The AIDS Project: Creating a Public Health Policy - Rights and Obligations of Health Care Workers

Karen H. Rothenberg

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Comments

THE AIDS PROJECT: CREATING A PUBLIC HEALTH POLICY—RIGHTS AND OBLIGATIONS OF HEALTH CARE WORKERS

Karen H. Rothenberg, Assistant Professor
AND
Mary Baldwin, School of Law
Miriam Cameron, School of Social Work
Michael Gentile, School of Law
Deborah Harcum, School of Law
Donnell Harris, Pharm., School of Pharmacy
Elizabeth C. Horn, School of Law
Alison Hyder, School of Social Work
Tracey Mitchell, School of Law
Bob Oliverio, School of Medicine
Carol Ann Rooks, R.N., M.S.N., School of Nursing
Mike Royal, M.D., School of Law
Harry Siegel, Schools of Law and Public Affairs
Ovette Slaughter, School of Law
Zachary Taylor, M.D., School of Medicine
Christiane Tellefsen, M.D., School of Medicine
Kathy L. Tubbs, School of Law
Terry Walman, M.D., School of Law
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Collaboration among professions is not a skill traditionally taught or encouraged. Faculty and students from different disciplines rarely join together in the process of professional education. In fact, many believe that health care professionals (HCPs) should not trust lawyers and vice versa. Yet such trust is critical in order to adequately address the complex health policy issues facing our society.

During the spring 1988 semester seventeen students from the law school and the health professional schools at the University of Maryland at Baltimore volunteered to be part of a unique collaborative experience. Students from the schools of nursing, medicine, pharmacy, and social work joined with law students to consider an acquired immune deficiency syndrome (AIDS) policy for the State of Maryland. To narrow the task, to address new issues, and to heighten interest, the seminar focused on the rights and obligations of health care workers (HCWs).

This interdisciplinary approach to learning sought to broaden the students' perspective and their enthusiasm for solving health problems together in the future. The main purpose of the seminar was to give these students the opportunity to collaborate on a project that would require them to listen to each other, to respect the perspective of each discipline, to learn to compromise, and to strive for a common goal.

The law students and the students from the health professional schools were divided into four interdisciplinary working groups.

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2. Acquired immune deficiency syndrome (AIDS) is defined as a “variety of clinical disorders,” such as a life-threatening opportunistic infection or Kaposi's sarcoma, resulting from infection with the human immunodeficiency virus (HIV). Groopman, The Acquired Immunodeficiency Syndrome, in TEXTBOOK OF MEDICINE 1799 (J. Wyngaarden & L. Smith eds. 16th ed. 1988) [hereinafter TEXTBOOK]. HIV is a virus that attacks white blood cells. U.S. DEP'T OF HEALTH & HUMAN SERVS., SURGEON GENERAL'S REPORT ON ACQUIRED IMMUNE DEFICIENCY SYNDROME 9 (Apr. 1987) [hereinafter SURGEON GEN.'S REP.].

3. The decision about whom to place in each group was based on a variety of fac-
Each group was assigned one of four major policy issues and was responsible for developing a policy position paper with recommendations. The four policy issues to be addressed were: (1) the rights of the HCW with human immunodeficiency virus (HIV); (2) testing in the health care institution; (3) confidentiality and the duty to warn; and (4) the obligation to treat.

Hopefully, the course will make a contribution to the development of public policy on the state level, enrich understanding and appreciation for how professionals from different disciplines approach complex problems and solutions, and promote future interdisciplinary initiatives. With these goals in mind, this introduction will provide a brief description and critique of the course, followed by the recommendations and policy papers of the students.

A. Course Description

The course met at least once a week throughout the spring 1988 semester in a law school seminar room. The students first learned about the pathophysiology of the HIV and its possible modes of transmission to HCWs. A review of published studies and an understanding of environmental contamination and disinfection convinced the group that the risk of transmission for HCWs was very slight. Yet the risk was not zero, so adherence to Centers for Disease Control (CDC) guidelines for reducing the risk of exposure for HCWs would be critical to the creation of policy in this area.

The students had the opportunity to hear from a number of experts. Representatives from the Occupational Safety and Health Administration (OSHA) and the Department of Labor discussed the legal basis for their enforcement of workplace safety standards and

tors: professional discipline (i.e., law or medicine), scheduling, professional experience, personal experience, and expressed interest.

4. Over the semester it became apparent that these issues did overlap, so that it was even more important to coordinate tasks.


6. Presentation by Priscilla Furth, M.D., Assistant Professor of Medicine and Director, AIDS Patient Care Program, University of Maryland School of Medicine (Jan. 27, 1988).

their development of a proposed AIDS and hepatitis B virus (HBV) standard for protecting HCWs. Representatives from a variety of medical groups and unions spoke on the issue of the obligation to treat. The students also interviewed these officials concerning the duty to warn, confidentiality, testing, assessment of the OSHA standards, and the rights of infected HCWs.

In addition to these experts, the leadership and staff of the Governor's Advisory Council on AIDS (Governor's Council) briefed the class on the politics of making AIDS policy in the State of Maryland. The Governor's Council is the official advisory body to the Governor of the State of Maryland on all AIDS matters.

To begin the process, the class analyzed an interdisciplinary case study. The interdisciplinary case study was designed primarily to enable each student to identify the issues at stake and to share his or her reasoning process with the rest of the class. The law stu-

8. Presentation by Susan Harwood, Ph.D., Health Scientist, Office of Risk Assessment, Occupational Safety and Health Administration (OSHA) and Claudia H. Thurber, J.D., Staff Attorney, Office of the Solicitor of Labor, Dept. of Labor (Feb. 10, 1988) (oral presentation). OSHA has the responsibility for promulgating and enforcing standards for safety in the workplace. Id. This presentation shed some light on the administrative law process and made the group appreciate the difficulties of operating with the federal bureaucracy.

9. Presentation by Fanny Haslebacher, J.D., Legislative Counsel, American Medical Association (AMA); Donna Richardson, J.D., R.N., Assistant Director, Congressional and Agency Relations, American Nurses' Association; and Leonard Wheat, Director of Governmental Affairs, American Dental Association (ADA) (Feb. 24, 1988) (oral presentation).

10. Presentations by Varda Fink, Acting Principal Counsel; Lori Klein, Staff Attorney, Maryland Attorney General's Office; Ruth Finkelstein, Staff, Governor's Advisory Council on AIDS; and Edward Brandt, Chairman, Governor's Advisory Council on AIDS and President, University of Maryland at Baltimore (Mar. 9, 1988) (oral presentation). The presentations revealed that there is much legal uncertainty surrounding the rights and obligations of HCWs. Id.

11. The Governor's Council on AIDS (Governor's Council) succeeded the Governor's Task Force on AIDS, which was established in 1985 and issued policy guidelines and recommendations in 1986. See generally Governor's Task Force, AIDS and Maryland (1986) [hereinafter Governor's Task Force]. That report provided the starting point for the development of the students' policy papers.

12. John, a 33-year-old male, is employed as the dietician at a small Catholic hospital in rural Maryland. John is gay, but in the last year has been virtually celibate, only occasionally having relations with Mike, his old and dear friend. John has been grieving about the end of his longstanding but very well-concealed relationship with Steve, which broke up a year ago. Steve had relinquished gay sexual activity and refused to even speak to John or any of his old friends. Steve had married Peggy, a registered nurse who knew nothing of his past.

In the winter, John developed what seemed to be a very bad chest cold. He consulted Dr. Rosen, his regular physician, who had known of John's sexual orientation and past relationship with Steve. Dr. Rosen diagnosed John as having pneumonia and admitted him to a large teaching hospital. Further tests were done which revealed that
Students focused on individual rights while the health professional students focused on patient needs. Everyone wanted to know if there

John had *pneumocystis carinii* pneumonia, an infection diagnostic of AIDS. A test for the HIV antibodies was positive, and Dr. Rosen told John that his diagnosis was AIDS.

Because he had never before cared for an AIDS patient, Dr. Rosen consulted an older colleague, Dr. Smith, about treatment. Dr. Smith told him of information she had read about azidothymidine (AZT) treatments, but then added that because she recently had had some health problems, she would rather not participate in treating John or even enter his hospital room. Dr. Rosen was surprised and distressed at this attitude but did not pursue the matter any further. He did pursue, however, the lead on AZT with the pharmacist at the hospital. The pharmacist explained that if John was willing to be part of an experiment on dose response (which the pharmacist hoped to get published as soon as possible, even though he had recently lost two subjects), he could get AZT for John for at least four months at no charge. Dr. Rosen knew that AZT was very expensive and in short supply and that John was desperate for some treatment to give him hope. Dr. Rosen was worried, however, that John did not fit within the Food and Drug Administration (FDA) protocols for effective AZT therapy even though the pharmacist tried to convince him that there was nothing to lose.

In counseling John about his illness, Dr. Rosen told him about the importance of informing present sex partners and practicing safer sex. John said he had no present sex partners. Dr. Rosen then said he should tell past partners so they could be tested. John responded that he would tell Mike, who probably was the one who infected him, but said that he and Steve had ended their relationship a year ago and were no longer on speaking terms. Dr. Rosen explained to John that the incubation period was in some cases very long and that Steve could very likely be infected. John said, even so, it would do no good to tell him, "since one can't do anything about being infected."

Dr. Rosen was very troubled by this. He knew that Steve had gotten married and that, if he was infected, he could very well infect his wife. Dr. Rosen had no personal or professional relationship with either Steve or Peggy. He took very seriously his duty to respect John's privacy. Yet he knew that even if Steve was infected, Peggy might not yet be, and he felt that he was possibly in a position to protect her from harm.

When John was feeling a bit stronger, Dr. Rosen broached the subject again, stressing the danger Peggy might be in. John was sympathetic, but still refused to contact Steve. John said that, if Steve did test positive for the virus, he was the sort to blame John and to leak the word of his homosexuality to his colleagues at the hospital, which might cost John his job. Dr. Rosen remained troubled about what, if anything, he should do. He even became so concerned about possible legal liability that he decided to consult his attorney.

In the meantime, Dr. Rosen encountered another dilemma. Mike came to see him after John told him of his diagnosis. Mike said he was sexually active, though not with any special person, and he wanted counseling about safe sex practices. Mike also wanted to have a complete physical, but he did not want to have the test for antibodies to the AIDS virus. He said that it would upset him too much if he tested positive and that he just did not want to know. Dr. Rosen told Mike that it was not fair for him to know that he was at high risk and to continue to have sex with people, even safer sex, without learning his actual status and then, if positive, informing them. Mike said he would feel guilty if he knew he was seropositive and did not inform sex partners, but he also knew he would be treated like a leper if he did inform them. Anyway, this was all moot because he did not want to know his antibody status. The primary reason he did not want to know was because the knowledge would be too traumatic for him to deal with.

Dr. Rosen's nurse also believed that Mike was in a state of denial and needed counseling to convince him to be tested. Furthermore, she thought she had a right to know if
were legal answers. Once it became apparent that there were no clear answers, the class shifted to defining the issues as ethical questions which would require policy solutions.

As noted above, the students were assigned to one of four working groups. Loyalty in each group grew rapidly. Each group began to sit together and meet regularly throughout the week. By the end of the second week, each group presented a preliminary list of issues that it would address. This list would continue to be revised for weeks to come.

To facilitate problem solving and analysis, as well as group process in the real world, each group was assigned its own case study to prepare for discussion. The individual group case studies were developed in collaboration with Professor Richard North, the founder of the University of Maryland's AIDS Legal Clinic. These case studies evolved from actual cases, but were modified to protect confidentiality and to better focus on particular policy issues. The case study method exposed the students to the diversity of legal and medical issues.

Any of Dr. Rosen's patients were HIV positive. She told Dr. Rosen that he should refuse to treat Mike unless he got tested.

Sadly, the dilemma about informing Steve soon disappeared because he likewise became ill. After being diagnosed as having AIDS by Dr. Sullivan, his personal physician, Steve told his wife of his past. The diagnosis came at a dreadful time because Peggy, a devout Roman Catholic, was four months pregnant. Dr. Brown, her obstetrician, urged her to be tested for the HIV antibody, but she was not sure what to do. Dr. Brown explained to her that both she and her baby were at risk of developing AIDS, even though she was feeling physically fine and without any symptom of illness. It was by no means certain, however, that the baby would develop AIDS. Dr. Brown also told her that sometimes a woman who is seropositive and asymptomatic will develop full-fledged AIDS when she is pregnant because pregnancy is a stress on the body. Steve and Peggy, in great distress, consulted Deidre Devine, a social worker with expertise on the psychosocial aspects of AIDS.

The interdisciplinary case study was adapted in part from materials prepared for The Commission on Interprofessional Education and Practice Seminar on Interprofessional Care, Ohio State University (Winter 1987).

13. This legal clinic, the first of its kind in the nation, provides legal services to AIDS patients and hospital staff at the University of Maryland Medical System. Students in the legal clinic are involved in a variety of issues including employment discrimination, custody, public benefits, housing discrimination, patient care matters, and hospital policy review. The students also provide legal opinions to treating physicians on the duty to warn sexual partners, confidentiality, and the obligation to treat.

14. Following are samples of the individual group case studies:

1. D.V.—D.V. is a young man employed as a nursing assistant in the Morton Center, a local nursing and chronic care facility. D.V. is HIV positive and has recently been hospitalized with a case of *pneumocystis carinii* pneumonia, which was treated without incident. D.V. has been out of the hospital for four weeks, and his physician has certified that he is able to return to work.

D.V. exhibits mannerisms or expressions which could lead a person to believe he is homosexual. On his job a few people have made comments to him; he has overheard
ethical issues faced by AIDS patients and HCWs. It also gave each

D.V. has been employed at Morton Center for six years. In his job he is assigned to provide nursing services to elderly, incapacitated patients. His patients often are incompetent. He bathes them, gives medication, and occasionally draws blood for routine tests. When D.V. has been absent from work, he has merely brought in a doctor's note stating that he was ill, was under treatment, and that he had been advised not to work until a certain date. The handbook delivered by the employer to all employees when they first become employed states that the employer's policy for sick leave requires a note from a physician certifying that an employee was under the physician's care and that the employee is cleared to return to work.

D.V. received a note from his doctor stating that he was cleared to return to work in a week. He took that note to his employer, but the head of personnel told him the note was not sufficient. The head of personnel stated that she wanted a statement from the physician that D.V. is able to return to his full duties, that she be told his diagnosis and his prognosis, and that the physician certify that D.V. is free of any infectious diseases. D.V. fears that release of this information could cause termination of his employment or, at the very least, subject him to ridicule and ostracism on the job. He feels very strongly that his employer has no right to know about his personal and private life. Dr. Smith, who treats D.V., also is uncomfortable with revealing such potentially damaging information. In addition, Dr. Smith says that he cannot certify that anyone is "free" of infectious diseases since everyone carries many germs. He understands D.V.'s job duties and feels that D.V. is fully capable of performing them.

D.V. called a lawyer to ask for help in concealing his diagnosis from his employer. The lawyer first called Dr. Smith, who felt strongly that no further information should be revealed to D.V.'s employer. The physician was very concerned about D.V.'s condition and felt that he needed to be protected from any further "harassment" from D.V.'s employer. Dr. Smith urged the lawyer to do whatever was possible to help them.

2. C.X.—C.X. is a 25-year-old man who is in the care of the Pullman Center, a psychiatric clinic attached to Holly Hospital. The Pullman Center provides voluntary inpatient services as well as outpatient services. If a patient meets the standard for involuntary commitment, the patient must be transferred from Pullman to a state psychiatric facility. C.X. has been treated by the psychiatric clinic for approximately two years and has been diagnosed as being mildly paranoid; he exhibits some maladaptive antisocial behavior and is manic depressive.

C.X. is HIV positive and has exhibited some symptoms that his HIV infection is progressing. Since learning that he is HIV positive, C.X. has been very angry with himself and with the world. He presently is residing in the Pullman Center but twice has been placed in residential "foster" homes under contract with the State for the housing of AIDS patients. Both placements have not worked out. The homeowners have asked that C.X. be removed because of his oftentimes angry or hostile behavior and his refusal to abide by any rules established by the homeowners.

One of the problems has been that C.X. brings home numerous persons at night ostensibly for purposes of engaging in sex. C.X. states that he is engaging in sex as often as he can, with as many partners as he can, and apparently without confining himself to safe sexual practices. He has been counseled repeatedly about the risk of transmission of the HIV infection posed by unsafe sexual practices, but his anger seems to lead him to continue to engage in unsafe sex.

The Pullman Center once attempted to have him involuntarily committed to a State psychiatric facility, but that facility determined that C.X. did not exhibit behavior which would make him "a danger to himself or others" (the commitment standard) and he was released immediately. C.X. is now back at the Pullman Center on a voluntary basis, but
group an opportunity to work on a discrete issue and work out how wants to leave. While at the State mental health facility, C.X. met a woman who had just been released from the facility after 15 years of confinement. She invited C.X. to live with her in her apartment in the city. C.X. would like to leave and move in with her, but refuses to discuss his intentions regarding his sexual practices.

The Pullman Center has contacted a lawyer to request guidance about what actions, if any, it should take in regard to the release of C.X., including possible notification to others of his HIV status. In the meantime, the Pullman Center wants to know what actions, if any, it should take regarding procedures for housing C.X. in its institution and what its obligations are to its employees and to other patients in the institution.

3. F.T.—F.T. is the paternal aunt of two children, John and Jane. When F.T. came to our law office seeking help, the mother of the two children had been in prison for the last 11 months. The father also was incarcerated and had had little or no contact with the children for the past few years. The older child, John, is six years old. The younger child, Jane, is three. Jane has AIDS.

F.T. has had custody of the two children ever since the mother went to prison. The mother, a substance abuser for several years, dropped the children off with F.T. a few days before her trial date without making any arrangements regarding the children's legal custody.

During the past year, Jane became ill. F.T. took her to the hospital for treatment. It was then discovered that Jane was HIV-positive. Jane later was diagnosed with AIDS. F.T. has no legal authority to give consent for medical care for either child. To date all of Jane's medical care has been rendered as an emergency service without consent.

John has not been tested to determine if he is HIV-positive, although it has been recommended by the treating physician. The hospital will not accept F.T.'s consent for the purpose of testing John.

The mother of the two children was not aware that she was HIV-positive. Two weeks after F.T. visited our law office, the mother was released from prison. She visited F.T., but she neither made any statements regarding the children nor sought to take them with her. After that visit, F.T. saw the mother two or three times on the street, at which times the mother appeared to be under the influence of some substance. F.T. said other family members advised the mother that she was HIV-positive.

Six weeks ago, the mother came by F.T.'s house and asked to take John for the weekend. F.T. allowed her to take John under the condition that he would be returned Monday afternoon. The mother returned Monday afternoon, but then took both children. The mother wanted to have the Social Services check, which F.T. had been receiving, diverted to herself as custodian for the children. F.T. advised the mother that Jane was due for a hospital visit the next day. Neither the mother nor Jane appeared at the hospital.

F.T. later learned the mother had left the children with Darlene Smith, the girlfriend of her brother, who lives in the same neighborhood. Darlene Smith, a mother of small children herself, told F.T. that she did not want custody of the children, but was willing to let them stay with her for a short period of time. Darlene did not know of Jane's diagnosis, but was aware of certain health needs to be taken care of at the hospital. She asked F.T. to take the children to the hospital numerous times, but F.T. was reluctant to get further involved. F.T. contacted Ida Hayes, the social worker at the hospital's pediatric clinic, to tell her what had happened with the children. Ms. Hayes noted that the children had not been seen for seven weeks, and the clinic staff was particularly concerned about Jane's health. Ms. Hayes was also concerned about the health risk to Darlene Smith and her family since she did not know of Jane's diagnosis and had not been counseled about blood and bodily fluid precautions.

Ms. Hayes was reluctant to tell Darlene Smith the diagnoses and risks posed by the children. She feared that Darlene would dump the children at the hospital if she knew.
to present its position to the rest of the class. Overall, each group

This had happened before, and Ms. Hayes had had a terrible time finding another placement for the children. There are no foster placements willing to take AIDS children and very few institutional beds. The one time she was confronted with the problem, the children were put in Hathaway Pediatric Hospital where they have remained for two years. Ms. Hayes visits them occasionally and has found that the hospital is unable to provide the type of individual loving care that one would want for children.

Ms. Hayes' supervisor has told her that she must tell Darlene Smith the diagnosis even over the objections of the mother. Ms. Hayes has come to our law firm for guidance. She is concerned that she may not be permitted by law to reveal confidential patient information. She worries that she might be legally liable if Darlene Smith harms the children. She also worries about what will happen to the mother if this information gets out in her neighborhood. On the other hand, she fears the consequences if Jane infects Darlene Smith or one of her children.

4. M.B.-M.B. is a 28-year-old man. M.B. has been diagnosed as having AIDS and was hospitalized at Mt. Victory Hospital in July 1987 for *pneumocystis carinii* pneumonia. M.B. presently is unemployed and his only income is from Supplementary Security Income (SSI) benefits, which total $383 per month. He sought out legal services in September 1987 when he received letters from a debt collection agency threatening him with legal proceedings over outstanding hospital bills approximating $22,000. These bills are for services rendered during his July hospitalization at Mt. Victory Hospital.

The interview with M.B. revealed that in October 1986 he began working for Mega Corporation as the manager of a department in one of its retail stores. His employer offered a company-administered group health insurance program for which M.B. could become eligible after successfully completing a 90-day probationary period with the corporation. In December of that year, M.B. began experiencing pain for which he saw a physician at Mt. Victory Hospital. After undergoing a battery of diagnostic tests, it was determined that his discomfort was caused by problems with his liver, which was treated by medication. As part of the diagnostic screening, an HIV antibody test was administered, which proved positive. In early January 1988, M.B. was informed of the results of his HIV test. In late January, he successfully completed his probationary period at work and was automatically enrolled in the company health insurance program.

In June 1988, M.B. became very ill. He began having fevers and feeling faint. At one point he collapsed in his house and his roommate took him to the local county hospital, Mullins General. He was admitted to the hospital through the emergency room, and within the first 24 hours of his admission, X-rays were taken and a bronchoscopy was performed. M.B. told Mullins General that he was HIV positive. The following day M.B. was discharged from that hospital and told to take aspirin every few hours to diminish his fever. After three days, when the fever did not diminish, M.B. went to Mt. Victory Hospital and saw the physician who had treated him in January. X-rays and a bronchoscopy were immediately done and *pneumocystis carinii* pneumonia was diagnosed. The physician told M.B. that the bronchoscopy taken five days earlier at Mullins General certainly would have revealed the same thing. M.B. was hospitalized for three weeks and discharged in July.

After his discharge, M.B. returned to his place of employment and reported for work. He was told to see his supervisor who informed him that they no longer needed his services. M.B. confronted his supervisor about the reasons for his discharge, and after 15-20 minutes of argument, the supervisor acknowledged that no one wanted to work around a person with AIDS. It seems that M.B. had requested insurance coverage for the bills incurred during his stay in the hospital and the employer learned of the diagnosis from the request for payment.

In September, M.B. again was hospitalized. During this hospitalization M.B. learned that he had a congenital heart problem for which he needed triple bypass sur-
appeared flexible enough to consider a variety of options, many of which called for no legal action.\textsuperscript{15}

The groups spent several weeks working on their position papers, then the papers were presented to the class. Following each initial presentation revisions were incorporated and each group had at least one more opportunity to make final recommendations. By the last session, consensus had been reached on over fifty recommendations. Some recommendations were not controversial at all. For example, no one believed that all hospital patients should be tested, nor did anyone believe that patients with AIDS should be quarantined for refusing to notify their sexual partners. A few other questions, however, were heavily debated and are worthy of highlighting here. Each area is discussed more in-depth in the student comments that follow.

1. Rights of the HCW with HIV.—The first controversial question considered was whether a surgeon with HIV should inform patients of his or her condition. Although the surgeon may have an ethical obligation to do so, the class did not recommend that a legal duty be imposed on the surgeon to disclose his or her medical condition to patients. Rather, as part of the informed consent process, the patient should be informed generally of the risks of transmission of HIV during surgery.

This group also considered how to balance the rights of a hospital patient with those of the HCW possibly exposed to HIV by that patient. Rather than force the patient to be tested to prove causation for workers' compensation purposes, the class endorsed the fol-

\textsuperscript{15} Professor North noted that the case study approach varied from the legal activism of the AIDS clinic students. To promote collaboration the class discussion of the case studies was videotaped so that the AIDS clinic students would have the opportunity to view the analysis of the four case studies.
lowing: An HCW’s seronegative status determined within two weeks of an exposure would raise a rebuttable presumption that an HCW’s subsequent HIV infection (within eighteen months) was contracted in the workplace.

2. Testing.—A major policy question considered by this group was whether a state-run testing program should be established. The students were divided on the question. There were serious concerns about cost, confidentiality, and the competency of the state bureaucracy. The students ultimately did endorse the testing program.

3. Confidentiality and Duty to Warn.—The most controversial question considered by this group was whether HCWs should have an affirmative duty to warn unsuspecting sexual partners. After being presented with a series of options, the class agreed not to establish a legal duty to warn. The underlying assumption was that such a duty would drive those in need of care underground and undercut the trust of the medical establishment. More importantly, the class was not convinced that the benefit of notification outweighed the breach in confidentiality.

4. Obligation to Treat.—The main question considered by this group was whether there should be a legal duty for HCWs to treat HIV patients. The class agreed that there should be an ethical obligation to treat those with AIDS, but was not sure how to actualize such a duty to a legal standard. After some debate they agreed to consider further, among other options, the threat of disciplinary action for those HCPs who refuse to provide professional services solely because of a person’s physical handicap. There also was heated debate on whether to disburse clean needles to drug addicts (rejected by the class for lack of evidence) and whether to deny fertility services to those women with HIV-positive status (no clear consensus).

B. Course Critique

Following the final consensus session, the students were asked to critique the experience. Their responses were compared with a questionnaire they filled out in the first week of class which asked them to outline their goals for the course. All of the students believed they had learned about AIDS, the making of public policy, and collaborating with other professionals in the process. They complained that it was much too much work—and perhaps it was for
one semester. In addition to the preparation of the policy paper and its recommendations, each student was expected to participate in class discussions, make numerous presentations, gather original source materials, and interview experts. Stamina, creativity, interpersonal skills, and flexibility were exhibited by the students throughout the process. They also recognized that the writing and analytical abilities were uneven, even among those students from the same disciplines. Because the project was policy oriented, the nonlaw students tended to rely on the law students for much of the analysis. Yet some of the most creative recommendations did not require legislation and the health professional students took the lead.

There did not appear to be much intimidation among the students. Perhaps this was self-selection. These students were motivated to want to work together and were willing to take the risk. Taking a class in the law school and using the law library were new experiences for the health professional students. They also had to endure and overcome institutional problems with scheduling, credits, and cross-registration.

The course raised a number of educational challenges as well. All the students were expected to understand the legislative system, infectious disease, psychosocial matters, financing, and ethics. The collaborative nature of this process required hard work, cooperation, patience, and mutual respect. Such a process takes time to perfect. If resources permit, a truly interdisciplinary course should be taught collaboratively by professors from varied disciplines. Core courses should be encouraged in medical ethics and public policy analysis as a prerequisite to an interdisciplinary policy course. Perhaps all students enrolled in the professional schools should be required to take at least one course with students from another discipline. Interdisciplinary courses will promote collaboration in the

16. The experience also left me with some unanswered questions. Health professionals have been enrolled in previous health care law courses, but they had to learn to play by the rules of a law school class. They had to learn to read cases and understand legal analysis. But the rules and expectations were different for this seminar than for those of a traditional law school class. Promotion of an interdisciplinary approach to making AIDS policy was desired, but the course was taught alone in a law school. What impact would this fact have on the class? Would all the health professional students think they would have to sound like law students? And is that what was really wanted? What was to be expected from health professional students that came from such varied backgrounds and experiences? How should one choose the materials that would be fair game for all the students? Would standards have to be compromised so that every class would be a watered down version of an "AIDS and the Law" class that could be offered to just law students?
future and increase the level of understanding and mutual respect among the professions.

Hopefully the following student recommendations and analyses will stimulate debate among the professions and enhance the development of future AIDS policy on the rights and obligations of HCWs. As a first step toward policy implementation, the AIDS Legal Clinic will pursue the development of state legislation which may address several of these recommendations.17

I. THE RIGHTS OF HCWS WHO ARE HIV-POSITIVE OR WHO HAVE AIDS

A. Introduction

This section addresses three areas of concern to HCWs18 who are HIV-positive or who have AIDS: discrimination, confidentiality, and employee assistance. The rights of infected HCWs—to continued employment, to confidentiality, and to employment benefits—are of paramount concern; these interests can be protected without serious health risks to patients, co-workers, or the HCWs themselves.

The discussion concerning discrimination addresses the general legislative protections available to those who are HIV-positive or who have AIDS, and then discusses how those protections should operate in the health care setting. Also considered is the issue of when and how an HCW who is HIV-positive or has AIDS should be accommodated in the workplace.

The issue of confidentiality in the workplace arises because employers, co-workers, and patients occasionally claim a right to be informed of the HIV status of those around them. These individuals'
concerns come into conflict with the HIV-infected employee's right of privacy. One basic question involving confidentiality concerns what an employer, co-worker, or patient would do differently if they knew an HCW had AIDS.

Next, this section addresses the issue of assisting the infected HCW. Concerns about the adequacy, or even applicability, of workers' compensation statutes are discussed.

Finally, this section discusses employee-management cooperation in providing benefits for HCWs with AIDS. This section identifies some of the common roles and expectations of labor and management on behalf of employees, especially infected workers, and specifically addresses the issues of peers in the workplace, attitudes, beliefs and behaviors, and educational efforts related thereto. In addition, alternative programs and options are proposed to benefit all employees with major medical problems and life-threatening illnesses. While the recommendations in this section are not geared exclusively towards or limited to infected HCWs, the AIDS crisis has brought these issues to the forefront and made their consideration a priority.

B. Discrimination

1. Protection Against Employment Discrimination.—Both federal and state laws offer protections against employment discrimination. Their protections will be separately addressed.

a. Federal Law.—Several federal statutes protect handicapped individuals against employment discrimination. Section 504 of the Rehabilitation Act of 1973 (the Rehabilitation Act), 19 which is applicable only against agencies of the federal government or programs receiving federal funds, provides that

\[\text{[n]}\text{o otherwise qualified handicapped individual in the United States, as defined in section 706(7) of this title, shall, solely by reason of his handicap, be excluded from the participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance . . . .}^{20}\]

The Rehabilitation Act defines "handicapped individual" as any person who:

(i) has a physical or mental impairment which substantially

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20. Id.
limits one or more of such person's major life activities, (ii) has a record of such an impairment, (iii) is regarded as having such an impairment. For purposes of sections 793 and 794 of this title as such sections relate to employment, such term does not include any individual who is an alcoholic or drug abuser whose current use of alcohol or drugs prevents such individual from performing the duties of the job in question or whose employment, by reason of such current alcohol or drug abuse, would constitute a direct threat to property or the safety of others.21

As more people become infected with HIV, the primary issue is whether infected individuals would be covered under the Rehabilitation Act. In School Board of Nassau County v. Arline22 the Supreme Court held that a school teacher with a history of tuberculosis was a handicapped individual within the meaning of the Rehabilitation Act. The school board argued that the teacher was discharged because of the contagious nature of her illness rather than the illness itself, and that the communicability of her disease was not a handicap covered by the Rehabilitation Act.23 The Court held that a carrier of a contagious disease may be protected by the Rehabilitation Act if the carrier is otherwise qualified for the position.24 While the Court specifically declined to decide whether "a carrier of a contagious disease such as AIDS could be considered to have a physical impairment, or whether such a person could be considered, solely on the basis of contagiousness, a handicapped person as defined by the Act,"25 Arline inferred that individuals with AIDS are subject to

21. 29 U.S.C. § 706(B)(B) (Supp. IV 1986) (formerly 29 U.S.C. § 706(B)(B) (1982)). Authorities on employment discrimination have explained this clause as follows:
   The clause excluding present substance abusers from the protected class when the abuse interfered with the individual's ability to safely perform the job . . . reflected congressional concern over the effect of regulation inclusion of substance abusers in the definition of handicap . . . The individuals identified in the second sentence are those an employer unquestionably would have been justified in excluding from the job prior to the amendment either because they were not 'qualified' handicapped individuals, or because of job-relatedness reasons. There are, however, practical consequences to the clause: Prior to the amendment the employer perhaps would have had to treat incapacity due to substance abuse on the same basis as it treated incapacity due to another handicapping condition, i.e., by providing comparable disability leaves. For the group defined out of the protected class . . . there is now no such requirement.

B. SCHLEI & P. GROSSMAN, EMPLOYMENT DISCRIMINATION LAW 262 n.62 (2d ed. 1983) (emphasis added) [hereinafter SCHLEI & GROSSMAN].

23. Id. at 281.
24. Id. at 285.
25. Id. at 282 n.7.
coverage under the Rehabilitation Act. Moreover, subsequent lower court cases have construed the Rehabilitation Act as applicable to AIDS carriers.26

On March 22, 1988, over a presidential veto, Congress passed the Civil Rights Restoration Act (the Restoration Act).27 The Restoration Act was designed primarily to overturn the Supreme Court's decision in Grove City College v. Bell,28 which held that the anti-discrimination language of Title IX of the Education Amendments of 197229 was not applicable to an entire institution which received federal funds but only to those specific departments or programs which received the federal funds.30 One portion of the Restoration Act, however, amended the Rehabilitation Act with respect to the treatment of contagious diseases.31 The amendment appears to remove HIV infection as a handicap:

For the purpose of sections 503 and 504, as such sections relate to employment, [the term "handicapped"] does not include an individual who has a currently contagious disease or infection and who, by reason of such disease or infection, would constitute a direct threat to the health or safety of other individuals or who, by reason of the currently contagious disease or infection, is unable to perform the duties of the job.32

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26. See, e.g., Shuttleworth v. Broward County, 639 F. Supp. 654, 660 (D. Fla. 1986) (county employee permitted to assert claim under the Rehabilitation Act that he was terminated because he had AIDS); Chalk v. United States Dist. Court, 840 F.2d 701, 709 (9th Cir. 1988) (teacher diagnosed as having AIDS was reassigned to an administrative job; the court held that the teacher was not required to disprove every theoretical possibility of harm, and the possibility that the teacher’s return to the classroom would produce fear and apprehension in parents and students was not grounds to deny the teacher’s return).


28. 465 U.S. 555 (1984). Legislative history reveals that the purpose of the Restoration Act is as follows:

to overturn the Supreme Court’s 1984 decision in Grove City College v. Bell . . . and to restore the effectiveness and vitality of the four major civil rights statutes that prohibit discrimination in federally assisted programs. . . . [These Acts are] Title IX of the Education Amendments of 1972, Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, and the Age Discrimination Act of 1975.


30. Grove City College, 465 U.S. at 571.


32. Id.
It is not clear what effect this amendment will have. The sponsors of the amendment stated that it "does nothing to change the current laws regarding reasonable accommodation as it applies to individuals with handicaps. . . ."\textsuperscript{35} The sponsors also stated that the effect of the amendment would be similar to the effect of the 1978 amendments covering substance abusers: "[A]s we stated in 1978 with respect to alcohol and drug abusers, . . . the two-step process in section 504 applies in the situation under which it was first determined that a person was handicapped and then it is determined that a person is otherwise qualified . . . ."\textsuperscript{34}

Some legislators voting for the amendment felt that it simply codified the \textit{Arline} decision,\textsuperscript{35} since persons who posed a medical threat to other people would not have been otherwise qualified under the Rehabilitation Act. Senator Simon,\textsuperscript{36} among others, questioned the desirability of removing contagious diseases from the definition of "handicapped." The concern of the legislators questioning the amendment was that, by doing so, the protections afforded by the Rehabilitation Act would be weakened.\textsuperscript{37} After adoption of the amendment, at least theoretically, a plaintiff could be considered a direct threat to the health of others, and thus not handicapped under the Act, whereas before the amendment the plaintiff may have been considered otherwise qualified.\textsuperscript{38} An additional reason for concern is that some of those supporting the amendment clearly understood it to dilute the \textit{Arline} decision and give employers more discretion in making employment decisions.\textsuperscript{39} Until the courts construe the language, particularly the phrase "constitute a direct threat," it remains unclear whether this amendment amounts to a simple semantic reshuffling which does not affect the post-\textit{Arline} law or whether it permits employers broader discretion in refusing to hire and in discharging those with contagious diseases. In either instance, this amendment injects an element of un-

\textsuperscript{34} Id.
\textsuperscript{37} Id. at S250.
\textsuperscript{38} The comparison to the 1978 amendments for substance abusers is disturbing given the questionable impact of that language on handicap protections. \textit{See} SCHLEI & GROSSMAN, supra note 21.
\textsuperscript{39} Senator Armstrong, who supported the bill and was extremely critical of the \textit{Arline} decision, said of the amendment, "we are making a very marginal improvement in a very bad situation." 134 CONG. REC. S254 (daily ed. Jan. 28, 1988).
certainty into the anti-discrimination area, thus highlighting the importance of state legislative protections.

**b. Maryland Law.**—Under Maryland law, it is unlawful for an employer

[t]o fail or refuse to hire or to discharge any individual, or otherwise to discriminate against any individual with respect to his compensation, terms, conditions, or privileges of employment, because of such individual’s race, color, religion, sex, age, national origin, marital status, or physical or mental handicap unrelated in nature and extent so as to reasonably preclude the performance of the employment. . . .

The Maryland Code defines a handicap as

any physical disability, infirmity, malformation or disfigurement which is caused by bodily injury, birth defect or illness including epilepsy, and which shall include, but not be limited to, any degree of paralysis, amputation, lack of physical coordination, blindness or visual impairment, deafness or hearing impairment, muteness or speech impediment or physical reliance on a seeing eye dog, wheelchair, or other remedial appliance or device; and any mental impairment or deficiency as, but not limited to, retardation or such other which may have necessitated remedial or special education and related services.

The Maryland courts have not addressed specifically the question of whether HIV infection is a statutorily defined handicap. Decisions in other jurisdictions, however, suggest that HIV infection would be covered. HIV infection and AIDS now are specifically included in the list of handicaps protected by the Maryland Commission on Human Relations (MCHR). The MCHR currently investigates complaints of employment discrimination alleged by those who have AIDS or are HIV-positive.

For purposes of section 16 of the Maryland Code, an employer is defined as "a person engaged in an industry or business who has fifteen or more employees for each working day in each of

41. Id. § 15(g).
42. See supra note 26.
43. MARYLAND COMM. ON HUMAN REL., HANDICAP DISCRIMINATION GUIDELINES, CODE OF MARYLAND REGULATIONS, 14.03.02 (Apr. 1988) [hereinafter GUIDELINES] (to be codified at Md. Regs. Code tit. 14, § 14.03.02).
44. MD. ANN. CODE art. 49B, § 16 (1986).
twenty or more calendar weeks in the current or preceding calendar year . . . ." Most employers of HCWs thus would be covered under the anti-discrimination language of section 16.

Section 8 of article 49B also prohibits discrimination on the basis of physical or mental impairment by persons or businesses licensed or regulated by the State Department of Licensing and Regulation. Health care employers exempt from the anti-discriminatory language of section 16 nevertheless may be precluded from discriminating by section 8.

The scope of the protection afforded by Maryland law is much broader than the protection available under the Rehabilitation Act, which applies only to federal employees, employees of federal contractors, and employees of institutions receiving federal funds. Virtually every HCW in the State is protected by either section 8 or 16 of article 49B.

Enforcement of the statutes by the MCHR is hindered by the time-consuming procedural requirements. Since the life expectancy of AIDS patients often is quite short, protracted enforcement mechanisms are futile. The MCHR recognizes the problem and is considering how best to treat it.

Although the protections afforded by the Rehabilitation Act are unclear at the moment, Maryland anti-discrimination statutes are adequate to protect seropositive HCWs. Currently, new state anti-discrimination legislation in the area of employment is not needed.

2. Accommodation in the Workplace.—The rights and benefits of the infected symptomatic HCW who misses time from work should be protected and accommodated when necessary. Under normal employment conditions, an HCW who has an illness that will cause

45. Id. § 15(b).
46. Id. § 8. Section 8-102(a) of article 41 lists the departments, agencies, boards, commissions, offices, divisions, and units of the state government that are included within the Department of Licensing and Regulation. Md. Ann. Code art. 41, § 8-102(a) (Supp. 1988).
47. This protection stems from the broad coverage of sections 8 and 16. Even if an employer is not licensed or regulated by the state and thus does not fall within the scope of section 8, the employer most likely still will be subject to the provisions of section 16, provided that the employer has 15 or more employees.
48. It is estimated that most HIV-infected patients die within two years after diagnosis. See Mfume, Special Report to the Seventh Congressional District: The AIDS Crisis 1 (Dec. 1987).
49. Interview with Lee Hoshall, AIDS Coordinator, Maryland Comm'n on Human Rights (MCHR), at the University of Maryland School of Law, Baltimore, Md. (Apr. 1, 1988).
frequent absences presumably will be afforded entitled benefits and
will be reasonably accommodated. An HIV-infected employee
should be treated like any other employee with an illness for whom
reasonable accommodations are made.\textsuperscript{50}

A related issue is whether to accommodate the employee who
fears working closely with an employee who is, or is suspected of
being, infected with the HIV virus. Should the fearful co-worker be
accommodated by being transferred to another work site if the co-
worker desires?

\textsuperscript{50} For example, unions that work as employee advocates can and should play an
active role in protecting the rights and benefits of the HCW with AIDS. Representatives
of two local unions that represent HCWs recently expressed their positions on accom-
modation of employees with AIDS and the employee who fears working closely with the
HIV-infected employee.

Marjorie Taylor, executive secretary of Local 1199E, Health Care and Medical Em-
ployees of Labor International Union of North America, AFL-CIO, which represents
employees of Johns Hopkins Hospital, Sinai Hospital, Liberty Medical, Maryland Gen-
eral, Greater Baltimore Medical Center, George Washington University Hospital, and
many Maryland nursing homes, indicated that she, as a representative of the union, felt
that the rights and benefits of the employee with AIDS or who is HIV-positive should be
protected. In institutions represented by Local 1199E, an employee is entitled to a one-
year leave of absence, if necessary for medical reasons, after all sick and accrued time are
used. Ms. Taylor indicated that most hospitals are large enough to transfer an HIV-
infected employee to other units or time schedules if such accommodations are re-
quested. She also believes that an employee with a fatal disease probably would eventu-
ally leave the job as a result of the progression of the disease.

The employee who fears working closely with an infected employee probably will
not be accommodated in terms of transfer to another unit. Ms. Taylor has indicated that
if there is mass hysteria in a particular department as a consequence of an infected em-
ployee, an interdepartmental educational seminar would be warranted to alleviate fears.
In the case of a single employee afraid of working with an infected co-worker, similar
educational steps would be taken. In all probability, the fearful co-worker would not be
accommodated if, after education, he or she still felt threatened by working closely with
the infected co-worker. Interview with Marjorie Taylor, Executive Secretary of Local
1199E, Health Care and Medical Employees of Labor International Union of North

Joe Jackson, then Business Manager of the Hospital Employees' Union, Local 1273,
represented employees of Bon Secours Hospital, Park Manor Nursing Home, Jewish Con-
valescence and Nursing Home, Inc., and the West Baltimore Community Health
Center. Like Ms. Taylor, Mr. Jackson believed that the employee with AIDS must be
protected. The negotiated contract between Local 1273 and the health care institutions,
however, provides fewer protections for infected employees than those available to Lo-
cal 1199E. Despite these lesser benefits, it was Mr. Jackson's position that the infected
employee should not be treated differently from any other employee whose illness or
disease causes frequent absences and is reasonably accommodated. Interviews with Joe
Jackson of Local 1273, Hospital Employees' Union, in Baltimore, Md. (Mar. 28, 1988).
Both Mr. Jackson and Ms. Taylor believed that accommodating employees in nursing
homes would be more problematic since there are fewer departments in nursing homes
than in hospitals. Interview with Majorie Taylor, supra; Interviews with Joe Jackson,
supra.
a. Legal Background.—The Rehabilitation Act\textsuperscript{51} protects “qualified handicapped individual[s]” but does not specifically contain an accommodation requirement.\textsuperscript{52} Regulations promulgated by the Department of Health and Human Services (DHHS)\textsuperscript{53} define “qualified handicapped persons” as “person[s] who, with reasonable accommodation, can perform the essential functions of the job in question.”\textsuperscript{54} Additionally, in \textit{Southeastern Community College v. Davis},\textsuperscript{55} the Supreme Court indicated that failure to reasonably accommodate may violate the Rehabilitation Act.\textsuperscript{56} The \textit{Davis} Court noted that “situations may arise where a refusal to modify an [employer’s] existing program might become unreasonable and discriminatory.”\textsuperscript{57}

What constitutes a reasonable accommodation by an employer? Unfortunately, this question does not yet have a definitive answer. Under section 701(j) of Title VII of the Civil Rights Act of 1964\textsuperscript{58} an employer must “reasonably accommodate” an employee’s religion unless there is “undue hardship on the conduct of the employer’s business.”\textsuperscript{59} The \textit{Equal Employment Opportunity Commission Guidelines on Discrimination Because of Religion}\textsuperscript{60} suggest alternatives for accommodating religious practices, such as voluntary swaps, lateral transfers, flexible scheduling, and job assignment changes.\textsuperscript{61}

The reasonable accommodation standard in religious cases has been clarified by case law. In \textit{Transworld Airlines Inc. v. Hardison}\textsuperscript{62} the Supreme Court stated that reasonable accommodation is required so long as it does not result in “undue hardship” on the business.\textsuperscript{63} The term “undue hardship” was defined by the Court as occurring whenever the accommodation results in “more than a \textit{de minimis} cost” to the employer.\textsuperscript{64} In \textit{Hardison} the Court held that while paying premium wages for substitute employees to accommodate the plaintiff on a regular basis would not be \textit{de minimis}, doing so on an

\begin{itemize}
  \item \textsuperscript{51} 29 U.S.C. § 794 (Supp. IV 1986).
  \item \textsuperscript{52} \textit{Id}.
  \item \textsuperscript{53} 45 C.F.R. §§ 84.1 to .61 (1987).
  \item \textsuperscript{54} \textit{Id}. § 84.3(k).
  \item \textsuperscript{55} 442 U.S. 397 (1979).
  \item \textsuperscript{56} \textit{Id} at 412-13.
  \item \textsuperscript{57} \textit{Id}.
  \item \textsuperscript{58} 42 U.S.C. § 2000e(j) (1982).
  \item \textsuperscript{59} \textit{Id}.
  \item \textsuperscript{60} 29 C.F.R. §§ 1605.1 to .3 (1988).
  \item \textsuperscript{61} \textit{Id}. § 1605.2.
  \item \textsuperscript{62} 432 U.S. 63 (1977).
  \item \textsuperscript{63} \textit{Id}. at 74-75.
  \item \textsuperscript{64} \textit{Id}. at 84.
\end{itemize}
infrequent basis would be de minimis. In *Ansonia Board of Education v. Philbrook* the Supreme Court held that it was not discriminatory for an employer who offered a reasonable accommodation not to accede to the employee's preference for an alternate accommodation. There is no requirement for an employer to show that each alternate accommodation would result in undue hardship.

These recent cases narrowly interpret religious accommodation. If the accommodation results in more than a de minimis cost, the employer may use undue hardship as a defense. In handicap cases, however, there is evidence that the duty to accommodate will be read in a broader manner. A goal of the Rehabilitation Act was to "enable handicapped persons to achieve their full productive capability, foster their self-sufficiency and independence, and integrate them into the community." A de minimis approach would not achieve this end.

Several recent cases have attempted to articulate a standard for reasonable accommodation in handicap cases. *Turillo v. Tyson* involved parents who sought private education for their handicapped child. The court stated that the school in question was obligated, under the Rehabilitation Act, to modify its programs and facilities to accommodate the child, but not to the point to which such modifications would place an "undue financial and administrative burden" on the facility. Although the language is similar to that used in religious accommodation cases, it is apparent that the employer must show significantly more than a de minimis effect.

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65. *Id.* at 84-85.
66. 479 U.S. 60 (1986).
67. *Id.* at 68-69.
68. *Id.* at 68.
71. *Id.* at 587. This is a reiteration of the standard in *Southeastern Community College v. Davis*, 442 U.S. 397 (1979), the first Supreme Court case decided under the Rehabilitation Act. In *Southeastern*, the Court held that reasonable accommodation does not include "fundamental alteration" or "financial and administrative burdens." *Id.* at 410, 412. The college refused to admit Davis to its nursing program because she was unable to understand speech without lip reading. The Court held that the school was not required to make "substantial modifications" to its educational program, such as waiving the clinical requirement or providing a teacher to supervise closely the clinical program. *Id.* at 409-10, 413. The Court noted that the Rehabilitation Act language, purpose, and legislative history contained no affirmative obligation to accommodate. *Id.* at 411.
Similarly, in *Majors v. Housing Authority* 73 the court found that housing laws prohibiting pets could be required to be modified, although only to a reasonable degree, to accommodate a handicapped individual. 74 In *Ackerman v. Western Electric Co.*, 75 a handicapped employee lawsuit, the court found that reassigning twelve percent of an employee’s workload to accommodate her handicap was a reasonable accommodation for the employer to make. 76 Finally, in *Rhode Island Handicapped Action Committee v. Rhode Island Public Transit Authority* 77 the court found that devoting 3.5 percent of the defendant’s federal mass transit funds for modifications to accommodate the handicapped was reasonable under the circumstances. 78

In *School Board of Nassau County v. Arline* 79 the Supreme Court did not change the law of accommodation, but did expand the scope of individuals to be accommodated under the Rehabilitation Act. 80 In *Arline* the Court acknowledged that communicability of a disease might prevent a person from performing essential functions of a job, even with reasonable accommodation, and remanded the case for specific findings of fact on this question. 81 In the case of HIV infection, AIDS, and other diseases, the differences between permitted and prohibited actions may turn entirely on medical and scientific evidence regarding the probability of transmitting the disease in light of the facts of the specific case.

Unfortunately, there are no cases dealing with accommodation of handicapped HCWs under the Rehabilitation Act. Although the above cases demonstrate that more than a de minimis accommodation is required, the uncertainty for health care employers remains. Part-time work or modification of work schedules, job restructuring, physical modification, or relocation of particular offices or jobs most likely will be considered as reasonable accommodation. In addition, if the HCW presents a risk of infection to patients, the employer may be required to reassign the HCW to a comparable position with less direct patient contact, rather than discharge the HCW.

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73. 652 F.2d 454 (5th Cir. 1981).
74. *Id.* at 458.
75. 643 F. Supp. 836 (N.D. Cal. 1986).
76. *Id.* at 851-52.
77. 718 F.2d 490 (1st Cir. 1983).
78. *Id.* at 497.
80. *Id.* at 285-86.
81. *Id.* at 288-89. The Supreme Court adopted the AMA’s position that employment decisions about persons with contagious diseases should be based on reasonable medical judgments given the state of medical knowledge about the nature, duration, severity, and transmission of the disease. *Id.* at 288.
b. Scientific Background.—To what degree of risk is a patient exposed when an HCW is infected with HIV? This concern now will be addressed, both in a surgical and nonsurgical context.

(1) Transmission of HIV to the Patient During Surgery.—There have been no documented cases of HCW-to-patient HIV transmission, although blood-linked transmission has occurred with HBV, which is significantly more contagious and transmissible. Since transmission of HIV, like HBV, occurs only with exposure to blood or bodily fluids, it is in the case of an infected surgeon or other member of an operating team that the theoretical likelihood for such transmission is the greatest.
The risk of HIV transmission from surgeon to patients probably is far lower than the data for HBV dictates. Multiple variables in each situation must be considered. Skin-puncture calculations assume that the risk of transmission from surgeon to patient and from patient to surgeon are identical. There is usually direct injection of patient blood into the surgeon's hand with skin punctures. With puncture wounds or scalpel cuts to the surgeon's hand, little bleeding is produced and the hand is rapidly removed from the surgical field and regloved, thereby greatly lessening the risk to the patient. In addition, there was a somewhat less careful attitude toward glove and skin punctures when the calculations were made. Now surgeons are more likely to be especially cautious for fear of contracting AIDS. Surgeons wear two pairs of gloves and take extra care to avoid skin punctures, thus lessening considerably the risk of transmission of HIV in either direction. Finally, variables such as the expertise or experience of the surgeon, the magnitude or type of surgical case, and advances in operative techniques and equipment must be considered in skin-puncture calculations. Certainly changes in surgical behavior, greater years of experience, greater expertise or training, minor and elective surgery, and improved techniques and equipment all would work to significantly decrease the risk of physician-to-patient or patient-to-physician transmission to levels far below the risk from screened, but falsely HIV-negative, blood transfusions.

Medical Center indicate that reported incidences of skin puncture are approximately 3%, but these are surely underreported. Hagen, supra, at 1357. The rate of HBV seroconversion after percutaneous or mucous membrane exposure is approximately 25%. Therefore, one can calculate the skin-puncture-to-infection rate (for HBV) to be 1 per 43 operative cases (2.1% HBV seroconversions per year divided by 360 cases per year yields one seroconversion per every 17,000 operations).

The risk of HIV seroconversion after percutaneous exposure is between 0.003% and 0.9%. McRae, Occupational Risk of AIDS Among Health Care Workers, 314 New Eng. J. Med. 1127 (1986); 'Small Risk' for Health Workers, 3 AIDS Policy & Law 2 (Feb. 24, 1988) (reviewed 8 studies with 2284 HCWs exposed to HIV, in which only 4 seroconversions were documented). Therefore, with an operative skin-puncture rate of 1 per 43 cases, the rate of transmission of HIV from surgeon to patient during surgery would range from 1 per 143,000 cases up to 1 per 478 cases, or a range of 1 patient infected per 39.7 surgeon-operating years up to 1 patient infected per 1.3 surgeon-operating years. Obviously, this analysis grossly oversimplifies and ignores multiple variables.

See supra note 85.

Epidemiologic data suggest that the risk of HIV transmission from patients to HCW after percutaneous exposure is very low at approximately 0.5%. Eickhoff, supra note 83, at 462.

In addition, the incidence of infections among other members of the operative team must be examined.

The risk for transmission of HIV secondary to falsely negative blood transfusions
(2) **Transmission of HIV to the Patient During Nonsurgical Patient Care Activities.**—The potential risk for HCW-to-patient transmission of HIV in nonsurgical patient care activities is likely to be no greater than the risk documented between family members. Aside from the risks during invasive procedures, the degree of contact between HCWs and patients is much less than that between family members. The risk also is lessened in the health care setting by the use of universal precautions. Studies of families in which one member is HIV-positive show no evidence of transmission through casual contact, including sharing kitchen utensils and bathroom facilities, as well as toothbrushes. In the nonsurgical health care setting, HCWs come into contact with a patient's blood or bodily fluids but the risk is decreased by the HCW's observance of the universal precautions. Following these precautions, as recommended by the CDC, and mandated by OSHA, should guarantee that the risk remains negligible.

**c. Emerging Trends.**—The AMA Council on Ethical and Judicial Affairs (the AMA Council) has stated that

> [i]f a risk of transmission of an infectious disease from a physician to a patient exists, disclosure of that risk to patients is not enough; patients are entitled to expect that their physicians will not increase their exposure to the risk of contracting an infectious disease, even minimally. If no risk exists, disclosure of the physician's medical condition to his or her patients will serve no rational purpose; if a risk does exist, the physician should not engage in the activity.

The General Medical Council of Great Britain (the British Council) has taken a similar stance: "It is unethical for doctors who
know or believe themselves to be infected with HIV to put patients at risk by failing to seek appropriate counselling, or to act upon it when given." The British Council believes that even a theoretical risk is too great; surgeons infected with HBV (and presumably with HIV) should cease operating.

The CDC hedges its position somewhat: "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."

All active duty military personnel now are subject to mandatory testing. The Navy and the Air Force remove seropositive physicians from all patient care duties. The Army follows the approach outlined by the American Medical Association (AMA) and does not allow seropositive physicians to perform invasive procedures.

At its 1987 annual meeting the Texas Medical Association adopted the position that seropositive physicians need not tell their patients of their HIV status. This statement implies that a seropositive surgeon may continue to operate regardless of the risk.

In Doe v. County of Cook a staff neurologist with AIDS had his privileges suspended in February 1987 by Cook County Hospital. Seven months later the hospital restored some of his privileges on the condition that he comply with CDC guidelines and double-glove for certain invasive procedures. A formal consent decree eventually was signed on February 24, 1988, requiring that Dr. Doe double-glove for minor invasive procedures and when in contact with a patient’s mucous membranes. The consent decree also limited the hospital director’s ability to further restrict Dr. Doe’s

97. CDC Recommendations: No. 25, supra note 7, at 318.
98. Interview with Dr. Maureen Francis, Regional AIDS Coordinator for the U.S. Army, Fort Meade, Md. (Apr. 15, 1988) (oral interview).
99. Id.
100. Doctors’ Care is Optional, Texas Medical Group Says, 2 AIDS Pol’y & Law 7 (Dec. 2, 1987) (the meeting took place in Austin, Texas on November 21, 1987).
102. Id. at 7.
103. Doctor, Hospital Settle Suit Over Staff Privileges, 2 AIDS Pol’y & Law 8-9 (Sept. 23, 1987).
104. See Physician’s Consent Decree, supra note 101, at 7.
privileges to those situations in which he posed "a significant health or safety risk to himself or others." This limitation reflects concern that Dr. Doe's future performance might be impaired by future complications including AIDS dementia or problems from opportunistic infections. The court ordered that Dr. Doe receive seven days' notice of such additional restrictions, except in cases of emergency, i.e., situations in which actions are "necessary to prevent or alleviate a significant and immediate threat to patient safety." The resolution of this case appears to be an excellent model for reasonable accommodation in health care settings.

d. Policy Analysis.—Recent Office of Personnel Management (OPM) guidelines dealing with AIDS in the workplace stated that HIV-infected employees should be allowed to continue working as long as they are able to maintain acceptable performance and do not pose a safety or health threat to themselves or others in the workplace. . . . [A]gencies are encouraged to consider accommodation of employees' AIDS-related conditions in the same manner as they would other medical conditions which warrant such consideration. This position mandates a broad interpretation for the reasonable accommodation standard.

(1) Asymptomatic Seropositive HCWs.—The term "asymptomatic" includes those individuals who would be classified in groups I, II, and III of the CDC classification system for HIV infection. Group I includes individuals with initial HIV infection, e.g., a syndrome similar to infectious mononucleosis. Group II individuals have chronic asymptomatic HIV infection as manifested by laboratory abnormalities, including anemia, leukopenia, and

105. Id.
106. Id.
110. Id. Clinical symptoms of infectious mononucleosis include pharyngitis, lymphadenopathy, and fever. MEDICAL DICTIONARY, supra note 108, at 886.
lymphopenia. Individuals in group III have persistent generalized lymphadenopathy.

(a) HCWs Not Involved in Invasive Procedures.—Given the decreased risk for HCW-to-patient transmission of HIV in nonsurgical procedures, there is no reason for the health care facility to take any action solely because of the HCW’s HIV status if the HCW is asymptomatic. Unless the employee refuses to follow OSHA-mandated infection control guidelines, any change in the employee’s job, including a transfer out of direct patient care, is not warranted and may subject the employer to liability under discrimination laws. Such blind actions only fuel the existing AIDS hysteria among coworkers. Practically, it also creates a personnel void for the employer, at a time when there currently is a shortage of non-physician HCWs. If the employer wants to transfer the employee away from direct patient care and is determined to ignore the significant legal risks involved, however, it should attempt to do so with the employee’s consent, with absolute confidentiality, and without any reduction in either compensation or opportunity for advancement.

(b) HCWs Involved in Invasive Procedures.—Both the AMA and the British Council have recognized that HCWs who are seropositive have an ethical obligation to voluntarily withdraw from participation in invasive procedures. The obvious question is whether an employer may unilaterally require a seropositive HCW to do so. Should an employee refuse to be transferred away from direct involvement with invasive procedures, the employer arguably has a more defensible position for a unilateral transfer because of the theoretical risk of HCW-to-patient HIV transmission. This theoretical risk, however, certainly is small. Even indirect calculations from HBV data, which undoubtedly overestimate the risk, demonstrate this. Additionally, a ban from participation in all invasive procedures, as defined by the CDC, is overbroad since many of the proce-

111. Ostrow, supra note 109, at 11. Anemia is characterized by a low red blood cell count. MEDICAL DICTIONARY, supra note 108, at 66-67. Leukopenia is characterized by a low white blood cell count. Id. at 781. Lymphopenia is characterized by a low lymphocyte (a specific type of white blood cell) count. Id. at 821.
112. Ostrow, supra note 109, at 11. Patients in group III may be classified on the same laboratory basis as group II patients. Id. Lymphadenopathy is a disease of the lymph nodes. MEDICAL DICTIONARY, supra note 108, at 815.
113. See supra notes 90-93 and accompanying text.
114. See supra note 93.
115. See supra notes 94-96 and accompanying text.
116. See supra note 85.
dures have negligible risk of transmission to the patient. 117

If an employer unilaterally prevents seropositive HCWs from participating in invasive procedures and if another job is not readily available for the employee, courts may conclude that in the narrow case of an employee hired solely to perform invasive procedures, HIV-seropositivity prevents the employee from performing the essential functions of the job, irrespective of reasonable accommodation efforts. 118 Adopting this approach may cause the employer to mandate periodic HBV and HIV screening for individuals performing invasive procedures. 119

The CDC recommendations define the term "operative procedure" as the "surgical entry into tissues, cavities, or organs or repair of major traumatic injuries in an operating or delivery room, emergency department, or outpatient setting, including both physicians' and dentists' offices." 120 This definition encompasses procedures with little or no risk of HCW-to-patient HIV transmission. Cataract surgery is a perfect example of an invasive procedure with no real risk of transmission.

An employer that elects to follow a policy of unilateral transfers away from invasive procedures must be prepared to deal with a Pandora's box. Fearing reprisals, individuals who might have sought testing and counseling for suspected HIV infection will be driven underground. Therefore, the employer will have to institute mandatory periodic testing of all HCWs involved in invasive procedures. If such testing is instituted, surgeons will argue that, because the risk of patient-to-surgeon HIV transmission is higher than that from surgeon to patient, patients also should be tested for HIV infection prior to any invasive procedure. With everyone tested, confidentiality problems will multiply. A theoretical, and to date unproven, risk of transmission does not justify embarking upon such troubled waters.

Should the employer allow the infected HCW to participate in invasive procedures, the patient's informed consent becomes an issue. Because of the dismal prognosis associated with HIV infection, the AMA urges that the patient should be notified of the HCW's seropositive status even when there is only a theoretical risk of

117. See supra note 85.
119. Id.
120. See Governor's Task Force app. H, supra note 82, at H-7.
Due to the AIDS hysteria, such notification would have the practical effect of removing the HCW from involvement with invasive procedures. If the employer and the infected HCW elect not to inform the patient, does a patient who seroconverts after an invasive procedure have the right to review an employer’s documentation of HCWs’ HIV status?

Neither course outlined above is satisfactory. The first approach will serve only to drive the seropositive HCW out of the health care setting. With the second approach, patients will not be fully informed of potential risks when they are consenting to an invasive procedure. It may be best to pre-operatively inform each patient that there is a very small risk of HIV seroconversion from falsely negative blood transfusions and from unknowingly seropositive HCWs who bleed into the operative wound after an inadvertent skin puncture. This balanced approach would protect both the HCWs’ privacy and the patients’ right to be fully informed.

Any restriction of physicians’ hospital privileges will have to be pursued with strict adherence to medical staff and hospital bylaws. Such a decision should be made by the seropositive physician’s personal physician in conjunction with the facility’s medical director and health service personnel director. Seropositive physicians who practice independently should not be treated any differently than employed physicians or other HCWs.

Title VII cases involving independently contracting HCWs provide some guidance as to how they might be handled under the Rehabilitation Act. Title VII defines “employee” as an individual employed by an employer. Most Title VII and Rehabilitation Act statutes which define unlawful employment practices do not use the term “employee,” but rather use the term “individual.”

121. See supra note 94 and accompanying text.
122. This position is supported by the Texas Medical Association. See supra note 100 and accompanying text.
123. In Maryland there are no statutory grounds which could serve as the basis for an adverse privilege action based solely on a physician’s HIV status. Md. HEALTH OCC. CODE ANN. § 14-504 (1986 & Supp. 1988).
124. See CDC Recommendations: No. 25, supra note 7, at 318.
126. See id. § 2000e(f).
127. Title VII states:
   It shall be an unlawful employment practice for an employer—
   (1) to fail or refuse to hire or to discharge any individual, or otherwise to discriminate against any individual with respect to his compensation, terms, conditions, or privileges of employment, because of such individual’s race, color, religion, sex, or national origin. . . .
term "individual" implies that it is not necessary for a person to have a direct employment relationship to receive protection.

_Sibley Memorial Hospital v. Wilson_128 is the leading Title VII case. The _Sibley_ court stated that

[the Act defines "employee" as "an individual employed by an employer," but nowhere are there words of limitation that restrict references in the Act to "any individual" as comprehending only an employee of an employer . . . Those words should, therefore, be given their ordinary meaning so long as that meaning does not conflict with the manifest policy of the Act.129

While the court did not define the exact nature of the relationship that would trigger Title VII protection, Title VII protection apparently attaches when an employer is involved in the employment practices of an individual.130

The Title VII cases involving physician privilege denials have taken divergent paths. _Pao v. Holy Redeemer Hospital_131 followed the course taken by _Sibley_.132 The _Pao_ court stated that the hospital shared an employment relationship with the plaintiff physician because it controlled his access to "prospective patients who are his ultimate 'employers.' "133 Other cases, however, have distinguished _Sibley_ by finding the physician to be an independent contractor to patients, as well as to the hospital, and not an employee of either, therefore holding Title VII protection to be inapplicable.134 There

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128. 488 F.2d 1338, 1339 (D.C. Cir. 1973) (holding that a private nurse hired by the patient, but referred by the hospital through a local nurses' registry, is protected under Title VII).
129. _Id._ at 1341.
130. The court stated:
   On the facts as alleged, although not yet proved, appellant is so circumstanced, and its daily operations are of such a character as to have such a nexus to third parties in this case; and we think neither the spirit nor, more essentially, the language of the Act leave it outside the reach of Title VII.

132. _Id._ at 494-95.
133. _Id._ at 494. _See also_ Doe v. St. Joseph's Hosp., 788 F.2d 411, 422 (7th Cir. 1986) (holding that plaintiff physician should have been allowed to argue that Title VII does not require an employment relationship as a prerequisite to a claim under Title VII).
134. _See e.g._, Beverley v. Douglas, 591 F. Supp. 1321, 1327 (S.D.N.Y. 1984) (finding the relationship between the hospital and voluntary staff was not one of employment within Title VII coverage); Nanavati v. Burdette Tomlin Mem. Hosp., 42 Fair Empl. Prac. Cas. (BNA) 197, 200 (D.N.J. 1986) (holding that since the hospital did not have the
is no clear consensus on this issue, but facilities should be cautious in restricting the privileges of HIV-positive physicians, whether they are hospital employees or independent contractors.

(2) Symptomatic Seropositive HCWs.—Theoretically, individuals in group IV are considered symptomatic under the CDC classification system.¹³⁵ Group IV is subclassified into those individuals with: (a) constitutional diseases, (b) neurological diseases (e.g., dementia), (c) secondary infectious diseases, (d) secondary cancers, and (e) other conditions not fitting the above classifications.¹³⁶

Once an HCW either develops symptoms that impair job performance or becomes immunocompromised and at increased risk of acquiring infections from patients, the employer may unilaterally transfer the employee out of direct patient care. Practically, to avoid litigation, this should be done by prior agreement after confidential discussions with the HCW, the HCW’s physician, and the medical director of the facility. An open atmosphere will diffuse the situation, allow for appropriate reasonable accommodation, and avoid the possibility of seropositive HCWs failing to report their illness. The transfer, even when done unilaterally, should be accompanied by stringent confidentiality and no reduction in compensation or opportunity for advancement. Termination probably will not be defensible until the HCW’s illness causes chronic absenteeism or physically impairs the performance of the essential job duties, even with reasonable accommodation.

In Maryland, statutory defenses are available to an employer who transfers an employee whose condition would create a hazard or risk of danger to others.¹³⁷ In Mass Transit Administration v. Maryland Commission on Human Relations¹³⁸ the court held that one valid defense to a discrimination allegation was that the handicap or disability in question would interfere with the employee’s ability to perform the work adequately.¹³⁹

Related to the concerns about discrimination in employment

means to control the staff physician’s performance, the physician was not an “employee” for purposes of Title VII).

¹³⁵. See Ostrow, supra note 109, at 12.
¹³⁶. Id. at 12-13.
¹³⁷. See Md. Ann. Code art. 49B, § 16(a), (e), (g) (1986).
¹³⁸. 68 Md. App. 703, 713-14; 515 A.2d 781, 786 (1986), cert. denied, 308 Md. 382, 519 A.2d 1283 (1987) (holding that city bus drivers with high blood pressure presented a potential “life threatening danger” to the public and that low blood pressure was therefore a “bona fide occupational qualification”).
¹³⁹. Id. at 713, 515 A.2d at 786.
are concerns that the Maryland regulations require certain employees with a communicable disease to notify the Secretary of the Department of Health and Mental Hygiene (DHMH) and to obtain permission to continue working. A carrier of a communicable disease who works with young children, the elderly, food, or in patient care must obtain the permission of the Secretary of DHMH or a delegated state health officer in order to continue working. Factors which may be considered by the Secretary of DHMH include:

a) the seriousness of the disease;
b) the route of transmission;
c) the communicability of the disease;
d) the susceptibility to the disease of those likely to be exposed to the carrier;
e) the precautions that may be taken to minimize or eliminate the danger of transmission;
f) precedents in the practice of public health.

These regulations, at least as applied to AIDS and HIV-infected HCWs, have several drawbacks. First, the regulations are difficult to enforce, but may serve to make some HCWs reluctant to disclose their illness. Second, the regulations are in conflict with the sweeping policy of confidentiality. Since HIV is not readily transmitted in the health care environment, the regulation serves no useful purpose and should not be applicable to infected HCWs. While under the current regulations the Secretary of DHMH could permit infected HCWs to continue working, such HCWs still would be required to notify the Secretary of their condition.

140. A communicable disease is defined as an illness due to a specific infectious agent or its toxic products which arises through transmission of that agent or its products from an infected person, animal, or inanimate reservoir to a susceptible host, either directly or indirectly through an intermediate plant or animal host, vector, or other inanimate environment.

AM. PUB. HEALTH ASS'N, CONTROL OF COMMUNICABLE DISEASES IN MAN: AN OFFICIAL REPORT OF THE AMERICAN PUBLIC HEALTH ASSOCIATION 447 (14th ed. 1985). The definition of terms included in this book are accepted as official and applicable to the control of diseases in the State of Maryland. Md. REGS. CODE tit. 10, § 10.06.01.01 (1981).

141. Md. REGS. CODE tit. 10, § 10.06.01.04C(1) (1981).

142. Id.

143. Id. at (2).

144. See GOVERNOR'S TASK FORCE app. H, supra note 82 and accompanying text. There have been no incidents of transmission of AIDS from HCWs to patients. Bristow, Reducing the Risk of Blood-Borne Infection to Health Care Workers, Statement of the AMA to the Employment & Housing Subcomm., Comm. on Gov't Operations, U.S. House of Representatives 4 (July 1987).
The DHMH should eliminate the regulatory requirement that HIV-infected HCWs seek permission before continuing to work. The regulation is unenforceable, unnecessary to protect the public health, and inconsistent with the privacy rights and interest in confidentiality.

C. Confidentiality With Respect to HIV-Infected HCWs

A number of confidentiality issues arise with respect to HIV-infected HCWs. The question of whether employers, co-workers, and patients have a right to be informed of the HCW’s seropositivity is controversial. The individual HCW’s right to privacy and desire for protection from discrimination competes with the employer’s concerns about potential liability if the infected HCW transmits the infection to a patient or co-worker. Co-workers and patients have fears of becoming infected. Common to these issues is the question of whether an infected HCW has an ethical duty to inform co-workers and patients.

First, it is generally not advisable for an employer to inform HCWs that a fellow employee has AIDS. The HCW’s right of privacy requires that a court balance an employer’s legitimate business interest in disseminating the information against the nature and substantiality of the intrusion into the privacy of the individual. 145

Employers should be aware that medical documentation submitted to a federal agency for the purpose of an employment decision and made part of the file pertaining to that decision becomes a record protected by the Privacy Act. 146 The Privacy Act generally forbids federal agencies to disclose a protected record without the consent of the subject of the record. 147 These records, however, are available to agency officials needing the information for an appropriate management purpose. 148 Officials who have access to such information are required to maintain the confidentiality of that information. 149 In addition, supervisors, managers, and others making and implementing personnel management decisions involving employees with AIDS should strictly observe applicable privacy and

145. See, e.g., National Treasury Employees Union v. Raab, 816 F.2d 170, 180 (5th Cir. 1987) (the court “balanced” the employee’s right of privacy against the employer’s business interest in holding that a drug testing program for employees seeking promotions was constitutional).
147. Id. § 552a(b).
148. Id. § 552a(b)(1).
149. Id. § 552a(b).
confidentiality requirements. Therefore, employers who disclose protected information may be in violation of the Privacy Act and subject to legal consequences. 150

The use of universal precautions in the health care setting should eliminate the need to inform employees that co-workers are seropositive. If an employee is injured or becomes ill and requires treatment, universal precautions should be used with the employee just as with any other patient. Workers in, *e.g.*, an operating or emergency room, need to know the identity of HIV-infected co-workers so that precautions may be better observed. The employer should counsel the infected HCW and discuss the issue of privacy and how it should be handled as the disease progresses.

A second confidentiality issue is whether a patient should be told that an HCW who is caring for him or her is seropositive. As with co-workers, the use of universal precautions should virtually eliminate the risk of transmission from HCW to patient. If the employer has determined that the employee is physically able to perform the job and does not present a danger to others, then there is no obligation or reason to disclose such information to the patient. To do so without the employee’s consent could violate state laws regarding confidentiality and could result in liability on the part of the hospital while at the same time unnecessarily alarming the patient. If a patient has a parenteral or mucous membrane exposure to an employee’s blood or other bodily fluids, however, the patient should be informed of the exposure, and testing should be undertaken to determine whether an HIV infection was transmitted.

A third confidentiality issue is whether the infected HCW should be obligated to inform the employer of the HCW’s seropositive status. In the vast majority of situations, mandatory disclosure cannot be justified and may subject an employer to liability. Employers are generally not permitted to base employment decisions on a person’s AIDS or HIV status. 151

The one exception to this rule is a situation where the nature of the HCW’s employment creates a risk of transmission of AIDS to third parties. As with sexual partners, if third parties are potentially at risk and if the employee refuses to take steps to prevent the risk,

150. In addition, the common-law theory of defamation prohibits an employer from defaming an employee by improperly publishing a false statement that an employee has a contagious disease. W. KEETON, D. DOBBS, R. KEETON & D. OWEN, PROSSER & KEETON ON TORTS § 112, at 788 (5th ed. 1984).

151. See supra text accompanying notes 40-47. See also AM. ACAD. OF HOSP. ATT’YS, AIDS & THE LAW 328 (Aug. 1987).
the employer may compel the employee to disclose. These situations should be rare, however, even for employees such as physicians or nurses who are required to participate in invasive procedures.

If the employee voluntarily decides to inform the employer, the information should be subject to the stringent confidentiality guidelines discussed earlier. Disclosure of information should be confined to the HCW’s personal physician and the medical directors and health service personnel staff of the employing institution or hospital.

D. Employee Assistance

1. Workers’ Compensation.—Workers’ compensation is designed to pay workers for illnesses or injuries sustained on the job. Workers’ compensation pays an employee’s medical expenses for job-related injuries and continues to pay a disabled or injured worker a percentage of the earned salary at the time of the illness or injury. Typically, a permanently disabled employee in Maryland receives two-thirds of that employee’s average weekly salary from the date of disability until the employee returns to work, reaches retirement age, or dies.

This compensation system is inadequate for the HCW who contracts HIV in the workplace. First, the amounts paid for workers’
compensation are insufficient to accommodate the needs of the infected HCW. The costs associated with AIDS are enormous\(^\text{160}\) and while an employee’s direct medical expenses are covered,\(^\text{161}\) the reduced salary imposes a hardship at a time when the employee is least able to cope with it. Also, the workers’ compensation system does not automatically take into account potential earnings, but only the salary at the time of the injury or disability.\(^\text{162}\) This would be particularly inadequate compensation for young physicians who could expect rapid and significant increases in income.\(^\text{163}\) Finally, physicians who are not employed by a hospital, but who contract AIDS in a hospital, probably are not covered by workers’ compensation statutes.\(^\text{164}\)

While the probability of HCws contracting AIDS on the job is quite low, the anxiety produced among HCWs has been great.\(^\text{165}\) The State should be concerned about this as it faces potential shortages of HCWs willing to treat AIDS patients. For example, an Ohio municipality has established a plan for its firefighters that would supplement their workers’ compensation award if they con-

examination has taken place, and no compensation shall be payable during or for account of such period.


\(^\text{163. The Maryland statute does provide, however, that if “the injured employee was of such age and experience when injured as that under the natural conditions his wages would be expected to increase, this fact may be considered in arriving at his average weekly wages.” Md. Ann. Code art. 101, § 46 (1985). Thus, the workers’ compensation board may make an adjustment. This adjustment should be made mandatory, rather than discretionary.}\)

\(^\text{164. Employees subject to the provisions of Maryland Workmen’s Compensation Act are described in section 21(b) of article 101. Md. Ann. Code art. 101, §§ 21(b), 67(3) (1985). An independent contractor is not an employee for purposes of the Workmen’s Compensation Act. Bowers v. Eastern Aluminum Corp., 240 Md. 625, 627, 214 A.2d 924, 925 (1965). The Workmen’s Compensation Act does not specifically define independent contractor, but cases distinguishing between an employee and an independent contractor have defined independent contractor as “one who contracts to perform a certain work for another according to his own means and methods, free from control of his employer in all details connected with the performance of the work except as to its product or result.” Gale v. Greater Wash. Softball Umpires Ass’n, 19 Md. App. 481, 487, 311 A.2d 817, 821 (1973). Physicians who are not employed by a hospital, but who contract AIDS in a hospital, presumably fall into this class of independent contractors excluded from the benefits of the Workmen’s Compensation Act.}\)

\(^\text{165. Gruson, AIDS Fear Spurs Ethics Debate As Some Doctors Withhold Care, N.Y. Times, July 11, 1987, at A1, col. 3.}\)
tract AIDS. Under the plan, a firefighter who contracts AIDS would continue to receive his or her full salary from the date of disability until death or retirement, with the city making up the difference between the workers' compensation award and the salary. One noteworthy feature of this plan is that the firefighter need not prove how or where he or she acquired AIDS.

Maryland has similar no-fault presumptions for police and firefighters who develop hypertension, heart disease, or certain types of cancer. Development of these conditions is "presumed to be compensable . . . and to have been suffered in the line of duty . . . ." This no-fault feature is attractive because one of the difficulties with Maryland HCWs receiving workers' compensation for AIDS is that, because pre-existing disorders are not covered, the worker would have to show that the illness was contracted on the job. This burden of proof can be very difficult because knowledge of the AIDS infection may not come until months or years after the exposure. Nevertheless, the no-fault standard should be rejected since its adoption might encourage abuse and excessively burden the workers' compensation system.

There is an alternative to a no-fault standard while still alleviating the burden of proof for the HCW. An HCW who reports a possible exposure to HIV-infected blood or bodily fluids should be tested immediately. If the test is negative but within eighteen months tests HIV-positive, the HCW will have established a rebuttable presumption that the infection was acquired on the job.

Another possibility is to provide employees who contract HIV in the workplace as a result of employer negligence with the option of bringing a tort action against the employer. Thus, for instance, an employer who failed to mandate the use of universal precautions could be subjected to a tort action by an employee who suffers an exposure that could have been avoided using those precautions. Maryland already provides for the tort option where an employee's

166. Public Safety Workers, Ohio City's Firefighters Would Get AIDS Benefits, 3 AIDS POL'Y & LAW 7-8 (Mar. 23, 1988). No firefighters in Warrensville Heights have any AIDS symptoms. Id. at 8. The union leader who negotiated that contract provision noted the small number of work-related AIDS infections among medical personnel nationwide and stated, "it's not a big cost item, nor does it threaten to become one, yet it does address a concern of workers." Id.
167. Id. at 7.
168. Id. at 8.
171. The current workers' compensation statute provides for other types of rebuttable presumptions. See Md. ANN. CODE art. 101, § 64 (1985).
injury is the result of intentional misconduct by the employer.\textsuperscript{172}

HCWs who become infected outside of the work environment still may be entitled to workers' compensation if the work environment worsens their condition.\textsuperscript{173} Since immunosuppressed HCWs are likely to be exposed to a variety of illnesses in the course of their work, the likelihood of their work environment harming their condition is quite great. The HCW, however, has the difficult burden of showing that the opportunistic infection or illness was acquired in the work environment. Although the risk of work-related infection might be decreased by removing the immunosuppressed HCW from patient contact, it may conflict with reasonable accommodation requirements of the anti-discrimination statutes.\textsuperscript{174}

Private physicians who contract AIDS in a health care environment do not appear to have a solution under the workers' compensation program. The State might consider the possibility of arranging similar protections for private physicians through insurance subsidies for physicians treating AIDS patients.

All employers of HCWs should be required, in order to retain their licenses, to establish procedures for their employees to report possible exposures to HIV and for exposed employees to make subsequent HIV test results known to the employer. Further, Maryland should establish a plan to supplement workers' compensation payments to HCWs who become infected with HIV in the workplace. Infected individuals should have their workers' compensation payment supplemented so that it would equal the salary level they would have reached had they not contracted the disease. The amounts paid to these HCWs should be adjusted to account for estimated potential income which the employees will have lost.

2. Labor and Management Role and Responsibility.—a. Work Site Issues.—Experienced managers and union officials are wholly cognizant of the effects of major medical and/or psychiatric illness in the employee population. The problems are likely to include, but are not limited to, the following: Increased tardiness, excessive absen-

\textsuperscript{173} In Maryland, where a permanent disability is caused in part by a pre-existing illness or injury, compensation is apportioned by the percentage equivalent to the percentage in which the work environment caused the injury. Md. Ann. Code art. 101, § 36(6) (1985 & Supp. 1988).
\textsuperscript{174} For a discussion of the reasonable accommodation requirement, see supra notes 51-81 and accompanying text.
Fatigue on the job, implausible excuse, reduced productivity, heightened sensitivity to infection, reduction in ability to handle stress, reduced tolerance for criticism, memory lapses and/or poor judgment, and changes in relationships with peers. These fairly classic patterns could be applied to any number of medical or emotional conditions, but the focus here will be on a comparison between alcoholism and AIDS.

Though differing in their etiology and means of transmission, AIDS and alcoholism have some remarkable similarities in terms of the workplace perspective and historical treatment of these diseases. Whereas AIDS was not a workplace issue prior to 1981, and in fact has only recently been acknowledged as such, alcoholism gained credibility as a medical rather than moral problem in the mid-1950s, and as a workplace issue in the early 1970s.

The right to work, the right to treatment, and the right of reasonable accommodation on the job during the recovery period are rights preserved for alcoholic federal employees protected by federal statute or employed by companies with an employee assistance program (EAP). When the EAP policy is a joint union-management policy for all employees, stigmatized illnesses are acknowledged in the same manner as other problems that can and do affect job performance. Persons so afflicted can be identified, treated with dignity, offered options and rehabilitation, and returned to the job.

With the determination that HIV positivity and AIDS now qualify as handicapping conditions, some of the decisionmaking problems previously encountered by employers may be alleviated, especially those involving pressure from workers, peers, or community. Although the law can and does affect decisions, procedures,
and even behaviors, rarely does a change in the law produce any immediate change in attitudes. Accordingly, even though union and management personnel may comply with the law, the negative response of co-workers to an infected individual—largely due to irrational fears, homophobia, prejudice, and lack of knowledge about AIDS—can be significant.

b. In-Service Education and Training.—Recent surveys have indicated that a growing portion of the adult population is aware of and has some knowledge about AIDS.180 The media can be largely credited with this awareness.181 Little or no empirical research exists as to the accuracy of the public’s knowledge, and with the exception of a few very limited studies in health care facilities targeting specific groups of HCWs,182 virtually no survey data exist as to the attitudes and behaviors of workers in locations where a member of the work force is seropositive.

HIV and AIDS education in the workplace is not enough. Excellent medical information is now available that can be readily comprehended by most laypersons. The bottom line is that HIV is a very fragile virus,183 difficult to contract,184 and unless one is using intravenous (IV) drugs or engaging in sexual activity on the job, the likelihood of contracting the virus at the work site, even for HCWs, is virtually nil.185 Education of workers, then, must go beyond the mere medical facts. The challenge for both management and union personnel becomes apparent when one realizes that the major issues are not the medical ones but rather the psychosocial ones: fear of the unknown, fear of death, irrational fears, homophobia, stigma,

181. Education about AIDS and the specific routes of virus transmission has had mixed results in the two populations which still represent the majority of those afflicted. In the San Francisco area, the annual rate of new infection among homosexual and bisexual men has dropped significantly in the last few years, a fact attributed to the extensive educational efforts directed at safe sex practices. Ember, supra note 178, at 50. In contrast, similar efforts with intravenous (IV) drug users has been largely unsuccessful. Id. at 50-51. It is the latter group that has been identified as the primary "bridge" for the transmission of HIV into the heterosexual population and newborns. Id.
184. Id. at 1133.
185. Id. at 1131-32.
labeling, prejudice, moral judgments, censure, and a sense of helplessness. These attitudes have their roots in a multitude of influences including but not limited to family of origin, region of origin, race, ethnic heritage, religion, gender, sexual orientation, education, environmental factors, legal sanctions, and prohibitions.

The dichotomy for managers and union personnel becomes apparent when the right of the infected worker to continue employment is compounded by subtle to active discriminatory acts and behaviors of peers on the job. The federal government addresses these concerns as follows:

There may be situations where fellow employees express reluctance or threaten refusal to work with HIV-infected employees. . . . Usually an agency will be able to deal effectively with such situations through information, counseling, and other means. However, in situations where such measures do not solve the problem and where management determines that an employee’s unwarranted threat or refusal to work with an HIV infected employee is impeding or disrupting the organization’s work, it should consider appropriate corrective or disciplinary action against the threatening or disruptive employee(s). . . . In pursuing appropriate action in these situations, management should be sensitive to the possible contribution of anxiety over the illness to work behavior and to the requirements of existing Federal and agency personnel policies, including any obligations the agency may have to consider reasonable accommodation of the HIV-infected employee.186

For those organizations that already have a comprehensive employee assistance program (EAP) policy, a revision of that policy to include HIV infection is a relatively simple matter. If, because the psychosocial effects of the disease process require additional specificity, a regulation addressing the key issues similar to the federal government’s bulletin187 should suffice. As noted above, there is a remarkable similarity between managers working effectively with persons who are alcoholic and persons with HIV. For each, one of the most critical aspects is the attitude of the manager and the role model displayed with respect to job expectations and behaviors.

The federal government’s directive also notes that AIDS in the workplace may be an appropriate area for co-

186. See OPM Bulletin 792-42, supra note 107, at 4-5.
187. Id.
operative labor-management activities, particularly with respect to providing employees education and information and alleviating AIDS-related problems that may emerge in the workplace. In addition, to the extent that an agency proposes AIDS-related policies or programs which would affect the working conditions of bargaining unit employees, unions must be accorded any rights they may have to bargain or be consulted . . . .

Once irrational fears, prejudices, and political hysteria associated with AIDS are identified and neutralized, policies and procedures need be no more specific or complex than those for other debilitating or terminal illnesses. The overworked truism that there is "no need to reinvent the wheel" aptly applies. At most, adding an additional "spoke" should suffice.

c. EAPs.—The current EAP models trace their origins to occupational alcoholism programs developed by business and industry in the 1940s. The major thrust for such programs occurred in the 1970s and 1980s. EAPs now are considered a rather standard employee benefit. Supported, for the most part, by policy statements and with a clearly defined commitment to confidentiality, EAPs serve as an advocate for the employee who is experiencing trouble on the job, for whatever reason.

The federal government's OPM, unlike some of its local and state counterparts, clearly recognizes, supports, and encourages active use of an agency's EAP for counseling those who may have concerns; as an excellent source of information, counseling, and referrals; as a neutral linkage for supervisors and employees; and as a source of supervisory and managerial training. OPM emphasizes the role of the EAP in maintaining confidentiality of any medical and other information about AIDS-related concerns. In effect, OPM has merely added HIV infection as another spoke to the EAP wheel. Comprehensive EAPs, therefore, should be identified as the primary agency resource for all personnel concerned about

188. Id.
189. EAPs are a logical and cost-effective means of providing on-site counseling support, education, and training regarding HIV infection and its impact on the workplace. EAP personnel have extensive experience in working with other stigmatized or potentially fatal conditions such as alcoholism, drug abuse, and mental disorders, therefore suggesting that they might be competent to assist infected HCWs with only minimal additional training. EAP personnel have access to a wide range of resources and services, and credibility with employees, management, and unions.
190. See OPM Bulletin 792-42, supra note 107, at 3.
191. Id.
HIV infection. Services, information, education, counseling, and referrals may be fully utilized by employees and their significant others, management, and union personnel for matters pertaining to HIV infection in the workplace. Confidentiality should be protected and utilization of this resource should be encouraged regardless of the nature or severity of the concern.

Agencies or facilities lacking an EAP are encouraged to immediately establish a joint labor-management advisory committee to explore the options for implementing an on-site program or a contracted EAP to provide the full range of services for the staff. AIDS education and assistance will be only one aspect of this full-service program.

d. Employee Benefits: Leave Options and Alternatives.—The availability of sick leave and reasonable accommodation for HIV-infected HCWs is a critical issue. The reasons include the erratic progression of HIV infection, the unknown factors concerning duration from seropositivity to full-blown AIDS symptoms, and the potential for a reduction in the ability of infected HCWs to work a full day or for extended uninterrupted periods.

(1) Flexitime.—Flexible working hours, adjustments of arrival and departure times, partial work days, and the option to take home work assignments, collectively known as flexitime, are possibilities to help compensate for the loss of stamina associated with AIDS. Whereas some positions lend themselves to flexitime, others preclude it entirely. Additionally, management styles tend to vary widely in this area. Those managers who do provide flexitime options on a limited or as-needed basis usually do so on their own. If such options were made available to infected persons, the potential for a grievance based on discrimination exists. When this type of reasonable, humane consideration is available to all employees on a medical need basis, then the procedure is tantamount to informal policy.

(2) Sick Leave.—Sick leave policies vary from agency to agency in terms of the amount allocated per year, the availability of annual or personal leave if sick leave is exhausted, and alternatives should an entire leave balance be depleted. Persons with major life-threatening illnesses, a history of chronic illness, certain disabilities, and persistent mental or emotional problems, as well as HIV, are likely to have minimal leave balances at any one time. One bout of illness
could wipe out the individual's leave balance well before the medical problem has abated.

(3) Sick Leave Banks.—Foresighted unions and management in a number of agencies have offered the option of sick leave banks for a number of years. 192

The concept behind sick leave banks is very simple. Members contribute a predetermined amount of sick leave to join, generally about two days, and are assessed an additional day at the beginning of each fiscal year. 193 When the sick leave is exhausted, bank members may apply for bank grants for periods of time not to exceed thirty working days per application. 194 Determination of eligibility is made by a committee of three, two of whom are members of the union, and one of whom is a staff member of the personnel department. 195 Requests for leave must be accompanied by appropriate medical documentation, including an estimated date for returning to work. 196 The banks serve as a highly effective self-insurance program for contributors, as well as a form of leave sharing with peers in mind.

(4) Leave Sharing.—A leave-sharing program permits employees to make direct donations of their own accumulated leave to fellow employees in need. 197 Although the altruistic benefits to both the donor and donee may be significant, the accounting involved with multiple donors, plus the requirement that unused leave be

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192. One of the pioneers in the State of Maryland was the Montgomery County Education Association (MCEA) that established a sick leave bank in 1971 for professional employees. The following year a comparable program was offered by the Montgomery County Council of Supporting Services Employees (MCCSSE) for the noncertified employees in the Montgomery County Public Schools (MCPS). The concept was not original to Montgomery County but the benefits have been enormous for employees with catastrophic illness, medical emergencies, and extended periods of disability. See MONTGOMERY COUNTY, MD., CODE ch. 33, art. II app., § 15.8 (1977 & Supp. 1982) (providing additional sick leave for employees who have exhausted all accrued leave).

193. Federal Employees Leave-Sharing Act of 1988, Pub. L. No. 100-566, 102 Stat. 2834 (1988). The Federal Employee's Leave-Sharing Act has characteristics of a leave bank and a leave-sharing program, in that an individual bank member may contribute leave for general use or for the benefit of a named federal employee. Id. Because the federal program may become the model for state and local programs, the attributes of the federal program are generalized for the purposes of illustration.

194. Id.

195. Id. In the present legislation, at least one member of the committee must be a member of an employees' labor organization. Id.

196. Id.

prorated and returned to the donor, could in time create an administrative nightmare.

It is suggested that public and nonprofit agencies, health care facilities, and corporations with 500 or more employees operating in the State of Maryland should be encouraged to offer as an employee benefit a sick leave bank as a self-insurance protection against unforeseen medical emergencies. For those companies of less than 500 employees, the pooling of resources should be explored as a possible alternative.

Union and management personnel working cooperatively on behalf of all employees can effectively implement such a program within a matter of months. Whether the sick leave bank is under the jurisdiction of the union or of the personnel department need not be a matter of controversy. Regardless of the arrangement, members of each group need to be represented on the leave bank board that reviews and approves grant applications. Records of leave donations and leave use should be maintained by the payroll division in each agency, with accounting at the end of each fiscal year.

The State of Maryland has had extensive experience in this area, specifically in the Montgomery County Public School (MCPS) system. Sick leave banks have helped to “save the lives” of many employees, long before the development of the AIDS epidemic. They have enabled alcoholics and addicts to recover in extended treatment programs, knowing that their jobs were secure and their families would not be left destitute. They have supported persons during extended periods of disability, major illness, and recovery periods. And, more recently, they have maintained the dignity of persons with AIDS in the final stages of their illness.

E. Recommendations to the Maryland Legislature

1. Anti-discrimination Legislation.—Although the protections afforded by the Rehabilitation Act are unclear at the moment, Maryland anti-discrimination statutes are adequate to protect infected HCWs. There does not appear to be need for new state anti-discrimination legislation, at least in the area of employment.

2. Workers’ Compensation.—Maryland should establish a plan to supplement workers’ compensation payments to HCWs who become infected with HIV in the workplace. The workers’ compensa-

198. See supra note 192.
tion payment of these HCWs should be supplemented so that their compensation would be equivalent to the salary they would have made had they not contracted the disease. The amounts paid to these HCWs should be adjusted to account for estimated potential income which the employees will lose as a result of the disease. The money used to compensate HCWs could be contributed in part by both the employers and the State. An employee’s seronegative status determined within two weeks of exposure would raise a rebuttable presumption that if an employee was determined to be infected within the following eighteen months the infection was contracted in the work environment.

3. HIV-Positivity as a Communicable Disease.—The Maryland Legislature should resolve the present confusion over whether the term “communicable disease” includes HIV-positivity. Current Maryland regulations require that certain employees with communicable diseases seek the permission of the Secretary of DHMH in order to continue working. Because of the negligible risk of HIV transmission when proper precautions are used, these regulations should be rescinded, at least with respect to HCWs with AIDS or HIV-positivity.

4. HIV-Positivity Reporting.—All employers of HCWs should be required, in order to retain their licenses, to establish procedures for their HCWs to report possible exposures to HIV, and these HCWs should submit the results of subsequent tests for HIV-positivity.

F. Recommendations to the MCHR

The MCHR should set up procedures to expedite complaints filed by infected individuals.

G. Recommendations to the Health Care Facility

1. Confidentiality.—The HIV status of any HCW should be held under strict confidence.
   
   a. An employer of an infected HCW should not breach that confidence by informing co-workers of the employee’s status.
   
   b. Patients should not be told whether their treating HCWs are infected. If the employer has made the determination that the employee is physically able to perform the job and does not present a

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danger to others, then there is no obligation or reason to disclose such information to the patient. To do so without the employee’s consent could violate state laws regarding confidentiality and could result in liability on the part of the hospital, while at the same time unnecessarily alarming the patient.

c. HCWs should not be required to disclose their HIV status to their employer. In the vast majority of situations, employer-mandated disclosure cannot be justified and may subject an employer to liability under anti-discrimination laws. AIDS generally is not transmissible in the workplace and employers generally are not permitted to base employment decisions on a person’s AIDS or HIV status. The one exception to this rule would be in a situation where the nature of the HCW’s employment creates a risk of transmission of HIV infection.

2. Universal Precautions.—All facilities should strive to ensure compliance with OSHA-mandated universal precautions to reduce the risk of HIV transmission. Each facility should evaluate its compliance with OSHA precautions and identify target areas for education.

3. Reasonable Accommodation.—a. Infected HCWs should be allowed to continue working as long as they are able to maintain acceptable performance and do not pose a safety or health threat to themselves or others in the workplace.

b. HIV infections should be treated as any other medical condition for the purposes of accommodation.

c. Any change in the employment status of an asymptomatic seropositive HCW is unreasonable if the change is made solely because of the HCW’s infected status.

d. Symptomatic seropositive HCWs should be accommodated with job transfers to nonpatient care activities if a risk to the HCW or patient is present, as long as the HCW is qualified to assume the new position.

e. The seropositive HCW who has a high rate of absenteeism as a result of his or her illness should be fully accommodated with accrued sick leave time.

f. Terminating the employment of a symptomatic seropositive HCW should be deemed unreasonable unless the individual is so

202. See supra note 151 and accompanying text.
203. See supra notes 152-153 and accompanying text.
incapacitated by the disease as to be unable to perform his or her job even with reasonable accommodation.

g. A facility should not unilaterally remove asymptomatic seropositive HCWs from participation in invasive procedures.

h. The irrational contagion concerns of a suspected or known seropositive HCW’s co-worker should not be accommodated. Education about the risk of HIV infection should be the only required accommodation.

4. Employee Assistance.—a. All employers should provide minimum health and disability benefits to employees. Leave options, insurance coverage, and disability retirement options warrant special consideration, as does appropriate confidential counseling assistance in the workplace. Labor and management should jointly address these concerns, and new or existing programs should be supported for all employees.

b. Labor and management should work together to identify comprehensive EAPs as the primary agency/facility resource for all personnel’s concerns related to HIV and AIDS. Facilities lacking an EAP are encouraged to immediately establish a joint labor-management advisory committee to explore the options for implementing an EAP to provide these services.

c. All health care facilities in Maryland should be encouraged to offer, as an employee benefit, a sick leave bank as a self-insurance protection against unforeseen medical emergencies. EAPs should explore the possibility of offering employee benefits such as flexible work schedules, alternative work assignments, creative leave packages, and leave-sharing.

H. Recommendations to the HCW

1. Invasive Procedures.—Seropositive HCWs should voluntarily remove themselves from participation in those invasive procedures presenting a theoretical risk of transmission of HIV infection to the patient.

2. Disclosure to Patients.—Seropositive HCWs need not divulge their HIV status to patients. The informed consent requirement may be satisfied by informing the patient of the extremely small risk of transmission of HIV infection during the invasive procedure from falsely negative blood transfusions or from unknowingly seropositive HCWs who bleed into the operative wound after an inadvertent skin puncture.
3. Periodic Examinations.—Asymptomatic seropositive HCWs should voluntarily undergo periodic examinations to evaluate for progression to group IV (symptomatic) HIV infection. If the HCW is found to have progressed to symptomatic infection, he or she should be temporarily removed from direct patient care, if warranted, while the condition persists.

I. Recommendations to Professional Organizations

The CDC, American College of Surgeons (ACS), AMA, American Hospital Association (AHA), American Nurses' Association (ANA), American Dental Association (ADA), and other interested groups should further evaluate all invasive procedures to determine which present significant risks of transmitting the HIV from the seropositive HCW to the patient.

II. HIV TESTING IN THE HEALTH CARE INSTITUTION

A. Testing and Counseling: An Overview

AIDS has been compared to "the day after Hiroshima—the world has changed and will never be the same again." A serologic test has been commercially available for detecting the HIV virus since March 1985. The ability to test for the virus has similarly changed the way society formulates policy on the AIDS epidemic. Societal policy will continue to change when new, more accurate antigen tests are developed. Any testing program instituted will need to balance the civil liberties of those who test positive against the necessity of curtailing the epidemic.

Before beginning a legal analysis of current policy positions, this section will present a brief survey of the various policies which have been presented to date regarding HIV testing, including education and financing.

205. A serologic test is one which uses serums. Serologic testing is a derivative of serology, the science of preparation, use, and properties of serums. WEBSTER'S NEW TWENTIETH CENTURY DICTIONARY 1657 (2d ed. 1983) [hereinafter WEBSTER'S].
207. Antigen testing uses a substance, usually a protein, carbohydrate, or fat-carbohydrate complex which is capable of forming, or inducing the formation of, antibodies when introduced directly into the body. WEBSTER'S, supra note 205, at 80.
1. **Different Classes of AIDS Testing.**—First, the scope of possible HIV testing must be measured within the ambit of rights and obligations of HCWs and consumers. The requirement for several testing categories is evident from an examination of the different purposes for AIDS testing, the different methods of testing, and the diverse backgrounds of the individuals to be tested. The formation of several categories, or test classes, is helpful in this analysis. The first category, HCWs, can be broken into a number of subcategories: (a) testing HCWs for HIV status as a condition of accepting employment, (b) periodically testing HCWs currently employed in a high risk setting, and (c) testing HCWs subsequent to a blood or bodily fluid-related exposure on the job, regardless of the known or unknown HIV status of such blood or bodily fluid. The second category, patients, also has several subcategories: (a) periodically testing patients under the care of HCWs who may be exposed to the virus, and (b) testing patients under the care of HCWs who are known to have recently been exposed to blood or bodily fluid, regardless of the known or unknown HIV status of such blood or bodily fluid.

The testing categories raise various possible justifications for HIV testing. The need to protect the health and welfare of both HCWs and patients may be enough, in some cases, to justify a testing program. The AMA lists four justifications for HIV antibody testing:

1. To identify infected persons and to offer treatment where possible and to protect uninfected third parties.
2. To offer education and counseling that would modify high risk behavior.
3. To solicit patient cooperation for locating and referring sex partners.
4. To obtain broadened epidemiological statistics on the prevalence of HIV infection in the population.

Despite the rapid incorporation and widespread use of testing, there remain concerns. For example, in low prevalence populations the screening test, ELISA, may have a relatively high false positive rate which may unnecessarily frighten and stigmatize citizens.

209. A high risk setting would be a setting where HCWs normally care for individuals who are in high risk groups, as defined by the CDC guidelines. These groups include male homosexuals and IV drug users. See infra note 214.


211. Hermann, Liability Related to Diagnosis and Transmission of AIDS, 15 LAW, MED. &
The second test, the Western Blot, is a much more complicated but confirmatory test. HIV testing is highly sensitive and subject to interpretation and operator performance. Studies have demonstrated differences in test results performed on the same blood at different laboratories.

2. CDC.—In 1987 the CDC of the United States DHHS issued their most recent guidelines on testing and counseling. In general, the guidelines call for mandatory testing only for donor blood, tissue, and organs. All other testing is voluntary, confidential, and conducted under informed consent. Pre- and post-test counseling also is suggested. The guidelines suggest that medical care should not be conditioned on testing and that a prospective assessment of efficacy should be made before instituting a testing program. Lastly, the guidelines provide a protocol for bodily fluid-related injuries and exposure. The source patient must be tested and the injured worker must have baseline and periodic retests.

The CDC guidelines have been accepted or promoted by many professional societies including, among others, the AMA, the AHA, and the ANA. The guidelines also have been endorsed by the Maryland Governor’s Task Force on AIDS and the Maryland Hospital Association.

Despite seemingly widespread support, there exist several areas
of controversy. One such controversy is a matter of semantics. For example, there are three types of testing practices to which the CDC guidelines refer, but their distinctions are unclear. The three types have been succinctly defined by the American College of Physicians (ACP) as voluntary, mandatory, and routine testing. Mandatory testing is that which is performed on certain individuals or groups specified by laws or regulation. Examples include the testing of military personnel and federal prisoners. Voluntary testing is defined as that which is done on any person desiring to be tested. Routine testing, sometimes considered to be a subset of voluntary testing, is defined as the testing, with informed consent, of certain individuals or groups when recommended by health care providers or government policy. Routine testing is sometimes applied to high risk groups. This section will focus on the routine testing programs.

a. Routine Testing Programs.—Routine testing has been recommended for many different situations including, but not limited to, hospital admissions, individuals seeking marriage licenses, and women of childbearing age in endemic areas. There has been little argument in the literature about what comprises a high risk group, but concerns have been raised about testing for hospital admissions or routine preoperative screening. For example, there is concern that medical care could be adversely altered based on the results of an HIV test, or that such routine testing practices would greatly increase the costs of medical care. There is additional concern that the use of the term "routine" may lead to capricious testing without regard for informed consent.

Despite these concerns, many medical experts support the recommendation of routine testing for specific high risk groups. The CDC has suggested that it may be appropriate for a hospital to routinely test all hospital admissions of individuals in specific age

225. Id. at 464.
226. Id.
227. Id. at 465.
229. Id.
230. Id. at 465.
231. Meyer, supra note 213, at 238.
groups known to have a high prevalence of HIV infection,\textsuperscript{234} individuals known to be in high risk groups,\textsuperscript{235} and women receiving prenatal care in geographic areas having a high prevalence of HIV infection.\textsuperscript{236} The AMA has recommended screening preoperative patients who live in high prevalence areas.\textsuperscript{237} A common rationale for these recommendations is the prevention of unnecessary transmission of the virus in the operating room. There have been several reports, however, of HIV transmission documented from the donated organ to the recipient.\textsuperscript{238} As a result, CDC guidelines have called for the screening of all specimens for donation when possible.\textsuperscript{239}

The CDC guidelines also address dialysis patients.\textsuperscript{240} Published reports have shown a great increase in mortality among HIV-seropositive individuals in contrast to overall survival rates among liver and renal transplant patients.\textsuperscript{241} Dialysis patients as a group have been noted to have a higher prevalence of HIV than the general population.\textsuperscript{242} In addition, an increased false positive test rate, most likely related to the requirement of multiple blood transfusions, is characteristic of this special group.\textsuperscript{243} The CDC, however, has not recommended mandatory testing of this group.\textsuperscript{244} Instead, universal precautions and disinfection and sterilization procedures already routinely practiced in dialysis centers are cited as adequate to prevent transmission of HIV.\textsuperscript{245} Although a major study has noted that there is no reported benefit from screening these patients,\textsuperscript{246} one of the major benefits from testing these individuals would be the opportunity to provide consultation regarding the dis-

\textsuperscript{234} CDC Recommendations: Testing, supra note 214, at 513.
\textsuperscript{235} Eickhoff, supra note 83, at 464.
\textsuperscript{236} Id.
\textsuperscript{239} CDC Recommendations: Testing, supra note 214, at 511.
\textsuperscript{240} Id.
\textsuperscript{241} Rubin, Jenkins, Shaw, Shaffer, Pearl, Erb, Monaco & Van Thiel, The Acquired Immunodeficiency Syndrome and Transplantation, 44 TRANSPLANTATION 1, 2 (1987).
\textsuperscript{242} Baltimore-Boston Collaborative Study Group, Human Immunodeficiency Virus Infection in Hemodialysis Patients, 148 ARCHIVES INTERNAL MED. 617, 618 (1988).
\textsuperscript{243} Id.
\textsuperscript{244} See generally CDC Recommendations: Testing, supra note 214.
\textsuperscript{245} Baltimore-Boston Collaborative Study Group, supra note 242, at 617-19.
\textsuperscript{246} Id. at 618-19.
ease. A concern remains that if screening is instituted, dialysis may potentially become conditioned on the results of the test. This in itself may be a strong enough reason not to test dialysis recipients.

b. Voluntary Testing Programs.—In 1987 the CDC revised its original guidelines on testing women of childbearing age to include in the high risk group those women who are living in communities or born in countries where there is a known or suspected high prevalence of infection among women. The CDC recommends that this testing be done on a voluntary basis with the informed consent of the patient.

Several studies have noted a failure of voluntary testing programs to identify women at risk. A study conducted in Brooklyn, New York, found that self-reporting and physician interviews identified only fifty-eight percent of seropositive patients giving birth in their hospital. A second study from New York University found that voluntary testing failed to detect eighty-six percent of HIV-infected mothers and their children at risk for HIV infection. Due to the ineffectiveness of voluntary testing, routine testing would be a better alternative since it would be more successful in early detection of children at risk and would afford the opportunity for counseling on alternatives at earlier stages of pregnancy.

c. HCWs.—HCWs have been encouraged to follow the CDC guidelines for universal precautions and for testing. While the risk of transmitting HIV antibodies from patients to HCWs is slight, it cannot be ignored. Therefore, adherence to the CDC guidelines on minimizing the risk of transmission becomes critical. Specifically, the CDC recommends that HCWs be gloved, masked, and gowned whenever there is even a minimal risk of exposure to HIV antibodies. The CDC recommends many additional precau-

251. CDC Recommendations: No. 2S, supra note 7, at 305.
252. See Wash. Post, supra note 7.
253. CDC Recommendations: No. 2S, supra note 7, at 308.
There has been some debate as to whether routine testing of HCWs is necessary to reduce the risk of HIV infection, although there are still no documented cases of transmission from HCW to patient. The National Institutes of Health (NIH) recently announced a policy for testing laboratory and hospital personnel who regularly work with the AIDS virus. Under the policy, employees will be tested every four months on a voluntary basis. The primary purpose of the policy is to detect early cases of infection in laboratory workers and prevent transmission to sexual partners or future offspring.

HCWs are encouraged to be tested following an exposure, and the CDC has provided guidelines on the protocol for such testing. There has been some debate, however, regarding the testing of source patients in these exposures. The ACP has stated that, ethically, these patients may be tested regardless of their consent. Most other writers have discounted the importance of testing the source patient because of the "window of infectivity." Special consideration has been given to mental health institutions and the unique problems associated with the patients and HCWs at those institutions. Some writers have proposed that routine or mandatory screening might be appropriate in mental hospitals or residential homes for the retarded given the reduced competence of such patients and the potential lack of understanding of the risk of sexual contact with others. The American Psychiatric Association (APA) has recommended that testing be done on a case-by-case basis when medically prescribed, with informed consent or appropriate consent by a responsible guardian.

254. Id. at 312-15.
256. Eickhoff, supra note 83, at 465.
258. Id.
259. Id.
260. CDC Recommendations: No. 25, supra note 7, at 316-17.
262. Simply put, the term "window of infectivity" is used to define the period of time following an exposure that may be necessary for the virus to incubate and present itself. While the medical profession is still unsure, clinical evidence of infection may not surface for years following exposure. CDC Recommendations: Testing, supra note 214, at 509.
263. See, e.g., Bayer, supra note 208, at 1772.
3. Testing and Education.—It is argued that if members of high risk groups simply assume themselves to be HIV-positive and adopt appropriate behavioral changes, there would be no need for testing.\textsuperscript{265} This is supported by a decreasing incidence over the years of HIV in the male homosexual population of San Francisco and New York.\textsuperscript{266} According to the head of the California Medical Association's Committee on AIDS and Sexually Transmitted Diseases, there are a number of studies showing that people who are counseled but who do not come back to receive their test results tend to change their behavior just as much as those who return for their results.\textsuperscript{267} Doctor Silverman therefore believes that counseling may be equally as important as testing in helping people make behavioral changes.\textsuperscript{268} Due to the continuing uncertainty about how effective education and counseling efforts have been in creating behavioral changes, testing has still been encouraged by most authors.\textsuperscript{269}

Generally, there are two reasons cited for counseling. The first is to provide education for patients on the importance of decreasing any possible high risk behavior which could expose other individuals. The second is to provide support for patients throughout the testing process. The CDC has recommended testing to be conducted with pre- and post-test counseling.\textsuperscript{270} Despite this, a recent study conducted at a 450-bed medical center in Minnesota indicated that as few as 10 percent of the 275 patients tested between April 1985 and August 1986 provided consent.\textsuperscript{271}

The fact that increased suicide rates have been reported in AIDS patients also encompasses the need for proper patient counseling.\textsuperscript{272} The correlation between AIDS and suicide is consistent with other studies that show increased suicide rates for patients with chronic and life-threatening diseases.\textsuperscript{273} Quite unexpected, however, are the reports of patients attempting to commit suicide by exposing themselves to AIDS.\textsuperscript{274} This compounds the already existent need for counselors at testing centers to be trained to identify

\textsuperscript{265} Bayer, \textit{supra} note 208, at 1773.
\textsuperscript{266} Id.
\textsuperscript{267} Id.
\textsuperscript{269} Id.
\textsuperscript{270} Id.
\textsuperscript{271} See CDC Recommendations: Testing, \textit{supra} note 214, at 511.
\textsuperscript{272} Maki & Crossley, \textit{Analysis of the Use of HIV Antibody Testing in a Minnesota Hospital}, 259 J. A.M.A. 229, 229 (1988).
\textsuperscript{274} See generally Flavin, Franklin & Frances, \textit{The Acquired Immune Deficiency Syndrome and
psychiatric problems such as mood and anxiety disorders, emotions increasingly reported in high risk group patients which stem from anxiety about their HIV status.275

4. Financing for Testing Programs.—The AMA has recommended that public funding be provided to "promptly and efficiently counsel and test for AIDS"276 and to subsidize the cost for those who cannot afford the cost of such testing.277 Experts suggest that testing should be publicly funded because many who are at high risk may not be able to afford it.278 Furthermore, experts believe that the cost of testing should be paid for by those who derive the most benefit from it, namely society.279

B. Legal Analysis and Current Policy Positions

Legal analysis of the issues associated with HIV testing has been scarce. This section attempts to draw attention to and focus on the legal principles applicable to HIV testing. Of special concern are the legal implications of the policies and guidelines just discussed.

1. Constitutional Issues.—Extracting blood for HIV testing from either HCWs or patients, in the absence of informed consent, raises serious constitutional issues. The fourth amendment to the United States Constitution guarantees individuals the right "to be secure in their persons, houses, papers, and effects, against unreasonable searches and seizures..."280 These rights are implicated only if the conduct at issue infringes an expectation of privacy that society is prepared to consider reasonable.281 These fourth amendment rights are enforceable against the states through the fourteenth amendment.282

275. Faulstich, supra note 175, at 552.
277. Id. at 11.
278. Bayer, supra note 208, at 1774.
279. Id. The Presidential Commission on the Human Immunodeficiency Virus Epidemic (the President's Commission) concurs with these analyses, but it remains to be seen whether Congress will approve funding commensurate with these suggestions. See PRESIDENTIAL COMM'N ON THE HUMAN IMMUNODEFICIENCY VIRUS EPIDEMIC, REPORT OF THE PRESIDENTIAL COMMISSION ON THE HUMAN IMMUNODEFICIENCY VIRUS EPIDEMIC 74-75 (June 1988) [hereinafter PRESIDENT'S COMM'N].
280. U.S. CONST. amend. IV.
In *Glover v. Eastern Nebraska Community Office of Retardation* a search and seizure issue was raised concerning the testing of individuals for HIV without informed consent. Briefly, *Glover* involved a local human services agency that required employees to submit to HIV testing as well as testing for other diseases. The *Glover* opinion addressed the fourth amendment problem as follows:

Individuals have a reasonable expectation of privacy in the personal information their body fluids contain. Compulsory administration of a blood test "plainly involves the broadly conceived reach of a search and seizure under the Fourth Amendment." The mandatory testing required by the policy involves an involuntary intrusion into the body by the State for the purposes of withdrawing blood and constitutes a search and seizure for purposes of the Fourth Amendment. Having determined that the mandatory blood tests required by the policy constitutes a search and seizure, this Court must then determine whether the search meets the Fourth Amendment test of reasonableness.

As the *Glover* opinion illustrates, the most difficult constitutional burden in determining the legality of HIV testing without informed consent is the reasonableness standard of the search and seizure clause of the fourth amendment. If the individual being tested signs an informed consent form, and such a form is characterized as a waiver made knowingly, intelligently and voluntarily, the fourth amendment concerns may vanish. Moreover, it is not clear, given the classes of testing, that the search and seizure concern will always be present. The reasonableness of the search conducted in

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284. Id. at 250.
285. Id. at 244.
286. Id. at 250 (citation omitted). In *Glover* the governing board of the defendant, Eastern Nebraska Human Services Agency (ENHSA), adopted a policy requiring certain employees to submit to mandatory testing for tuberculosis (TB), HBV, and HIV. Id. at 245. ENHSA's rationale for the testing policy was "the pursuit of a safe work environment for all employees and a safe training and living environment for its clients." Id. at 250. The *Glover* court first granted a temporary restraining order against the testing and then formally struck down the policy as violating the reasonable search and seizure requirement of the fourth amendment. Id. at 247, 251.
287. See supra Section II.A.1, at 145-46.
288. Following is an example of when the fourth amendment's search and seizure "reasonableness" test might be met. In *Glover* the "at risk" rate for HCWs was well below 1%, 686 F. Supp. at 249, and the community contained practically no high risk groups. Because of this relatively low rate of infection, a search, *i.e.*, blood test, probably would not meet the fourth amendment reasonableness standard. Where the risk of infection is much higher, however, blood tests more likely will be considered reasonable.
a specific testing program is dependent upon the surrounding circumstances, including the risk of transmission to others, the high risk status of the individual concerned, and the forum of the testing.

2. Federal Statutes and Regulations.—As previously discussed, in August 1987 the CDC of the DHHS issued recommendations for the prevention of HIV transmission in health care settings. These recommendations constitute the only federal guidelines established to reduce the transmission of HIV between HCWs and their patients. The CDC guidelines, however, are intended only as recommendations. In fact, the CDC guidelines clearly state that "the utility of routine HIV serologic testing of patients as an adjunct to universal precautions is unknown. ... Decisions regarding the need to establish testing programs for patients should be made by physicians or individual institutions." The CDC recommends that any developed testing programs include the following principles:

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

These CDC guidelines do not provide health care employers or providers with adequate direction on how to limit legal liability through testing.

Although the legal aspects of HIV testing have not been ad-
dressed by the CDC, there is one additional federal source for potential insight. In 1987 President Reagan established the Presidential Commission on the Human Immunodeficiency Virus Epidemic (President’s Commission).\textsuperscript{292} In June 1988 the President’s Commission sent a report to the President, urging greater federal spending and stricter anti-discrimination laws. The President’s Commission, like the CDC guidelines, did not endorse mandatory testing of any group of individuals.\textsuperscript{293} The President’s Commission’s report makes it highly evident that they will not focus on any testing issues beyond what CDC already has provided.

The President’s Commission made ten recommendations for providing testing and counseling.\textsuperscript{294} These recommendations encouraged states to promulgate AIDS confidentiality statutes, and en

\textsuperscript{292} Exec. Order No. 12,601, 5 C.F.R. 238 (1988), \textit{reprinted in} 1987 \textit{U.S. Code Cong. \& Admin. News} B65-66. The mandate of the President’s Commission is to (1) advise the President, Secretary of the Department of Health and Human Services (DHHS) and other relevant Cabinet heads on the public health dangers including the medical, legal, ethical, social, and economic impact of the spread of HIV and resulting illnesses; (2) recommend measures that federal, state, and local officials can take to protect the public from contracting HIV; and (3) assist in finding a cure for AIDS and in caring for those who presently have the disease. \textit{id.} at 238.

\textsuperscript{293} President’s Comm’n, supra note 279, at 74-75.

\textsuperscript{294} Id. Specifically, the 10 recommendations read as follows:

6-1 States should adopt statutes that ensure confidentiality in testing and in reporting to public health authorities.

6-2 People who fall into any of the following categories should seek testing and counseling services from their physician or public health agency, regardless of the presence or absence of symptoms:

- recipients of blood, blood products, donated semen, or organs since 1977.
- intravenous drug abusers.
- men who have engaged in sexual activities with other men.
- persons who have engaged in sexual activities with more than one partner since 1977.
- any person who believes his or her sexual partner, either current or past, is any of the above.

6-3 Voluntary testing for HIV infection on a nationwide basis should be widely encouraged by government at all levels, and physicians and other health care professionals should promote voluntary testing for their potentially exposed patients. To facilitate the performance of such tests, a variety of facilities such as mobile vans should be made widely available by funding through public health agencies and by the private sector.

6-4 Each state, through the local public health system, should increase the number and availability of anonymous and/or confidential testing and counseling sites.

6-5 State departments of health should make new funds available that will ensure that HIV testing and counseling services are a part of the services of
couraged high risk individuals to seek testing and counseling. Although the President's Commission does not endorse widespread mandatory HIV screening, it does strongly encourage voluntary testing. The President's Commission supports public financing for HIV testing and advocates that testing must be accompanied by appropriate counseling.

The United States Public Health Service at the CDC produced an educational brochure in the spring of 1988, which was disseminated nationwide. In the brochure the United States Surgeon General, Dr. C. Everett Koop, urged "responsible behavior" from individuals to reduce the risk of HIV transmission. Again, no form of mandatory testing for any group of individuals was advocated. It thus seems that aside from prisoners and military personnel, there will be no federal recommendations for mandatory testing.

ferred by sexually transmitted disease clinics, family planning centers, drug treatment clinics, and community health centers.

6-6 Private physicians should regularly offer their patients the opportunity for an HIV antibody test.

6-7 State and local departments of health should aggressively advocate the use of HIV testing and counseling services through public health education campaigns. These should highlight the assurance of confidentiality in order to induce more individuals to use the public health system. Special efforts should be focused on those geographic areas or members of groups in which there is evidence of high seroprevalence.

6-8 An incentive grant program should be created to support voluntary testing in counties or other well defined geographic areas where the incidence of HIV infection rises above a designated level. These funds should be made available by the Centers for Disease Control on an expedited basis to applicants, who can be public or private non-profit agencies. Applicants must show that their program is consistent with the overall state HIV plan, and that those tested will be referred to appropriate community services. Funds may be used for both the testing itself and for aggressive outreach and advertising of the program in the target population.

6-9 Where anonymous testing services are offered, the appropriate state or local health authorities should assure that the services are consistent with those offered at other sites, including full access to partner notification assistance and reporting data generated into seroprevalence monitoring systems.

6-10 State laws should not prohibit private laboratories from performing HIV analysis.

Id.

295. Id. at 74.

296. Id. at 75.

297. President's Commission, supra note 279, at 75.


299. See Eickhoff, supra note 83, at 464.
3. The AMA Policy Position.—The AMA has made nine recommendations concerning testing and counseling. The recommendations are as follows:

[1.] Tests for the AIDS virus should be readily available to all who wish to be tested. The tests should be routinely subsidized for individuals who cannot afford to pay the cost of their test.

[2.] Testing for the AIDS virus should be mandatory for donors of blood and blood fractions, organs and other tissues intended for transplantation in the U.S. or abroad, for donors of semen or ova collected for artificial insemination or invitro fertilization, for immigrants to the United States, for inmates in federal and state prisons and for military personnel.

[3.] Voluntary testing should be regularly provided for the following types of individuals who give an informed consent:

[a.] Patients at sexually transmitted disease clinics.
[b.] Patients at drug abuse clinics.
[c.] Pregnant women in high risk areas in the first trimester of pregnancy.
[d.] Individuals who are from areas with a high incidence of AIDS or who engage in high risk behavior seeking family planning services.
[e.] Patients who are from areas with a high incidence of AIDS or who engage in high risk behavior requiring surgical or other invasive procedures. If the voluntary policy is not sufficiently accepted, the hospital and medical staff should consider a mandatory program for the institution.

[4.] As a matter of medical judgment, physicians should encourage voluntary HIV testing for individuals whose history or clinical status warrant this measure.

[5.] Individuals who are found to be seropositive for the AIDS virus should be reported to appropriate public health officials on an anonymous or confidential basis with enough information to be epidemiologically significant.

[6.] Physicians should counsel patients before tests for AIDS to educate them about effective behaviors to avoid the risk of AIDS for themselves and others. In public screening programs, counseling may be done in whatever form is appropriate given the resources and personnel available as long as effective counseling is provided.

[7.] Physicians should counsel their patients who are found to be seropositive regarding (a) responsible behavior to prevent the spread of the disease, (b) strategies for health protection with a compromised immune system, and (c) the necessity of alerting sexual contacts, past (5-10 years) and present, regarding their possible infection by the AIDS virus. Long-term emotional support should be provided or arranged for seropositive individuals.

[8.] Patients should knowingly and willingly give consent before a voluntary test is conducted.

[9.] Public funding must be provided in an amount sufficient (1) to promptly and efficiently counsel and test for AIDS (2) to conduct the research necessary to find a cure and develop an effective vaccine, (3) to perform studies to evaluate the efficiency of counseling and education programs on changing behavior and (4) to assist in the care of AIDS patients who cannot afford proper care or who cannot find appropriate facilities for treatment and care.301

Generally, these recommendations are self-explanatory and, for the most part, noncontroversial. The AMA has continued to support these recommendations.

4. State Testing Statutes.—States are taking the initiative with regard to the HIV/AIDS crisis. Statutes have been considered and passed on topics ranging from quarantine and tort liability laws to protecting firefighters and others from the dangers of commingling blood or other bodily fluids with HIV-positive individuals.

Arizona, California, and Oklahoma have statutes requiring notification of blood donors who may be HIV-positive.302 At some donor sites in California, individuals may be specifically tested for HIV antibodies.303 Colorado allows testing of certain individuals without their consent to protect health personnel.304 Florida tests those arrested for prostitution or persons injuring law enforcement officers or firefighters.305 Iowa provides free confidential HIV testing for

301. Id.
303. Each donor site in California must provide notice where antibody test sites are located. Cal. Health & Safety Code § 1603.3 (West 1988). Therefore, a donor site may be a test site if proper notice is provided.
those who are at high risk for AIDS.\textsuperscript{306} Texas gave its approval to mandatory testing if the Commissioner of Health declares "a sudden and imminent threat to public health."\textsuperscript{307}

Most states require informed consent before one can be tested.\textsuperscript{308} When a state mandates HIV testing for marriage applicants,\textsuperscript{309} it is possible that their citizens may go elsewhere to be married. Some states now screen prisoners, following the federal policy.\textsuperscript{310} Finally, a large number of states allow screening of body parts for either transplantation or embalming reasons.\textsuperscript{311}

As can be discerned from this potpourri of statutes, the states certainly are not uniformly responding to this crisis. In some ways this may be justifiable because different issues arise depending on the prevalence of high risk groups in a given geographical area. That is, North Dakota is unlikely to have the same experiences with AIDS as New York City.

\textit{a. Maryland Testing Statutes}.—In November 1985 the Governor of Maryland appointed a task force to develop public health policies, educate the public, and promote the development of medical and social programs to deal with the AIDS crisis in Maryland. The task force presented the Governor with its findings and recommendations in December 1986.\textsuperscript{312} The recommendations specifically addressed the areas of screening, testing, and counseling.\textsuperscript{313} Like the

\textsuperscript{306} IOWA CODE § 139.41 (1988).
\textsuperscript{307} TEX. REV. CIV. STAT. ANN. art. 4419b-1 (Vernon 1988).
\textsuperscript{308} See, e.g., CAL. HEALTH & SAFETY CODE § 199.22 (West 1988).
\textsuperscript{309} See ILL. ANN. STAT. ch. 40, para. 204 (Smith-Hurd 1988).
\textsuperscript{310} See generally Lewis, \textit{Acquired Immunodeficiency Syndrome—State Legislative Activity}, 258 J. A.M.A. 2410, 2413 (1987); PRESIDENT'S COMM'N, supra note 279, at 134-35.
\textsuperscript{312} GOVERNOR'S TASK FORCE, supra note 11, at 4.
\textsuperscript{313} The Governor's Task Force presented ten recommendations: (1) The Task Force opposes mandatory and mass screening of any population for HIV infection. It approves of routine testing of blood, tissue and organs, but all testing of individuals should be voluntary and with informed consent. The Task Force also recommends that all information regarding risk factors be ascertained voluntarily and in strict privacy. (2) Obtaining informed consent applies only to testing for HIV antibodies and not to other non-AIDS related blood tests. (3) If informed consent has not or cannot be obtained, and if the patient has known medical and behavioral risk factors, HCWs should use precautions to prevent transmission of HIV infection. (4) Positive test results are defined as a positive confirmatory test such as a Western Blot after having documented two positive ELISA tests. (5) Serologic testing for HIV antibodies should never be mandated as a prerequisite for providing other services. (6) Testing should occur if adequate pre- and post-test counseling by trained counselors is available. (7) Physicians or other HCWs ordering HIV tests are responsible for handling test results as well as educating and counseling patients. Physicians who feel they cannot perform these tasks should
President’s Commission, the Governor’s Task Force disapproves of mass or mandatory screening of any group for HIV infection.\textsuperscript{314} The Governor’s Task Force cited several reasons for its conclusion. It argues that the technology of the ELISA test is imprecise and thus dangerous to use except under ideal laboratory conditions and with proper confirmatory tests. Also, the tests only record HIV antibodies, not the virus itself.\textsuperscript{315} Even more importantly, the Task Force commented that counseling and education to take proper precautions against transmitting the disease can best be obtained through public education, by making tests available free of charge and anonymously, and by relying on HCWs to encourage voluntary testing of persons believed to be at high risk of infection.\textsuperscript{316}

In 1988 Maryland’s General Assembly passed a few testing-related statutes. Attending physicians now are required to notify firefighters and other rescue workers of their exposure to HIV antibodies.\textsuperscript{317} In addition, sperm in sperm banks must be tested; the sperm may not be used if it is HIV-positive.\textsuperscript{318} Finally, directors of medical laboratories where serum samples are tested must report to the DHMH, though the identity of those found HIV-positive cannot be disclosed.\textsuperscript{319}

\textbf{C. Recommendations}

1. \textbf{General HIV Testing}.—First, voluntary testing of individuals for HIV antibodies in high risk groups with informed consent and counseling should be encouraged. The assumption underlying this recommendation is that the universal precautions established by the CDC will be practiced by all HCWs to prevent the transmission of the virus, thus eliminating the need for testing.\textsuperscript{320}

\textsuperscript{314} \textit{Id.} at 20.
\textsuperscript{315} \textit{Id.}
\textsuperscript{316} GOVERNOR’S TASK FORCE, supra note 11, at 20. Finally, the Task Force contends that mass screening would increase the risk of coercion or breaches in confidentiality, possibly jeopardizing one’s employment and mental and social well-being. \textit{Id.}
\textsuperscript{318} \textit{Id.} § 18-334 (codifying H.B. 712, 1988 Sess.).
\textsuperscript{319} \textit{Id.} § 18-207 (codifying H.B. 1329, 1988 Sess., and S.B. 826, 1988 Sess.).
\textsuperscript{320} Many health professional groups oppose mandatory testing of individuals with the exception of those donating blood, organs, or bodily fluids. \textit{See supra} notes 215, 219, 220 & 221 and accompanying text. Among the reasons given for the opposition is the
It is also recommended that current statutes mandating the testing of sperm and sperm donors for HIV status be endorsed. Testing of blood, organs, tissues, bodily fluids, and ova for transfusion, transplantation and other purposes also should be mandatory. All donors of such specimens also should be tested and, where appropriate, counseled. Specimens from positive donors should not be used. In unusual or emergency situations where there may not be time for testing or time to wait for a nonpositive specimen, recipients or their families should be fully informed of the potential risks and transplantation should only occur with consent. Testing of recipients should not be mandatory but should be encouraged on a voluntary basis when medically appropriate.  

This recommendation is based on the belief that homosexuals and IV drug users, two groups in which AIDS has been prevalent, will not seek help in the health care system if they are forced to submit to testing. Id.

In regard to HCWs, it is widely thought that by following the CDC guidelines, potential for exposure in the health care workplace will be greatly limited and thus there will be no need for mandatory testing of HCWs. In addition, there have been very few reports of transmission of HIV from patient to HCW. Surgeon Gen.'s Rep., supra note 2, at 10.


Distributing blood is considered a service, thus the legal "warranties of fitness and merchantability" do not apply. Id. at 2411. Under Maryland law, for example, a legally authorized blood bank is not subject to (1) strict liability in tort, (2) the implied warranty of merchantability and (3) the implied warranty of fitness. Md. Health-Gen. Code Ann. § 18-402 (1987). For this reason, blood banks cannot be held liable. See also Roberts v. Suburban Hosp. Ass'n, Inc., 73 Md. App. 1, 532 A.2d 1081 (1987). In that case a hemophiliac contracted AIDS through a blood transfusion. Id. at 2, 532 A.2d at 1082. The court of special appeals said that a blood transfusion is a sale of a service, not a sale of a product. Id. at 16, 532 A.2d at 1089. The court thus held the appellant was required to exhaust his administrative remedies under the Health Claims Arbitration Act before taking judicial action. Id. The counts for strict liability and breach of the implied warranties of merchantability and fitness therefore were dismissed. Id. But see Doe v. Miles Laboratories, Inc., 675 F. Supp. 1466, 1475-80 (D. Md. 1987) (sale of blood-coagulation-factor concentrate contaminated with AIDS-Related Complex (ARC) did not subject the producer to liability based on breach of warranty, but did subject the producer to strict liability because the production was a product rather than a service). The extent
tion should be implemented by incorporation into existing hospital policy, with reference to protocol in the event of an emergency.

Testing must be accompanied by both pre- and post-test counseling. Pre-test counseling is necessary to facilitate support for patients while awaiting test results, to help patients acknowledge the risk factors, and to provide guidance on sexual behavior patterns. Studies have shown that patients who are counseled and tested but who do not return to receive their results often tend to change their behavior just as much as those who do return for the test result.322

2. Financing.—The State should pay for all HIV testing and pre- and post-test counseling in both public and private settings. Pre- and post-test counseling should be available at both the public test sites and private facilities. If noncompliance with applicable guidelines becomes a problem in the private facilities, civil penalties may be considered. Pre-test counseling should include an anonymous questionnaire with demographic and other relevant data, to be used for research purposes only with informed consent.

This recommendation is made because it is quite clear at this time that there will be no national solution to the financial problems associated with the cost of HIV testing. Therefore, notwithstanding a federal preemptive effect, the cost of testing issue becomes a state challenge.

Several alternatives are available to the State. The State could force employers or insurance carriers to pay for the costs of the testing. Alternatively, the State could require individuals being tested to pay testing costs. Each alternative seems equally undesirable, however. If employers were to pay for the costs, they undoubtedly would pass those costs on to employees, customers, or others. If the insurance industry were to pay for testing, premiums would dramatically and needlessly increase. Finally, if individuals were re-

322. See supra note 267 and accompanying text.
quired to pay for their own tests without help from other sources, it might preclude voluntary testing altogether.

The mechanics of a successful state program would allow the State to bear the entire costs of testing. It would be economically efficient, socially and morally correct, and easy to administer.

a. State Program Office.—An office could be established in the State DHMH to house the program. The duties of the office would be fourfold: (1) to establish criteria for private facilities so they can qualify as test sites, (2) to set and re-evaluate reimbursement rates paid to certified private test sites for their testing and counseling costs, (3) to set up a formal quality review, and (4) to provide reimbursements to the private facilities upon a proper showing of the costs incurred, both for actual testing and pre- and post-test counseling.

b. Public Test Sites.—The public test sites would be available.

c. Courier Service and State Laboratory.—All blood samples would be sent by courier to a state laboratory, which would be the only certified facility to analyze the tests. The State would pay for the establishment of these courier systems.

d. Confidentiality.—Each vial of blood that is taken from an individual would be assigned a random number. No names would be taken. As a result, confidentiality problems would not exist. State legislation would help to ensure that private providers would be reimbursed without having to provide the names of the individuals being tested.

e. Anonymous Questionnaire.—All individuals being tested would, during pre-test counseling, fill out an anonymous questionnaire with demographic and other relevant research information. This document would only be used for research purposes.

f. Periodic Program Review.—A comprehensive review of the program would be conducted at the end of the first year with a determination whether to renew the program. If renewed, the term could be for a three- to five-year period, after which time the program would automatically conclude. Internal quarterly reviews also are attractive to ensure that new problems are dealt with swiftly.

It is acknowledged that there are many potential problems with this recommendation. First, the public market for testing is an unknown. As a result, if the program is phased in incorrectly or simply
fails, the State could be burdened with major losses. Second, it is unclear how such a program would be implemented in the private setting. Private test sites probably would have to pay for the costs of administering the tests themselves with subsequent reimbursement from the State. Third, a very important question is how to maintain testing standards. Would state inspectors be assigned to the public and private test sites? Would private test licenses be required? And what of the state preemption of an economic market? The implementation of such a program would preclude profit making in testing services. Finally, the political opposition to such a program could be insurmountable.

These concerns clearly are outweighed by the benefits of a state-run testing program. Such a program surely would result in increased access to AIDS testing to patients and those who feel they may be infected with the virus. If the costs were carried entirely by the State, the resulting economic efficiency would rapidly reduce the costs of testing. Tests analyzed in one or two laboratories would make it easier for the State to monitor and control the program and reduce the inaccuracies that currently exist when nonexperts analyze tests. In addition, the State, through anonymous surveys of all tested, could create a large uniform database of information concerning the population being tested. This would be extremely helpful to researchers.

One remaining issue to be addressed in more depth is state immunity. Will state laboratory employees be given immunity for negligent actions? Mislabling of sample containers, inaccurate transfer of test information, and laboratory accidents are very real possibilities. Under Maryland law, for example, the Maryland Tort Claims Act provides immunity and is applicable if the HCWs fall within the statutory definition of state personnel. 323

It is also recommended that state funding be increased, with particular emphasis on developing more accurate and lower cost tests. Present expenditures of funds in this area will create a com-

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323. **Md. State Gov't Code Ann.** § 12-101 (1988). The Maryland Tort Claims Act defines state personnel as "a classified, unclassified, or contractual employee of the State whose compensation is paid wholly or partly from state funds." *Id.* at (1). The term "state personnel" includes any "person, as a volunteer who, with or without compensation, is providing service to or for the state." *Id.* at (3). These two definitions of "state personnel" may be applicable in the testing setting. Maryland, however, does not waive its immunity for punitive damages, interest before judgment, any tortious act or omission that is not within the scope of the public duties, an act or omission made with malice, or a gross negligence cause of action arising from the claimant's use of the state testing facility. *Id.* § 12-104.
prehensive and economically efficient scheme in the future for financing the State's AIDS crisis. In addition, additional state dollars should be spent to educate HCWs and the general public.

The legislature has not provided adequate funding to deal with the AIDS epidemic. It is recommended that state funding be sharply increased in each of the current funding areas. These areas include laboratory testing, social services, medical services, and surveillance/disease prevention. First, research must be conducted to develop improved testing measures. Several new tests currently are being developed. Second, money should be spent on streamlining the administration of testing programs, so that the cost of testing will be reduced. Third, the State should increase dollars spent on the actual test sites. This is important to be able to maintain the current level of services and increase them in the future. Finally, educating both HCWs and the general public must become a priority.

3. Accidental Exposures in the Health Care Workplace.—There are three recommendations in this area.

a. Testing Requirements.—Mandatory testing of source patients in blood-related accidents should not be encouraged. Voluntary testing of patients should be urged when informed consent is obtained and pre- and post-test counseling is provided. Voluntary post-accident testing of HCWs also should be encouraged for obtaining baseline, three-month, six-month, and twelve-month serum level information. This type of sequential testing would assure accurate and complete screening for exposure.

Current practice in most hospitals, when HCWs are potentially inoculated with a patient’s blood, is to obtain samples of both the patient’s and the HCW’s blood for HBV testing. This testing occurs with or without the patient’s consent. Due to the negative stigma attached to HIV testing and the potential consequences if confidentiality is not maintained, the practice of obtaining blood samples for HIV testing without patient consent should not be allowed. Additionally, even if the source patient initially tests negative, it is possible that they are in the “window” period in which antibodies might not be present in sufficient quantity for detection by the HIV screening tests. Rather, HCWs should be encouraged to get initial and follow-up testing when accidents have occurred.

b. Preserving Confidentiality.—If confidentiality in the workplace becomes a problem for HCWs, they should be encouraged to go
outside the employer's facility for testing. Other health care institutions or public centers are possible alternatives.

Potential breaches in the confidentiality of test results must be eliminated. Employer knowledge of test results usually will jeopardize the employee only if the employer acts to discriminate against the employee. In many states, including Maryland, HIV-positive status is considered a handicap, hence employment action against someone on the basis of handicap would be subject to the highest burdens of justification.324

c. Testing After Exposure.—Institutions must offer HCWs free and confidential voluntary HIV testing following a blood-related exposure. Civil penalties such as fines should be imposed on the employer when such testing is not made available.

When a blood-related exposure to an HCW occurs during the course of employment, the employer must be responsible for adequate follow-up testing. After the employee has been tested for HIV antibodies, if the employer has followed proper pre- and post-test counseling guidelines mandated by the State, the employer will be reimbursed by the State for the costs of testing and counseling.

The HCW's employer should be required to offer this testing. The HCW, of course, may waive this right and be tested elsewhere if that person feels uncomfortable being tested in the work environment. If the employer does not provide the test free of charge and with adequate guarantees of confidentiality, the employer should be subject to civil penalties such as a fine, as determined by the DHMH.

One counter-argument to this proposal must be noted. It could be argued that the employer should not be required to both provide and pay for testing, since both public and private facilities exist elsewhere for this purpose. The employer, however, would be eligible to recoup the cost from the State once the test and accompanying counseling are provided.

4. Counseling and Education.—Four recommendations are made concerning counseling and education.

a. Trained Counselors.—Counselors should be trained to recognize and manage adverse psychological reactions to testing. Counselors should be supervised by psychiatric professionals and provided the opportunity for emotional catharsis.

This counseling is important because studies have demon-

324. See supra note 43 and accompanying text.
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strated a marked increase in the suicide rate for AIDS patients.325 Other reports have shown increased incidence of other psychiatric illnesses in patients upon learning of positive test results.326 These illnesses include anxiety or mood disorders.327 Testing counselors should be aware of the potential psychological effects of the testing process and trained to react appropriately. Counselors should have ongoing supervision by psychiatric professionals to provide this training. The supervision also could be helpful in giving counselors an opportunity to discuss their own feelings of the grief and frustration which typically accompany intensive work of this kind.

b. Funding Priority for Counseling and Education Programs.—As state and federal resources become limited, priority should be given to counseling and education programs as opposed to testing programs. Counseling and education can be very effective in decreasing the incidence of AIDS.328

c. Education for Other Professionals.—Greater education should be provided for professionals outside traditional medical settings who have contact with groups engaging in high risk behavior. These groups include, but are not limited to, policemen and social service personnel.

Educational efforts should be directed at those agencies who come into contact with high risk individuals to provide them with information, encourage them to seek counseling and testing, and to give guidance on how to minimize possible exposure. Police and social work employees also could be used as a first line of counseling and education for those in the high risk group.

The counseling and educational programs, of course, must be incorporated into existing policies and budgets of the DHMH and other appropriate agencies. Where more funding is needed, legislation may be required.

325. See supra note 273 and accompanying text.
326. See supra note 275 and accompanying text.
327. Id.
328. In the male homosexual population there has been a decreasing incidence of AIDS. Wash. Post, Nov. 22, 1987, at A20, col. 1. This trend, apparently occurring even prior to the advent of testing, is indicative of the effect of educational efforts. It is not clear, however, how effective education and counseling alone would be with other emergent high risk populations such as IV drug abusers. IV users have additional needs for drug abuse treatment; counseling and education programs also may be useful to encourage patients to participate in drug abuse treatment.
d. Educational Seminars for Elected Officials and the Media.—In Maryland, the Governor’s Council should sponsor educational seminars for both elected officials and the media to educate those bodies on the issues raised by AIDS.

One obstacle to implementing AIDS policies is elected officials. Since most recommendations will require affirmative legislation, elected officials who ultimately will decide whether such proposed policies will be implemented must be educated. Such education can take several forms: lobbying, education seminars, and written reports. Each county delegation should be targeted for individual education seminars. In Maryland, the logical body to conduct these seminars would be the Governor’s Council. As Council members’ schedules probably would not permit attendance at educational seminars, others, such as the Attorney General’s Office, the MCHR and the DHMH should assist the Governor’s Council in sponsoring such seminars for others. Elected officials need extensive education about the issues and alternatives within these proposed policies so that they can make knowledge-based decisions about the issues and alternatives.

The media also must be educated. Many people rely on the media for their information. Inaccurate reports can cause unnecessary panic. Education, therefore, is imperative so the public is provided with accurate and current information.

5. Testing Accessibility.—The State should provide greater access to those who want to be tested. Creative ideas such as mobile HIV testing units should be considered to reach those who are either unable or unwilling to go to existing facilities.

Regional areas could be established in which routes could be devised to cover potential high risk areas, along similar lines as blood drives seeking donors. Blood tests could be taken and results could be communicated along with counseling. Perhaps blood donation programs, such as those established by the American Red Cross, could be utilized on a contractual basis with the State to help identify and test for the prevalence of HIV. Recent testimony before a House subcommittee stated that HIV tests among low risk populations have been less accurate than previously feared due to variability in the level of experience and accuracy in some testing centers.\(^\text{329}\) The establishment of regional testing centers, along

\(^{329}\) 133 CONG. REC. E4218-01 (daily ed. Oct. 24, 1987) (statement of Rep. Cooper). The difficulty in performing the Western Blot test has resulted in false positive error
with appropriate testing guidelines and controls, may help alleviate the number of false positive test results produced by inappropriately conducted tests.

6. Further Study.—A study should be commissioned to determine the efficacy of voluntary testing to determine future recommendations. One major focus of the study should analyze whether targeted populations for HIV testing are availing themselves of the public service.

At least one study on voluntary testing indicated that high risk populations rarely use voluntary testing services even when available.\textsuperscript{330} Maryland and other states need to determine whether current voluntary HIV testing practices are sufficient.

In addition, a study should be commissioned to determine whether the public test sites should add additional services, such as increased care and referral services to HIV-positive individuals, at a slow and gradual rate.

The public testing facilities were originally envisioned to provide counseling and testing. These centers, however, have the potential to do a whole lot more. It is clear that the State should maintain the current level of services at these testing sites. It is equally clear that the sites should be encouraged—if not mandated—to seek out how they might be able to continue to provide increased services to HIV-positive individuals. For those who cannot obtain private medical treatment, these test sites can provide information and active assistance in locating medication or other needed services. In addition, these centers also could slowly become outpatient clinics for these individuals, as most would need continuous monitoring and treatment.

The cost to the State would be incremental and probably would be within the current budget percentage increases envisioned by the Governor's Council.\textsuperscript{331} In Maryland, the Department of Fiscal Serv-

\textsuperscript{330} Krasinski, \textit{supra} note 250, at 185. In this study, 52 pregnant women admitted having a history of risky behavior potentially exposing them to HIV infection but only 25 consented to actual testing. Of the 25 tested, 4 tested positive. Concurrently, the hospital conducted an anonymous study of blood samples and discovered a total of 28 infected women. The anonymous study indicated that the voluntary testing program failed to identify most of the infected women. \textit{Id.}

\textsuperscript{331} The Governor's Task Force projected spending $3.3 million, $3.87 million, and $4.7 million in fiscal years 1988-90, respectively. \textit{GOVERNOR'S TASK FORCE, supra note 11, at 80-81.}
ices in Annapolis should be able to project the financing implications of such a program. The State should commission a study from the Department of Fiscal Services for that purpose.

III. Confidentiality Issues

Persons who have AIDS or who are HIV-seropositive carry the stigma of being infected with a virus that can cause a fatal illness in themselves and others. Confidentiality of an AIDS or HIV-infected person’s identity, therefore, is the most important public policy issue facing the health care field. There already have been cases of employment, housing, and insurance discrimination against patients with AIDS or HIV infection, and public officials are now under increasing pressure to quarantine or segregate HIV-infected individuals. While there are some good policy reasons for providing certain public institutions with access to information on HIV-infected persons, societal discrimination against persons who are HIV-seropositive makes it necessary to ensure that the availability of such information does not result in a breach of confidentiality.

Confidentiality is a basic postulate of medical practice. Traditionally confidentiality was based on the empirical consideration that “if patients did not believe that doctors kept their secrets, they might not disclose the full information or provide the cooperation needed for optimal care.” According to the Scottish Director of the Institute of Medical Ethics at the University of Edinburgh, doctors face the dilemma of balancing their special confidential relationships with their ordinary “moral obligations toward innocent

332. See Textbook, supra note 2, for a definition of AIDS.
333. See Surgeon Gen.’s Rep., supra note 2, for a definition of HIV.
334. See, e.g., cases cited supra note 26.
338. For the Hippocratic Oath, see infra note 461.
339. Boyd, The Moral Challenge of AIDS, 80 J. Royal Soc’y Med. 281, 282 (1987). Boyd argues that by keeping a patient’s secrets a doctor upholds a value (respect for autonomy) which is important to the survival of civilization. Id. at 283.
bystanders who may be at risk.'

The critical need for testing and providing counseling to persons who engage in high risk behaviors or belong to high risk groups has increased the importance of strict confidentiality. Furthermore, the publication of test results in violation of confidentiality or discrimination resulting from such disclosure may create a disincentive to voluntary testing.

A. Confidentiality Issues in the Context of AIDS and HIV Infection

A breach of confidentiality can occur in a variety of circumstances under existing practices within some health care agencies. If information contained in various medical, public health and other records is insufficiently protected, for example, unauthorized persons, even members of the general public, may have access to the information. A second problem arises in the context of reporting AIDS or HIV infection to a public health agency. If agencies are required by law to report the names of HIV-seropositive patients, a breach of confidentiality is forced upon the HCW-patient relationship. Third, contact tracing, which involves tracking down persons

340. Id. at 283.

341. In fact, several health organizations have issued policies concerning HIV infection, AIDS, and confidentiality. The AMA stated that "[t]he ability of the health care community to maintain the confidentiality of patient information . . . is . . . vital to an effective program of preventing and controlling AIDS." AMA Rep. YY, supra note 210, at 15. The ANA in an emergency report on AIDS testing stated that "[c]onfidentiality of test results must be maintained to prevent discrimination, especially in such areas as insurance, employment, and housing." Am. Nurses' Ass'n, AIDS Testing and ANA Policy Emergency Report, Rep. BOD-M, at 2 (1987). The Association of State and Territorial Health Officials maintains that disclosure of information without the consent of the patient should be permitted only when it is necessary for the individual's medical care or is required by law. Ass'n of States & Territorial Health Officials, ASTHO Position on Duty to Warn, Guide to Public Health Practice: AIDS Confidentiality and Anti-Discrimination Principles, Interim Report, reprinted in Report of Governor's Advisory Council on AIDS, § I(B)(6) (Mar. 15, 1988). The American College of Physicians (ACP) recommends that the "identity of a person diagnosed with HIV-infection should be limited to the greatest extent possible without sacrificing the protection of the public health." INTERGOVERNMENTAL HEALTH POL'Y PROJECT, GEORGE WASHINGTON UNIV., 1 AIDS: A PUBLIC HEALTH CHALLENGE 4-1 (1987) [hereinafter GWU REP.]. The American Hospital Association (AHA), however, warns that excessively stringent confidentiality regulations could interfere with patient care. AMERICAN HOSP. ASS'N, AIDS/HIV INFECTION POLICY: ENSURING A SAFE HOSPITAL ENVIRONMENT vii (1987). The Maryland Hospital Association (MHA) is concerned about the potential liability of hospitals that accidentally disclose HIV test results. Maryland Hosp. Ass'n, supra note 223. The MHA would support legislation protecting hospitals from liability by requiring notification of fire and rescue personnel of exposure to AIDS. Id. at 2.

342. Landesman, AIDS and a Duty to Protect -Commentary, 17 HASTINGS CENTER REP. 23, 23 (Feb. 1987).
who have had sexual contact with an HIV-seropositive patient can create a two-stage breach of confidentiality. Confidentiality can be breached in two stages if the identity of an infected person is revealed to a public health agency and then to those who have had contact with the infected person. Finally, HCW-patient confidentiality is threatened if the HCW is faced with an ethical or legal duty to warn third parties who may be at risk of contracting an HIV infection.

1. Medical, Public Health, and Other Records.—One of the first considerations in developing a policy concerning confidentiality is deciding who should be informed if a patient has a positive HIV test or is diagnosed as having AIDS. HCWs with direct patient care responsibilities need to know the patient’s HIV status in order to provide health care. The debate in the health care setting centers on whether all employees or providers who come in contact with a patient have a right to know if the patient is HIV-seropositive. If the employee or provider knows, it is argued, then they are in a better position to protect themselves from infection. This could create a false sense of security though, since the provider will likely come in contact with persons who are seropositive and have not had HIV antibody testing done or who have had a false positive HIV test. The best protection for the HCW under those circumstances is to follow universal precautions when dealing with all patients.343

Paramedics, emergency medical technicians, firefighters, and police officers also would like to know when they have come in contact with an HIV-seropositive individual.344 Such knowledge, however, would sacrifice patient confidentiality without protecting these personnel. They would be informed after contact with the HIV-seropositive individual, which will not prevent transmission of the virus and probably will cause unnecessary anxiety. This could result in antagonism towards HIV-infected individuals. Consequently, these employees must be educated and taught to follow universal precautions with all patients.

Similarly, morticians and other individuals responsible for the

disposition of deceased persons should not be informed of a patient's HIV antibody status. As more people become seropositive, it is likely that some people will die without their HIV antibody status being known. If morticians only take precautions with those individuals who are known to be HIV-positive, then they will be at risk of infection from seropositive persons of whom they are not aware. Therefore, the best protection in those cases will result from following universal precautions with all deceased persons.

Confidentiality of records held by third-party payors and insurance companies also is a genuine concern. Payors should be provided access only to medical information that is necessary for payment and planning. Life insurance companies should not have access to HIV test results or medical diagnoses without the specific written consent of the patient.

Since there have been cases of job discrimination involving HIV-seropositive individuals, employers only have a right to know that an employee is HIV-seropositive if the employee is unable to function in the job. Other employees are not at risk because HIV infection does not result from the type of casual contact that occurs on the job.

a. Medical Records.—There remains the practical problem of how the information concerning HIV-positive tests and the diagnosis of AIDS can be kept confidential. Specifically, should there be changes in medical record-keeping which will insure greater confidentiality? The medical record should be a complete documentation of a patient's medical problems. This certainly would include all test results and diagnoses. The medical record is also a legal documentation of the process of diagnosis and treatment of a patient. Strategies to insure greater confidentiality which involve fragmentation of the medical record likely will impact on the efficiency and quality of medical care.

Hospitals and providers' offices should consider special policies to protect HIV test results or the diagnosis of AIDS, but they must weigh any gains in confidentiality with losses in efficiency of the delivery of medical care. It also should be recognized that taking spe-

345. The CDC guidelines for preventing transmission of the HIV specifically include morticians in their definition of HCWs who should take precautions in the workplace. Matthews & Neslund, supra note 311, at 349.
346. See id. at 348 & n.73.
cial precautions with only certain charts or certain patients will focus attention on those patients and charts.

It is important to protect the integrity of the medical record and deliver efficient, quality medical care, while also protecting the confidentiality of HIV-seropositive patients. These objectives can be accomplished by improving the confidentiality of all medical records; a special procedure for HIV test results or for charts of AIDS patients would be inefficient.

The disclosure of AIDS-related information from medical records currently is covered by state statutes governing general medical records. These statutes vary in number and scope and may inadequately address the specific problems of confidentiality with respect to AIDS. The CDC recommends that states review their general medical laws and strengthen them, when necessary, to afford special confidentiality protection for AIDS-related information.

To protect the confidentiality of HIV test results several states, including California, Idaho, Illinois, Indiana, Kentucky, Massachusetts, and Texas have statutes regulating disclosure. California and Massachusetts have the most restrictive definition of how and to whom test results may be disclosed. Both states prohibit disclosure of test results to any third person without written authorization.

Maryland currently has a law concerning the disclosure of medical records. Medical information contained in those records may not be revealed unless authorized by the individual on whom the record is kept. There are exceptions for persons involved in delivering medical care to the patient, medical review committees, and government agencies performing their duties. Individuals can re-

348. 1 GWU REP., supra note 341, at 4-7.
349. Id.
350. CAL. HEALTH & SAFETY CODE §§ 199.20 to .21 (Deering 1988).
352. ILL. ANN. STAT. ch. 111-1/2, para. 7309 (Smith-Hurd 1988).
353. IND. CODE ANN. § 16-1-9.5-3 (West 1988).
355. MASS. GEN. LAWS ANN. ch. 111, § 70F (West 1988).
356. TEX. REV. CIV. STAT. ANN. art. 4419b-1 (Vermont 1988).
357. CAL. HEALTH & SAFETY CODE § 199.21 (Deering 1988).
358. MASS. GEN. LAWS ANN. ch. 111, § 70F (West 1988).
359. Id.; CAL. HEALTH & SAFETY CODE § 199.21 (Deering 1988).
361. Id. at (b).
362. Id. at (c)(1)-(3).
cover damages in cases where there is unauthorized disclosure of the medical records.\textsuperscript{363} The law should be expanded, however, to include medical information that may be contained in other types of records.

\textit{b. Public Health Records.}\textemdash Mary\'s DHMH also may have records linking patient names with HIV test results or the diagnosis of AIDS. In general, access should be limited to specified employees who require this information to compile data or aid infected individuals. The records should be physically secured and should be protected from subpoena, except for \textit{in camera} review by a judge under special circumstances.\textsuperscript{364} The records should not be available to other agencies.

2. \textit{Reporting of AIDS and HIV Infection.}\textemdash The purpose of reporting diseases is to locate the source of the infection and increase understanding of the disease process, to trace epidemics, and to identify individuals who might be subject to cure, treatment, and quarantine.\textsuperscript{365}

Historically, reporting procedures have been required for communicable diseases such as tuberculosis, cholera, and venereal disease.\textsuperscript{366} Reporting procedures for these diseases have not created as much controversy as reporting procedures for AIDS because cures, treatments, and \textit{temporary} quarantine are effective when these diseases are airborne and highly contagious.\textsuperscript{367}

Most states have developed laws requiring the reporting of certain diseases to public health officials by physicians and other diagnosing HCWs.\textsuperscript{368} Separate laws and methodologies, particularly contact tracing, often were developed for sexually transmitted diseases so that individuals could be notified and offered a cure.\textsuperscript{369}

\textsuperscript{363} \textit{Id.} at (d).
\textsuperscript{364} See Lewis, \textit{supra} note 310, at 2412.
\textsuperscript{366} \textit{Id.} at 31-33.
\textsuperscript{367} \textit{Id.}
\textsuperscript{369} Curran, \textit{supra} note 365, at 30.
a. Reporting of AIDS.—Data on AIDS cases is necessary for the DHMH to track the course and movement of the disease, plan comprehensive care, receive grants and plan funding, and obtain morbidity and mortality information. Reporting the names of patients, however, is not needed for these purposes. A central registry of persons with AIDS serves no viable function, and indeed could jeopardize care if the mood of the public prompts punitive legislation. Formation of a particular code is needed to reduce duplication of reports which can occur if a person with AIDS sees a variety of physicians and HCWs as the disease progresses. AIDS cases should be reported using the last five digits of the patient’s social security number, a method which has been used successfully in other states. Demographic information also should be collected to ensure the accuracy of the data and to safeguard the confidentiality of patients and their families as much as possible.

Anonymous information on AIDS cases should be reported directly to the state health department, as opposed to county or local governments, as the state has more resources to collect and correlate the data, and to approve funding and design programs based on the results. The state health department has an interest in analyzing demographic patterns, and they can easily pass along the ongoing results of the data in periodic reports to the local governments and health departments for their planning and service provi-

370. 1 GWU Rep., supra note 341, at 3-37.
371. AIDS is currently reportable to the CDC in 50 states, but the CDC does not request identifiers. Curran, supra note 365, at 28. In Maryland AIDS also is reportable to the county health officer but the information requested includes the name and address of each patient. Md. Health-Gen. Code Ann. §18-201 (1987).
372. 1 GWU Rep., supra note 341, at 3-12. Arizona, Colorado, Idaho, Minnesota, Missouri, South Carolina, and Wyoming currently require the reporting of the HIV infection with some type of identifier. Id.
373. Some states require reporting AIDS and HIV infection directly to the state public health department, while in others, county and local health departments have set up systems to monitor the disease. 1 GWU Rep., supra note 341, at 3-2 to -5. Local reporting may allow counties to more closely follow each case, and to plan and provide services, but reporting to the state generally provides for more complete information and better overall coordination. Id. at 3-3. Also, reporting to the state allows for the creation of a central registry of AIDS cases, as has been done in Illinois. See Ill. Ann Stat. ch. 111-1/2, para. 7354 (Smith-Hurd 1988).

A central registry allows easy access to the identity of far more patients than under a decentralized reporting system. The state also has better mechanisms than local health authorities for instituting quarantines and other punitive methods.

On the other hand, local health agencies, with their closer ties to the community, are more likely to “know” the patient, especially in rural areas. This could have both positive and negative consequences, depending on the attitude of the officials toward people with AIDS and HIV infection and their duty to protect the “public good.”
sion needs. If a local department has the need for a specific type of information, they can make it known to the state health department which can include it in the data requested or can allow a local health official to work along with the state workers on the study.

Reporting cases of AIDS should be the sole responsibility of physicians. Medical laboratory technicians, pharmacists, school principals, social workers, and ministers are not trained to deal with the full consequences of diagnosing and treating AIDS. They may recognize the symptoms, but they cannot empirically determine the diagnosis, nor can they treat the patient. These professionals may refer individuals to doctors, but should not be involved in reporting.

Practical and public health nurses who may be the first to diagnose AIDS in a patient should refer that patient to a doctor who can provide ongoing services and treatment. That doctor then would make the report to the state. The state, with the cooperation of the medical schools, should train physicians to diagnose and report the disease. Part of this training should stress the need to protect and maintain the confidentiality of patients, as well as basic psychosocial and treatment issues of people with AIDS. Physicians and other HCWs also should receive training on universal precaution methods; this could be included in the same in-service training program.

Reporting should include the following information: (1) the last five digits of the patient's social security number, as the only identifying device; (2) demographic information such as age, gender, race, risk factor, and home zip code or county of residence; (3) presenting diagnoses and associated problems; (4) data concerning

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374. Public health officials may choose an active or passive role in monitoring the disease. Passive surveillance requires little more than contacting the physician after receiving the report and verifying the information given. Minimal time and personnel are required, but this method does not require initiative and active compliance on the part of those reporting. Not all cases will be reported as a consequence.

In active surveillance a more systematic and sustained effort is required of both public health officials and HCWs. Health officers must be more active in searching for cases, and supporting key sentinel hospitals, clinics, and physicians. Public health officials must disseminate accurate information on reporting techniques, and prevention and treatment methods. Some officials check death certificates, tumor registries, and other sources. Finally, such in-depth and sustained efforts require ongoing evaluation and validation studies.

The advantages to an active system include increased accuracy and completeness of data. As the information gathered is useful for epidemiological reasons, CDC often will fund active surveillance systems. This somewhat lessens the disadvantage of increased costs, but this method still requires time and trained staff, as well as the cooperation of health care providers. Some question the need for such methods and the accuracy of the results. The perceived value of an active surveillance program may depend on the extent of the disease within the state.
the isolation and identification of infectious agents; and (5) potential treatment and service needs of the patient. This information should work toward revealing the morbidity and mortality trends of the syndrome, data on the immunity levels, and spread of the disease in various populations such as women, older patients, and racial or ethnic groups.

b. Reporting of AIDS-Related Complex (ARC).—ARC, now classified as stage III HIV infection by the CDC, is not reported by most states. Those states which do require ARC reporting have found that it is difficult to define. The symptoms of ARC can be easily confused with those of the flu, mononucleosis, and other common diseases. New Jersey, for example, revised its reporting system within a short time of its inception, due to definitional problems.

Because ARC is difficult to define, it should not be reported in a formal manner in Maryland. Doctors may make individual assessments of ARC cases and communicate them to the state health department, or hospitals may pass along the results of any studies which they conduct, but physicians should not be required to diagnose and report ARC as they do AIDS.

There are some advantages to reporting HIV positivity by name because information gathered on HIV infection is used for statistical, epidemiological, and planning purposes. Officials may be able to catch duplicate reporting, increase the accuracy of the data, and locate HIV-positive persons for follow-up counseling, education, and treatment updates. The margin of error in anonymous reporting, however, is minimal and calculable and, in the long run, the benefits of anonymous reporting outweigh sacrifices in accuracy.

Reporting without identifiers allows for anonymous test sites. These test sites encourage participation from many infected persons who do not wish to be identified, particularly those who engage in high risk, illegal behavior. Anonymous test sites can increase the

375. "AIDS-Related Complex (ARC) is a condition caused by the AIDS virus in which the patient tests positive for AIDS infection and has a specific set of clinical symptoms. ARC patients' symptoms, however, are often less severe than those with [AIDS]." Surgeon Gen.'s Rep., supra note 2, at 11.
376. 1 GWU Rep., supra note 341, at 3-7.
377. Id.
378. Id. at 3-10.
379. Interview with Edward Brandt, Jr., former Assistant Secretary for Health; Chairman, Maryland Governor's Advisory Council on AIDS (Mar. 16, 1988).

The Oregon Task Force notes that reporting without names lessens the "potential for inciting bigotry, hatred and significant discrimination" which the virus can engender. 1 GWU Rep., supra note 341, at 3-27.
number of people being tested, educated, and counseled, and these practices help control the disease.\footnote{Anonymous HIV reporting can be augmented with seroprevalence studies, a type of anonymous spot-check, using various special groups. Maryland already has conducted seroprevalence studies with the inmate population; other states have used inmates, IV drug users, prostitutes, or particular high prevalence regions. Seroprevalence studies can help states design programs to educate and provide services to HIV-infected persons. Seroprevalence studies also can help organizations obtain additional funding and evaluate intervention techniques. By maintaining anonymity they do not compromise the privacy of the individuals tested. Anonymous reporting helps test-site workers to maintain good relationships with their patients. The patient is more likely to maintain contact with the doctor or counselor if they can be trusted not to report them; this contact and trust is important in treating the patient, and in encouraging them to disclose personal information important in counseling and treatment. The patient is more likely to listen to the counseling, benefit from information on transmission prevention and self-care, and follow up on referrals made to other services. Finally, the patient may be more likely to discuss and accept assistance in notifying partners if the patient is certain that the worker has no legal authority, and is acting only out of concern. Maryland's current reporting system for HIV infections can be improved. A system similar to the following reporting procedures which have been proposed in Oregon is recommended: (1) Physicians are supplied with forms which request the age, gender, race, and area of residence of the patient, as well as information regarding previous HIV testing, and blood and sperm donations. The test site should also give their name and address. (2) All testing sites must give each patient state-approved edu-}

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\footnote{For a discussion of test sites, see supra Section II, at 144.\footnote{Anonymous HIV reporting can be augmented with seroprevalence studies, a type of anonymous spot-check, using various special groups. Maryland already has conducted seroprevalence studies with the inmate population; other states have used inmates, IV drug users, prostitutes, or particular high prevalence regions. Seroprevalence studies can help states design programs to educate and provide services to HIV-infected persons. Seroprevalence studies also can help organizations obtain additional funding and evaluate intervention techniques. By maintaining anonymity they do not compromise the privacy of the individuals tested. Anonymous reporting helps test-site workers to maintain good relationships with their patients. The patient is more likely to maintain contact with the doctor or counselor if they can be trusted not to report them; this contact and trust is important in treating the patient, and in encouraging them to disclose personal information important in counseling and treatment. The patient is more likely to listen to the counseling, benefit from information on transmission prevention and self-care, and follow up on referrals made to other services. Finally, the patient may be more likely to discuss and accept assistance in notifying partners if the patient is certain that the worker has no legal authority, and is acting only out of concern. Maryland's current reporting system for HIV infections can be improved. A system similar to the following reporting procedures which have been proposed in Oregon is recommended: (1) Physicians are supplied with forms which request the age, gender, race, and area of residence of the patient, as well as information regarding previous HIV testing, and blood and sperm donations. The test site should also give their name and address. (2) All testing sites must give each patient state-approved edu-}}
cational materials, as well as pre-test counseling and the opportunity to ask questions at the time of testing.

(3) The form must verify that counseling has occurred and that materials were supplied to the patient.

(4) The tester must send the form to the laboratory with a blood sample of the patient.

(5) The tester must send this form directly to the public health department if the patient is being tested in an out-of-state laboratory.\(^\text{385}\)

This system helps ensure that patients are not only tested, but counseled and educated as well. Under this system, Maryland can maintain a list of laboratories, doctors, clinics, and test sites so that information on new therapies and developments can be systematically disseminated on a regular basis to those who can ensure that those who are treating HIV-infected patients are well informed. This reporting system also helps the State acquire more accurate information for program planning and epidemiology, while still maintaining the patient’s confidentiality.

3. Contact Tracing.—Contact tracing has existed in the United States since the 1930s when it was first used as an attempt to prevent the spread of venereal disease.\(^\text{386}\) The main objective of any contact tracing program is to break the chain of disease transmission by notifying and treating those persons who have been exposed to an infected individual.\(^\text{387}\) This usually is accomplished by asking the infected individual for the names of that person’s sexual contacts. The named persons are contacted and informed that they may have been exposed to the disease in question. They also are told how they can get further information, testing, and treatment.\(^\text{388}\) The index person, or infected individual, usually is not identified in the process.

Various benefits can be realized from an active AIDS/HIV infection contact tracing program. Changing behavior is the best way to stop the spread of the disease, and since contact tracing can reach a large number of people for early testing and counseling, it provides an important vehicle for attempting to change behavior. Contact tracing by the public health agencies also can maintain the infected person’s anonymity more effectively than voluntary face-to-

385. Id.
386. Id.
387. 1 GWU Rep., supra note 341, at 3-37.
388. Id.
face notification because public health officials can notify the contact without identifying the infected person. Moreover, contact tracing has been used previously to control a variety of sexually transmitted diseases, and public health agencies have had a good record of maintaining confidentiality in these situations.389

Contact tracing not only breaches HCW-patient confidentiality, but also may discourage some from seeking treatment due to the fear of the possible consequences.390 Any time confidential information escapes the confines of the HCW-patient relationship there is a danger that the information will go further than intended.391 Therefore, contact tracing, as well as other public health initiatives, always involves a balancing between the individual’s privacy interests and the interests of public health.392

Currently, states implementing contact tracing programs have utilized one of four models, although a fifth model has been recommended in Maryland and in Oregon. The first type of program is active contact tracing. Active contact tracing involves solicitation of the names of all AIDS- and HIV-infected individuals’ sexual and needle-sharing contacts. The contacts are then notified by the public health department and are offered testing and counseling. Active contact tracing generally is coupled with a law requiring that AIDS- and HIV-infected individuals be reported by name to the public health department.393

A second option is limited contact tracing. This program is based on active solicitation of contacts considered to be in high risk or especially vulnerable groups. San Francisco’s limited contact tracing program, for example, is aimed at heterosexual contacts of individuals with AIDS.394 The philosophy behind limited contact tracing is that those who may be unaware should be notified and offered testing.395

390. Id.
391. Id. at 31.
392. Id.
393. Colorado implemented an active contact tracing program in 1987, and from 475 infected persons, about 340 persons were named. 1 GWU REP., supra note 341, at 3-43. Of this number, 15% could not be located, and of the 290 persons notified, 10% had been tested previously and were positive for HIV, about 80% agreed to be tested, and 10% refused testing. Id. About 14% of those tested were HIV-positive. Id. at 3-43.
394. 1 GWU REP., supra note 341, at 3-42. Out of approximately 3000 AIDS cases, 104 heterosexual contacts were named. Fifty could not be contacted, and of those remaining, 50% agreed to testing. Of this group, 7 individuals, or 26%, tested positive. Id.
395. Id. at 3-28.
A third option is voluntary contact tracing. Under a voluntary system the individual is counseled and strongly urged to inform all sexual and needle-sharing partners of their possible exposure. Maryland implemented such a program in February 1987. The program is aimed at physicians who work with local health departments and testing sites. All physicians are encouraged to take an active role in helping infected individuals notify their contacts and to make AIDS information available to their patients. The program encourages infected individuals to seek the help of their physicians if they feel they cannot inform their partners. If a patient does not wish to directly inform sexual and needle-sharing partners, the patient can either refer partners to a testing site where a trained counselor will inform and counsel them or ask public health officials to notify their partners without identifying the infected person. This option may be useful to infected persons who fear that their partners may become violent. Minnesota also has a volunteer partner outreach program in which extensive counseling is provided to both infected persons and their partners.

A fourth option, implemented in a number of states, is a special program in which notification of contacts is required in special situations. This involves certain personnel who may be exposed to HIV in the line of duty or as part of their employment—generally firefighters, emergency medical technicians, paramedics, police officers, and funeral-related personnel. Maryland's statute requires that emergency or rescue personnel be notified when a person with whom they have come into contact is diagnosed as having a contagious disease. Recently, legislation has been enacted which would include AIDS among the covered contagious diseases.

The fifth contact tracing option, which has been proposed in Maryland and Oregon, is mandatory notification of certain persons in certain situations. The duty to notify these persons would arise when an HCW knows of specific individuals who are at a significant risk of infection, but whom the infected person refuses to notify. The duty also would arise when the HCW reasonably believes

396. Id. at 3-40.
397. Id.
398. 1 GWU REP., supra note 341, at 3-40.
399. Id.
400. Id. at 3-41.
401. Id. at 3-25.
403. Id.
404. 1 GWU REP., supra note 341, at 3-27.
that these persons will not be notified. This contact tracing program would be applied to various situations, including: (1) when the HCW helps to locate persons who have received contaminated blood or blood products, (2) when the HCW has counseled the patient as to the importance of informing partners and the infected person has specifically refused to notify contacts, (3) when the infected person does not have the capacity to notify any contacts, or (4) when the infected person requests that the HCW inform his or her contacts.405

Mandatory contact tracing raises privacy issues406 because the practice requires collection of a great deal of highly personal information on a patient without obtaining permission. Several commentators stated that

[s]ince the very purpose of contact tracing is to locate and contact persons who may have been exposed to infection, the chances for inadvertent disclosure of confidential information are great. There is no foolproof means of preventing the contacts from disclosing the information they have learned.407

While the courts generally analyze public health measures under a rational basis test,408 if they restrict fundamental rights, they can be justified only if they are narrowly tailored409 to achieve a compelling governmental interest.410 Therefore, the benefits of a mandatory

405. ld. at 4-17.
406. The Supreme Court recognized a constitutional right to privacy in Griswold v. Connecticut, 381 U.S. 479 (1965). Writing for the majority, Justice Douglas held that the "specific guarantees in the Bill of Rights have penumbras, formed by emanations from those guarantees that help give them life and substance." ld. at 484. The generalized right to privacy was formulated by the combination of these penumbral rights.

In Roe v. Wade, 410 U.S. 113 (1973), the Supreme Court provided further support for the right of privacy in the fourteenth amendment's concept of personal liberty. ld. at 153. The court ruled that "[o]nly rights that can be deemed 'fundamental' or 'implicit in the concept of ordered liberty' are included in this guarantee of personal privacy." ld. at 152.

408. See Williamson v. Lee Optical of Oklahoma, 348 U.S. 483, 487-88 (1955) (to find a law constitutional, "[i]t is enough that there is an evil at hand for correction, and that it might be thought that the particular legislative measure was a rational way to correct it.").
409. Roe, 410 U.S. at 155 ("Legislative enactments must be narrowly drawn to express only the legitimate state interests at stake.").
410. Akron v. Akron Center for Reproductive Health, 462 U.S. 416, 427 (1983) ("restrictive state regulation of fundamental rights ... must be supported by a compelling state interest"); Roe, 410 U.S. at 155 ("Where certain 'fundamental' rights are involved, the Court has held that regulation limiting these rights may be justified only by a 'compelling state interest.' ").
contact tracing program would have to be balanced against the damage resulting from infringing upon the fundamental right to privacy. The benefits of mandatory contact tracing, however, would not outweigh "the damage that could be done to public health efforts if individuals were discouraged from seeking early testing."411

A mandatory program would tend to drive those in need of testing and counseling underground. AIDS and HIV infection are not completely analogous to sexually transmitted diseases such as syphilis because there is no cure or effective treatment;412 the social, psychological, and economic consequences of being labeled HIV-positive are much greater than the consequences of other sexually transmitted diseases.

Another important consideration is the extremely long lag time between exposure to HIV and seropositivity. During this six-month to five-year period,413 the infected person may pass the virus on to many others; contact tracing may conceivably find these infected persons, but it probably will not prevent them from becoming infected.

Active or mandatory contact tracing also generally involves a vast expenditure of financial and human resources. The funds and time probably are better spent on education and counseling programs, especially to those in targeted high risk groups.

Finally, it must be noted that all contact tracing programs are voluntary by nature. Infected persons may not be forced to divulge the names of their contacts. Many of these contacts are partners in activities which are criminal in most states,414 which is in itself a strong disincentive to identify one's contacts.

Therefore, Maryland should maintain its current voluntary partner notification program. A voluntary system encourages infected persons, or those at risk, to get tested, counseled, and educated about the infection.

Maryland should adopt a more extensive program to educate physicians and other HCWs, however, to ensure that they are able to address the social, psychological, ethical, and emotional aspects of HIV infection and AIDS. HIV infection, in all of its manifestations, is more than a physical state and HCWs will not be able to

413. Curran, supra note 365, at 31.
meet the needs of their patients unless they are trained to handle the full dimensions of the disease. One alternative under Maryland's partner notification program is for the infected person to request the physician's help in notifying contacts. Maryland should support the viability of this alternative by preparing HCWs for the unpleasant and uneasy task of notifying an infected person's partners.

Maryland also should follow the Minnesota program by putting more emphasis on counseling services. Counseling services must be available to help prepare infected persons for the task of informing partners. Implementation of procedures for test-site counselors to contact the DHMH on behalf of the infected person and give the DHMH the names of the persons to be contacted is recommended. This would encourage even those without a physician to notify their contacts if they feel they cannot do so face to face. Notification by the DHMH protects the patient's identity. Moreover, the DHMH may have more resources than a physician to notify an infected person's contacts.

A program of mandatory notification of "certain persons" when the infected person refuses to notify those persons should not be implemented. A mandatory notification program, especially one which forces a physician or other HCW to breach the confidences of a patient, is counterproductive because it discourages infected or at-risk persons from seeking testing, counseling, and educational services.

4. Duty to Warn.—Two statutes in Maryland address HCW-patient confidentiality. Section 4-301 of the Health-General Article states that a "provider of medical care may not reveal specific medical information contained in those records to any person unless authorized by the individual on whom the record is kept." Section 4-301 permits HCWs to reveal information without the patient's authorization, however, when the HCW is "providing information re-

415. 1 GWU REP., supra note 341, at 3-41. Minnesota offers a partner outreach program that gives seropositive patients additional counseling sessions to teach them how and what to tell their partners. Id.

416. Id. at 4-17. Maryland's guidelines cite circumstances where the HCW may be obligated to notify persons with significant risk of exposure to HIV infection such as (1) assisting the American Red Cross in tracing contacts who may have received contaminated blood, (2) when the patient refuses to notify sexual or needle-sharing contacts, (3) when the patient is mentally or physically incapable of informing contacts, or (4) when the patient voluntarily requests assistance in notifying contacts. Id. See also supra text accompanying note 405.

quired to conduct the proper activities of the health care provider." Section 9-109(b) of the Maryland Courts and Judicial Proceedings Article provides that "[u]nless otherwise provided, in all judicial, legislative, or administrative proceedings, a patient or his authorized representative has a privilege to disclose, and to prevent a witness from disclosing communications relating to diagnosis or treatment of the patient's mental or emotional disorder."  

Although HCW-patient confidentiality receives a considerable amount of protection under these laws, the landmark decision of Tarasoff v. Regents of the University of California has raised serious questions about the limits of confidentiality when a patient poses a threat of serious harm to identifiable third parties. In that case the California Supreme Court held that when a psychotherapist determines that a patient poses a serious danger to another, the psychotherapist has an "obligation to use reasonable care to protect the intended victim against such danger." Under the court's ruling, the therapist may be obligated to warn the potential victim, notify the police "or [take] whatever other steps are reasonably necessary under the circumstances." The court reasoned that the special relationship between the patient and the psychotherapist may create an affirmative duty toward third parties. The court also noted that protecting members of society from violent assault is more important than improving the quality and efficacy of treatment for the mentally ill.

Maryland has neither specifically rejected nor adopted the duty to warn dilemma in Tarasoff. Yet, if Tarasoff is adopted it will pose

418. Id.
421. For an in-depth analysis of the application of Tarasoff and the duty to warn in the AIDS context, see Comment, supra note 211.
422. 17 Cal. 3d at 431, 551 P.2d at 340, 131 Cal. Rptr. at 20.
423. Id.
424. Id. at 436, 551 P.2d at 343-44, 131 Cal. Rptr. at 23-24.
425. Id. at 440, 551 P.2d at 346-47, 131 Cal. Rptr. at 26.
426. See Shaw v. Glickman, 45 Md. App. 718, 726-27, 415 A.2d 625, 680-31, cert. denied, 288 Md. 742 (1980) (communications between patient and psychiatrist-psychologist protected against disclosure by statute in judicial, legislative and administrative proceedings; the court extended this privilege to statutorily seal shut the lips of the psychiatrist-psychologist subject solely to the express authorization of the patient); Lamb v. Hopkins, 303 Md. 236, 253, 492 A.2d 1297, 1306 (1985) (probation officers owed no duty to Lamb because they had not taken charge of the probationer under section 319 of the Restatement (Second) of Torts); Furr v. Spring Grove State Hosp., 53 Md. App. 474, 489, 454 A.2d 414, 421 (1983) (victim was not readily identifiable; therefore Tarasoff duty did not exist). The Restatement (Second) of Torts states: "One who takes
a critical threat to HCW-patient confidentiality in the AIDS context because the psychotherapist-patient relationship is largely analogous to the physician-patient relationship. In both cases the HCW has an obligation to maintain confidentiality in the relationship, and in both cases the HCW is sometimes aware that the patient poses a serious potential threat to a third party.

Yet, some important differences exist in the two relationships. The psychotherapist-patient relationship is based on solving the patient’s mental problems. The psychiatrist is trained to recognize and resolve psychological problems which could lead to violence. A physician, on the other hand, is trained to heal a patient’s physical problems and is not necessarily trained to diagnose or treat psychological disorders. Therefore, physicians should not be held to as high a standard as are psychotherapists in predicting dangerous propensities in a patient.

Moreover, a psychotherapist has greater control over patients because a psychotherapist can control their patients’ violent tendencies by committing them to institutions. Rather than breaching patient confidentiality, the therapist can protect third parties by committing the patient. A physician, on the other hand, has the theoretical possibility of placing patients in quarantine, but in most states quarantine procedures are antiquated and unworkable.

Regardless of whether physicians have the legal power to quarantine a patient, it is an undesirable alternative which should never be implemented. The use of quarantine would be counterproductive in the containment of the HIV because it would act as a disincentive for infected individuals to be tested, counseled, and treated. The public hysteria over the disease, the ignorance about modes of transmission, and the discrimination that results from a diagnosis of HIV already are deterrents for any citizen to seek medical help. To threaten loss of liberty to AIDS patients would further discourage high risk groups from utilizing the health care system altogether.

charge of a third person whom he knows or should know to be likely to cause bodily harm to others if not controlled is under a duty to exercise reasonable care to control the third person to prevent him from doing such harm.” RESTATEMENT (SECOND) OF TORTS § 319 (1965).

427. Although most of the speculation about a duty to protect third parties has been directed toward the medical profession, physicians may not be the only professionals who risk liability. The combined effect of the Tarasoff case and the plethora of medical malpractice suits has riveted public attention on HCWs and a broad range of negligence issues. Nevertheless, should the Tarasoff holding be expanded to include physicians, lawyers and ministers would not escape the umbrella of responsibility because they may have as much control over their clients and parishioners as physicians do over their patients.
Historically, quarantine was used to control diseases that were much more easily transmitted than HIV positivity. While HIV transmission requires a voluntary act on the part of both the infected individual and the sexual or needle-sharing partner, mere physical proximity was the mode of transmission for these other diseases.

Scientific information about the modes of transmission of HIV help narrow the list of persons to whom an HCW would have a duty to warn. Because HIV can be spread only through exposure to blood and exchange of bodily fluids, employers, co-workers, friends, and most family members are not at risk of infection. Only sexual partners and needle-sharing partners of IV drug abusers (and the fetus of the HIV-positive woman) are vulnerable to infection from an HIV-positive partner. Only when an HCW has an HIV-positive patient who refuses to warn his or her sexual partners and needle-sharing partners of the deadly risk they undertake is the HCW placed in an ethical dilemma.

Moreover, while AIDS was initially thought to be a highly contagious infection, the risk of seroconversion is surprisingly low from heterosexual encounters. A recent report concluded "that a single act of vaginal sex without using a condom with a partner who is known to be infected with the HIV carries a one in five hundred risk of infection." A heterosexual encounter with a partner not belonging to a high risk group and not using a condom poses a risk of infection of one in five million. The use of a condom with this same partner lowers the risk to one in fifty million. Due to this lower than expected degree of risk the rationale behind disclosure is not compelling; patient confidentiality should be maintained in this context.

The Maryland Governor's Task Force on AIDS (the Governor's Task Force) strongly supports confidentiality. It states:

The maximum level of confidentiality must be maintained when handling HIV test results and patient records. The Task Force believes that maintaining such confidentiality, together with opposing mandatory reporting of test results and the mandatory tracing of all possible third parties, will increase the number of persons willing to be tested

428. See Curran, supra note 365, at 31-33.
430. Id.
431. Id.
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voluntarily.\textsuperscript{432}

The Governor's Task Force, however, also imposes a duty on HCWs under certain circumstances to breach HCW-patient confidentiality by warning or informing third parties known to have significant exposure to HIV infection.

Health care providers should strongly encourage HIV-infected patients to speak directly to and refer their own sexual or needle-sharing contacts for counseling and medical evaluation. There are instances, however, when these professionals may be obligated to notify persons known to have had significant exposures to HIV infection. In such cases, the duty to notify is a matter of good medical practice and supercedes the need to maintain confidentiality. . . . The special instances when known third parties should be notified include: . . . When the health care provider encourages the HIV-infected patient to communicate to his/her sexual or needle sharing contacts the need to be evaluated and such cooperation is explicitly refused.\textsuperscript{433}

Although failure to warn a patient's "partner" may have dire consequences, implementing a policy which imposes a duty on HCWs to notify partners also has significant negative consequences. With a duty to warn, the doctor-patient relationship would be eroded by distrust and fear. The relationship between the physician and the HIV-positive patient would become adversarial and the healing gift of medical care would provide yet another source of rejection for HIV-positive persons. A policy of partner notification also could have devastating personal consequences on the HIV-positive patient because public knowledge of an individual's seropositive condition often results in social rejection as well as discrimination in employment, housing, and insurance benefits.

Confidentiality is an absolute concept. Any qualification or alteration of its application ultimately results in the loss of confidentiality. According to the Scottish Director of the Institute of Medical Ethics at the University of Edinburgh, "breaking the rule of medical confidentiality seems justifiable only as a rare exception, since if the rule is broken often or openly, it loses its utility."\textsuperscript{434}

The AMA recognizes the ethical dilemma and the morass of legal liability faced by physicians regardless of whether they choose

\textsuperscript{432} Governor's Task Force, supra note 11, at 27.
\textsuperscript{433} Id. at 21-22 (emphasis in original).
\textsuperscript{434} Boyd, supra note 339, at 283.
to warn third parties or protect HCW-patient confidentiality. The AMA recommends specific statutes to provide consistency and to relieve the HCW of the tortuous choice between medical ethics and legal liability:

While protecting to the greatest extent possible the confidentiality of patient information (a) provide a method for warning unsuspecting sexual partners [and] (b) protect physicians from liability for failure to warn the unsuspecting third party but (c) establish clear standards for when a physician should inform the public health authorities.435

The AMA policy allows physicians to follow their conscience without fear of legal liability. If a physician feels morally obligated to warn a third party of potential risks, the physician may do so without adverse legal consequences; if the physician feels morally obligated to protect patient confidentiality, the physician may refrain from warning third parties without legal penalties. The AMA’s proposal resolves potential legal problems for physicians, and it allows physicians to follow their conscience. This policy, however, fails to resolve the fundamental question of whether a duty to warn under certain circumstances within the context of AIDS is an appropriate public policy.

In establishing policies that concern AIDS and HIV, there must be a careful balancing of an AIDS patient’s right to privacy, the right of the patient’s contacts to reasonable safety, and society’s interest in preventing the spread of a fatal disease. Public welfare can be best protected without imposing a duty on HCWs to warn third parties of their patient’s seropositive condition. A policy of warning contacts may protect those few individuals immediately at risk, but will not effectively contain the disease. In fact, a duty to warn third parties may discourage AIDS victims from using the health care system. There are already limited incentives for AIDS victims to use the health care system because no cure exists for the disease and the diagnosis of AIDS poses a terrible social stigma. Since a duty to warn third parties would effectively discourage individuals from determining their HIV status, this policy would result in more people being exposed to the virus.

B. Recommendations

I. Medical Records.—a. Hospitals and Provider Offices.—Hospitals and provider offices should strengthen the confidentiality of all

medical records. Information concerning HIV-positive patients and AIDS patients can best be protected in this manner without drawing attention to them. Medical charts should have notices that emphasize that it is a confidential record and that unauthorized release of confidential information can result in penalties.

b. Public Health Records.—Public health records which link HIV-positive tests and AIDS cases with names should be held securely and should have access limited to specified individuals who require the information in compiling records or aiding infected individuals.

c. Legislation.—Legislation should be drafted which includes the following provisions:

1. Confidentiality of information in records concerning HIV infection held by government agencies, health care providers, physicians, laboratories, clinics, blood banks, insurance companies, third-party payors of medical care, or other organizations should be strictly maintained. The information held in public health records should not be released or made public upon subpoena or any other method of discovery. Private medical records that are subpoenaed should be sealed and the patient should be notified that the records are being subpoenaed.

2. Public health records can be released without identifiers for statistical purposes.

3. Public health records can be released with identifiers when the specific written consent of the person identified is obtained. It also can be released to medical personnel when necessary for delivery of medical services. The informed consent obtained prior to the test should include how the information concerning the test will be kept confidential, where it will be recorded, and under what circumstances it will be shared with other providers and public health officials.

4. Disclosure is allowed to blood banks, plasma centers, and organ and tissue banks. This disclosure is protected as confidential and is only released to designated individuals.

5. Individuals cannot be compelled to consent to the release of protected information in order to obtain or maintain housing, employment, or education.

2. Reporting of AIDS, HIV Infection, and ARC.—a. Reporting of AIDS.—(1) AIDS should be reported not by name, but by using a coded format, such as the last five numbers of the patient's social security number.
(2) AIDS should be reported directly to the state health department by physicians who receive training from the State.

(3) County and city governments should receive data from the State.

b. Reporting of HIV.—(1) HIV should continue to be reported anonymously.

(2) A system should be employed as in Oregon, wherein physicians or responsible persons at test sites and clinics must send demographic reports and documentation of pre-test counseling for each patient to the lab with each blood sample and test request.\textsuperscript{436}

(3) The lab should be responsible for reporting seropositivity directly to the State, along with the physician’s report.

(4) Seroprevalence studies may continue to be employed.

c. Reporting of ARC.—There should be no formal reporting requirements for ARC.

3. Contact Tracing.—a. Current Program.—Maryland should maintain its current program of voluntary partner notification.

b. Patient Counseling and Educational Services.—The DHMH and other health and counseling services should offer more extensive counseling and educational services to help infected persons to notify their contacts of HIV status.

c. HCW Counseling and Educational Services.—Maryland’s HCWs, especially physicians, should be more involved in HIV and AIDS education and counseling so that they will be better prepared to meet their patient’s needs, including assisting in partner notification if they are asked to do so.

d. Procedural Requirements.—The DHMH should implement a specific procedure by which contacts of infected individuals may be notified at the request of infected individuals. A test site counselor, for example, should be permitted to notify the DHMH of a contact’s identity after receiving authorization from the infected person.

e. No Mandatory Notification.—Maryland should not implement a policy of mandatory notification of certain at-risk persons when the infected individual refuses to notify them. This imposes a duty to warn upon HCWs and forces them to breach HCW-patient confidentiality.

f. Policy Reevaluation.—If and when a cure of an effective pre-

\textsuperscript{436}. 1 GWU Rep., supra note 341, at 3-37.
ventative treatment for AIDS or HIV infection becomes available, this policy should be re-evaluated.

4. Duty to Warn.—a. Legislation.—Maryland must promulgate legislation which would absolve the HCW of the duty to warn third parties. Legislating the rejection of an HCW’s duty to warn is not analogous to imposing on HCWs a duty not to warn sexual partners at risk. An HCW’s decision in these cases involves ethical considerations which should be examined on a case-by-case basis. In some cases an HCW may believe that the most successful means to protect the sexual or needle-sharing partners of an HIV-positive patient who resists divulging this information to contacts is to continue a relationship of treatment and counseling. With the provider-patient relationship intact, the provider has the opportunity to convince the patient to inform partners and to practice “safer sex.”

On the other hand, there are circumstances when an HCW will feel ethically bound to warn a sexual or needle-sharing partner. If an infected individual has received counseling, and still refuses to inform all partners, the HCW may determine that the situation is hopeless and will be free to warn the contacts. Removing an obligation to warn does not prohibit the HCW from warning third parties; removing the obligation or duty merely releases the HCW from legal liability for failure to warn.

A duty not to warn is not recommended. It is recognized that there may be limited circumstances where the HCW should be encouraged to warn partners who believe they are not at risk. If an HIV-positive patient actively conceals the HIV-positive status, as well as sexual history, or present and past drug-abusing practices, this patient’s contacts may need to be warned. Since a duty not to warn is not supported, it is recommended that the courts carve out a narrow exception to the confidentiality in those very few instances where partners are unsuspecting and vulnerable.

b. Education Program.—Maryland must implement an education program which disseminates accurate information to the public concerning the methods of HIV transmission, dispelling the myths that have been spawned by ignorance and fear. For a policy concerning an HCW’s duty to protect third parties to be rational, the following medical facts must be communicated to the public in an effective manner: (1) HIV is a communicable disease that can be transmitted through blood and bodily fluids, (2) exposure to blood, homosexual intercourse, heterosexual intercourse, and pregnancy are all means through which the virus can be transmitted, and (3) HIV cannot be communicated through toilet seats, casual contact, or food
If the public is aware of the behavioral activities that create a risk and of activities that are safe, they will assume greater responsibility for their own health. When individuals are able to assume responsibility for their own behavior, the need for requiring HCWs to warn third parties will be greatly diminished. If individuals know that certain conduct carries with it a high risk of contracting the HIV, then they knowingly assume the risk and are responsible for the consequences.

Since medical technology does not provide a means to determine with certainty the HIV status of any individual, statewide education should stress that individuals must act on the assumption that all people are HIV-positive. The bottom line prescriptions on behavior should be to never share needles in IV drug abuse, to practice only safe heterosexual or homosexual sex with an individual who could possibly have been exposed to the virus, and to be tested before becoming pregnant if there is a possibility of HIV exposure.

Nevertheless, even if all individuals know that sharing needles and having intercourse without condoms are high risk behaviors, situations where HIV-positive patients refuse to inform partners of their health status still will arise. It is important to emphasize, however, that there have been dramatic changes in the sexual behavior of some HIV-positive individuals. In most cases, even after an initial period of anger, the patient will feel concern or responsibility for those who might have been infected. Even those who feel reticent can be counseled, cajoled and, if necessary, coerced into divulging their HIV-positive status to their contacts. Before an HCW considers breaching confidentiality by informing the patient’s partners, every effort must be made to persuade the patient to discharge the obligation.

IV. Obligation to Treat

An individual with AIDS or HIV-positive status needs competent, compassionate health care treatment, and should not face dis-
AIDS. Well-documented evidence indicates that the AIDS virus is not transmitted by casual contact. HCWs can further prevent transmission of the AIDS virus by following established guidelines for the care of infected patients. Given this scientific knowledge of HIV transmission and the existence of guidelines for preventing HIV transmission in health care settings, there can be no rational argument against an affirmative duty to treat HIV-positive individuals. Such a duty is hollow and unrealistic unless accompanied by specific policies and recommendations. At a minimum, these policies and recommendations must cover the issue of decision-making in the treatment process as well as the issue of disciplinary measures.

AIDS presents the health care community with the dilemma of either maintaining a traditional, autonomous climate where HCWs enjoy the power to restrict their patient population or imposing an affirmative obligation to provide care to individuals who theoretically pose a risk of infection to them. Allowing HCWs to maintain their autonomy may limit the HIV-infected individual's access to health care. That is, as long as HCWs believe that the risk of contracting the virus overrides any obligation to provide care—and no legal obligations are at stake—an HIV-positive individual may be denied access to adequate health care. Imposing an obligation on HCWs to provide treatment, however, presents other difficulties (e.g., forcing such a relationship runs counter to the legal principles of contract).

Despite these difficulties, the medical community must make available treatment for those with HIV-positive serology. The health care system should be designed to avoid discrimination because of race, creed, or any other bias in the provision of care. Unfortunately, those who are HIV-positive seem to have become yet another target of discrimination. The argument for allowing this discrimination to go unchecked stems from concern that the HCW

440. See Friedland, Saltzman, Rogers, Kahl, Lesser, Mayers & Klein, Lack of Transmission of HTLV-III/LAV Infection to Household Contacts of Patients with AIDS or AIDS-Related Complex with Oral Candidiasis, 314 New Eng. J. Med. 344, 348 (1986); Sande, Transmission of AIDS: The Case Against Casual Contagion, 314 New Eng. J. Med. 380, 382 (1986). The AIDS virus is spread through sexual intercourse, by the injection of contaminated blood, and in utero from a pregnant woman to her fetus. See Sande, supra, at 380-81. Individuals at high risk of acquiring the virus include homosexual and bisexual men, IV drug abusers, persons receiving infected blood products intravenously, and children born to infected mothers. Id. Individuals who engage in heterosexual intercourse with high risk individuals are at risk of infection. Id. at 381.

441. CDC Recommendations: No. 25, supra note 7, at 305.
may be exposed to an unreasonable risk of infection if required to treat these patients. In reality, few HCWs have become infected directly from infected patients. Nevertheless, the risk of HIV infection is less than that of contracting HBV. HCWs usually do not refuse to treat patients with HBV, in spite of the risk of infection. AIDS, however, presents a more complex problem. That is, discrimination may be the result of homophobia or distaste for IV drug users as well as the fear of contracting a potentially fatal disease.

Although the stigma associated with HIV infection is an emotional issue, treatment decisions should be made on rational medical grounds. The right of access to medical care, along with a correlative duty to treat, outweighs the underlying emotional issues and risk of transmission. This obligation, however, is difficult to enforce. Through institutional incentives and remedies, HCWs must be induced to act on this obligation and to ensure the availability of health care for those who are infected.

A. Historical Perspective

1. The Rise of Plague Doctors.—Historically, the medical community has not responded consistently in times of epidemiological crises. Prior to the mid-nineteenth century, no organization had established standards of behavior for physicians to follow in times of epidemic crises. Consequently, the responses of individual physicians varied greatly. During most epidemics for which records survive, physicians generally treated patients who sought their help, although they frequently charged higher fees. In all epidemics for which physician activities were chronicled, large numbers of physicians fled the urban areas. Many did so under the guise of attending to the wealthier families who employed them. Others

442. The CDC reported that 2586 HCWs had been diagnosed with AIDS as of March 14, 1988. Of these, 135 HCWs, or 5.3%, had an undetermined risk of infection. That is, they exhibited no high risk behavior and may have been infected through occupational exposure to the virus. Centers for Disease Control, Update: Acquired Immunodeficiency Syndrome and Human Immunodeficiency Virus Infection Among Health-Care Workers, 37 Morbidity and Mortality Weekly Rep. 229, 230 (1988) [hereinafter CDC Update]. See also Wash. Post, supra note 7, at A4, col. 4 (fewer than 0.5% of HCWs "mistakenly exposed to AIDS-tainted blood . . . become infected with the lethal virus . . . .").


444. Id. at 31.


remained in the city, but refused to become involved in the care of those infected.448

This pattern of individual response gave rise to the development of so-called plague doctors, physicians designated by their colleagues or by civil authorities to stay in the cities to tend to the sick and dying during times of pestilence, thus relieving their fellow physicians of responsibility.449 Plague doctors were required to live in isolation during the outbreak of the infestation, but they were remunerated well with both money and prestige.450 During outbreaks of bubonic plague in fourteenth century Europe, negotiations between groups of merchants in the cities and entrepreneurial physicians who agreed to visit the sick and dying resulted in lucrative personal services contracts.451 Such arrangements amounted to little more than business propositions driven by the merchants' fears over loss of commerce in their cities and the physicians' individual economic interest.452 Ethical concerns did not appear to be a consideration.

During outbreaks of yellow fever in the United States, physicians reacted as their European predecessors had centuries before.453 As before, many affluent citizens and their physicians fled to the healthier countryside.454 The merchants again exerted civic authority to negotiate contracts with plague doctors who saw personal opportunity in the epidemic.455

Not until the twentieth century was civic authority for institutionalizing plague doctors "vested in permanent agencies of government rather than in temporary committees of influential businessmen and physicians."456 In modern times public health departments have taken on this responsibility, and clinics have specifically employed physicians to care for the sick and disadvantaged. Medical care of the sick poor has become institutionalized for the more recent disease epidemics of influenza and polio in this century—originally by resident physicians in post-graduate medical programs, and later by medical faculty as a source of income.457

448. Fox, supra note 446, at 5.
450. Fox, supra note 446, at 6-7.
451. Id. See also Zuger, supra note 445, at 1925.
452. Fox, supra note 446, at 7.
453. Id. at 9-10.
454. Id. at 7-8.
455. Id.
456. Fox, supra note 446, at 8.
457. Id.
Foreign medical school graduates have sought career opportunities by treating diseases among the poor. The similarity with the previous plague doctor arrangements is striking: Again, younger, less-established physicians took up the calling to gain acceptance into communities where they previously had minimal influence. Modern plague doctors, especially those associated with academic institutions, are rewarded differently than their predecessors: Rather than personal income, research funds and academic prestige may accompany care and study of the infected disadvantaged. Physicians in this century do not leave infected communities.

2. Moral Obligation to Treat.—There has been no professional tradition of an obligation for physicians to treat epidemic victims. In crises prior to the establishment of public health institutions, decisions by physicians to stay in town to care for the disadvantaged sick were individual determinations governed by conscience or economic incentive.

Such a tradition may be lacking because no ethical code existed to govern professional behavior in these circumstances. Neither the Hippocratic Oath, the Oath of Maimonides, nor other simi-

458. Id.
459. Id. at 9.
460. See Loewy, Duties, Fears and Physicians, 12 SOC. SCI. & MED. 1363, 1364 (1986).
461. The Hippocratic Oath:

I swear by Apollo Physician and Asclepias and Hygieia and Panaceia and all the gods and goddesses, making them my witnesses, that I will fulfil according to my ability and judgement this oath and this covenant:

To hold him who has taught me this art as equal to my parents and to live my life in partnership with him, and if he is in need of money to give him a share of mine, and to regard his offspring as equal to my brothers in male lineage and to teach them this art—if they desire to learn it—without fee and covenant; to give a share of precepts and oral instruction and all the other learning to my sons and to the sons of him who has instructed me and to pupils who have signed the covenant and have taken an oath according to the medical law, but to no one else.

I will apply dietetic measures for the benefit of the sick according to my ability and judgement; I will keep them from harm and injustice.

I will neither give a deadly drug to anybody if asked for it, nor will I make a suggestion to this effect. Similarly I will not give to a woman an abortive remedy. In purity and holiness I will guard my life and my art.

I will not use the knife, not even on sufferers from stone, but will withdraw in favor of such men as are engaged in this work.

Whatever houses I may visit, I will come for the benefit of the sick, remaining free of all intentional injustice, of all mischief and in particular of sexual relations with both female and male persons, be they free or slaves.

What I may see or hear in the course of the treatment or even outside of the treatment in regard to the life of men, which on no account one must
lar statements regarding proper physician conduct of patient care address a practitioner's obligation to victims of infectious disease. Even the Royal College of Physicians, which issued an ethical code during London's intermittent plagues in 1543, did not attempt to regulate its members' duties in this respect.463

An early reference to the selfless duty owed by physicians to the public during epidemics appeared in an editorial in the Philadelphia Federal Gazette during the 1793 outbreak of yellow fever. Physicians who fled the city during the epidemic were scorned and ridiculed. The editorial admonished that physicians, like military men, are considered public property, and part of their profession involves being "in the way of danger" on occasion.464

Approximately fifty years later, the AMA was formed and devised its first code of medical ethics in 1847. In a section entitled "The Duties of the Profession to the Public," the organization took an unprecedented step.465 The AMA formulated a standard of duty for physicians during epidemics: "it is [the physicians'] duty to face the danger, and to continue their labors for the alleviation of the suffering, even at the jeopardy of their own lives."466 This unconditional stance probably represented the AMA's quest to establish honor and prestige within the medical profession rather than a con-

spread abroad, I will keep to myself holding such things shameful to be spoken about.

If I fulfil this oath and do not violate it, may it be granted to me to enjoy life and art, being honored with fame among all men for all time to come; if I transgress it and swear falsely, may the opposite of all this be my lot.

462. The Oath of Maimonides is as follows:
Thy eternal providence has appointed me to watch over the life and health of thy creatures.
May the love for my art actuate me at all times. May neither avarice nor miserliness, nor thirst for glory, or for a great reputation engage my mind, for the enemies of truth and philanthropy could easily deceive me and make me forgetful of my lofty aim of doing good to thy children.
May I never see in the patient anything but a fellow creature in pain. Grant me strength, time and opportunity always to correct what I have acquired, always to extend its domain, for knowledge is immense and the spirit of man can extend infinitely to enrich itself daily with new requirements. Today he can discover his error of yesterday and tomorrow he may obtain a new light on what he thinks himself sure of today.
O, God, thou hast appointed me to watch over the life and death of thy creatures. Here am I ready for my vocation, and now I turn unto my calling.

Id. at 8.
465. Id.
466. Id. (quoting AM. MED. ASS'N, CODE OF ETHICS ADOPTED MAY 1846 (1871)).
sensus of behavior already in practice. Indeed, after the charter AMA code (despite the continuing visitation of epidemic diseases), only in a few recorded instances did physicians refuse to care for the needy sick or to accept the risks associated with infectious epidemics.

Indeed, after the charter AMA code (despite the continuing visitation of epidemic diseases), only in a few recorded instances did physicians refuse to care for the needy sick or to accept the risks associated with infectious epidemics.

Unfortunately, the language of the early AMA Code of Ethics can no longer be found in the present code. Another perspective crept into the AMA’s creed. First appearing in 1912, and remaining in its most recent revision, is the principle that “[a] physician shall, in the provision of appropriate patient care, except in emergencies, be free to chose [sic] whom to serve . . . .” While continuing to emphasize physicians’ duties to society and to exhort doctors to provide “competent medical service with compassion and respect for human dignity,” in 1957 the AMA Code of Ethics deleted the section discussing physicians’ duties during epidemics. The apparent reason was to shorten the code and because medicine had successfully conquered the known pestilential diseases.

For thirty years, none of the modern ethical codes addressed the standard of duty in accepting personal risk in patient care. The AIDS epidemic prompted a reaffirmation of the AMA’s statement in the original Code of Ethics. In November 1987 the AMA’s Council on Ethical and Judicial Affairs reaffirmed a duty of physicians to treat HIV-infected patients in spite of the known risks to the medical community. This unambiguous report clarified the previous conflicting message of the Code of Ethics.

B. Legal Aspects of an Obligation to Treat

1. “No Duty Rule.”—Under American tort and contract law, “absent some special relationship, no citizen owes any other citizen anything.” This principle holds true for physicians dealing with individuals who are not their patients. Otherwise, physicians have contractual obligations to their patients based on the physician-pa-
tient relationship. In the free market of the American health care system, however, a physician generally operates under the "no duty rule," i.e., absent a consensual doctor-patient relationship a physician is not obligated to treat any particular patient. When no prior agreement, statute, or regulation applies, physicians "can, in deciding whether to accept patients, discriminate among them on the basis of all sorts of irrelevant and invidious criteria . . . ."

By contrast, physicians working in emergency rooms must treat all patients with a medical emergency. Any person experiencing a medical emergency has a legal right to treatment. As a matter of public policy, even carriers of the most contagious diseases need emergency care to prevent undue pain and suffering. AIDS and HIV-infected patients should be within this emergency treatment rule. Emergency personnel have the right to take reasonable precautions to protect themselves, i.e., complying with the CDC recommendations for prevention of HIV transmission in the health care setting. Reasonable protection, however, does not include refusal to treat.

The emergency treatment rule may have only limited usefulness in alleviating the problems of HIV-infected individuals. This rule only guarantees medical attention to the HIV-infected individual who is suffering a real medical emergency in an emergency treatment facility. Relatively few HIV-positive patients require such emergency treatment. Even then, if the emergency treatment rule were the only principle in force, the obligation would end with stabilization of the emergency condition.

474. See Zuger, supra note 445, at 1927 ("The contract, voluntarily created by patient and physician, imposes a fiduciary obligation on the physician to act in the patient's interest and to provide the patient with a standard of competent medical care.").


476. Annas, supra note 443, at 26 (emphasis in original).

477. Id. (noting that courts have rejected the free choice concept that would allow emergency room physicians to deny emergency medical care).

478. Id. (noting that a patient's race, age, or ability to pay are irrelevant when a patient is "experiencing a medical emergency"). Courts have reasoned that patients have a right to emergency treatment because citizens may reasonably rely upon the expectation that emergency medical care is available to all who need it at facilities designated and licensed by local authorities. Id. at 27.

479. Id. See also CDC Recommendations: No. 25, supra note 7, at 305.

480. Annas, supra note 443, at 27.

481. Id.

482. Id.
2. The Duty to Continue Treatment.—Once a consensual physician-patient relationship is formed, the physician must continue treating the patient as long as the patient needs the services of the ministering physician. The law recognizes the inequality of the lay patient in a relationship with the trained professional care provider. Therefore, the patient is given more power in the relationship and the physician more responsibility, that is, a patient, unlike a physician, may unilaterally end the physician-patient relationship without giving notice. In contrast, the physician can only terminate the relationship under certain limited circumstances. Applying these criteria to HIV-infected patients, a physician may not refuse to care for a patient already under his or her care because that person is infected with HIV. The physician must at least give reasonable notice that allows the patient an opportunity to find another practitioner of similar expertise. If, after being given notice, an HIV-infected patient could not find another doctor willing to enter into a physician-patient relationship because of the patient’s HIV status, termination of the physician-patient relationship may be improper.

HIV infection is distinct from a diagnosis of AIDS. Treating an individual with AIDS requires the knowledge and skill needed to treat a specific disease; treating an HIV-infected patient requires knowing what precautions to take to avoid infection. Most physicians have sufficient medical knowledge to treat HIV-positive individuals. Not all physicians have, or could be expected to have, the knowledge and skill to treat patients with AIDS. Therefore, a patient with a disease that his or her physician is unqualified to treat may properly be transferred to the care of a more qualified provider. Adequate numbers of practitioners hopefully will specialize in the unique aspects of AIDS and will accept these new patients. Until such specialists become adequately available, however, the AIDS patient’s physician must continue to care for the patient if the

484. Annas, supra note 443, at 27.
485. Id.
486. Id. The physician may terminate the doctor-patient relationship if the patient consents, if the physician’s services are no longer needed, or if the physician gives adequate notice to permit the patient time to find appropriate medical care. Id.
487. Id.
488. Annas, supra note 443, at 27.
489. Id.
patient's status requires medical care.490  

C. Anti-Discrimination Law

1. Federal.—Three sources of federal law may provide anti-discrimination standards for AIDS- or HIV-infected patients: Title VI of the Civil Rights Act of 1964,491 the Rehabilitation Act of 1973,492 and School Board of Nassau County v. Arline.493

The Civil Rights Act of 1964 prohibits public places from discriminating against individuals on the basis of race, color, or national origin.494 The Rehabilitation Act, enacted nine years later, prohibits entities participating in federally assisted programs, federal employees, or those accepting federal contracts from discriminating on the basis of any handicap, if an individual is otherwise qualified.495 Under one view, a person infected with a potentially contagious disease may be handicapped but still able to effectively perform employment duties, and therefore under the Rehabilitation Act cannot be discriminated against.496 The recent Arline case reinforces this argument. In Arline the Court ruled that a person with tuberculosis (a potentially contagious disease) is a handicapped individual within the meaning of the Rehabilitation Act.497 Because of the similarities between TB and AIDS, an HIV-infected individual also should fall within the Rehabilitation Act's definition of "handicapped."498 The remaining unanswered question, then, is whether an HIV-positive individual also is protected.

2. Maryland Law.—Anti-discrimination protection under Maryland law is equally unclear. Maryland statutes prohibit discrimination in public accommodations against physically or mentally

490. Id. at 28.
496. See Annas, supra note 443, at 28; Parmet, AIDS and the Limits of Discrimination Law, 15 LAW, MED. & HEALTH CARE 61, 67 (1987).
497. 480 U.S. at 289. The Court in Arline noted that the Rehabilitation Act was aimed at protecting "handicapped individuals from deprivation based on prejudice, stereotypes, or unfounded fear, while giving appropriate weight to such legitimate concerns of [recipients of federal funds] as avoiding exposing others to significant health and safety risks." Id. at 287 (footnote omitted). "Significance" is determined by reference to the "reasonable medical judgments of public health officials." Id. at 288 (footnote omitted).
498. For a discussion of the Restoration Act's impact on the definition of "handicapped," see supra Section I, at 109-10.
handicapped persons, and prohibit such discrimination by persons and businesses licensed or regulated by the Department of Licensing and Regulation. Such protection extends to employment discrimination. No Maryland appellate court has addressed whether HIV positivity, ARC, or AIDS is a handicap under the Maryland statute. The court of special appeals regards AIDS as a disease that causes death, but that recognition is a far cry from establishing clear laws of anti-discrimination against AIDS patients, much less HIV-positive individuals. The MCHR guidelines, however, now specifically include HIV infection and AIDS in the list of protected handicaps.

3. Contractual Anti-Discrimination.—A physician who contracts with a health maintenance organization or health care institution is bound by the organization’s policies. A physician who dislikes the contract terms may take his/her services elsewhere.

In the area of public assistance programs, the federal government, persons accepting federal contracts, or persons participating in federal public assistance programs may not discriminate on the basis of handicap. Therefore, AIDS patients, and possibly HIV-infected individuals, who are recipients in federal public assistance programs have an absolute right to medical treatment by a physician participating in that program. As with the private industry programs, a physician unwilling to agree to these terms may refuse to participate in the program. Physicians in the program, however, are bound by the anti-discrimination provisions of the Rehabilitation Act.

500. Id. § 8.
501. Id. §§ 14-16.
504. See supra note 43 and accompanying text. See also infra note 519.
505. See Annas, supra note 443, at 29. Such organizations could impose upon physicians an obligation to treat HIV-infected individuals; refusal to do so would amount to a breach of contract. Of course, no employer could force a physician to dangerous exposure without proper precautions, but the CDC guidelines to protect HCWs sufficiently addresses this concern. See CDC Recommendations: No. 25, supra note 7, at 305.
507. Id. §§ 791-794.
D. Other Perspectives

1. The President's Commission.\textsuperscript{506}—The President's Commission did not identify a legal obligation for physicians to treat HIV-infected individuals. Instead, the President's Commission made three other findings. First, states should enact strong anti-discrimination statutes.\textsuperscript{509} Second, professional organizations representing health professionals should publicize statements that physicians have an ethical obligation to treat HIV-infected individuals.\textsuperscript{510} Finally, the federal and state governments should create education programs aimed at health professionals to provide them with the facts and possible risks of treating HIV-infected individuals.\textsuperscript{511}

2. Maryland Governor's Task Force.\textsuperscript{512}—The Governor's Task Force on AIDS has recommended that "[t]here must be no discrimination in employment, health care or receipt of public services solely because of HIV infection, AIDS Related Complex (ARC) or AIDS."\textsuperscript{513} This recommendation, if approved by the Governor, could lead to an anti-discrimination statute which still would give physicians significant freedom in choosing which patients to treat. The Governor's Task Force further stated that physicians' decisions to treat persons with HIV infection may be made on a case-by-case basis.\textsuperscript{514} This position does little to establish a legal obligation to treat HIV-infected persons.

E. Recommendations

As many as one and a half million individuals in the United States have the HIV antibody, up to 77,000 of whom suffer from AIDS.\textsuperscript{515} If this disease spreads as projected,\textsuperscript{516} the apprehension that stimulates discrimination against persons with AIDS and discourages those at risk from seeking help also will grow. Strong steps must be taken to insure a proper legal and medical response to

\textsuperscript{506} See President's Comm'n, supra note 279.
\textsuperscript{509} Id. at 3.
\textsuperscript{510} Id. at 137.
\textsuperscript{511} Id. at 29-30.
\textsuperscript{512} Governor's Task Force, supra note 11.
\textsuperscript{513} Id. at 3.
\textsuperscript{514} Id.
\textsuperscript{516} The CDC estimates that by the year 1991 there will be over 300,000 reported cases of patients with AIDS. See id.
the challenges of AIDS. The recommendations that follow address issues arising out of the duty to treat theory.

1. **Education.**—Implement a comprehensive plan of AIDS education for HCWs, with participation in the education program a requirement of maintaining professional licensure.

Education will help prevent the spread of AIDS and HIV infection. HCWs must be educated about medical and social aspects of the disease. High risk groups also must be targeted for education.

2. **Legislation.**—Include HIV-positive status in the statutory definition of "handicap."

The possibility of discrimination in the delivery of medical services to HIV-infected individuals is great. The Supreme Court has held that a person suffering from a contagious disease is a handicapped person. Explicit statutory guidance, however, is needed to establish anti-discrimination with respect to AIDS patients and individuals infected with HIV.

In Maryland, only uncertain legal protection is available to persons with AIDS or HIV infection. No Maryland appellate deci-
sion addressed whether article 49B defines AIDS as a handicap. The only indication that AIDS is a "handicap" comes from an administrative agency, the MCHR. With so much at stake, sound anti-discrimination legislation must be implemented. This legislation must do more than merely recognize an HCW's duty not to refuse treatment to a patient whose condition is within the HCW's current realm of competence, solely because the patient is HIV-seropositive. Including HIV status in the statutory definition of a physical or mental handicap would eliminate the need for the slow process of litigation to clarify the nature of the protections.

3. Eligibility for Health Programs.—Broaden eligibility requirements of public health assistance programs to give low income patients increased access to dental, medical, and nursing home services.

Low income populations (especially black and Hispanic populations) are disproportionately at risk to HIV infection, but are least likely to have adequate health insurance or to receive comprehensive preventive health care. Broadening eligibility requirements will enhance access to treatment.

4. Internal Nondiscriminatory Policies.—Define discriminatory practices that would be prohibited by a comprehensive nondiscriminatory policy to be enforced internally by the hospital or health care institution itself.

To satisfy state licensing and certification regulations, hospitals and other health care institutions (e.g., nursing homes, clinics, hospices) should be required to implement and enforce a nondiscriminatory treatment policy which would outline a set of prohibited discriminatory practices. The obligation to develop nondiscriminatory treatment practices should be mandatory. The health care institutions themselves would be vested with the authority to develop their own guidelines, which would be subject to the approval of and periodic review by the DHMH.

Guidelines, supra note 43. Also, the MCHR now interprets its jurisdictional authority as encompassing "virtually every" Maryland HCW. Letter from Henry B. Ford, Acting Attorney General, & Lee D. Hoshall, AIDS Coordinator, to Edward J. Brandt, Jr., Chairman of the Governor's Advisory Council on AIDS, at 1 (May 23, 1988). This interpretation is based on the MCHR's jurisdiction over persons and businesses regulated by the Maryland Department of Licensing and Regulation. See Md. Ann. Code art. 41, § 8-102(a) (Supp. 1988). Most health care entities employ one or more employees, giving the MCHR jurisdiction over them. Id.

520. See Guidelines, supra note 43.
Historically, discriminatory practices have been difficult to prove. Defining and prohibiting certain conduct as discriminatory will tend to eliminate excuses for non-treatment of AIDS- or HIV-infected individuals. For example, discriminatory conduct requiring an immediate automatic investigation should include postponement of surgery on an AIDS or HIV-infected patient more than three times within a determined time period.

5. Disciplinary Statutes.—Amend the statutory disciplinary provisions affecting licensed physicians,\(^5\)\(^2\)\(^1\) to provide for a duty to treat AIDS patients.

At the heart of the duty to treat issue lies the question of whether there should be a legal mandate obligating HCWs to render treatment to patients. The medical community has vigorously opposed imposition of a legal duty to treat and would prefer to remain autonomous in the regulation and discipline of its members. Policymakers, on the other hand, argue that a physician's recognition of an ethical duty to treat does not sufficiently safeguard against the categorical discrimination. For example, physicians could avoid an ethical obligation to treat by making a referral purportedly because treatment is not within their realm of competence. Again, because the potential for discrimination is so serious, comprehensive legal protection must be adopted.

6. CDC Guidelines.—CDC universal barrier guidelines\(^5\)\(^2\)\(^2\) should be used in the treatment regimen of all patients regardless of known antibody status.

This recommendation applies to all HCWs, including but not limited to dentists, nurses, doctors, surgeons, and support staff.

Because the AIDS virus attacks primarily the cells that protect the body from infections, the immune system is severely compromised. Patient management decisions must be made with the objective that immune suppression—not AIDS diagnosis—is the operative factor. That is, treatment should be the same as in other cases of immunosuppression, such as leukemia. Situations may develop whereby immunosuppressed individuals (those with recurrent opportunistic infections) may not undergo elective surgery; various factors must be weighed to determine whether non-elective procedures should be performed. In the case of the AIDS patient, the decision to give or withhold treatment should be no different than if

\(^{522}\) See CDC Recommendations: No. 2S, supra note 7.
the diagnosis were chronic immunosuppression rather than AIDS. Patients exhibiting only the presence of the HIV antibody in the blood should be treated like individuals with no HIV antibody titres. Above all, the CDC guidelines detailing precautionary measures in patient treatment and handling of blood or other bodily fluids should be followed regardless of HIV status.

7. Phase of Illness.—a. Emergent Care.—Any hospital or facility advertising or claiming emergency facilities must provide emergent care regardless of diagnosis or HIV status; adequate and willing staff must be available.

b. Acute and Chronic/Extended Care.—Such care must be made available for the AIDS patient.

c. Terminal Care.—The AIDS patient should have access to terminal care,523 whether in a home, hospice, or institutional (nursing home or hospital) setting. During an AIDS patient’s short life expectancy, the patient should be provided with adequate medical care to alleviate as much pain and suffering as possible. AIDS patient treatment, however, currently costs an estimated $40,000 per year.524 Absent a national health insurance program, cooperative measures between business, government, and hospitals to provide and finance care should be instituted.

8. Specialty Wards and Hospitals.525—HIV-positive status does not change the obligation of the HCW or institution to treat illnesses and provide routine health maintenance, and the presence of HIV antibody should not affect the decision to treat or the extent of treatment.

Although demographically AIDS and HIV-positivity target certain segments of the population, probably every specialty will encounter HIV-positive individuals or individuals with the syndrome. As a basic principle, HIV status should not determine the availability of treatment. To impose a duty to treat every HIV-positive patient in a specialty ward/hospital regardless of illness would be unreason-

523. Id.
524. President’s Comm’n, supra note 279, at 142.
525. Specialty wards or hospitals are facilities that are uniquely equipped to treat or care for a subtype of patient (e.g., children) or patients with a certain type of disease (e.g., psychiatric or medical).
able, as a practical matter. The test, therefore, should be one of appropriateness of treatment regardless of HIV status.

9. Accepted/Conventional Therapies.—A patient has the right to be informed of all available traditional therapies which a reasonable physician would deem medically appropriate, where the patient’s HIV antibody status is not an issue.

HIV infection manifests itself as immunosuppression allowing opportunistic infections. This HIV-induced immunosuppression is medically important in determining certain modes of treatment, and the sequelae of such immunosuppressed states are valid medical factors to be considered in making decisions regarding what is “medically appropriate.” The antibody status itself is not a valid medical factor.

10. Experimental Treatment.—A patient has the right to be informed of all available experimental/therapeutic therapies which a reasonable physician would deem medically appropriate in light of protocol restraints.

Nontherapeutic treatments instituted for scientific studies may only be carried out without duress, with full disclosure, and with strict informed consent. The patient’s health may not be jeopardized, nor may the disease condition be exacerbated. If either of these two conditions occur the patient should be withdrawn from treatment. The patient has the right to refuse and/or withdraw from treatment at any time and should be given the opportunity to draw up instruments expressing intentions to that effect in case of future incompetency.

The HIV-positive or AIDS patient might be in a vulnerable position in a scientific study situation where investigators may knowingly or unknowingly take advantage of the patient. Additional safeguards are needed to protect such individuals.

11. Needles and Drug-Addicted Persons.—Providing new, sterile needles to drug-addicted persons is not the method of choice for stopping the spread of HIV infection among this subgroup. Preventing HIV spread via shared needles should be accomplished by dealing with the drug abuse problem itself. An urgent national commitment to educate the public, rehabilitate the current drug addict population, and prevent new drug use should be undertaken. In the interim, public authorities should provide bleach solution at no cost to IV drug users.

The availability of new, sterile needles does not change the
practice of needle-sharing among addicts. In fact, legitimately provided needles have been saved and resold on the underground market. Also, providing additional paraphernalia to a vulnerable segment of society does not stem drug addiction. Providing a bleach solution kit for sterilizing needles is likely to stop the spread of HIV infection without promoting IV drug use. The ideal method of preventing HIV transmission through needle-sharing is to squarely address this Nation's increasing drug dependence.

V. CONCLUSION

Much thought has gone into the recommendations presented by the students in the seminar. While some steps have been taken to combat the problems associated with AIDS, more work is needed. Hopefully the students' recommendations will help stimulate further progress toward developing AIDS policy on the rights and obligations of HCWs.