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WHY THE DEBATE ON RESTRICTING HEALTH CARE WORKERS WITH HIV SHOULD END: A RESPONSE TO PROFESSOR CLOSEN

MARC E. ELOVITZ*

I. INTRODUCTION

Professor Closen's article is eighty-three pages long, with four hundred forty-eight footnotes. To respond to Professor Closen's contentions point by point would require a substantial number of pages and footnotes. That is not the response I have written because I do not think it necessary; in fact, I think it dangerous.

Implicit in Professor Closen's article, and in the Symposium itself, is the idea that the issue of restrictions on health care workers with HIV is a legitimate subject of debate about which reasonable minds may differ. I disagree. Because there is no evidence to support the existence of a significant risk of transmission of HIV to patients, there is no real basis for dispute. Continuing to engage in this debate is not a harmless diversion, nor even just a waste of resources; rather, it furthers discrimination against health care workers with HIV. By its very existence, the debate lends credence to the view that special employment restrictions are justified—and unjustifiably positions freedom from these restrictions at an extreme.

During the Symposium I called upon proponents of restrictions to justify those restrictions. I no longer believe that is enough. I now propose that those who would debate the issue, from either side, must be called on to justify the debate itself.

II. THE CONTEXT

In the Spring of 1996, I was asked to participate in the Symposium, *Job Restrictions and Disclosure Requirements for HIV-Infected Health Care Professionals*,[1] at New York Law School. Because a frequent proponent of such restrictions, Professor Michael Closen, was scheduled

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1. Symposium, *Job Restrictions and Disclosure Requirements for HIV-Infected Health Care Professionals: Whose Privacy Is It Anyway?*, 41 N.Y.L. SCH. L. REV. 5 (1996).

to speak, I felt an obligation to attend and present the opposing viewpoint. As it turned out, on the day of the Symposium I discovered that the other two panelists—Dr. Norton Spritz, Chief of the Medical Service at the New York Veterans Administration Medical Center, and Kathryn Meyer, Senior Vice-President for Legal Affairs and General Counsel of the Beth Israel Medical Center—shared my basic views. Thus, three of us spoke against special restrictions on health care workers (HCWs) with HIV and one in favor. I tried to confront Professor Closen with the lack of evidence of transmission and the significance of this in light of the mandate of federal non-discrimination laws requiring fair treatment of people with HIV.[2] He replied—as he and other proponents of restrictions have in the past—that because HIV could theoretically be transmitted to patients, the government's interest in non-discrimination is trumped.[3] I left the Symposium feeling satisfied that I had done a decent job and that both sides of the debate had been presented. Shortly after, I was told that the Symposium transcript would be published and that Professor Closen would be submitting a full-length article to accompany it. Again, I felt an obligation to respond, concerned that the back-and-forth of the debate captured in the transcript would not be a sufficient response to an entire article from the opposing point of view.

When I began drafting a point-by-point response to Professor Closen's article, however, it occurred to me that there is nothing new to say. The issue of restrictions on HCWs with HIV is far from novel. The bibliography of legal articles addressing this issue is vast.[4] There is no

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2. *Id.* at 30-32.

3. *Id.* at 25-30.

4. Barbara Matthews Anderson, *"First Do No Harm . . .": Can Restrictions on HIV-Infected Health Care Workers Be Justified?*, 33 SANTA CLARA L. REV. 603 (1993); Mark Barnes et al., *The HIV-Infected Health Care Professional: Employment Policies and Public Health*, 18 LAW MED. & HEALTH CARE 311 (1990); Mary Anne Bobinski, *Risk and Rationality: The Centers for Disease Control and the Regulation of HIV-Infected Health Care Workers*, 36 ST. LOUIS U. L.J. 213 (1991); Edward N. Brandt, *Health Care Workers and AIDS*, 48 MD. L. REV. 1 (1989); Michael L. Closen, *A Call for Mandatory HIV Testing and Restriction of Certain Health Care Professionals*, 9 ST. LOUIS U. PUB. L. REV. 421 (1990); Kenneth A. DeVille, *Nothing to Fear But Fear Itself: HIV-Infected Physicians and the Law of Informed Consent*, 22 J. L. MED. & ETHICS 163 (1994); Steven Eisenstat, *The HIV Infected Health Care Worker: The New AIDS Scapegoat*, 44 RUTGERS L. REV. 301 (1992); Chai R. Feldblum, *A Response to Gostin, "The HIV-Infected Health Care Professional: Public Policy, Discrimination, and Patient Safety,"* 19 LAW MED. & HEALTH CARE 134 (1991); Lois Frankel, *Commentary: AIDS Testing of Health Care Workers*, 16 NOVA L. REV. 1161 (1992); Larry Gostin, *The HIV-Infected Health Care Professional: Public Policy, Discrimination and Patient Safety*, 18 LAW MED. & HEALTH CARE 303 (1990); Lawrence Gostin, *CDC Guidelines on HIV or HBV-Positive Health Care Professionals Performing Exposure-Prone Invasive Procedures*, 19

LAW MED. & HEALTH CARE 140 (1991); Lawrence Gostin, *HIV-Infected Physicians and the Practice of Seriously Invasive Procedures*, HASTINGS CENTER REP., Jan.-Feb. 1989, at 32; Donald H.J. Hermann, *Commentary: A Call for Authoritative CDC Guidelines for HIV-Infected Health Care Workers*, 22 J. L. MED. & ETHICS 176 (1994); Scott H. Isaacman, *The Other Side of the Coin: HIV-Infected Health Care Workers*, 9 ST. LOUIS U. PUB. L. REV. 439 (1990); Gordon G. Keyes, *Health-Care Professionals with AIDS: The Risk of Transmission Balanced Against the Interests of Professionals and Institutions*, 16 J.C. & U.L. 589 (1990); Theodore R. LeBlang, *Obligations of HIV-Infected Health Professionals to Inform Patients of Their Serological Status: Evolving Theories of Liability*, 27 J. MARSHALL L. REV. 317 (1994); Karen C. Lieberman & Arthur R. Derse, M.D., *HIV-Positive Health Care Workers and the Obligation to Disclose*, 13 J. LEGAL MED. 333 (1992); Mary K. Logan, *Who's Afraid of Whom? Courts Require HIV-Infected Doctors to Obtain Informed Consent of Patients*, 44 DEPAUL L. REV. 483 (1995); Janice K. Lunde, *Informed Consent and the HIV-Positive Physician*, 38 MED. TRIAL TECH. Q. 186 (1991); Donald J. McNeil & Laurie A. Spieler, *Mandatory Testing of Hospital Employees Exposed to the AIDS Virus: Need to Know or Unwarranted Invasion of Privacy?*, 21 LOY. U. CHI. L.J. 1039 (1990); Sandra L. Mitchell, *Employment Issues Facing HIV-Infected Health Care Workers*, 3 J. PHARMACY & L. 5 (1993-1994); Brenda S. Reid, *HIV in the Health Care Workplace: Challenges Involving HIV-Infected Employees and Physicians*, 14 WHITTIER L. REV. 24 (1993); Reed E. Schaper, *HIV in the Health Care Workplace: Challenges Involving HIV-Infected Employees and Physicians*, 14 WHITTIER L. REV. 33 (1993); Wm. Clark Stanton, *HIV in the Health Care Workplace: Challenges Involving HIV-Infected Employees and Physicians*, 14 WHITTIER L. REV. 15 (1993); Patricia S. Atkins, Note, *The Constitutional Implications of Mandatory AIDS Testing in the Health Care Industry*, 17 SW. U. L. REV. 787 (1988); Jane H. Barney, Comment, *A Health Care Worker's Duty to Undergo Routine Testing for HIV/AIDS and to Disclose Positive Results to Patients*, 52 LA. L. REV. 933 (1992); Arthur J. Becker, Jr., Comment, *The Competing Interests in HIV Disclosure for Infected Health Care Workers: The Judicial and Legislative Responses*, 97 DICK. L. REV. 777 (1993); P. Dean Brinkley, Comment, *Health Care Worker's Legal Duty to Disclose HIV-Positive Status to Patients Before Performing Invasive Procedures*, 29 TULSA L.J. 429 (1993); Stacey Turner Caldwell, Casenote, *Discrimination or Protection of the Public: An Examination of* Estate of Behringer v. Medical Center at Princeton, 14 GEO. MASON L. REV. 469 (1991); Jeffery W. Cavender, Note, *AIDS in the Health Care Setting: The Congressional Response to the Kimberly Bergalis Case*, 26 GA. L. REV. 539 (1992); Susan L. DiMaggio, Note, *State Regulations and the HIV-Positive Health Care Professional: A Response to a Problem That Does Not Exist*, 19 AM. J.L. & MED. 497 (1993); Vallori K. Hard, Comment, *Mandatory Disclosure of AIDS Status by Health Care Workers*, 21 W. ST. U. L. REV. 295 (1993); Jennifer Hertz, Comment, *Physicians With AIDS: A Proposal for Efficient Disclosure*, 59 U. CHI. L. REV. 749 (1992); Mark D. Johnson, Comment, *HIV Testing of Health Care Workers: Conflict Between the Common Law and the Centers for Disease Control*, 42 AM. U. L. REV. 479 (1993); Thomas E. Margolis, Commentary, *Health Care Workers and AIDS*, 13 J. LEGAL MED. 357 (1992); Joel Neugarten, Note, *The Americans With Disabilities Act: Magic Bullet or Band-Aid for Patients and Health Care Workers Infected with the Human Immunodeficiency Virus?*, 57 BROOK. L. REV. 1277 (1992); R. Bradley Prewitt, Comment, *The "Direct Threat" Approach to the HIV-Positive Health Care Employee*

new medical or scientific information supporting restrictions on health care workers. Indeed, not one documented case exists where a patient contracted HIV from a health care worker.[5] The only medical news is that, with all of the HCWs with HIV continuing in their employment, there continues to be no evidence of transmission. And, as for the courts, little is up for discussion. The courts continue, as they have for several years, to uphold employment discrimination against people with HIV despite the lack of evidence of its transmission.[6] These courts have disregarded the non-discrimination mandate of the disability rights statutes, relying instead on fear of the perceived fatality of HIV and the fact that scientists cannot say that HIV transmission from HCW to patient could never happen.[7]

Under the ADA, 62 MISS. L.J. 719 (1993).

5. Studies of the HIV status of patients of HCWs with HIV show that not one case of transmission to a patient has been documented. *See* Laurie M. Robert et al., *Investigations of Patients of Health Care Workers Infected with HIV*, 122 ANNALS INTERNAL MED., 653, 653-57 (1995). While there is one widely reported case of possible transmission, the Centers for Disease Control has not been able to establish—despite extensive investigation—how, or even if, that case involved transmission from a dentist to several of his patients. *Id.*

6. Doe v. University of Md. Med. Sys. Corp., 50 F.3d 1261 (4th Cir. 1995); Bradley v. University of Tex. M.D. Anderson Cancer Ctr., 3 F.3d 922 (5th Cir. 1993); Mauro v. Borgess Med. Ctr., 886 F. Supp. 1349 (W.D. Mich. 1995); Scoles v. Mercy Health Corp., 887 F. Supp. 765 (E.D. Pa. 1994); Doe v. Washington Univ., 780 F. Supp. 628 (E.D. Mo. 1991); Leckelt v. Board of Comm'rs, 714 F. Supp. 1377 (E.D. La. 1989), *aff'd*, 909 F.2d 820 (5th Cir. 1990); Estate of Behringer v. Medical Ctr., 592 A.2d 1251 (N.J. Super. Ct. Law Div. 1991); *In re* Milton S. Hershey Med. Ctr., 595 A.2d 1290 (Pa. Super. Ct. 1991), *aff'd*, 634 A.2d 159 (Pa. 1992).

7. The Supreme Court has noted that "[f]ew aspects of a handicap give rise to the same level of public fear and misapprehension as contagiousness." School Bd. v. Arline, 480 U.S. 273, 284 (1987). *See, e.g.*, *Bradley*, 3 F.3d at 922 (stating that although the risk of HIV transmission from doctor to patient may be "exceedingly low," it is nevertheless real); *Doe*, 780 F. Supp. at 633 (granting summary judgment in favor of dental school that disenrolled an HIV infected student because of the risk of HIV transmission from student to patient during invasive procedures); *Leckelt*, 714 F. Supp. at 1377 (concluding that although the probability of an HCW transmitting HIV to a patient may be extremely low, no cure exists for HIV or AIDS, and the potential harm of infection is extremely high); *Hershey*, 595 A.2d at 1290 (affirming trial court's order that physician disclose his identity after physician exposed HIV-positive blood to patient; court reasoned that disclosure was necessary because HIV is infectious and full-blown AIDS is always fatal).

III. Professor Closen's Article

Because there is nothing new to say about restrictions on HCWs with HIV, I think it is useful to look at exactly what Professor Closen does say in his article. The article is built upon an erroneous assumption about the likelihood of transmitting HIV from HCW to patient. Professor Closen justifies restrictions on HCWs with HIV based only on the theoretical risk of transmission. He claims that "numerous patients" have been infected even though not one documented case exists.[8] He repeatedly cites one court's unfounded assumption that a "staggering" number of patients have been infected.[9] And in one of the least explicable passages of the article, Professor Closen seems to suggest that barbers present a risk of HIV transmission, citing no less a medical authority than conservative Judge Richard Posner.[10] When it comes right down to it, Professor Closen relies on the assumption that because he can imagine transmission from HCWs to patients it must occur.[11] His only proofs are models and estimates of transmission built upon that assumption.[12]

To back up this faulty view of the likelihood of transmission, Professor Closen cites public opinion polls and federal court rulings showing that people are afraid that HIV can be transmitted from HCWs

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8. The fact that there are no documented cases of transmission does not prove that transmission could never happen in a health care setting where universal precautions are used; rather, it shows that the risk is extremely low. Professor Closen's example of a documented case of transmission of HIV by biting in 1994 does not mean that it had been wrong to say that the risk of transmission by biting is very low. *See* Michael L. Closen, *HIV-AIDS Infected Surgeons and Dentists and the Medical Profession's Betrayal of Its Responsibility to Patients*, 41 N.Y.L. SCH. L. REV. 57, 79-80. The important question is whether we shape policy based on extraordinarily rare circumstances. For example, does Professor Closen believe that the single biting case means that the thousands of children with HIV in this country should be kept out of school? After all, Closen apparently believes that HCWs with HIV should be forced out of their jobs based on an assumption of transmission that has not even been born out by a documented case. *See id.*

9. *Id.* at 80 n.99.

10. *See id.* at 97 n.234.

11. He repeatedly lays out a chain of causation that seems to makes sense: an HIV-infected surgeon cuts himself with a sharp instrument, and then bleeds into the patient's body. *See id.* at 58 n.2, 65 n.36. But this imagined scenario ignores infection control procedures, such as gloves and blunt-ended instruments that break the chain, as well as the difficulty of connecting sufficient quantities of a surgeon's blood with a patient's blood to result in transmission of the virus.

12. *See id.* at 61 n.20, 62 n.24.

and want to avoid this possibility.[13] He cites data that eighty to ninety percent of people polled want mandatory testing of HCWs.[14] But since when do we decide cases based on popular vote?[15] Incredibly, he relies on public opinion to justify restrictions on HCWs with HIV, yet when public opinion goes too far even for him, he says that it should not be followed.[16] Professor Closen offers no explanation as to how to determine when law by popular vote will be followed and when the public will be dismissed as "not . . . well informed and precise."[17]

Professor Closen also touts the "twenty-five to thirty state and federal trial and appellate judges" who have upheld restrictions against HCWs with HIV.[18] But, since when do we decide whether cases are properly decided by counting the number of judges who voted a certain way? If Professor Closen is interested in counting judges,p he might consider the number of Supreme Court Justices who held that unfounded fears of transmission of tuberculosis did not justify discrimination against a schoolteacher.[19]

In addition to exaggerating the likelihood of transmission, Professor Closen entirely avoids discussion of the non-discrimination mandate, in which context the issue of restrictions on HCWs with HIV arises.[20] People with HIV, including HCWs, are covered by non-discrimination laws that prevent unequal treatment without justification.[21] Professor Closen assumes that any risk of transmission—no matter how small or theoretical—provides a justification for discrimination against HCWs with HIV.[22] This type of thinking is exactly why disability non-discrimination laws are so important: to ensure that the treatment of people with

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13. His discussion of public opinion is not a mere aside—he includes an entire section titled "Public Opinion." *Id.* at 97.

14. *See id.* at 97 n.235.

15. *But see* ROBERT H. BORK, SLOUCHING TOWARDS GOMORRAH (1996) (proposing popular votes following court rulings).

16. *See* Closen, *supra* note 8, 97 n.235 (advocating limited testing of HCWs although the public supports testing of all HCWs).

17. *Id.*

18. *Id.* at 88-89.

19. *See* School Bd. v. Arline, 480 U.S. 273, 275 (1987) (If he were so inclined, Professor Closen would count seven: Brennan, J., delivered the opinion, and White, Marshall, Blackmun, Powell, Stevens, and O'Connor, JJ., joined.).

20. *See* Closen, *supra* note 8, at 64 n.32.

21. *See* Americans with Disabilities Act of 1990, 42 U.S.C. § 12112 (1994); Rehabilitation Act of 1973, 29 U.S.C. §§ 701-97 (1990).

22. *See* Closen, *supra* note 8, at 65.

disabilities is based on facts, not the fears and stereotypes that have traditionally limited their opportunities.

Professor Closen's discussion of HCWs with HIV is framed in terms of an arrogant and powerful group—health care workers—putting their egos and profits ahead of the safety of their patients.[23] According to Professor Closen, there is a "conspiracy of silence" among medical professionals in which "patients are viewed to be expendable" by doctors with "runaway egos."[24] But despite the hyperbole, HCWs with HIV are not a good illustration of the medical establishment's abuse of power. Unlike the researchers in Tuskegee, repeatedly cited in the article as analogous,[25] HCWs with HIV who follow universal infection control precautions do not subject patients to a significant risk of harm.[26]

Professor Closen devotes a significant part of the article to explaining how a wide range of legal claims might be made with regard to HCWs with HIV.[27] He discusses medical malpractice, negligence, intentional tort claims that allow punitive damages (claims such as battery, fraud, intentional infliction of emotional distress, and breach of fiduciary duty or implied contract), and criminal charges.[28] Professor Closen addresses these theories in detail, finding—not surprisingly—that they each offer grounds for recovery against a HCW with HIV.[29] He calls, as he has elsewhere,[30] for mandatory testing of HCWs and notes that "[t]he public opinion data . . . show that such measures would be quite popular with the public."[31] He also calls for "sizable" punitive damages awards for plaintiffs in these cases to punish and to deter other HCWs from committing "such abuses."[32]

Professor Closen does not just write about such cases—he also brings them. In his article, he discloses that he has brought a class action suit on behalf of HIV-negative people who were treated by a dental student with

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23. *See id.* at 59, 72, 81, 103-04.

24. *Id.* at 116-17.

25. *See id.* at 62.

26. In addition, a strong social policy reason exists for HCWs not to disclose their HIV status—the unfounded but pervasive fears of the public that would significantly harm, if not destroy, their careers.

27. *See* Closen, *supra* note 8, at 122-23.

28. *See id.*

29. *See id.*

30. *See* Michael L. Closen, *A Call for Mandatory HIV Testing and Restriction of Certain Health Care Professionals*, 9 ST. LOUIS U. PUB. L. REV. 421 (1990).

31. Closen, *supra* note 8, at 133.

32. *Id.* at 132.

HIV.[33] The patients sought money damages based on the patients' fear that they might have been infected by the student.[34] Closen makes much of their suffering: "Imagine the feelings of shock, anger, frustration, despair and betrayal."[35] The greater the fear, the greater the suffering and the greater the money damages award will be. It is not surprising then, that Professor Closen's article maintains that the risk of transmission is significant and that fears of such transmission are reasonable.[36]

IV. THE DEBATE

The debate in which Professor Closen engages, both in his article and in his litigation, is not a new one. Because there is no new evidence showing a risk of transmission greater than that which we have known for several years, the important point to address is why we keep this debate going. We support the status quo—discrimination against HCWs with HIV—by engaging in debate that implies that there are reasonable grounds for dispute. There has never been a justification for discriminating against HCWs with HIV, but unfortunately, that fact is overshadowed by our continued debate over whether or not such discrimination is justified. Meanwhile, year after year, discrimination against HCWs with HIV has continued and courts have upheld such discrimination with a view to playing it safe while the debate goes on.

For example, the court in one case upheld a policy restricting HCWs with HIV on the basis that "[r]easonable persons professing knowledge of the subject matter may differ as to whether there is 'any' risk involved in an invasive surgical procedure by a surgeon carrying [HIV]."[37] Similarly, Professor Closen writes:

> If we assume that at least some of the medical experts on each side of the fight are capable, qualified, and rational, it would appear the ultimate conclusion to be drawn for the time being is that reasonable medical experts are uncertain about the extent of danger of HIV transmission to patients.[38]

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33. *See id.* at 60, 129, 132, 138.

34. *See id.* at 132.

35. *Id.* at 91.

36. *See id.* at 132-33.

37. Estate of Behringer v. Medical Ctr., 592 A.2d 1251, 1277 (N.J. Super. Ct. Law Div. 1991).

38. Closen, *supra* note 8, at 104-05.

First, I do not assume the capability, qualifications or rationality of medical experts who support restrictions on HCWs with HIV.[39] Even more importantly, I do not conclude that there is a "relevant" degree of uncertainty as to the danger of transmission. A theoretical risk which a doctor might note does not constitute a "significant risk" for purposes of non-discrimination laws. In other words, just because we can never say that something with a theoretical risk will never happen does not mean that this risk justifies the destruction of careers.

Another way that the debate skews understanding of this issue is the argument that because a "reasonable" disagreement over the likelihood of transmission continues, some middle ground or compromise position as to restrictions should be reached. For Professor Closen, the reasonable compromise is to restrict HCWs who perform procedures he considers invasive.[40] Others view lesser or greater restrictions as a reasonable compromise,[41] but the question should be why a compromise is sought when no evidence supports restrictions at all.

The ongoing debate has ramifications beyond the issue of HCWs with HIV. For example, in *Weeks v. State*,[42] a ninety-nine year sentence for attempted murder was upheld on the notion that HIV could be transmitted by spitting, even though such transmission is only a "theoretical possibility" and has never happened.[43] In *Abbott v. Bragdon*,[44] a dentist argues that he should be allowed to refuse treatment to a patient with HIV because of the risk that the patient will transmit the virus to him.[45]

The debate promotes unreasonable fears of transmission—fears that are encouraged and exacerbated by money damages claims for recovery based on those fears. Fearing liability, hospitals sometimes try to err on

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39. For example, one of the "experts" who testified whether HIV can be transmitted by spitting was a non-medical doctor who "resigned from the American Psychological Association to avoid charges of his unethical conduct as a psychologist," and who a federal judge in another case found had "made misrepresentation to this Court" in his capacity as an "expert" witness. Baker v. Wade, 106 F.R.D. 526, 536-37 n.31 (N.D. Tex. 1985). Despite his lack of credentials and his history, the court in *Weeks v. State* accepted his testimony that HIV could be transmitted. 834 S.W.2d 559, 562-63 (Tex. Crim. App. 1992, pet. ref'd).

40. Closen, *supra* note 8, at 104-05.

41. *See, e.g.*, Barnes et al., *supra* note 4; Eisenstat, *supra* note 4. *But see, e.g.*, Estate of Behringer v. Medical Ctr., 592 A.2d 1251 (N.J. Super. Ct. Law Div. 1991).

42. 834 S.W.2d 559.

43. *Id.* at 563.

44. 912 F. Supp. 580 (D. Me. 1995), *appeal docketed*, No. 96-1643 (1st Cir. May 13, 1996).

45. *Id.* at 587.

the safe side by restricting practice by HCWs with HIV and by sending letters warning patients who have been treated by HCWs with HIV. Professor Closen criticizes hospitals for setting policies about HCWs with HIV without informing patients,[46] but he ignores the fact that the fear of liability drives this practice.

By exaggerating the fear of transmission from HCW to patient, the debate encourages discrimination against HCWs with HIV, as well as against HCWs who are perceived to have HIV or to be at a greater risk of having HIV. Again, Professor Closen encourages such discrimination with his fear-based money damages suits. In one case Professor Closen is litigating, the plaintiff class alleges that the defendant dental student should have warned his patients that he was sexually active with other men.[47] Does this mean that *all* HCWs should warn their patients if they have sex, or only gay men? What about a heterosexual woman who suspects her husband of using intravenous drugs, or of having sex with men—must she warn her patients of these possibilities? If Professor Closen believes in giving patients as much information as he says he does, and he believes that information about a HCW's HIV-risk activities is relevant to patients, then where would he draw the line? Would HCWs be required to tell all potential patients about any behavior that could possibly lead to HIV infection? No matter how likely that the disclosure would subject them to unjustified discrimination? These extreme results, mandated by Professor Closen's arguments, show the broad-ranging effects of the skewed debate on HCWs with HIV.

V. CONCLUSION

Readers looking for a detailed explanation of why special restrictions on HCWs with HIV are not justified should look elsewhere.[48] The point of this response is that the detailed explanation has already been made, and no new evidence exists to change it. Continuing to debate the issue presents a skewed version of the facts to the public, the courts, and ourselves. I therefore respond to Professor Closen's article, and the Symposium for which it was written, with a call that we consider the debate itself. Perhaps then, we will realize the way it supports the status quo of discrimination and the even broader harms it engenders.

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46. *See* Closen, *supra* note 8, at 58 n.2.

47. *See id.* at 120-21.

48. *See, e.g.*, Ad Hoc Comm. on AIDS, Association of the Bar of the City of N.Y., *HIV-Infected Health Care Workers and Employment Discrimination Law*, 51 RECORD 246 (1996), *reprinted in* 41 N.Y.L. SCH. L. REV. 151 (1996); Anderson, *supra* note 4; Eisenstat, *supra* note 4; McNeil & Spieler, *supra* note 4.