NEW YORK LAW SCHOOL

NYLS Law Review

Volume 41
Issue 1 *Volume XLI, Number 1, 1996*

Article 6

January 1996

REPORT OF THE AD Hoc COMMITTEE ON AIDS: HIV-INFECTED HEALTH CARE WORKERS AND EMPLOYMENT DISCRIMINATION LAW

The Association of the Bar of the City of New York *

REPORT OF THE AD HOC COMMITTEE ON AIDS:* HIV-INFECTED HEALTH CARE WORKERS AND EMPLOYMENT DISCRIMINATION LAW**

THE ASSOCIATION OF THE BAR OF THE CITY OF NEW YORK

Federal law prohibits unjustified employment discrimination on the basis of Human Immunodeficiency Virus (HIV) infection[1] by all programs receiving federal financial assistance or having federal contracts[2] or employing fifteen or more workers.[3] In many jurisdictions state or local law also prohibits such discrimination. Discrimination is considered to be justified if it is necessary to avoid a "direct threat" to the health or safety of others.[4] The United States Supreme Court has ruled that individuals

---

* Ad Hoc Committe on AIDS: Susan Lyn Hendricks (Chair), M. David Zurndorfer (Secretary), Marjorie E. Berman, Richard F. Bernstein, Elizabeth B. Cooper, Trilby E. De Jung, Laura E. Drager, Marc E. Elovitz (member of the Subcommittee on HIV-Infected Health Care Workers), David A. Hansell, Alan M. Koral (member of the Subcommittee on HIV-Infected Health Care Workers), Edward S. Kornreich, Arthur S. Leonard (Chair of Subcommittee on HIV-Infected Health Care Workers), Lori R. Levinson, Nancy B. Mahon, Catherine H. O'Neill, William J. Rold, Cynthia J. Schneider, Michael R. Sonberg, Norton Spritz. The Subcommittee acknowledges the research assistance of Helen Ullrich, New York Law School 1996.

** This report is reprinted with permission from *The Record* of The Association of the Bar of the City of New York, © 1996. 51 THE RECORD 246 (1996). The report has been reprinted in its original form. No revisions have been made by the editorial staff of the *New York Law School Law Review.*

1. HIV is believed by medical researchers to be a causative agent in the development of Acquired Immunodeficiency Syndrome (AIDS). Legislative history and court decisions have established that HIV infection is a disability covered under federal discrimination law. *See* U.S. Sen. Comm. on Labor and Human Resources, Aug. 30, 1989 at 22, citing U.S. Dept. of Justice, *Application of Sec. 504 of the Rehabilitation Act to HIV-Infected Individuals*, Sept. 27,1988, at 9-11, 28 C.F.R. §36.104(1)(B)(ii)(DOJ regulation). *See also,* Doe v. Dolton Elementary School Dist. No. 148, 694 F.Supp. 440 (N.D.Ill. 1988)(holding that HIV-infected student would likely prevail in showing that he was "handicapped individual"); Doe v. Atty. Gen. of U.S., 723 F.Supp. 452 (N.D.Cal. 1989)(holding that AIDS is a "handicap" for purposes of the Rehabilitation Act); Howe v. Hull, 873 F.Supp. 72 (N.D.Ohio 1995)("AIDS and HIV infection are both disabilities within the meaning of the ADA"). *But see* Ennis v. Nat'l Ass'n of Bus. & Ecuc. Radio, Inc., 53 F.3d 55, 59-60 (4th Cir. 1995) (noting in dicta that HIV infection should not be a *per se* disability).

2. Secs. 503 and 504, Rehabilitation Act of 1973, 29 U.S.C.§793, 794(a).

3. Title I, Americans With Disabilities Act, 42 U.S.C. §12111(5)(A). Under both ADA and the Rehabilitation Act, having a disability includes having a record of a disability and being perceived as having a disability.

4. See 29 U.S.C.§706(D) and 42 U.S.C. §12113(b).

with contagious diseases who are otherwise able to perform their jobs are protected from discrimination unless their condition presents a "significant risk" of transmission to others in the workplace.[5]

Despite these legal principles, health care workers who either have HIV infection or were believed by their employers to have HIV infection have been notably unsuccessful in winning reinstatement to their jobs in federal disability discrimination litigation.[6] Almost without exception, federal courts have adopted an approach that finds HIV-infected health care workers to present a significant risk of transmission,[7] even though there have been no documented cases of HIV transmission by surgeons, surgical technicians, or nurses while providing care to patients.[8] A review of the facts about HIV transmission and the relevant legal principles shows that the federal courts have erred with respect to both the facts and the law in their interpretation and application of federal disability law. In the absence of unusual circumstances, HIV-infected health care workers should be allowed to practice their profession.

I. HIV TRANSMISSION

HIV is a blood-borne virus. Since the AIDS epidemic was first documented by the CDC in the early 1980s, epidemiological study of reported cases has identified a limited number of ways that the virus can be transmitted. The most common means of transmission are through sexual intercourse or shared use of hypodermic injecting equipment. Prior to the development and licensing of a screening test for blood, transmission also occurred through blood transfusions and the use of blood-based products, such as clotting medication used by hemophiliacs. There are also documented cases of HIV transmission from infected mothers to children in utero, or during childbirth or breastfeeding. However, there is no evidence that HIV is spread through kissing,

---

5. School Bd. of Nassau County, Fla. v. Arline, 480 U.S. 273, 289, 107 S.Ct. 1123, 1132 (1987).

6. Reinstatement with backpay is the primary remedy under federal employment discrimination law. *See* 42 U.S.C. §12117.

7. *See infra* Part III.

8. The only case of suspected occupational transmission by a health care worker involved a Florida dentist, Dr. David Acer. Despite extensive investigation, the Centers for Disease Control and Prevention have been unable to establish how Dr. Acer might have transmitted HIV to several of his patients, or even whether the transmission might have been among patients and from a patient to Dr. Acer. ANN. INTERN. MED. 1992: 116:798-804, ANN. INTERN. MED. 1994; 121:886-88. Unfortunately, this one case - out of millions of health care worker/patient contacts - has shaped much of the debate about discrimination against HIV-infected health care workers.

touching or breathing. Furthermore, despite widespread fears that were actually embodied in an amendment to the Americans With Disabilities Act,[9] there is no evidence that HIV can be spread to restaurant patrons by HIV-infected food workers. Indeed, in most workplaces, the presence of an HIV-infected worker indisputably presents no significant risk to others.

One workplace where HIV transmission is a legitimate and serious concern, however, is the health care institution, where the possibility of acquiring HIV infection is a real occupational risk for health care workers. Some nurses, surgeons, and emergency medical service workers have acquired HIV infection through blood exposure during surgery, emergency treatment of bleeding patients, and through needle-stick or other accidental exposures to patient blood.[10] It is estimated that hundreds of health care workers have become infected - many through occupational exposure - in the two decades that HIV has been present in the United States. The phenomenon of HIV transmission from patients to health care workers has received considerable study, and the CDC has been able to calculate the likelihood that a health care worker will acquire HIV-infection as being small but not negligible.[11] The response of the Centers For Disease Control has been to publish Guidelines requiring that all health care workers take "universal precautions", i.e. basic health care practices that minimize contact with bodily fluids, when dealing with patients.[12]

Many, perhaps most, HIV-infected health care workers have continued their normal work routines for considerable periods of time without knowing that they were infected.[13] Others, knowing of their infection

---

9. *See* 42 U.S.C. 12113(d). Such fears led to the passage of this amendment which requires that the Secretary of Health and Human Services gather information regarding infectious and communicable diseases which may be transmitted through food handling and disseminate such information to the general public. The Secretary, however, has not designated AIDS as a condition subject to this provision.

10. Of course, some health care workers have acquired HIV infection outside their workplaces, through the other identified mechanisms of infection.

11. *See, e.g.*, Gerberding, Bryant-LeBlanc, et al, *Risk of Transmitting The Human Immunodeficiency Virus, Cytomegalovirus, and Hepatitis B Virus To Health Care Workers Exposed To Patients With AIDS and AIDS-Related Conditions,* 156 J. INFECTIOUS DISEASES 1-8 (1987); American Bar Association AIDS Coordinating Committee, *Calming AIDS Phobia: Legal Implications of the Low Risk of Transmitting HIV in the Health Care Setting*, 28 U. MICH. J. L. REFORM 733, 739-42 (1995) (hereinafter "ABA AIDS Coordinating Committee Report").

12. 52 C.F.R. 41818 (1987).

13. This is particularly likely to have occurred among health care workers who were not infected through occupational exposure. For example, a woman may unwittingly acquire HIV infection through sexual intercourse with an infected man and, in the absence of overt symptoms, not learn of her infection for years. However, during the

and fearing discrimination, have continued to work while keeping their HIV status a secret. By now, midway through the second decade of the AIDS epidemic in the United States, thousands of patients have been treated by HIV-infected surgeons and other health care professionals in procedures that include the possibility of blood exposure. Numerous studies have been conducted of the patients of those health care workers (including surgeons) whose HIV status became known. As of mid-1995, there is not one documented case where a patient contracted HIV from an infected health care worker.[14]

Despite the lack of any confirmed cases of health care worker to patient transmission to form the basis for a calculation, the CDC has estimated the likelihood of transmission from an infected health care worker to a patient as between 0.0024% (1 in 42,000) and 0.00024% (1 in 417,000), using the transmission rate from patients to health care workers in needle-stick injury as a basis for statistical modelling.[15] The CDC produced these estimates in response to speculation that a Florida dentist, Dr. David Acer, had transmitted HIV to several of his patients during the course of treatment. Although DNA analysis showed that the dentist and his patients were infected by the same strain of the virus, the CDC has never been able to establish conclusively whether the virus was actually transmitted by the dentist to his patients, or how it was transmitted. Neither has the CDC established that the risks of HIV transmission in the course of dental treatment provide an appropriate basis for drawing conclusions about transmission risk during other types of health care procedures.

---

early years of the epidemic, and certainly before the HIV-antibody screening test was available, workers who suffered needle-stick injuries might have gone for considerable periods of time before learning of their positive HIV status. By contrast, since the inception of the screening test, health care workers who suffer needle-stick injuries routinely seek testing.

14. A summary review of ongoing research on the HIV status of patients of HIV-infected health care workers published in the May 1, 1995 issue of *Annals of Internal Medicine* confirmed that, apart from the dental cases involving Dr. Acer, not one case of health care worker-to-patient transmission had been documented. As mentioned above, the CDC investigation of the Acer case has not resulted in a definite determination of how HIV infection was spread among his patients. *See* Laurie M. Roberts et al., *Investigations of Patients of Health Care Workers Infected With HIV,* 122 ANN. OF INTERN. MED. 653-57, May 1, 1995; Wendy K. Mariner, *AIDS Phobia, Public Health Warnings, and Lawsuits: Deterring Harm or Rewarding Ignorance?*, 85 AM. J. PUB. HEALTH 1562, November, 1995.

15. *See* Doe v. University of Maryland Medical System Corp., 50 F.3d 1261, 1263 (4th Cir. 1995) (citing CDC, *Open Meeting on the Risks of Transmission of Blood-borne Pathogens to Patients During Invasive Procedures*, Feb. 21-22, 1991).

II. THE LEGAL FRAMEWORK

When claims of discrimination based on AIDS or HIV infection began to reach the courts in the mid-1980s, they were dealt with under Section 504 of the Rehabilitation Act of 1973, a federal law that prohibits disability discrimination by programs receiving federal financial assistance, or under existing state or local laws forbidding employment discrimination on the basis of handicapping conditions.[16] However, at that time there was no definitive judicial precedent establishing that persons with contagious conditions were protected by disability discrimination law.

In 1987, the United States Supreme Court ruled in *School Board of Nassau County, Florida v. Arline*[17] that a person with a contagious condition could be considered "handicapped" under Section 504, provided that her condition met the literal requirements of "a physical or mental impairment which substantially limits one or more of such person's major life activities" or otherwise fulfilled the Act's extension of coverage to persons who had a record of such an impairment or who were regarded as having such an impairment. Focusing on the facts of *Arline,* which involved an elementary school teacher with recurrent active tuberculosis, the Court held that the factor of contagiousness was relevant to determining whether the individual was qualified, despite her handicapping condition, to continue working. In a footnote, the Court stated:

> A person who poses a significant risk of communicating an infectious disease to others in the workplace will not be otherwise qualified for his or her job if reasonable accommodation will not eliminate that risk. The Act would not require a school board to place a teacher with active, contagious tuberculosis in a classroom with elementary school children.

The Court instructed the district court to undertake "an individualized inquiry" to determine whether the individual presented a "significant risk."[18]

> In the context of the employment of a person handicapped with a contagious disease, we agree with amicus American Medical Association that this inquiry should include:

---

16. Arthur S. Leonard, *Employment Discrimination Against Persons With AIDS,* 10 U. DAYTON L. REV. 681 (Spring 1985).

17. 480 U.S. 273 (1987).

18. *Id.* at 288-89.

> (findings of) facts, based on reasonable medical judgments given the state of medical knowledge, about (a) the nature of the risk (how the disease is transmitted), (b) the duration of the risk (how long is the carrier infectious), (c) the severity of the risk (what is the potential harm to third parties) and (d) the probabilities the disease will be transmitted and will cause varying degrees of harm.
>
> In making these findings, courts normally should defer to the reasonable medical judgments of public health officials. The next step . . . is for the court to evaluate, in light of these medical findings, whether the employer could reasonably accommodate the employee under the established standards for that inquiry.

Congress subsequently codified this approach in amendments to the Rehabilitation Act and the later-enacted Americans With Disabilities Act.[19] Congress provided that employees who present a "direct threat" of transmission of contagious conditions in the workplace could be excluded, and noted in legislative history that the analysis set forth by the Supreme Court in *Arline* was to be used in evaluating individual cases.[20] Courts deciding discrimination claims by HIV-infected health care workers have cited *Arline* as the authoritative source of interpretive guidance to the requirements of Section 504 and the ADA.[21]

III. COURT DECISIONS INVOLVING HIV-INFECTED HEALTH CARE WORKERS

No HIV-infected health care worker has ever won reinstatment from a court that purported to apply the *Arline* standards. Rather, apparently ignoring the requirement that an individualized assessment of risk be made and that "reasonable medical judgments of public health officials" receive judicial deference[22], courts have interpreted the *Arline* standard so as to disqualify from protection any individual with a contagious condition where the following two requirements are met: (1) the contagious agent, if transmitted, may prove fatal; and (2) there is any risk, no matter how

---

19. *See* Civil Rights Restoration Act, 1988-89 (adding "(3) Direct threat, The term 'direct threat' means a significant risk to the health or safety of others that cannot be eliminated by reasonable accommodation"); 42 U.S.C. §12111(3).

20. *See supra* n.1, at 27, stating that determination that a person would pose a direct threat to others must be made on a case-by-case basis, consistent with the standards set forth in *Arline*.

21. *See infra*, part III.

22. *Arline*, 480 U.S. at 288.

small or theoretical, that the contagious agent will be transmitted occupationally. In short, the courts have adopted a "zero risk" approach in determining whether HIV-infected health care workers are "qualified" to continue working despite their disability.[23]

The decision of the United States Court of Appeals for the Fourth Circuit in *Doe v. University of Maryland Medical System Corporation*[24] illustrates this analytical process. The case involved a neurosurgery resident (identified as Dr. Doe) who suffered a needle-stick injury and subsequently tested HIV-seropositive. He was suspended from performing surgery and the hospital referred his case to an internal panel of experts on blood-borne pathogens. The panel recommended that Dr. Doe be allowed to resume practicing surgery except for certain procedures considered particularly risky due to the use of exposed wire,[25] but did not recommend that Doe be required to disclose his HIV status to patients. The hospital administration, however, rejected the panel's recommendation. It permanently suspended Doe from practicing neurosurgery at the hospital and instead offered him alternative residencies in non-surgical fields. Doe claimed that this violated his employment rights under federal disability law.

After invoking the *Arline* formula for determining whether an individual presents a significant risk that cannot be eliminated by reasonable accommodation, the court concluded that Doe did not qualify for protection. It reasoned:

> Although there may presently be no documented case of surgeon-to-patient transmission, such transmission clearly is possible. And, the risk of percutaneous injury can never be eliminated through reasonable accommodation. . . . Thus, even if Dr. Doe takes extra precautions (such as wearing two pairs of

---

23. The only exception to date is a recent unpublished decision by the United States Court of Appeals for the Ninth Circuit concerning a doctor whose contract to perform physical examinations was terminated by the Federal Bureau of Investigation, ostensibly because the Bureau lost confidence in the doctor when he would neither confirm nor deny rumors that he had AIDS. Significantly, the Circuit Court's decision came well after the death of the doctor, thus reducing the claim to one for money damages by his estate rather than one for "reinstatement" or specific performance of his contract with the Bureau. In addition, this case is significantly different from other HIV-infected health care worker cases addressed by courts because it is unlikely that a doctor performing routine physical examinations will be undertaking invasive procedures presenting any measurable risk of HIV transmission. Doe v. Atty Gen. of the U.S., 62 F.3d 1424 (9th Cir., June 30, 1995) (table - unpublished disposition) (text available at 1995 WL 392178).

24. 50 F.3d 1261 (1995).

25. *Id.* at 1262.

> gloves, making stitches with only one hand, and using blunt-tipped, solid-bore needles) some measure of risk will always exist because of the type of activities in which Dr. Doe is engaged.

The court placed significant weight on the evidence that the hospital's "decision to terminate Dr. Doe was thoroughly deliberated."

> UMMSC carefully reviewed the recommendations of the panel on blood-borne pathogens, which in turn considered all then-current knowledge of the transmissibility of HIV in the health-care setting. In spite of the low risk of transmission, UMMSC made a considered decision to err on the side of caution in protecting its patients. And, there is nothing in the record to indicate that UMMSC acted with anything other than the best interests of its patients and Dr. Doe at heart.

What the court left unsaid is that UMMSC *rejected* the recommendation of its expert panel, which had concluded that Dr. Doe would *not* present a significant risk of HIV transmission to patients if he refrained from performing certain procedures. That the decision to remove Dr. Doe from the surgery residency was "thoroughly deliberated" is irrelevant under Section 504 and the ADA Title I; according to *Arline,* what is relevant is whether the best available advice from medical and public health experts supports the conclusion that a particular individual presents a "significant risk of transmission." The internal expert panel considered all the available evidence and recommended against the course subsequently taken by the hospital administrators, who decided to "err on the side of caution."[26] The very words used by the court indicate the discordance between its decision and the policy underlying Section 504 and ADA Title I. "Erring" on the side of caution means eliminating highly trained, qualified persons with disabilities from jobs which they are competent to perform safely.

The court also pointed to recommendations by the CDC that HIV-infected surgeons be restricted from performing "those procedures identified by the hospital as exposure-prone." The hospital's expert panel identified such procedures and recommended that Dr. Doe be restricted from performing them, but not that he be restricted from performing any surgery whatever. It was the hospital administration, which overruled its own expert medical panel, whose determination was deferred to by the court. It is unlikely that the CDC intended to have the determination of

---

26. *Id.* at 1266.

whether a procedure is "exposure-prone" turn on factors other than the judgment of medical experts.

It is possible that the hospital administrators acted out of fear of potential legal liability and/or fear that if word got out that a surgeon at the hospital was HIV-seropositive the hospital might suffer adverse publicity and a loss of patients. These are exactly the sorts of considerations that the disability discrimination laws are supposed to preclude. Both the court and the hospital in *Doe v. UMMSC* and other cases cited below appear to have given neither credence nor weight to medical expertise regarding HIV-transmission risk.[27]

The Fourth Circuit's decision is not an isolated instance of such reasoning, but rather is typical of the approach taken to such cases by the federal courts. See, e.g., *Bradley v. University of Texas M.D. Anderson Cancer Center*, 3 F.3d 922 (5th Cir. 1993), cert. denied, 114 S.Ct. 1071 (1994)(surgical technician); *Leckelt v. Board of Commissioners of Hospital District No. 1*, 909 F.2d 820 (5th Cir. 1990) (licensed practical nurse); *Mauro v. Borgess Medical Center*, 886 F.Supp. 1349 (W.D.Mich. 1995) (surgical technician); *Scoles v. Mercy Health Corporation*, 887 F.Supp. 765 (E.D.Pa. 1994) (orthopedic surgeon); *Doe v. Washington University*, 780 F.Supp. 628 (E.D.Mo. 1991) (dental student); cf., *In re Application of Hershey Medical Center*, 407 Pa. Super. 565, 595 A.2d 1290 (1991), aff'd 535 Pa. 9, 634 A.2d 159 (1993) (ob/gyn resident); *Estate of Behringer v. Medical Center at Princeton*, 249 N.J. Super. 597, 592 A.2d 1251 (1991) (otolaryngologist and plastic surgeon).

Courts have also raised the issue of "informed consent," reasoning that disclosure of a surgeon's HIV-seropositive status to the patient may be required by ordinary tort law doctrines.[28] The informed consent requirement has never been construed to require physicians to disclose their "personal qualifications to perform the procedure at issue," such as their experience in performing the procedure in the past, their medical school academic record, their physical or emotional health, or the like.[29] Informed consent has normally referred to the established risks and

---

27. In *Arline,* the Supreme Court specifically addressed the problem of stereotyping and fear of contagion. ("Few aspects of a handicap give rise to the same level of public fear and misapprehension as contagiousness.") 480 U.S. 284, Fn. 12. In additional, the 4th Circuit in effect placed the burden on the plaintiff to prove that his employment as a surgeon would not present a significant risk to patients. The burden of proving risk is normally on the defendant as an affirmative defense. The court characterized the plaintiff as not "qualified" because it believed that no accommodation could reduce the risk to zero.

28. *E.g., Scoles v. Mercy Health Corp., supra; Estate of Behringer v. Medical Center at Princeton, supra.*

29. ABA Coordinating Committee Report, *supra.*

potential outcomes of a particular medical procedure. The Centers for Disease Control took the position that disclosure of HIV-seropositive status may be required before the performance of an "exposure-prone invasive procedure" -- that is, a procedure that has been determined by medical experts to present an enhanced risk of HIV transmission -- but that otherwise disclosure is not normally required.[30] Ordinary principles of informed consent require disclosure of actual risks. Because the risk of HIV transmission during surgical procedures is, at best, speculative, informed consent principles should not be construed to require an HIV-seropositive health care worker to disclose his or her status to the patient. Significant risk of HIV transmission is not established, and even if the risk models published by the CDC are treated as if they reflected an actual body of transmission data, the risks calculated by the CDC fall far below the level of many risks that are normally not required to be disclosed.[31]

IV. CONCLUSION

In *Arline*, the Supreme Court made clear that decisions about restricting the employment of individuals with contagious conditions should be made on an individualized basis and be based on the best available medical evidence and the informed recommendations of public health authorities. The Supreme Court emphasized that decisions about the employment of persons with disabilities should be based on medical facts, not fear or speculation. Yet it appears that fear and speculation may be driving those courts that have ruled against HIV-infected health care workers.

The precise risk of HIV being transmitted from health care worker to patient can never be pinpointed. The AIDS epidemic has not yet reached the end of its second decade and, despite invasive procedures performed on thousands of patients by HIV-infected health care workers, there remain no documented cases demonstrating transmission from workers to patients during treatment. If there is an actual risk of transmission during surgery by surgeons, surgical technicians, nurses, or others who are following approved "universal precautions" against being infected themselves, it has yet to be demonstrated by actual experience. The probability of infection calculated by the CDC is so minute that it might be claimed that no case has yet been documented because not enough

30. Centers for Disease Control, *Recommendations for Preventing Transmissions of Human Immunodeficiency Virus and Hepatitis B Virus to Patients During Exposure-Prone Invasive Procedures*, 40 MORBIDITY & MORTALITY WKLY. REP. 2, 5. The American Medical Association and some state health departments have taken similar positions. ABA Coordinating Committee Report, *supra*, at 770.

31. ABA AIDS Coordinating Committee Report, *supra*, at 770-71.

contacts between HIV-infected health care workers and patients have occurred to date. If this is truly the case, then it is hard to understand how a serious claim could be made that the risk of transmission is "significant" unless that term is defined to mean "theoretical possibility."

It is equally hard to understand how courts can believe they are fulfilling the requirement of making an individualized determination of risk in particular cases when they adopt an undifferentiated approach that categorically excludes HIV-infected health care workers from being considered "qualified", without regard to the sorts of nuances that were taken into account by the expert internal panel in *Doe v. University of Maryland*. Yet it is an individualized approach that is mandated by *Arline* and the pertinent statutory provisions.

Whether Section 504 and Title I of the ADA should be interpreted to protect HIV-infected health care workers from being excluded from performing "invasive procedures" has been the subject of considerable academic debate.[32] A majority of the academic commentators have either decried the approach being taken by the courts or called upon the CDC to issue more specific guidelines, while a minority have supported restricting HIV-infected health care workers from performing any procedures presenting a theoretical risk of transmission. The Committee believes that the majority of academic commentators have correctly understood the issues presented by this situation and have correctly concluded that the

---

32. *See, e.g.*, ABA Coordinating Committee Report, *supra*; Barnes, Rango, Burke & Chiarello, *The HIV-Infected Health Care Professional: Employment Policies and Public Health*, 18 L. MED. & HEALTH CARE 303 (Winter 1990); Bobinski, *Risk and Rationality: The Center for Disease Control andthe Regulation of HIV-Infected Health Care Workers*, 36 ST. LOUIS U. L.J. 213 (Winter 1991); Closen, *A Call for Mandatory HIV Testing and Restriction of Certain Health Care Professionals*, 9 ST. LOUIS U. PUB. L. REV. 421 (1990); Eisenstadt, *The HIV Infected Health Care Workers: The New AIDS Scapegoat*, 44 RUTGERS L. REV. 301 (Winter 1992); Feldblum, *A Response to Gostin, 'The HIV-Infected Health Care Professional: Public Policy, Discrimination and Patient Safety'*, 19 L. MED. & HEALTH CARE 134 (Spring/Summer 1991); Gostin, *The HIV-Infected Health Care Professional: Public Policy, Discrimination and Patient Safety*, 18 L. MED. & HEALTH CARE 311 (Winter 1990); Hermann, *Commentary: A Call for Authoritative CDC Guidelines for HIV-Infected Health Care Workers*, 22 J. L. MED. & ETHICS 176 (Summer 1994); Isaacman, *The Other Side of the Coin: HIV-Infected Health CAre Workers*, 9 ST. LOUIS U. PUB. L. REV. 439 (1990); Keyes, *Health-Care Professionals with AIDS: The Risk of Transmission Balanced Against the Interests of Professionals and Institutions*, 16 J.C. & U.L. 589 (Spring 1990); Reid, Schaper, Stanton, *HIV in the Health Care Workplace: Challenges Involving HIV-Infected Employees and Physicians*, 14 WHITTIER L. REV. 25 (1993); Watson, *Eliminating Fear Through Comparative Risk: Docs, AIDS and the Anti-Discrimination Ideal*, 40 BUFF. L. REV. 739 (Fall 1992). In addition to these articles, there are many others dealing with tort and informed consent issues, and dozens of student notes and comments focusing on particular cases.

courts have inadequately protected the legitimate employment rights of HIV-infected health care workers.

The Committee concludes that the CDC should issue new, specific guidelines making clear that the commands of federal disability law must be followed in cases involving HIV-infected health care workers. Such guidelines should focus on actual, documented risks, and recommend against exclusion of health care workers in situations where the risk of transmission is negligible. In light of the growing body of evidence that HIV-infected health care workers have not spread the virus to patients during surgical procedures, the CDC should reconsider its position on disclosure to patients before performance of an "exposure prone invasive procedure," which position was developed at a time when there was much less relevant evidence and a significant amount of political pressure stemming from the Acer case. Furthermore, there is a special need, demonstrated by court decisions to date, for the CDC to address the situation of health care workers other than surgeons, such as surgical technicians and nurses, whose exclusion may be premised on judicial misunderstanding of the concept of invasive procedures and the ways in which a blood-borne pathogen can be transmitted.