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Introduction

HEALTH CARE WORKERS AND AIDS

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My association with the disease known as acquired immune deficiency syndrome (AIDS) began in the spring of 1981. Dr. William Foege, then director of the Centers for Disease Control (CDC), was briefing me in preparation for my Senate confirmation hearings on my nomination as Assistant Secretary for Health. At the end of the briefing, Dr. Foege mentioned the reports of three young homosexual men in Los Angeles. Each of these men had severe immune deficiency of unknown cause and *pneumocystis carinii* pneumonia. Immune deficiency is a very unusual finding in otherwise healthy people and there usually is a clear cause, such as certain medications. In this instance, there was none. Within the next couple of months, two additional cases were reported from the University of California-Los Angeles Medical Center (UCLA) and on June 5, 1981, the CDC published a description of the first five cases.¹ This was followed approximately one month later by a report of more than twenty young men primarily from New York with severe immune deficiency and Kaposi's sarcoma.² Since then, the number of

* President, University of Maryland at Baltimore. B.S., University of Oklahoma, 1954; M.D., University of Oklahoma School of Medicine, 1960; Ph.D., University of Oklahoma, 1963. The views and conclusions in this introduction are based on the author's experience and knowledge in addressing the social, medical, and legal problems associated with the acquired immune deficiency syndrome (AIDS).

1. Centers for Disease Control, *Pneumocystis Pneumonia—Los Angeles*, 30 MORBIDITY & MORTALITY WEEKLY REP. 249, 250-51 (1981).

2. Centers for Disease Control, *Kaposi's Sarcoma and Pneumocystis Pneumonia Among Homosexual Men—New York City and California*, 30 MORBIDITY & MORTALITY WEEKLY REP. 305 (1981).

reported cases of AIDS has grown to well over 70,000.³ There have been more than 41,000 deaths⁴ and the best estimates are that approximately one and one-half million Americans are infected with the virus that causes this illness.⁵

Although three states have reported over half the cases in the United States,⁶ each of the fifty states has reported at least one case.⁷ New York City has the largest number of cases among major American cities.⁸ In fact, epidemiological studies indicate that New York City has one of America's highest incidences of infection.⁹ Furthermore, every region of the world has reported cases.¹⁰ The central African countries have been especially hard hit by this epidemic. In the last three years, the World Health Organization (WHO) has mobilized a world-wide effort to fight this infection. Headed by an American, Dr. Jonathan Mann, this effort is beginning to show results with education primarily directed towards decreasing the sexual spread.¹¹

The history of AIDS is one of remarkable scientific achievement. Never in the history of man has so much been learned about so complex an illness in so short a time. Consider, for example: the disease was described in June 1981,¹² the epidemiology was described by May 1983,¹³ and it has changed very little since then; the cause was known by April 1984,¹⁴ a blood test for antibodies to the

3. Centers for Disease Control, *United States Cases Reported to CDC*, AIDS WEEKLY SURVEILLANCE REP., Oct. 17, 1988, at 1.

4. Centers for Disease Control, *Cases of AIDS and Case-Fatality Rates By Half-Year of Diagnoses, United States*, AIDS WEEKLY SURVEILLANCE REP., Oct. 17, 1988, at 5.

5. A recent article by scientists with the AIDS Program of the Centers for Disease Control (CDC) reported that the prevalence of HIV antibodies in United States military recruits ranges from 3 to 10 times the incidence of reported AIDS cases. Curran, Jaffe, Hardy, Morgan, Selik & Dondero, *Epidemiology of HIV Infection and AIDS in the United States*, 239 SCI. 610, 613 (1988) [hereinafter Curran]. Although this data cannot be used directly to predict exposure in the general population, it is suggestive of the extent of the problem.

6. Centers for Disease Control, *AIDS Cases by State of Residence and Date of Report to CDC*, AIDS WEEKLY SURVEILLANCE REP., Oct. 17, 1988, at 2.

7. *Id.*

8. Centers for Disease Control, *AIDS Cases by Date of Diagnosis and Standard Metropolitan Statistical Area (SMSA) of Residence*, AIDS WEEKLY SURVEILLANCE REP., Oct. 17, 1988, at 3.

9. Curran, *supra* note 5, at 613.

10. Piot, Plummer, Mhalu, Lamboray, Chin & Mann, *AIDS: An International Perspective*, 239 SCI. 573, 578 (1988).

11. *Id.* at 574.

12. S. PANEM, *THE AIDS BUREAUCRACY* 7-8 (1988) [hereinafter S. PANEM].

13. *Id.* at 15.

14. *Id.* at 25-26.

causative agent was commercially available by June 1985;¹⁵ and a treatment was available late in 1986.¹⁶ Let me hasten to add that this treatment is not a cure, but in many instances, it has been successful in improving the quality of life and lengthening the life of those taking it.

I. CAUSE AND METHODS OF THE SPREAD OF AIDS

The cause of this disease is a virus known as human immunodeficiency virus (HIV). It is a retrovirus, a class of viruses which is rarely involved in human disease. We now know a great deal about the biology of this virus and most new treatments are based upon this understanding.

The methods of transmission of HIV also are well known.¹⁷ HIV can be transmitted by sexual intercourse, either vaginal or anal; by the contamination of uninfected blood by infected blood; and by maternal transmission to an unborn child.¹⁸ It is clear that this virus is not transmitted by mosquitoes or other insects;¹⁹ by casual contact such as shaking hands, hugging, or simply being around another person, sneezing, coughing or breathing;²⁰ or by inanimate objects such as toilet seats or eating utensils.²¹ HIV is spread by particular human behaviors, primarily sexual activity. It is preventable if people can be convinced to change their behavior.

The typical clinical course of HIV infection is as follows. The first phase is one of asymptomatic infection. In this situation, the individual is infected with the virus but has no evidence of illness. Infected people are capable of transmitting the virus; it is important, therefore, that they know they are infected so they can be taught to protect others. Infection is detected by the presence of antibodies to the virus circulating in the blood stream. A second phase is often called AIDS-Related Complex (ARC), which describes people who are symptomatic but do not fit the definition of AIDS put forth by the CDC.²² Nevertheless, people with ARC are ill and require treatment. Finally, there is AIDS itself, characterized by HIV infection,

15. *Id.* at 114-15.

16. S. PANEM, *supra* note 12, at 66, 177 n.7.

17. Curran, *supra* note 5, at 614-15.

18. *Id.* at 614.

19. *Id.* at 615.

20. *Id.*

21. Curran, *supra* note 5, at 615.

22. U.S. DEP'T OF HEALTH & HUMAN SERVS., SURGEON GENERAL'S REPORT ON ACQUIRED IMMUNE DEFICIENCY SYNDROME 11 (Apr. 1987).

severe immune deficiency, and a secondary illness that is potentially fatal.

II. NEW NATIONAL REPORTS

This year two new reports on the epidemic were released.²³ These reports were prepared by independent groups, yet they are remarkably similar in their strategies for containing the epidemic. One of their primary recommendations is that the illness be referred to as HIV disease rather than AIDS.²⁴ This makes sense because most studies indicate that a majority of people with the infection will become symptomatic. A second major recommendation is enhancement of education designed to persuade people to alter their behavior to protect themselves from infection.²⁵ Education is our only vaccine at present. Convincing people to change sexual behavior is very difficult. Nevertheless, we must try.

AIDS is a preventable disease. All people must know how to protect themselves. In the United States, the United States Public Health Service recently mailed to every household a brief pamphlet that described precisely how one can prevent being infected.²⁶ It is too early to know how effective this pamphlet has been, but studies will be undertaken. Of special importance are health care workers (HCWs). HCWs must understand this infection, how it is spread, and the clinical picture that it presents. There are two reasons for this. First, HCWs may very well enter treatment situations with infected persons, and they must know that necessary precautions, such as wearing protective clothing when performing any invasive procedure, must be taken. Second, they should be able to teach others to protect themselves. Most people look to HCWs for information about health, and an accurate response is possible only if there is knowledge.

III. BLOOD TESTING

One cannot discuss the epidemic of HIV disease without dis-

23. INST. OF MED., NAT'L ACAD. OF SCI., *CONFRONTING AIDS—UPDATE 1988* (1988) [hereinafter *CONFRONTING AIDS UPDATE*]; PRESIDENTIAL COMM'N ON THE HUMAN IMMUNODEFICIENCY VIRUS EPIDEMIC, *REPORT OF THE PRESIDENTIAL COMMISSION ON THE HUMAN IMMUNODEFICIENCY VIRUS EPIDEMIC* (June 1988) [hereinafter *PRESIDENT'S COMM'N*].

24. *CONFRONTING AIDS UPDATE*, *supra* note 23, at vi; *PRESIDENT'S COMM'N*, *supra* note 23, at xvii.

25. *PRESIDENT'S COMM'N*, *supra* note 23, at 75.

26. CENTERS FOR DISEASE CONTROL, U.S. PUB. HEALTH SERV., *WHAT YOU SHOULD KNOW ABOUT AIDS* (1988).

cussing the issues of testing and counseling. Blood tests are available to detect the presence of antibodies to the HIV. The presence of these antibodies is clear evidence of infection but the converse is not necessarily true. To preserve confidentiality and encourage participation, test sites have been established all over the United States, providing either anonymous testing or absolute protection of identifying information.²⁷ Counseling is a critical element in the testing environment. All people who volunteer for testing should be taught the methods of transmission and how they can protect themselves and their sexual partners from this virus. Testing without counseling accomplishes little.

During the past five years, numerous proposals have been put forth to require testing of one or another group. The federal government has mandated testing for persons entering federal prisons, enlistees in the military services, blood and tissue donors, and persons seeking entry into the United States for purposes of obtaining citizenship.²⁸ Legislation has been introduced in various states to require testing of persons applying for marriage licenses, prisoners, persons entering hospitals, and persons arrested for sex crimes.²⁹ Indeed, both Illinois and Louisiana have passed laws mandating testing of all persons applying for marriage licenses.³⁰ Illinois is now taking steps to repeal this law because very few positive tests were obtained and the law caused very long delays in obtaining marriage licenses.³¹ In addition, the number of marriage licenses issued dropped markedly as persons went to other states to get married.³²

Mandatory testing raises a number of issues, not the least of which are civil rights issues. On a more pragmatic level, there is the very high cost associated with testing and counseling, as well as the very low prevalence of infection. For example, current regulations require the testing of all blood donated for use in other people.³³ Approximately four of every ten thousand units donated are infected.³⁴ Although it is important to test blood to be used for transfusions, as well as organs that are to be transplanted, in order to avoid direct transmission, the results are consistent with known epi-

27. Dickens, *Legal Rights and Duties in the AIDS Epidemic*, 239 SCI. 580, 581 (1988).

28. *Id.* at 580-81.

29. CONFRONTING AIDS UPDATE, *supra* note 23, at 75-79.

30. *Id.* at 77.

31. *Id.* at 77-78.

32. *Id.*

33. CONFRONTING AIDS UPDATE, *supra* note 23, at 75.

34. Curtan, *supra* note 5, at 613.

demiology.³⁵ Furthermore, mandatory testing will not stop the spread of the virus unless persons testing positive are prevented from engaging in sexual activity.

Another issue is confidentiality. If we undertake a massive mandatory testing program, will it be possible to maintain the results in a confidential manner? What will be done with the information? For example, would the state prevent an uninfected person marrying an infected one? If not, would it prevent them from engaging in sexual activity? For all of these reasons, the Maryland Governor's Advisory Council on AIDS (the Governor's Council),³⁶ and virtually every other group, including the Presidential Commission on the Human Immunodeficiency Virus Epidemic (the President's Commission) and the Institute of Medicine Study Committee, have recommended voluntary testing rather than mandatory testing.³⁷ Yet all of these groups encourage voluntary testing of people who engage in high risk behavior, who are taking intravenous (IV) drugs, or who are engaging in sexual activities outside of a mutually monogamous relationship.³⁸ In that way, they can be taught how to protect their sexual partners and persons with whom they share needles.

Some HCWs, especially surgeons, have gone on record favoring mandatory testing of all hospital admissions or all people who will undergo some invasive medical procedure.³⁹ This view apparently is based on grounds that they would take additional precautions in performing such procedures if they knew the patient was infected. Yet that position ignores the fact that, following infection, it takes from six weeks to six months for a person to develop antibodies sufficient to be detected by the currently available blood test. Consequently, there is a period during which a person will test negative but will, in fact, be capable of transmission. HCWs who do not take precautions with persons testing negative are nevertheless still at great risk of becoming infected.

IV. DUTY TO WARN

The phrase "duty to warn" has engendered suspicion and fear

35. *Id.*

36. GOVERNOR'S TASK FORCE, AIDS AND MARYLAND, 18 (1988).

37. CONFRONTING AIDS UPDATE, *supra* note 23, at 75; PRESIDENT'S COMM'N, *supra* note 23, at 75.

38. CONFRONTING AIDS UPDATE, *supra* note 23, at 74-75; PRESIDENT'S COMM'N, *supra* note 23, at 75.

39. CONFRONTING AIDS UPDATE, *supra* note 23, at 98.

in health care professionals (HCPs). The connotation that this responsibility supersedes all others is a concept that is in direct conflict with the ethical precept that the primary duty of physicians, or other HCPs, is to their patients.

The current intense interest in a duty to warn has been engendered by the AIDS epidemic. HIV disease has given rise to many moral, religious, and ethical concerns. Furthermore, there is a whole body of law and tradition pertaining to sexually transmitted diseases (and some other infectious diseases) that does not pertain to other acute illnesses.⁴⁰ For all of these reasons, consideration of the duty to warn has assumed great importance.

My purpose is to present an overview of aspects of the debate now underway, not an exhaustive review of all of the major factors to be considered.

One can approach a duty to warn from many points of view. One approach involves the obligation of citizenship. By tradition and custom rather than law, every citizen is expected to contribute to the quality of life in the community. That includes reporting crime and the potential for crime. Child abuse and spousal abuse, for example, are heavily dependent on reports of neighbors and other citizens. In this context, persons who are aware of someone's knowingly spreading HIV by continued sexual activity would be expected to report what they know. Because sexual activity is such a private matter, not likely to be known by anyone other than the participants, this is not an important factor in stopping the spread of AIDS. Yet there are anecdotal reports of sexual partners, including spouses, who have become suspicious of their partners and reported them to local health officials.

A second approach to a duty to warn concerns legal responsibilities, especially those of professionals. For example, physicians are required to report certain infectious diseases specified by health officials. In virtually every state, this includes many of the sexually transmitted diseases, including AIDS. Furthermore, there is frequently a system of sexual contact tracing by which infected people are asked to identify their sexual contacts. Those persons are then contacted and informed of their potential exposure. In the case of treatable sexually transmitted diseases, such as gonorrhea, treatment is offered. Although such laws are at variance with the accepted medical ethic of preserving the confidentiality of patients,

40. See, e.g., Dickens, *supra* note 27, at 583.

legislatures have determined that they are necessary to protect the public health.

The third approach involves moral and ethical responsibilities. Here, there is great conflict. For example, every professional code of ethics mandates some form of confidentiality for the person being provided services.⁴¹ To inform a third party of the existence of an illness could be considered a violation of that ethical principle. At the same time, however, HCPs also have an implicit ethical obligation to protect society from harm. Accordingly, a person who proclaims that he or she is going to harm another individual should not receive the same degree of confidentiality. The fundamental question is: when is that line crossed? At what point is an individual such a threat to someone else that confidentiality can be breached?

The issue facing physicians, and all other HCPs, is the conflict between two desirable goals: maintaining confidentiality for individual patients and protecting others from harm or unnecessary risk. This conflict has stimulated debate and study.⁴²

One can ask who is responsible for protecting us from unnecessary risk? A related question then becomes: to what extent should we be responsible for protecting others from risk? There are no definitive or universally accepted answers, and that too contributes to the debate.

Some would argue that if we know we are a threat to other people, then we are responsible for protecting them or, at least, warning them. In many situations, this position is unrealistic. For example, the thief carrying a gun will not warn his or her victim. At the same time, there are risks that are obvious and need no specific warning. For example, heterosexual sexual intercourse without the use of contraceptives carries the risk of pregnancy. Men do not view it as their responsibility to warn their female sexual partners of this risk.

AIDS is a fatal illness transmitted primarily by a very private action, sexual intercourse. It is impossible to know or insure that warnings actually do occur. Cases of AIDS must be reported to health officials in all fifty states, but not cases of infection that do not yet meet the definition of AIDS.⁴³ There is little evidence as to the efficacy or value of sexual contact tracing of HIV infections. Because AIDS is a disease that is spread person-to-person, most peo-

41. CONFRONTING AIDS UPDATE, *supra* note 23, at 15.

42. Walters, *Ethical Issues in the Prevention and Treatment of HIV Infection and AIDS*, 239 SCI. 597, 599 (1988).

43. PRESIDENT'S COMM'N, *supra* note 23, at 1-3.

ple believe and expect health authorities, and through them physicians and other HCPs, to protect them.

The Maryland Governor's Council has spent a great deal of time investigating the duty to warn. It has obtained testimony from professional societies, legislators, and individuals.⁴⁴ The real problem appears to be a few individuals who, for whatever reason, do not and will not warn their sexual partners.⁴⁵ No extensive governmental intervention is necessary. The Governor's Council has maintained that all testing for antibodies to HIV must be accompanied by counseling or education, especially as to methods of transmission and methods to prevent or at least diminish the risk of transmission.⁴⁶ That is a vital step to control this epidemic.

This spring the Governor's Council approved four basic principles for HCWs: (1) It is the responsibility of the HCW providing care to the HIV-infected person to counsel the infected person to inform all sexual and needle-sharing partners; (2) if the infected person is mentally or emotionally incapable of informing such partners, it is the responsibility of the HCW to provide assistance with notification; (3) if the infected person refuses to notify partners, the HCW may then inform the local health officer of the existence of an individual to whom the usual definition of "public health nuisance" applies; and (4) each local health officer should have access to a multidisciplinary treatment team and a continuum of structured settings so that an individual referred to the local health officers will receive appropriate care.⁴⁷

In my view, and that of the other Advisory Council members, this is a responsible and reasonable position. It should assist in stopping the further spread of the virus while not discouraging people from seeking treatment. If the duty to warn issue becomes so significant that people who suspect they are infected or at risk of becoming infected do not pursue treatment, they may increase the spread. This is a difficult but critical line to walk.

44. Minutes of the Maryland Governor's Advisory Council on AIDS (March 15, 1988) [hereinafter Governor's Council].

45. *Id.* See also Martin Wasserman, M.D., Issue Paper (presented to Governor's Council); B. Frank Polk, M.D., The Duty to Warn (draft statement presented to Governor's Council); MARYLAND DEP'T OF HEALTH & MENTAL HYGIENE, Physicians' Duty to Warn Partners of HIV-Positive Patients (presented to Governor's Council); AMERICAN MED. ASS'N, MODEL STATE LEGISLATION ON AIDS 4 (rev. Dec. 1987).

46. Governor's Council, *supra* note 44.

47. *Id.*

V. DRUG USE

IV drug abusers who share needles with others are engaged in a very efficient method for transmitting HIV. When one injects oneself with a syringe and needle, some blood is trapped in the needle. If that needle is then used on a second person, the entrapped blood is inoculated directly into the bloodstream of that second person. If the first person is infected, HIV will be injected into the second. To stop the spread of HIV, it is critical that we reduce or eliminate IV drug abuse. Education is the key, but equally important steps include having treatment facilities available for those already addicted and intervention in the supply of those drugs. Current debate in the United States centers around the relative priorities of these three steps. Educational efforts have begun but their effectiveness is not yet determined.

A second approach is to eliminate the sharing of needles. Persons able to communicate with IV drug abusers have been attempting educational efforts to convince people not to share needles. Sharing needles, however, seems to be of symbolic and ritualistic importance.⁴⁸ As a result, these efforts do not seem to be having much effect thus far.⁴⁹ The third approach has been to supply clean needles or small bottles of bleach to clean needles between users. This technique has been used in several foreign countries, although needle sharing is considerably less common in those cultures than it is in the United States.⁵⁰ Groups in California have been distributing small bottles of bleach (household bleach "kills" HIV), but the evidence of its effectiveness is wanting.⁵¹

Quite apart from the problem of HIV transmission, IV and oral drug abuse in this country must be dealt with aggressively. The abuse of drugs can be fatal in and of itself. In any event, it interferes with a person's ability to function as an individual. In my view, we must address the issue of drug abuse without being sidetracked by the HIV transmission issue.

VI. CONFIDENTIALITY AND DISCRIMINATION

Both the President's Commission and the Institute of Medicine stress that discrimination, or the fear of discrimination, has interfered and is interfering greatly with the ability of the public health

48. *Id.*

49. *Id.*

50. Governor's Council, *supra* note 44.

51. *Id.*

officials to control this epidemic.⁵² There are numerous examples of discriminatory practices, including children being denied the opportunity to attend school because they are infected, and persons losing their jobs, losing their homes, and even being denied medical services.⁵³ Discrimination is closely linked with confidentiality. If all records were completely confidential, it would not be possible to discriminate against someone who is infected. Until the confidentiality of medical records becomes protected universally, it will not be possible for us to control discrimination against persons infected with HIV or many other illnesses or disabilities. The Governor's Council has addressed this issue and has been amazed at the extent of discrimination in our society. On the recommendation of the Governor's Council, the Maryland Commission on Human Relations (MCHR) has determined that it has authority over such discrimination and has issued regulations to control it.⁵⁴ Cases are now pending before the MCHR.⁵⁵

VII. SUMMARY

HIV infection and AIDS are preventable illnesses. They do require significant behavioral changes, however, in areas that people find difficult to change. Education is our most powerful weapon, and it must be used widely and repeatedly. With knowledge, this epidemic can be controlled.

52. CONFRONTING AIDS UPDATE, *supra* note 23, at 63; PRESIDENT'S COMM'N, *supra* note 23, at 119.

53. Governor's Council, *supra* note 44.

54. *Id.* MARYLAND COMM'N ON HUMAN REL., HANDICAP DISCRIMINATION GUIDELINES, CODE OF MARYLAND REGULATIONS, 14.03.02 (Apr. 1988) (to be codified at Md. REGS. CODE tit. 14, § 14.03.02).

55. Governor's Council, *supra* note 44.