based on HIV status is one based on “competence.”

306. For example, Washington provides that “[e]mployers are immune from civil action for damages arising out of transmission of HIV to employees or members of the public unless such transmission occurs as a result of the employer’s gross negligence.” WASH. REV. CODE ANN. § 49.60.172(5) (1990). Vermont has a similar provision, under which co-workers or other persons “[s]hall not have a cause of action in negligence for an injury occurring . . . on the account of an employer complying with” the HIV non-discrimination and HIV testing prohibitions of the statute. VT. STAT. ANN. tit. 21 § 495(d)(1),(2) (1991).

307. See supra note 205.

308. Employers might argue, for example, that HIV-infected individuals themselves might be at risk for acquiring a range of infectious conditions in the health care setting, particularly if they are already immunocompromised.

309. See supra note 83.

310. HIV-infected persons are at risk for a wide range of infectious conditions, most of which pose absolutely no danger to others with competent immune systems. See Beck, \textit{Mycobacterial Disease Associated with HIV Infection}, 6 (Supp.) J. GEN. INTERNAL MED. S19, S20-S21 (1991) (discussing possible infections and risks to others). Tuberculosis is a possible HIV-associated infection, and tubercular HIV-infected HCWs may not respond to the typical screening tests performed at most hospitals. See, e.g., Graham, Nelson, Solomon, Bonds, Rizzo, Seavotto, Astemborski & Vlahov, \textit{Prevalence of Tuberculin Positivity and Skin Test Anergy in HIV-1 Seropositive and
through central nervous system involvement,\textsuperscript{311} psychological distress,\textsuperscript{312} or medication side effects.\textsuperscript{313} 


312. Studies have indicated, for example, that males with HIV infection show significantly higher suicide rates than other males in their age group. \textit{See}, \textit{e.g.}, Marzuk, Tierney, Tardiff, Gross, Morgan, Hsu & Mann, \textit{Increased Risk of Suicide in Persons with AIDS}, 259 JAMA 1333 (1988); and Gross, \textit{900th Suicide Off Golden Gate Is Not Just a Number}, N.Y. Times, July 1, 1991, at A7, col. 1 (suicide of person with AIDS). Other researchers have noted that knowledge of HIV status alone is not necessarily a good indicator of suicidal ideation. Perry, Fishman, Jacobsberg, Young & Frances, \textit{Effectiveness of Psychoeducational Interventions in Reducing Emotional Distress After Human Immunodeficiency Virus Antibody Testing}, 48 ARCHIVES GEN. PSYCHIATRY 143 (1991) (discussing techniques to reduce distress caused by knowledge of HIV-antibody status); and Perry, Jacobsberg & Fishman, \textit{Suicidal Ideation and HIV Testing}, 263 JAMA 679 (1990) (noting no significant increase in suicidal ideation after notification of positive test results).

313. Zidovudine ("AZT"), a commonly prescribed drug for HIV-infected persons, has a number of potential side effects, including nausea, headaches, and insomnia.
Adopting the CDC's current or proposed recommendations will not eliminate an institution's concerns about litigation. Thus, institutions may still attempt to discriminate against infected HCWs in a broader range of circumstances than those contemplated by the CDC guidelines. Yet it is difficult to construct a separate state remedy for these problems. Seemingly, they can be adequately dealt with under the rubric of the federal and state anti-discrimination statutes, discussed in Part III. That is, hospitals and other health care institutions must individually evaluate a HCW to determine whether the HCW is capable of performing the essential aspects of his or her position after being given reasonable accommodation.

B. Testing and Disclosure for Infected HCWs: Guiding the Speeding

PHYSICIANS' DESK REFERENCE 804-05 (1992) (appearing in at least five percent of all patients taking AZT); see also Controller Taken Off Job over AZT Use, Houston Chron., May 19, 1990, at 18A, col. 1 (discussing FAA decision to remove air traffic controller from position based on AZT use and potential side effects).

314. It is more difficult to conceive of a singular risk assessment standard because of individual variations in the course of HIV infection and individual reactions to medications. A CDC-type standardized risk assessment would not be possible.

315. The risk of transmitting other contagious diseases could be examined by universal policies requiring all employees (or those who know they are HIV-positive) to report symptoms of tuberculosis and undergo effective testing for that condition. An institution could also monitor its employees for signs of an active contagious condition (such as coughing or lung congestion). Additionally, if an entity is legally permitted to collect information about an employee's HIV status, it could create a medical monitoring plan that would reduce the risk of tuberculosis transmission to patients and co-workers. In other words, an entity should follow the individualized assessment approach recommended in Arline and reiterated in Congress' amendment of the Rehab Act. See supra notes 174-76 and accompanying text. See also Rothenberg, supra note 178, at 126-128 (discussing employer options if an HIV-infected HCW poses a risk to others or to self). The risk of diminished mental or professional competence also should be evaluated on an individualized basis. See Maffeo, Making Fitness-for-Duty- Decisions About Persons With Disabilities Under the Rehabilitation Act and the Americans With Disabilities Act, 16 AM. J. L. & MED. 279 (1990) (psychological competence issues); and Wyld & Cappel, supra note 311, at 207-12 (discussing application of ADA to AIDS-related dementia); 56 Fed. Reg. 35,745 (interpretive guidelines for 29 C.F.R. § 1630.20(r)). But see Hentoff, supra note 159, at 621-22 (expansive view of employers' ability to consider mental impairment in making job determinations). Finally, under the current regulations, the institution might be able to discriminate against an HIV-infected worker to protect that worker's own health. EEOC Regulations Implementing the ADA, 56 Fed. Reg. 35,736 (1991) (to be codified at 29 C.F.R. § 1630.20(r)). See Connolly & Marshall, supra note 159, at 571; Hentoff, supra note 159, at 622-24. See also Local 1812, 662 F. Supp. 50. Assuming the ADA regulations are sustained, the employer would still be required to make an individualized determination of significance based on credible medical evidence.
Testing Train

Through amendments to licensure provisions or HIV testing legislation, states have an opportunity to settle many of the issues left unresolved by the CDC guidelines. States may wish to establish which HCWs will be tested, frequency of HCW testing, and whether practice restrictions are necessary while awaiting test results. States may also wish to establish disclosure limits and confidentiality in HIV test results.

The best approach to these issues is the voluntary and individualized testing approach explicitly recommended by every version of the CDC guidelines. For example, Texas recently adopted legislation that codified the CDC's individual "duty to know" approach to the testing problem. As the CDC notes, mandatory testing programs waste resources without providing appreciable benefits in risk reduction. Mandatory testing programs undercut public health efforts to encourage voluntary testing and education. However sensible this

316. See, e.g., Field, supra note 19, at 63-102 (Harvard AIDS Legislation Project) (discussing state testing programs for special populations, along with recommendations; no recommendations for testing of HCWs); Clark, AIDS Prevention: Legislative Options, 16 AM. J. L. & MED. 107, 150 (briefly discussing and dismissing HCW screening); Rothenberg, supra note 178, at 149-50, 160-62 (discussing and rejecting HCW screening).


318. TEX. HEALTH & SAFETY CODE ANN. § 85.201 (Vernon 1992). The statute specifically does not require testing, yet requires any testing to comply with the state HIV-antibody testing and confidentiality provisions. Id. at §§ 85.206(4), 85.201(b) (under which employers may impose HIV-antibody testing only if seronegative status is a BFOQ). The statute does not completely prohibit testing imposed by health care entities or employers.

Other states have tended to support voluntary testing without specifically affirming a ban on mandatory testing. See Discipline Urged for Workers Who Fail to Report Colleagues, 6 AIDS POL’Y & L. 3 (Oct. 31, 1991) (Minnesota health commissioner’s proposed guidelines support voluntary testing by HCWs who perform exposure-prone procedures); New York State Policy Would Protect HCWs From Forced Disclosure of HIV Status, 6 AIDS POL’Y & L. 1, 2 (Oct. 16, 1991) (same policy favored by New York State Health Department).

319. CDC, Health Care Recommendations — IV, supra note 51, at 6; accord, Gostin, supra note 217 at 306-07 (costs of screening programs).

320. See, e.g., CENTERS FOR DISEASE CONTROL, U.S. DEP’T OF HEALTH &HU-
approach, it might be difficult for legislatures or hospitals to resist public demands to require some form of HCW screening.\textsuperscript{321} Under these circumstances, the next best option is to ensure that any testing programs are carefully limited and regulated.

The CDC's current and proposed recommendations imply that only HCWs participating in exposure-prone or merely invasive procedures need to know their HIV status. States could effectively implement the CDC approach, by prohibiting testing of any worker who does not participate in such procedures as a regular and essential part of his or her duties.\textsuperscript{322} This would permit testing by licensing agencies or institutions only when HCWs participate in procedures that might put patients at risk. At the same time, this approach would protect HCWs from unnecessary privacy invasions.

Insurance company testing or mandatory disclosure requirements may be as, or more, important to HCWs than employer-imposed testing.\textsuperscript{323} Insurance companies, afraid of litigation and potential liability arising out of the professional practice of HIV-infected HCWs, may seek

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322. In defining this group of HCWs, the "reasonable accommodation" and "essential functions of the job" requirements of federal disability discrimination laws must be implemented. See supra notes 159-63 and accompanying text. For example, testing programs must not be based on the fact that a particular HCW might be called upon to perform exposure-prone or invasive procedures. Rather, the emphasis should be on the duties that the HCW actually must be able to perform regularly.

States should also consider defining either "exposure-prone" or "invasive" to clearly exclude a range of ordinary health care activities that pose no risk to patients, even though they might seem "invasive" in some sense. See supra note 83 (CDC restricts definition of "invasive" in proposed guidelines).

323. "Numerous malpractice insurers have either started demanding to know the HIV status of their insured or announced that they will no longer cover legal claims involving a patient's alleged seroconversion while undergoing an invasive procedure."
\textit{CDC Plans}, supra note 81, at 11 (letter to the CDC from the Lambda Legal Defense and Education Fund, the ACLU, and the Gay Men's Health Crisis); accord McLaughlin, \textit{AIDS Testing—How Far to Go?}, Boston Globe, Aug. 28, 1991, at 31A, col. 3, 4 ("Ironically, it is expected that malpractice insurers—not medical knowledge or concern for patients—will force the widespread testing of medical personnel."). Some malpractice insurance companies are reportedly offering incentive payments to HIV-infected physicians who restrict their practices. Mayer, \textit{Insurers Pay Docs with HIV to Quit}, HEALTH WEEK, Nov. 18, 1991 at 1, col. 4.
to reduce their liability by selective underwriting practices. They may require testing for practitioners who plan to perform invasive procedures or they might impose broader testing requirements for all health care workers. Malpractice insurance coverage is a virtual precondition for practicing as a health care professional. Therefore, inability to obtain coverage will have the same impact as outright employment discrimination.

For the most part, federal and state statutes prohibiting discrimination against individuals with disabilities are inapplicable to insurance company underwriting practices. Insurance companies are primarily

324. News reports indicate that the Acer case resulted in a million dollar payout to Kimberly Bergalis, establishing the potential for serious losses if transmission should ever occur. AIDS L. & LITIGATION REP. (Monthly Rev.) 11 (Feb.-March 1991).

Insurer payments are typically based on allegations of malpractice by the insured. Health care providers who transmit HIV to their patients or to co-workers while providing care conceivably might be held liable for malpractice. See, e.g., Davis v. Rodman, 227 S.W. 612 (Ark. 1921) (duty of physician to avoid spreading infectious diseases). Similarly, a physician's failure to inform a patient of his/her own HIV status might result in liability under the informed consent doctrine. See, e.g., Estate of Behringer, 592 A.2d 1251 (court upholds hospital restriction of HIV-infected physician's admitting privileges; restriction required physician to inform patients of his serostatus and obtain special consent). Liability in these cases is uncertain for a host of factual and legal reasons, including the problems of proving causation and the uncertainty surrounding the scope of the physician's duty to refrain from practice or to disclose her/his status. In fact, the CDC guidelines arguably establish a standard of care that requires only limited practice restraints and limited disclosure. See CDC, Health Care Recommendations — IV, supra note 51, at 5 (guidelines suggest that patients be notified if infected HCW will perform exposure-prone procedures); and CDC, Proposed Health Care Recommendations, supra note 83, at 2 (panel "may" recommend disclosure to patients).

Furthermore, even if a health care provider is found liable, insurance companies might evade defense or indemnification obligations. Insurance companies have avoided liability obligations in a parallel line of cases involving the transmission of herpes and other venereal diseases between sexual partners, under the theory that an insured's intentional acts are excluded from coverage. See, e.g., State Farm Fire & Casualty Co. v. Eddy, 218 Cal. App. 958, 267 Cal. Rptr. 379 (Cal. App.), reh'g denied, 1990 Cal. Lexis 2306 (Cal. 1990). But see S.S. & G.W. v. State Farm Fire & Casualty Co, 808 S.W.2d 668 (Tex. Ct. App.—Austin 1991) (writ filed July 23, 1991) (reversing summary judgment for insurer; holding that insurance company must show intent); Loveridge v. Chartier, 468 N.W.2d 146 (Wisc. 1991) (no evidence that insured knew of risk or intended to transmit herpes).

325. For instance, the ADA specifically excludes certain insurance practices from its coverage:

[The ADA's employment provisions] shall not be construed to prohibit or restrict—
subject to state regulation.\footnote{326} In most states, insurance companies may ask questions or perform examinations designed to determine the underwriting risk associated with a particular policy. Under this general rule, insurance companies may ask policy applicants about their HIV status or require applicants to undergo HIV-antibody testing.

A few states have regulated insurance company use of HIV-antibody testing.\footnote{327} However, state regulation often merely provides procedural protection to prevent discriminatory testing;\footnote{328} it generally does

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\item an insurer, hospital or medical service company, health maintenance organization, or any agent, or entity that administers benefit plans, or similar organizations from underwriting risks, classifying risks, or administering such risks that are based on or not inconsistent with State law; or
\item a person or organization covered by this chapter from establishing, sponsoring, observing or administering the terms of a bona fide benefit plan that are based on underwriting risks, classifying risks, or administering such risks that are not inconsistent with State law; or
\item a person or organization covered by this chapter from establishing, sponsoring, observing or administering the terms of a bona fide benefit plan that is not subject to State laws that regulate insurance.
\end{enumerate}

\textbf{42 U.S.C. § 12201(c) (Supp. 1991).} The only limitation to this exemption is that it cannot "be used as a subterfuge to evade the purposes of the employment discrimination provisions." \textit{Id.} Under these ADA provisions, a health care employer who provided employee malpractice coverage would be permitted to use HIV information to underwrite risk, unless such use were found to be a subterfuge designed to evade the anti-discrimination provisions.

Under the ADA's anti-discrimination provisions governing public accommodations, insurance offices are considered places of public accommodation. \textbf{42 U.S.C. § 12181(7)(F) (Supp. 1991).} One commentator has argued that this provision could be used to prohibit HIV-related discrimination against HIV-infected HCWs in malpractice insurance: "Under the ADA, a public accommodation (such as an insurance company) may not impose an 'eligibility criterion' that screens out persons with disabilities unless the business demonstrates that the criterion is 'necessary' for the provision of its goods or services." Feldblum, \textit{supra} note 44, at 137. The problem will be determining whether the risk of liability constitutes such a necessity.

\footnote{326} The McCarran-Ferguson Act provides that insurance company activities are subject to state control. \textbf{15 U.S.C. § 1012(a) (1988)} ("[t]he business of insurance, and every person engaged therein, shall be subject to the laws of the several States which relate to the regulation or taxation of such business"). To the extent that state regulation is absent, insurance companies are also subject to specifically applicable federal acts and federal antitrust laws. \textit{Id.} at § 1012(b).

\footnote{327} See, \textit{e.g.}, \textbf{TEX. REV. CIV. STAT. ANN. art. 21.21-4 (Vernon 1991)} (regulating use of HIV-antibody testing by certain insurers).

\footnote{328} See, \textit{e.g.}, \textbf{TEX. REV. CIV. STAT. ANN. art. 21.21-4.}
not prohibit testing itself.\textsuperscript{329}

As a result, insurance companies offering professional liability coverage may be free to either require HIV-antibody testing or ask applicants about their serostatus. Applicants who are HIV-positive may then be denied coverage or be given restricted coverage that does not cover injuries arising out of some class of “risky” practice procedures. States must, therefore, separately address the use of HIV-antibody testing in malpractice coverage underwriting, as some have already done with respect to health and life insurance coverage. A narrowly tailored state rule could at least prohibit HIV-antibody screening for underwriting decisions about HCWs who do not perform invasive procedures.\textsuperscript{330}

Identifying the HCWs subject to testing is merely the first step. The process of testing, itself, raises a number of mechanical and substantive subsidiary issues, including testing frequency and test result use, neither of which are mentioned in either the current or proposed CDC recommendations.\textsuperscript{331} State legislatures, licensing organizations and in-
stitutions must develop sensible policies to implement the CDC's broad policy statements.

Both procedural and substantive state regulation are very important. A state should establish guidelines to ensure that testing is applied uniformly, if it is to be required at all. States should also ease the implementation of the CDC guidelines by ensuring that strong state laws protect the confidentiality of test results.

Needle-sharing activity. Clearly, some HCWs would be subjected to frequent testing under this regime. See, Lo & Steinbrook, supra note 80, at 1102-03 (discussing uncertainties created by current CDC guidelines).

Therefore, mechanical details can be very important. A state should establish that a HCW has no duty to refrain from practice while awaiting post-exposure test results. A failure to establish such a principle will lead to impracticable and wasteful practice restrictions on many HCWs, while failing to appreciably reduce the risk to patients. Yet, in the absence of some state regulation, the fear of potential litigation might drive institutions or insurers to require such restrictions.

States may also wish to consider regulating many of these same issues in the patient testing sphere. See, e.g., Gostin, Hospitals, Health Care Professionals, and AIDS: The "Right to Know" the Health Status of Health Professionals and Patients, 48 Md. L. Rev. 12 (1989); Furrow, AIDS and the Health Care Provider: The Argument for Voluntary HIV Testing, 34 Vill. L. Rev. 823 (1989); and CDC Urges Tests for Hospital Patients; Says They Should be Offered Routinely, 6 AIDS POL'Y & L. 1, 8 (Oct. 2, 1991) (discussing CDC revisions of its patient testing recommendations).

Infected patients present a small risk of transmission to HCWs, but the risk is greater than HCW-to-patient transmission. Thus, the CDC guidelines indirectly raise the issue of patient testing. Health care workers, if HIV-positive, may now be subject to testing and practice limitations and may claim a right to know their patients' HIV-antibody status.

In theory, serologic testing of some patients could provide safety benefits for HCWs by helping them identify when universal precautions should be most stringently enforced, or by permitting the use of supplemental procedures or equipment that would be impractical for all patients, regardless of serostatus. The CDC has repeatedly failed to recommend blanket patient screening, instead leaving the decision to individual physicians and hospitals. See e.g., CDC, Health Care Recommendations — II, supra note 25, at 14S. However, the CDC has recently indicated that routine screening of some patients might be justifiable. CDC Urges Tests for Hospital Patients; Says They Should be Offered Routinely, supra, at 1.

The factors militating against such testing programs include: the threat to patient privacy; the economic costs of testing; and the fear that test results will be used to deny treatment to HIV-infected patients. "Routine" testing of physicians or hospital patients may result in injury if consent to testing is not truly informed or if positive test results lead to the loss of insurance or employment outside the health care setting. Such testing may also be extremely expensive, while providing only marginal and unknown benefits from risk reduction. These considerations are particularly important given the lack of opportunity for testing in emergency situations and the problems posed during the period when truly HIV-infected persons will nonethe-
Confidentiality is always an important factor in medical care and is particularly crucial to encourage HCW participation. Breaches of confidentiality can have devastating results, and confidentiality laws cannot be expected to completely stem the inexorable flow of highly sensitive information. Nevertheless, state rules will benefit practitioners and institutions concerned with the sometimes conflicting disclosure standards that are advocated by professional and public health groups.

The CDC’s current and proposed guidelines do not clearly suggest a single legally or medically permissible response to confidentiality problems. Therefore, the recommendations probably may not be used to legally limit publicly or privately imposed disclosure duties. However, the CDC’s recommendations do suggest that certain policy choices might be better than others. The CDC guidelines suggest an individualized and voluntary approach to HIV risk reduction, rather than a blanket coercive policy. Individual practitioners who wish to perform procedures that might put patients at risk should undergo private testing, with HIV-infected HCWs voluntarily restricting their practices or seeking the counsel of the CDC’s suggested “expert panel.” Despite these guidelines, HIV status disclosure will probably be imposed by a few state licensing agencies, some health care institutions, and many malpractice insurers. The HIV information collected by these groups requires the development of appropriate confidentiality safeguards. In addition, there is the related

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less test negative. Finally, many public health professionals are concerned that mandatory testing of HCWs will inevitably lead to diminished access to health care for the most needy patients in the system. See, e.g., New York Academy of Medicine, supra note 46; Whelan, Why AIDS Tests for Doctors Won’t Work, Wall Street J., July 19, 1991, A-16, col. 4-6.

States concerned with the issue of HCW testing may wish to consider patient testing in tandem, because of the close identification of the two issues. See, e.g., TEX. HEALTH & SAFETY CODE ANN. §§ 81.102-.103 (Vernon 1992) (testing and confidentiality requirements). In addition, states may wish to consider imposing legal obligations to treat HIV-positive patients. Physicians and others might have some ethical duty to treat HIV-infected patients under some circumstances. See, e.g., Daniels, Duty to Treat or Right to Refuse, HASTINGS CENTER REP. 36 (March-April 1991). The legal obligation to treat has been less clear, particularly outside the emergency room context. For example, private doctors’ offices have greater freedom to discriminate against HIV-infected patients, because they may not be covered by state disability discrimination statutes. The ADA will clearly protect against discrimination at such offices, assuming they have a sufficient impact on commerce. 42 U.S.C. § 12181(7)(F) (Supp. 1991) (defining places of public accommodation to include the “professional office of a health care provider, hospital, or other service establishment”). States could also specifically require health care providers to avoid discriminating against HIV-infected patients.

333. See infra note 335.
question of whether HCWs have any duty to inform their patients of their HIV status.\textsuperscript{334}

A few courts have already found hospitals liable for damages based on breach of their duty to keep HIV-related records confidential.\textsuperscript{335} Potential liability need not be limited to tort suits; failure to segregate and maintain the confidentiality of employee medical information could result in liability under federal or state statutes. The ADA will require that entities maintain the confidentiality of medical records of disability, with access denied to most persons in the workplace.\textsuperscript{336} Similarly, a number of states have laws requiring that HIV-antibody test results be

\textsuperscript{334} For example, Illinois has already adopted a stringent law requiring disclosure of a HCW's HIV-positive status to a patient who has undergone an invasive procedure. 1991 Ill. Legis. Serv. 87-763 (West); Notification Measure Signed in Ill.; Cost, Effectiveness Still Debated, 6 AIDS POL'Y & L. 2, 2-3 (Oct. 16, 1991). The disclosure can be made by the provider or by the state's contact tracing program.

\textsuperscript{335} Some of the difficulties of maintaining the confidentiality of this information have already been revealed in litigation. In the \textit{Behringer} case, a physician suffering from seemingly intractable pneumonia underwent HIV-antibody testing while a patient at the hospital in which he practiced. \textit{Estate of Behringer}, 592 A.2d at 1260-63. Although the hospital had a code system for maintaining the confidentiality of testing samples submitted to the hospital laboratory, it did not have special procedures for maintaining the confidentiality of results once they were hand-delivered to patients' charts. The hospital did not have procedures for segregating HIV-related information or for restricting access to charts, nor did it have an educational program designed to impress upon its staff the need for confidentiality. \textit{Id.}

The results in this case were predictable: within hours of the entry of Behringer's test results on his chart, he was receiving phone calls from hospital personnel, physicians, and even patients, all of whom showed an awareness of the nature of his condition. Behringer's practice was gutted after his patients fled. \textit{Id.}

The court described the duty to maintain confidentiality in broad terms: Because the stakes are so high in the case of a physician being treated at his own hospital, it is imperative that the hospital take reasonable steps to insure the confidentiality of not only an HIV test result, but a diagnosis which is conclusive of AIDS, such as PCP [\textit{Pneumocystis carinii} pneumonia]. These precautions may include a securing of the chart, with access only to those HCWs demonstrating to designated record-keepers a bona-fide need to know, or utilizing sequestration procedures for those portions of the record containing such information. \textit{Id.} at 1272-73. See generally Obade, \textit{Whisper Down the Lane: AIDS, Privacy, and the Hospital "Grapevine,"} 2 J. CLINICAL ETHICS 133 (1991); \textit{HIV-Infected Surgeons: Behringer v. Medical Center}, 266 JAMA 1134 (1991). \textit{See also Doe v. Westchester Medical Center}, discussed supra note 196.

\textsuperscript{336} Supervisors or managers might have access to the information if it is needed to fulfill the ADA's reasonable accommodations requirements. See 56 Fed. Reg. 8578, 8590 (EEOC regulations implementing the ADA) (to be codified at 29 C.F.R. \S\ 1630.14(b),(c)).
kept confidential. Public entities may have a constitutional duty to maintain the confidentiality of private information. States could establish standards for the separation of medical and employment information, they could require segregation of HIV information on medical charts, or they could impose stiff penalties for the unlawful disclosure of HIV status.

While some of the testing problems center on the need to keep HIV-status confidential, there also might be a duty to disclose a test result under some circumstances. Major developments in patient rights have occurred over the past twenty years. A patient’s right to control her own care is central to the doctrine of informed consent, which permits the patient to make informed decisions about the risks she wishes to encounter. A major focus of public and legislative debate has been the need to establish if and when a HCW must inform a patient of the HCW’s HIV infection.

338. Whalen v. Roe, 429 U.S. 589 (1977); Doe v. Coughlin, 697 F. Supp. 1234 (N.D.N.Y. 1988) (prisoner has protected privacy interest in HIV status); Woods v. White, 689 F. Supp. 874 (W.D. Wis. 1988). See also Schulman, AIDS Workplace Law and Policy: A Systemic Analysis, 9 ST. LOUIS U. PUB. L. REV. 543, 545-46 (discussing constitutional privacy interest in HIV-status information). In Whalen, the court suggested that there was a constitutionally protected interest in maintaining the confidentiality of certain information. L. TRIBE, supra note 107, at 1302-04. Although privacy rights are currently under attack, the informational strand of cases seemingly might survive if they can be severed from the abortion/sexuality cases. See Bowers v. Hardwick, 478 U.S. 186 (1986) (no protected interest in homosexual activity).
339. If a hospital or health care entity legally collects HIV information about employees or others, there may be some circumstances in which the information must be disclosed to others in order to safeguard health or safety. Any state statute should specifically define the range of circumstances in which disclosure is permitted. For example, presuming a valid testing program, a hospital infection control officer might be given legal access to a test result. There already has been some litigation centered on a hospital’s ability to disclose HIV information to patients. In re Application of the Milton S. Hershey Medical Center, 595 A.2d 1290 (Pa. Super. 1991) (permitting release of OB/GYN’s HIV status to patients under state HIV confidentiality statute); see also, N.Y. Supreme Court Justice’s Opinion Criticizes Abdication of Responsibilities in Testing, 7 AIDS POL’Y & L. 1 (Feb. 20, 1992) (discussing order granting state health department access to a deceased HIV-infected dentist’s patient records).
340. See supra notes 39 and 47. The debate has divided those who ordinarily would advocate a patient’s right to know, primarily because the right to know in this case may conflict with some HCWs’ practical ability to continue to practice. For other commentaries, see Daniels, HIV-Infected Health Care Professionals: Public Threat or Public Sacrifice, 70 MILBANK Q. 3, 32-39 (1992) (arguing that social benefit maximized where no duty to disclose); Gostin, supra note 267, at 304-05 (disclosure of risk to patients is not necessary: if risk exists, procedure should not be per-
Two different standards govern the scope of disclosure in informed consent cases. A slight majority of the states adhere to the medical practice standard, which requires disclosure of that which a physician of minimal competence would disclose in like circumstances. The second approach, which is patient-centered, requires disclosure of material risks that a reasonable patient would consider in making a determination about whether to undergo a particular procedure. In the majority of jurisdictions, the requisite scope of a physician's disclosure will be determined by good medical practice, and professional organization guidelines would be relevant. In the patient-centered jurisdictions, the problem becomes more difficult. The standard is premised on a reasonable patient's consideration of material risks, yet a significant proportion of patients may have difficulty "rationally" considering HIV-related risks. Only one court has confronted the issue, holding that a hospital could require a surgeon to disclose his HIV status to patients before performing invasive procedures.

The CDC guidelines might be said to establish a standard by implication, since they appear to require disclosure only when an infected HCW is performing certain risky procedures under the auspices of a medical expert panel's recommendations. The CDC guidelines are silent on the issue of additional disclosure requirements. Arguably, this represents a determination that the risks of other procedures are not material, or at the least, that they are not disclosable risks under standard medical practice. The resolution of these issues is made difficu-
cult by the different stances on disclosure taken by medical and professional organizations.

The CDC guidelines fail to deal adequately with many of the important issues raised by a HCW's new duty to know his or her HIV-antibody status. Although the guidelines explicitly reject mandatory testing, they are internally inconsistent. The CDC's recommendations may be used by states, hospitals, insurance companies, or others, to impose screening programs on HCWs. The groups of HCWs subject to testing, the frequency of testing, and the confidentiality of the results may all be subject to inconsistent private and public determinations. Furthermore, the scope of disclosure requirements may potentially lead to excessive disclosures, which do not advance patient autonomy so much as they may sow the seeds of irrational discrimination.

VI. CONCLUSION

The CDC reentered the debate about HIV-infected HCWs at a difficult moment, in the midst of public concern sparked by the Acer case. The CDC is apparently recommending new duties for HCWs who perform certain invasive procedures. Health care workers who perform invasive procedures now have the duty to know their HIV status and, if HIV-positive, have a duty to refrain from participating in certain—currently unspecified—procedures, unless permitted to do so by an expert medical review panel. With their focus on exposure-prone procedures, the CDC's current recommendations represent a subtle but clear shift away from the prior policy of individualized risk assessment for potentially infected health care workers. Proposed revisions to these recommendations would return to individualized assessment, but still fail to guide entities making these critical determinations.

The CDC's current policy lies outside the outer boundary of medically justifiable restrictions on the practice and privacy of HCWs. Courts may decide that this policy represents an irrational response to risk, or that it advocates impermissible discrimination against persons who pose no significant risk to others. If appropriately applied, the CDC's proposed revised policy might avoid the irrationality problems plaguing its July 1991 guidelines. Yet, the proposed revisions create other infirmities, including the risk of arbitrary and capricious determinations by standardless, ill-defined decision makers. Both the current and proposed policies present the specter of more mandatory HCW testing programs.

Despite these flaws, courts will likely uphold state or private actions implementing the CDC's proposed revised approach. On the other hand, state or private policies that impose more stringent restrictions should be vulnerable to constitutional or statutory attack. Finally, a
substantial and important role remains for the states, which must guide the regulation of HIV-infected health care workers. Patient protection ultimately depends on states’ willingness to confront some of the many issues left unresolved—or unrecognized—by the CDC.