J. INDIVIDUAL EMPLOYMENT RIGHTS, Vol. 1(3) 219-243, 1992-93

AIDS: A UNIQUE DILEMMA—THE HOSPITAL AS EMPLOYER AND CARE PROVIDER

SANDRA N. HURD

ELIZABETH C. WESMAN

Syracuse University
Syracuse, New York

ABSTRACT

This article presents a brief history of the development of AIDS and reviews the safety issues unique to a healthcare setting. The legal issues facing hospitals as employers and healthcare providers are reviewed and analyzed. Included are sections on the various federal and state laws and regulations that affect hospital employees and patients. The authors also offer recommendations for ways in which hospitals can deal with all of the AIDS-related concerns in an efficient, effective and equitable manner.

The epidemic now known as AIDS dates back to mid-1981 when a diagnosis of Kaposi's Sarcoma was made in New York City and treatment was given for a rare infection known as Pneumocystis carinii in Los Angeles. Since these first discoveries, "AIDS" has become a four-letter word arousing fear and panic fed by ignorance and rumor and fueled by the one certainty of AIDS: death.

In dealing with Acquired Immunodeficiency Syndrome (AIDS), a hospital has two duties that can come into conflict. The hospital's primary role as healthcare provider requires it to protect the physical, emotional, and legal rights of the patient with AIDS. As an employer, however, the hospital must provide a safe and supportive working environment for its employees [1]. How, then, should the hospital deal with the unique set of problems created by the inherent risk that an

doi: 10.2190/333W-D506-DAKY-CGHT
http://baywood.com

employee will be exposed to the AIDS virus?[1] And how should the hospital handle the problems generated when an employee actually contracts AIDS?

This article presents a brief history of the development of AIDS in Part I. In Part II, it reviews the safety issues unique to a healthcare setting. The legal issues facing the healthcare employer and provider are explored in Part III. Finally, in Part IV, recommendations for ways in which hospitals can effectively and fairly deal with these AIDS-related issues are made.

HISTORY OF THE DEVELOPMENT OF AIDS

Today, the acronym AIDS is a part of our everyday vocabulary. Virtually every newspaper has periodic articles about this disease even though as recently as seven years ago no one had heard of AIDS. The first cases of AIDS in the United States began appearing in Los Angeles in 1981 and, in late 1983, researchers in France and the United States isolated a cytopathic retrovirus from patients with AIDS and chronic lymphadenopathy. The infection from this virus, first called HTLV-III/LAV (Human T-Lymphotropic Virus Type III/ Lymphadenopathy- Associated Virus) and now simply HIV (Human Immunodeficiency Virus), appears to be chronic (a high percentage of infected people remain virus-positive for years, possibly life), and manifests itself in a broad range of symptoms [3].

AIDS seems to have originated in Africa, where it was first seen in 1970. A virus similar to that identified in infected humans is harbored in the African green monkey. The epidemiology of AIDS suggests that humans were infected by monkey bites or by ingestion of monkey flesh, common in the diet of some African cultures. The disease was spread to Haiti during the 1970s by visitors from Africa, and it is presumed that American homosexuals vacationing in Haiti then acquired the virus. The virus proliferated rapidly within the homosexual populations in San Francisco and New York and then spread to the heterosexual population through bisexuals and intravenous (I.V.) drug users [4].

The precise transmission mechanism for AIDS is not fully understood. It is believed to be a fluid-borne disease that attacks the body's natural immune system. The HIV virus destroys white cells in the body that normally serve to fight off invading germs, viruses, and other infections. The destruction of these cells leaves the body vulnerable to what are called opportunistic infections. These infections are caused by agents we encounter every day and with which we can normally cope, but in the presence of a weakened immune system they have a deadly effect.

[1] Employees in other occupations, such as police, firefighters, and teachers, whose primary mission is not health care may arguably be at risk, but not to the extent that hospital employees are. *But see* [2].

The HIV virus affects individuals differently. Some people remain apparently well after infection, with no physical symptoms. Although asymptomatic, these individuals are able to spread the virus to others. Some percentage of those who are HIV infected will go on to develop AIDS-Related Complex (ARC) or AIDS itself. The symptoms of ARC include fatigue, night sweats, fever, persistent diarrhea, severe weight loss, swollen lymph glands, and exhaustion. In addition, many victims develop neurological deficiencies such as balance problems, memory loss, and dementia. AIDS is actually the end stage of a spectrum of clinical manifestations of HIV infection. The most frequently cited data suggest that twenty to thirty percent of HIV infected people will develop AIDS within five years. AIDS is called a syndrome because no one dies from AIDS, but rather from one of the many complications caused by the disease. The two most common "opportunistic" diseases are Kaposi's Sarcoma, a rare form of cancer, and Pneumocystis carinii, an uncommon type of pneumonia and the most common cause of death for an AIDS patient [5]. Most AIDS patients die within two years following diagnosis of an opportunistic infection or malignancy [5].

HIV is transmitted from infected individuals to noninfected individuals by the exchange of body fluids. A person may acquire the virus during sexual contact if there is even a microscopically small tear in tissue in the rectum, penis, or vagina through which the virus may enter the person's bloodstream. The virus may also be transmitted by parenteral[2] exposure to infected blood through needlesticks or the sharing of hypodermic needles by intravenous drug users. In addition, HIV has also been transmitted to some people who have received transfusions of blood or blood products. These cases occurred primarily prior to March 1985 when routine screening of blood products for HIV began. Finally, a mother may transmit the infection to her fetus. The cumulative epidemiologic data indicate that HIV cannot be transmitted by casual social contact. Transmission requires direct, intimate contact with or parenteral inoculation of body fluids [6]. The former Surgeon General summarized the opinion of the medical community with the following statement [7, p. 21]:

> You cannot get AIDS from casual social contact. Casual social contact should not be confused with casual sexual contact which is the major cause of the spread of the AIDS virus. Casual and social contact such as shaking hands, hugging, social kissing, crying or sneezing will not transmit the AIDS virus. . . . You cannot get AIDS from toilets, doorknobs, telephones, office machinery, or household furniture.

This conclusion has been supported repeatedly by major studies [8].

[2] Parenteral refers to injection of substances into the body through any route other than via the alimentary canal, e.g., subcutaneous, intravenous, intramuscular, or intrathecal.

SAFETY ISSUES IN THE HEALTHCARE SETTING

Despite the fact that AIDS is difficult to contract, misconceptions and irrational fears persist among both employees and employers. Indeed, AIDS was predicted to be the number one health problem facing the workplace by 1991. In 1989, state and territorial health departments reported 35,238 cases of AIDS to the Centers for Disease Control (CDC), an increase of 9 percent over 1988 [9]. It is estimated that 40,000 people in the United States have AIDS, and more than one million are infected with the virus [10]. The following table (Table 1) shows the projected numbers of AIDS cases, deaths attributable to AIDS, and living persons with AIDS for the years 1989 to 1993, adjusted for underreporting [10, p. 117].

A central issue for the healthcare provider as it faces the AIDS challenge is how to ensure a safe environment for staff members, physicians, and patients. If the CDC estimates are correct, it is safe to say that within the next three years every healthcare worker will come in contact with a patient with AIDS. At the outset, many thought that this disease was a problem faced only in large cities, such as New York or San Francisco, but clearly that is not the case. Even small community hospitals can anticipate AIDS admissions; therefore, every healthcare worker must be made aware of the potential risks and how to minimize those risks.

What is the probability of a healthcare worker contracting AIDS? The evidence shows this likelihood to be extremely low, but workers are at risk to the extent that they are directly exposed to blood and body fluids. Statistically, a healthcare worker is much more likely to become infected with the Hepatitis B virus (HBV) than with HIV. Studies estimate that the risk of infection with HBV following a puncture with a contaminated needle ranges from 6 to 30 percent, far greater than the risk of incurring HIV infection under similar circumstances, which the CDC and others estimate at less than one percent [6].

Often, it is not possible to know without testing if a person is infected with HIV; only 10 to 15 percent of those exposed to HIV have any clinical signs of carrying the AIDS virus [11]. This situation compounds the difficulty hospitals have in

Table 1. AIDS Cases

Year	New Cases	Alive	Deaths
1989	44,000-50,000	92,000-98,000	31,000-34,000
1990	52,000-57,000	101,000-122,000	37,000-42,000
1991	56,000-71,000	127,000-153,000	43,000-52,000
1992	58,000-85,000	139,000-188,000	49,000-64,000
1993	61,000-98,000	151,000-225,000	53,000-76,000
Totals	390,000-480,000		285,000-340,000

ensuring a safe work environment. The CDC has issued guidelines to assist hospitals and other care providers in the prevention of infection of health care workers. The first CDC guidelines were issued November 15, 1985; supplemental guidelines were issued August 21, 1987 and were updated in mid-1988. The supplemental guidelines address two categories of prevention: "precautions to prevent transmission of HIV, which include universal precautions as well as those specifically for invasive procedures . . . ; and environmental considerations, which include sections on sterilization and disinfection, survival of HIV in the environment, housekeeping, cleaning and decontaminating spills of blood or other body fluids, laundry, and infective waste" [12, pp. 99-100]. Precautionary procedures include six specific recommendations [13, pp. 31-518]:

> 1. Appropriate barrier precautions such as gloves, gowns, masks, and protective eyewear should be routinely used to prevent skin and mucous membrane exposure when the healthcare worker anticipates any contact with blood or other bodily fluids of any patient.
>
> 2. Hands or other skin surfaces contaminated with blood or other bodily fluids should be washed immediately and thoroughly. Hands should also be washed immediately after gloves are removed.
>
> 3. Precautions should be taken to prevent injury from contaminated needles, scalpels, and other sharp instruments. Needles should never be recapped and appropriate disposal containers should be located as close as possible to the use area.
>
> 4. Mouthpieces, resuscitation bags, or other ventilation devices should be available for use to minimize the need for emergency mouth-to-mouth resuscitation, even though saliva has not been implicated in HIV transmission.
>
> 5. Healthcare workers who have open lesions or weeping dermatitis should not have direct contact with patients or handle patient-care equipment.
>
> 6. Although healthcare workers who are pregnant are not known to be at higher risk than those who are not pregnant, pregnant healthcare workers should adhere strictly to precautions to minimize the risk of perinatal HIV transmission.

In the supplement to the guidelines, the CDC clarified that the suggested universal precautions [14, p. 268]:

> apply to blood and to other bodily fluids containing visible blood, semen and vaginal secretions, tissues, and certain other body fluids. They do not apply to human breast milk, urine, feces, nasal secretions, sweat, tears, saliva, sputum, or vomitus unless they contain visible blood.

While these guidelines provide a starting point for hospitals' safety programs and policies, they do not address the related and equally problematic issues of liability.

LIABILITY ISSUES

Because of the often litigious mood of our society, hospitals need to be as concerned about the liability issues created by the AIDS epidemic as they are about the infection control aspects of the disease. As the AIDS epidemic grows, hospitals must be increasingly mindful of their legal responsibilities and vulnerabilities with respect to patients and employees. They must also be able to respond as knowledge about AIDS and its transmission increases. Ongoing clinical and research studies constantly provide new information. Emerging case law, legislation, and relevant agency regulations further define and change legal rights and duties.[3] This section examines the hospital's potential liability to its patients and to its employees.

Liability of a Hospital to Its Patients

There are a number of theories under which a hospital may arguably be held liable to a patient. These theories include refusal to treat; disease transmission through negligent hiring or supervision of an HIV-infected employee or through contaminated blood products or transplant organs; and invasion of privacy through disclosure of test results.

Refusal to Treat

A hospital's liability for refusal to treat may arise in one of two ways: 1) when the institution turns a patient away; or 2) when the institution's employees refuse to provide proper care for a patient who is, or is perceived as being, HIV-infected.

A hospital can place itself at clear risk if it refuses to provide emergency treatment for or to admit any patient. A hospital emergency room is required, under New York law, for example, to provide emergency services to people needing them [16]. The only valid reason for denying treatment is that the hospital does not have the appropriate expertise and/or necessary facilities. In the case of HIV infection, it would be virtually impossible for most acute care hospitals to argue that they lack either expertise or facilities. The emergency treatment needed by an AIDS patient involves one of the opportunistic infections and such treatment is well within the scope of most hospitals' treatment capabilities. In addition, hospitals that receive federal grants, loan guarantees, and interest subsidies for

[3] For example, during the first six months in 1989 more than 500 bills dealing with AIDS had been proposed in forty-eight states and twenty-three states had passed forty-five new AIDS laws. These new statutes brought to 360 the total number enacted since 1983 [15].

hospital construction and modernization under the Hill-Burton Act [17] are required to treat without discrimination.

Refusal to treat can also be the subject of a human rights violation complaint. During 1987 and 1988, six complaints were filed in New York based on hospitals' alleged discrimination against HIV-infected patients.[4] One can expect that as more individuals who are HIV-infected seek treatment and become more aware of their rights, the number of these complaints will increase.

Disease Transmission

Transmission of AIDS is of paramount concern for hospitals, both for humanitarian reasons and because it represents an area with potential for tremendous liability. There is a minimal, but conceivable, risk of HIV transmission to a patient from an infected employee or from transfusion of blood products or from organ transplants. A hospital arguably might be found liable for negligent hiring/retention/supervision or for negligence in providing blood products or transplant organs.

New York is one of the majority of state jurisdictions that recognizes a cause of action by an injured third party against an employer for negligent hiring, retention, and/or supervision of an employee [20]. To prevail in a lawsuit for negligent hiring of an employee, the injured plaintiff would have to prove that the hospital failed to use reasonable care in the hiring process and that such failure caused the resulting injury. Similarly, to prevail on a claim of negligent retention, the plaintiff would have to establish that the hospital failed to exercise reasonable care in not discovering the employee's HIV positive status or in continuing to employ the

[4] A related question is whether a physician may refuse to treat an HIV-infected patient. The answer is probably not. In December 1987, the Council on Ethical and Judicial Affairs of the American Medical Association issued a report entitled, "Issues Involved in the Growing AIDS Circle." The report noted that, in an epidemic, a physician must continue his/her labors without regard to risk to his/her own health. The report views AIDS as an epidemic and further states: "A physician may not ethically refuse to treat a patient whose condition is within the physician's current realm of competence solely because the patient is seropositive . . . Physicians should respond to the best of their abilities in case of emergency . . . and physicians should not abandon patients whose care they have undertaken." Principle VI of the 1980 Principles of Medical Ethics states that "a physician shall . . . except in emergencies, be free to choose whom to serve . . . " but does not permit categorical discrimination against a patient solely on his or her seropositivity. A physician who is not able to provide the services required by a person with AIDS should make an appropriate reference to those physicians or facilities that are equipped to provide such services [18, p. 23, 24]. This issue is currently being tested in a case that could affect doctors across New York State. A Syracuse physician, Dr. Daniel Epstein, has been charged by the New York State Division of Human Rights with discrimination for refusing to treat a thirty-five-year-old AIDS patient whom he had referred to an AIDS clinic when the man came to him with an undisclosed ailment. Epstein has challenged the probable cause finding on the grounds that the Division has no authority to interfere with a private physician's medical decision. The Division of Human Rights maintains, however, that doctors in private practice should be subject to human rights laws. This is the first time the New York State Division of Human Rights has taken action against a physician in private practice, thus raising the question of whether a doctor's office is considered a "public accommodation" and, therefore, subject to antidiscrimination laws [19].

employee following the diagnosis and that such failure was the cause in fact of the injury. These claims would be extremely difficult to establish. Routine, mandatory testing is not the norm. Failure to test or a decision not to discharge would not be unreasonable in light of the fact that there has not been, to date, a documented case of transmission of HIV from a health care professional to a patient [21]. A plaintiff who could establish causation might be successful in a negligent supervision action if he or she could show that the defendant hospital failed to train the employee in the proper use of precautions, failed to provide the supplies with which to exercise such precautions, or failed to take any steps to ensure that employees actually followed universal precautions. It is unlikely, however, that these situations will arise because they fly in the face of rational self-interest of both the hospital and the health care professionals.

Prior to March 1985, when blood products were first routinely tested for the presence of HIV antibodies, recipients of blood products were at high risk for contracting HIV infection through transfusions. Since the advent of extensive testing, however, the risk has been minimized and continues to decrease steadily. In 1989, for example, there were 295 reported cases of AIDS in adults/adolescents with hemophilia, and twenty-six in children [22]. These numbers represent, respectively, a two percent and 33 percent decrease over 1988 numbers [22]. Among transfusion recipients, there were 768 cases reported in adults/adolescents, a 12 percent decrease, and forty cases reported in children, a 39 percent decrease [22]. Potential for hospital liability has, therefore, declined commensurately.

Although a thorough discussion of a hospital's liability for transfusion-related claims is beyond the scope of this article, it should be noted that there are three theories of recovery in situations involving transfusion-associated AIDS: strict liability in tort based on a defective product, breach of implied warranty, and negligence. It is unlikely, in New York, that a plaintiff would be successful on any of these theories. Courts have been reluctant to subject providers of blood products to strict liability claims, either in tort or in contract, because of the negative effect such liability would have on the availability of blood products. In addition, since the advent of routine testing of blood products by all suppliers, it would be extremely difficult to establish the breach of duty essential for negligence.

Protecting the hospital from claims based on product liability theories, however, is not synonymous with relieving it from liability. The hospital must also make sure that it has informed consent from its patient before treatment. Informed consent regarding blood transfusions must be based on the latest medical and scientific findings and the patient must be told of the risks of contaminated blood escaping the screening tests.

Not all transfusion situations involve a risk of liability for the hospital. An autologous blood transfusion, in which the patient's own blood is used during surgery, is a generally accepted transfusion method that not only prevents

transfusion-acquired AIDS, but also has other advantages. Blood bank resources are conserved, blood incompatibility is eliminated, and the transmission of serum hepatitis is prevented. In some areas more than five percent of all blood transfusions are autologous [23].

Hospitals must also be aware of the possibility of HIV transmission through organ donation. The CDC recommends that serum for HIV testing be collected from the recipient and donor at admission and before the patient receives multiple transfusions. Failure to comply with this recommendation could subject a hospital to liability.

Invasion of Privacy/Confidentiality

An especially complex dilemma facing hospitals involves the patient's rights to privacy and confidentiality. Health care providers have an obligation to maintain the confidentiality of HIV test results [24]. If a hospital is negligent in its procedures or practices for record keeping or training staff with respect to privacy, it may be held liable. For example, if a hospital posted a list of HIV patients on a laboratory bulletin board or allowed the news media into a hospital waiting room, it could be held liable for invasion of privacy. In addition, a feeling of trust between the patient and the provider is essential to quality healthcare. The assumption that confidential information will not be disclosed encourages patients to undergo testing and share very personal health-related information. To establish and monitor systems for the treatment of AIDS patients and the prevention of transmission, confidentiality of patient information is essential. Yet this poses a conflict for hospitals. Many states have statutes that mandate confidentiality of medical records; however, quality medical care and transmission prevention often require access to and disclosure of patients' medical information. Also, under the demands of federal, state, and insurance carrier oversight, financial access to care often depends upon the hospital's knowing the patient's diagnostic history. In fact, use of the medical record has grown so much that it is frequently difficult to maintain confidentiality without being in conflict with regulatory requirements. In addition to being used to document care and to provide guidance for treatment purposes, the medical record is used for a variety of other purposes: peer review; quality assurance; third-party review (insurance and auditors); and social purposes, e.g., surveillance, research, welfare, employment, education, and judicial procedures [5]. When there are so many situations in which there is a legitimate need to have access to an individual's medical record, it is extremely difficult to maintain confidentiality. In addition, hospitals in New York State have a duty to report known or suspected cases of AIDS,[5] and must comply with state and federal right-to-know laws and regulations that require employers to notify employees of

[5] Anyone associated with the clinical recognition of a known or suspected case must notify the New York State Department of Health [25].

exposure to potentially hazardous working conditions [26, 27]. Maintaining a patient's privacy rights while at the same time protecting the rights of employees, patients, and third parties requires the hospital to engage in the difficult process of balancing these competing interests when choosing among courses of action.

In some cases, a provider's responsibility to maintain confidentiality can be overridden by societal needs. Early state communicable disease laws clearly introduced this concept [28] and the "social-good principle" was extended by the ruling of the California Supreme Court in *Tarasoff v. The Regents of California* [29] that a doctor may be subject to a civil suit for not disclosing information that could protect a third party from harm.[6] A special problem is presented in cases of HIV infection, however, because it is difficult to draw the distinction between those situations that are not potentially harmful and those that require disclosure of confidential information.

THE AIDS-INFECTED EMPLOYEE

The AIDS-infected employee presents a series of particularly difficult management issues for hospitals, including increased absenteeism, increased insurance costs, coworkers' resistance to working with an AIDS-infected employee, exacerbation of the victim's illness by physical or mental stress on the job or exposure to other diseases, and substantial loss of revenue from the public's fear of contracting AIDS. In addition, the hospital must address a number of difficult questions from both legal and ethical standpoints: May/should it refuse to hire an HIV-positive job applicant? May/should it mandate testing of healthcare workers? May/should it discharge an AIDS employee? May/should employment duties be restricted for the employee with AIDS? What response may/should be made to the employee who refuses to work with a coworker with AIDS or who refuses to treat an AIDS patient? Knowledge of a variety of federal and state laws as well as an awareness of the current medical and scientific facts[7] about AIDS is essential in attempting to deal effectively with these issues and respond to these questions fairly.

Federal Laws

There are a number of federal laws that may be considered applicable to employment decisions about HIV-infected employees. These include the

[6] A psychologist's patient carried out his threat to kill a person. The psychologist, relying on his responsibility to maintain patient confidentiality, failed to notify the victim or the police of his patient's threat.

[7] Medical facts are those that deal with modes of transmission and categories of exposure. Scientific facts are those that are gained from epidemiologic and laboratory studies.

Vocational Rehabilitation Act of 1973 [30], Title VII of the Civil Rights Act of 1964 [31], the Employee Retirement Income Security Act (ERISA) [32], the National Labor Relations Act (NLRA) [33], and the Occupational Safety and Health Act [34].

Rehabilitation Act

The Rehabilitation Act applies to hospitals that receive federal financial assistance [30, §794].[8] Because the receipt of Medicare payments constitutes federal financial assistance, the vast majority of hospitals are covered by the act, which provides that: "No otherwise qualified handicapped individual in the United States . . . shall, solely by reason of his handicap, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance" [30, §794]. A handicapped individual is "any person who (i) has a physical or mental impairment which substantially limits one or more of such person's major life activities, (ii) has a record of such impairment, or (iii) is regarded as having such impairment" [30, §706(7)(B)]. "Physical or mental impairment" is defined by the Department of Health and Human Services as [35]:

> any physiological disorder or condition, cosmetic disfigurement, or anatomical loss affecting one or more of the following body systems: neurological; musculoskeletal; special sense organs; respiratory, including speech organs; hemic and lymphatic; skin; and endocrine; or (B) any mental or psychological disorder, such as mental retardation, organic brain syndrome, emotional or mental illness, and specific learning disabilities.

"Major life activities" are defined as "functions such as caring for one's self, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning, and working" [35, §84.3(2)(ii)]. A handicapped person is otherwise qualified if he or she can perform "with reasonable accommodation" the essential functions of the job in question [36].

It has been argued persuasively that those with full-blown AIDS and those suffering from ARC, as well as individuals who are seropositive but asymptomatic, clearly meet the act's definition of "handicapped individual" because of actual or perceived impairment [37, 38]. Federal cases, a legislative amendment, and an administrative advisory opinion all support this conclusion.

Two important cases have addressed the issue of whether a contagious disease such as AIDS is a handicap under federal law. In *Arline v. Nassau County School Board* [39], the United States Supreme Court upheld the court of appeals decision

[8] This section was amended by Section 4 of the Civil Rights Restoration Act of 1987, Pub. L. No. 100-259 [32], 102 Stat. 28 (1988), to provide that the Rehabilitation Act applies to all of the recipient's activities even though only a portion of those activities is federally funded.

[40] that a teacher with tuberculosis was protected under §504 of the Rehabilitation Act. In its decision, the appellate court had reversed a district court holding that tuberculosis was not a protected handicap and remanded the case for a factual determination as to whether the risk of contagion precluded the plaintiff from being otherwise qualified and, if so, whether reasonable accommodation could be made [39, pp. 1125-1126]. The Supreme Court held that a contagious disease could be a handicap within the meaning of the statute [39, p. 1127]. In this case, the plaintiff's hospitalization in 1957 for tuberculosis was sufficient to establish that she had a record of impairment [39, p. 1127]. The Court remanded the case to the district court for consideration of whether she was otherwise qualified. The district court was instructed that its determination should include findings of [39, p. 1131]:

> 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 that the disease will be transmitted and will cause varying degrees of harm.[9]

Congress subsequently codified the result of *Arline* with its amendment of the Civil Rights Restoration Act of 1987 [44]. The amended definition of "handicapped individuals" in the act provides [44, §9]:

> (C) For the purpose of sections 503 and 504, as such sections relate to employment, such term 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.

In light of this amendment, those who want protection from discrimination under the Rehabilitation Act should be prepared to speak to the issues of whether they pose a direct threat to the health or safety of others and whether they are able to perform the duties of their jobs.

During this same time period, the Department of Justice issued an opinion reversing its 1986 determination that §504 does not protect those who are

[9] [36, p. 1131], Quoting Amicus Brief for American Medical Association at 19. In another federal case, *Chalk v. U.S. District Court for the Central District of California* [41], the Ninth Circuit Court of Appeals was faced with the case of an employee who claimed that his employer's action in barring him from his normal teaching duties and transferring him to an administrative position due to a diagnosis of AIDS was discrimination in violation of the Act. Relying on the *Arline* decision, the court held that Chalk was a handicapped individual under the statute even though his impairment was the result of a contagious disease. In two other cases, federal district courts held that excluding children with AIDS from school could violate §504 [42, 43].

discriminated against because they are, or are perceived as being, seropositive.[10] This opinion concluded that an HIV-infected individual is protected against discrimination only if he or she is able to perform the duties of the job and does not constitute a direct threat to the health or safety of others [46]. It determined, further, that the amendment to the Civil Rights Restoration Act merely codified and did not alter, the "otherwise qualified" standard discussed by the Supreme Court in *Arline*, including the provision of a means of reasonable accommodation that can eliminate the health or safety threat or enable the employee to perform the duties of the job, if such accommodation can be made under the employer's existing personnel practices and does not impose an undue administrative or financial burden [46]. Further, it opined, the reasonable accommodation requirement clearly does not require permitting an HIV-infected person to remain in a job where the infection poses a threat to others: "This would appear to be the case with infected health care workers who are involved in invasive surgical procedures, and it may also be the case with respect to other infected health care workers or individuals employed in jobs that entail responsibility for the safety of others [46, p. 2]. It gives as an example a surgeon in a teaching hospital who "might be restricted to teaching or other medical duties that do not involve participation in invasive surgical procedures" [46, p. 7].[11]

[10]In 1986, the Justice Department issued an opinion on whether §504 applied to individuals who suffer from AIDS, individuals who suffer from ARC, individuals who test positive for antibodies to HTLV-III but exhibit no symptoms, or individuals who fit into none of these three categories but are wrongly regarded as doing so. The opinion concluded that a person suffering from AIDS, because of the disabling effects of the disease, qualifies as handicapped but that the ability of the victim to communicate the disease to another person—present or past, real or perceived—does not in and of itself constitute a handicap. With respect to those suffering from ARC, the opinion stated that because of the inability to define the condition precisely, it is not possible to set down a uniform rule. Whether a particular person is handicapped must, therefore, be determined on a case by case basis. Under no circumstances, however, is communicability alone a handicap. An individual who is asymptomatic but tests positive for HTLV-III antibodies may be considered handicapped if he or she is perceived as suffering from the disabling effects of ARC or AIDS. But again, neither the ability to transmit the disease nor the incorrect belief that the individual can transmit the disease is a handicap.

[11]The applicability to AIDS patients of the reasonable accommodation requirement of §504 of the Rehabilitation Act was tested in a 1986 complaint issued by Health and Human Services' Office of Civil Rights. The complaint concerned a nurse with AIDS who was granted medical leave. Several physicians recommended that the nurse's illness not exclude him from duties that did not involve patient care; however, no such positions were available at that time. One year later, the nurse's physician said he could return to work. The hospital refused him employment until such time as he was cured or had proof that AIDS would pose no risk to others. The Office of Civil Rights found the hospital's initial decision to grant a medical leave within the guidelines of the act. The hospital was held to be in violation of the act, however, when it failed to modify its position in light of subsequent medical evidence, and was found guilty of discrimination when it failed to reconsider the employee's possible re-employment. Accordingly, the hospital was ordered to develop and implement an AIDS policy and apply it retroactively. By the time the order was made, however, the nurse had died. In addition, the hospital was ordered to furnish back pay and other benefits to his heirs. In its opinion the court further held that a hospital's duty to reasonably accommodate was not automatic, but depended upon the nature and duties of the job as well as the medical condition of the employee involved [47].

ERISA

The federal Employment Retirement Income Security Act of 1974 applies to all retirement pension, life insurance, and medical benefit plans maintained by private employers [32]. The two sections that would seem to be of most important to HIV-infected employees are §502 and §510. Section 502 gives the participant or beneficiary the right to bring a civil action to recover benefits due under the terms of the plan [32, §1132(a)(1)(B)]. The participant or beneficiary may seek to enforce or clarify rights and benefits provided by the plan. He or she may also seek to enjoin acts or practices that violate the terms of the plan [32, §1132(a)(3)]. Section 510 provides: "It shall be unlawful for any person to discharge, fine, suspend, expel, discipline, or discriminate against a participant or beneficiary . . . for the purpose of interfering with the attainment of any right to which such participant may become entitled under the plan" [32, §1140]. The legislative history of ERISA has been interpreted as focusing on protecting employees whose rights are about to vest, rather than those who have already qualified for coverage under a benefit plan [48]. However, an allegation that an employee was discharged to deny him/her continued participation in the company-provided life and medical insurance plan has been held to state a claim cognizable under §510 [49].

NLRA

The National Labor Relations Board (NLRB) has consistently held that changes in work rules, particularly those carrying disciplinary penalties, affect terms and conditions of employment and are mandatory subjects of bargaining. Although the NLRB has not yet ruled on AIDS testing, it will likely be considered a mandatory subject of bargaining because it speaks directly to terms and conditions of employment [33, 50, 51].[12] In the absence of a waiver by the employees' union(s) of the right to bargain, an employer would be required to give prior notice to the union(s) of any proposed AIDS testing policy and to bargain about such proposal if requested to do so. Any challenge to the unilateral implementation of an AIDS policy is likely to take the form of a grievance or a suit for an injunction rather than an unfair labor practice charge under the NLRA. In reaching a determination of whether unilateral implementation was permissible under the collective bargaining agreement, an arbitrator would be expected to examine the governing collective agreement language, if any, and the reasonableness of the testing policy [51, pp. 526-27].

[12]School board was held to have violated the collective bargaining agreement when it unilaterally adopted an AIDS policy, where the policy directly affected working conditions because it could remove a teacher from the classroom permanently.

There are two situations in which labor-management agreement provisions may have an impact on AIDS in the hospital workplace. First, many union contracts have antidiscrimination clauses that include discrimination on the basis of sex [52]. Because, at present, men are still disproportionately represented among AIDS victims, this type of clause could arguably be used to support a claim of AIDS discrimination. Employers need to be keenly aware of any antidiscrimination clauses in their union contracts, and they must assure that all clauses are applied in a neutral fashion so as not to have a disproportionate impact on any protected employee group [53]. For example, any contract provisions regulating disability leave would have to apply uniformly to all disability requests, including those from employees with AIDS. Second, the termination of any bargaining unit employee with AIDS would most likely be subject to the contract's grievance and arbitration procedures and to any just-cause standard established for employee termination [54]. Although no arbitration decisions determining whether HIV-infection provides just cause for termination have been reported, one might expect such a decision in the hospital context to center on whether discharge was reasonably related to the safe operation of providing health care [51, 55]. Only those employees in the terminal stages of AIDS would be physically incapable of maintaining adequate job performance. Other issues that might be important in a particular case include: "whether the company performed a fair and objective investigation before taking action; whether the rules, orders, and penalties were applied evenhandedly and without discrimination; . . . and whether the company acted arbitrarily or hastily [37, pp. 300-301, citing 56]."

In addition, hospital employees who refuse to care for AIDS patients may find protection in Section 7 of the NLRA, which guarantees a nonsupervisory employee the right to "engage in . . . concerted activity for the purpose of collective bargaining or other mutual aid or protection . . . " [33]. Employees covered by a union contract and most of those employed without a collective bargaining agreement who act collectively are afforded this right [54]. An employer may be prohibited from terminating or disciplining employees who collectively refuse to treat AIDS patients if such action is protected by the NLRA. However, in such a case, an employer may also be permitted to replace the refusing employees temporarily or permanently [57].

OSHA

The federal Occupational Safety and Health Act requires that each employer "furnish to each of his employees employment and a place of employment which are free from recognized hazards that are causing or are likely to cause death or serious physical harm to his employees" [58]. Because the scientific evidence indicates that AIDS is not transmitted by casual contact and does not present a risk in the workplace, employing an HIV-infected person does not violate OSHA. An employee might, nevertheless, protest working with an HIV-infected coworker. Employees who protest unsafe working conditions are protected

against retaliation by the employer. An employer may not take adverse action against an employee who refuses, after first seeking correction of the health hazard by the employer, to expose himself or herself to a health hazard that he or she in good faith reasonably believes poses a danger of death or serious injury [59]. Whether or not the employee's protest would be determined to be unreasonable in any given situation depends on the protective mechanisms available within the workplace and the current medical opinion on the transmissibility of the disease [60, 61]. An employee's refusal to work with a coworker with AIDS should not be protected by OSHA because the fear of infection, although real, is not reasonable. As long as the hospital is in compliance with the CDC guidelines, it should be able to defend successfully any action it takes in response to the employee's refusal. If the hospital fails, however, to provide employees with adequate protective equipment and procedures, liability may result. OSHA has cited facilities for inadequate protection of workers. From fall, 1987 to spring, 1988, OSHA issued citations and imposed more than $8,000 in fines after inspections made in response to employee complaints [62]. Since that time OSHA has also begun making inspections without waiting for complaints [62].

State and Local Laws

Hospitals must be familiar with any state or local laws that protect HIV-infected people and any amendments to those laws as well as judicial interpretations of them. All fifty states and the District of Columbia prohibit employment discrimination against the handicapped although the coverage of the statutes varies widely.[13] At least thirty-four states consider AIDS discrimination a violation of their handicap discrimination laws [63]. In addition, there are numerous laws that govern such issues as consent to testing and disclosure of test results that directly affect hospitals [64].

The New York Human Rights Law prohibits discrimination on the basis of disability, which is defined as "physical, mental or medical impairment resulting from . . . physiological or neurological conditions which prevents . . . normal bodily functions or is demonstrable by medically accepted clinical or laboratory diagnostic technique" [65]. Further, the New York State Division of Human Rights treats AIDS as a covered disability [66]. The division accepts complaints "from people who have HIV infection, are perceived to have HIV infection, belong to a group perceived to be particularly susceptible to HIV infection, are perceived to be particularly susceptible because they are related to or live with someone who has AIDS, or who have tested positive for HIV antibodies"

[13]For a complete discussion of state handicap discrimination laws, see John E. Brockhoeft [37, pp. 295-297, 302-303].

[66, p. 16]. During 1987 and 1988, there were 149 complaints filed with the division alleging discrimination on the basis of AIDS [67].[14]

There are also local laws or regulations that may affect a hospital as it works through AIDS-related questions. In August 1985, Los Angeles became the first city to have a local ordinance prohibiting discrimination against someone with AIDS or AIDS-related conditions in hiring, promotion, and firing [68]. Since that time, the cities of San Francisco, Berkeley, West Hollywood, and Sacramento as well as the counties of Sonoma, San Francisco, San Mateo, Riverside, Santa Clara, and San Luis Obispo have adopted similar ordinances or other measures [37, p. 297]. Several cities outside California, including Austin, Boston, and Philadelphia, have also adopted such ordinances or measures [37]. A hospital should check on the existence of local ordinances or regulations before it makes decisions on AIDS-related questions.

State OSHA

Hospital procedure also may be challenged under state occupational health and safety laws. In 1985, for example, the California Labor Commission rejected a complaint filed by four nurses at San Francisco General Hospital alleging discrimination and claiming the right to refuse to work under unsafe conditions. The hospital's policy said that protective gear was not necessary in treating most AIDS patients. Four nurses working the night shift requested to be allowed to wear protective clothing when treating AIDS patients. Subsequent to their request, they were transferred to day shifts for developmental training. The commission ruled against the nurses, holding that the hospital's policy was consistent with the latest infection control procedures suggested by the scientific community and the CDC [69].

[14]Of the 121 cases summarized, forty-three deal with medical care. From the information provided in the summaries, nine can be conclusively identified as involving a hospital. They deal with the following issues: breach of confidentiality, alleged disclosure of the results of an HIV antibody test leading to loss of employment (Case No. 117683, recommended for public hearing); alleged discrimination against a patient based on perceived AIDS (Case No. 117997, no further action was taken following no response from complainant); alleged restriction from patient contact following diagnosis of AIDS (Case Nos. 121890, 121950, 121988, recommended for public hearing); alleged inadequate care (Case No. 123301, no further action taken due to lack of response by complainant); alleged denial or proper care (Case No. 129981, pending); alleged destruction of personal property (Case No. 131803, settled); and alleged transfer and ostracism by co-workers after result of HIV test made public (Case No. 132299, in process). The other cases dealing with medical care involve doctors or dentists allegedly denying medical treatment (Case Nos. 117645, 120820, 124584, 124992, 130095, 130263, 130764, 131658, 132330); a medical specialist who was allegedly threatened with discharge (Case No. 125939); paramedics who allegedly did not provide adequate care (Case No. 126516); nursing homes allegedly denying admission to a patient because he had AIDS (Case Nos. 128895-128906, 128887-128894); nursing homes allegedly discriminating against AIDS patients in care giving (Case Nos. 127310, 132002); and an allegation that a nursing home fired a social worker for exposing unlawful discriminatory practices (Case No. 132238) [67].

State Workers' Compensation Laws

Hospitals face other liability issues under state workers' compensation laws. In general, workers' compensation laws do not cover preexisting conditions. However, if a preexisting condition is aggravated by conditions of employment, compensation benefits may be granted. For example, if an AIDS employee who had the disease prior to being employed by a hospital contracts an infectious disease on the job, compensation benefits may apply. The employee in this case may also be tempted to ignore the exclusive remedy provisions of workers' compensation laws and sue the hospital for negligence under another tort theory, alleging the hospital disregarded the risk of AIDS infection or failed to disclose the risk to the employee.[15]

Testing

New York requires written informed consent to HIV testing [71]. The statute also mandates pre- and post-test counseling [71]. A hospital should be familiar with all of the provisions of the testing laws and regulations, as they relate to both patients and employees, to avoid liability for conducting unauthorized testing.

Today, more and more employers are considering mandatory testing for AIDS. Amid the controversy surrounding AIDS testing, a hospital may be torn between respect for the employees' privacy concerns and its own desire to protect itself from liability and to decrease costs. For example, implementing a testing program, although inescapably intrusive, could result in a reduction in workers' compensation claims.[16]

The actual advantage of testing is in fact questionable. A positive test result does not necessarily mean that a person has AIDS. The presence of specific antibody to HIV indicates only prior exposure to this virus and the body's development of an immune response to it. It is not clear from a positive test result whether the individual tested has immunity and is thus protected from the virus, is asymptomatic but can transmit the virus to others, is in the process of developing an AIDS-related condition, or actually has AIDS. In addition, a negative result could mean that the person is not infected, is infected but not yet producing antibodies, or is producing antibodies but not in significant amounts. Given the number of reasonable inferences that can be drawn from both positive and negative results, the utility of testing as a predictor is marginal, and it is difficult to justify blanket screening. The United States Public Health Service does not recommend routine workplace screening. Since there is no evidence that AIDS is

[15]The exclusive remedy principle applies in all states except New York and Illinois [54, p. 9]. *But see Dole v. Dow Chemical* [70].

[16]Although workers' compensation carriers rarely go so far as to recommend testing, they are quick to point to its advantages—lower compensation costs, lower healthcare costs, lower malpractice dollars, and avoidance of a competitive disadvantage resulting from public relations problems [72].

transmitted through ordinary workplace contact, knowledge of an employee's serostatus is not viewed as being related to workplace safety [73].

STRATEGIES FOR DEALING WITH AIDS-RELATED ISSUES

A hospital trying to deal responsibly with AIDS-related issues finds itself in an unusually delicate and complex situation. Most employers need only concern themselves with employment-related issues. A hospital, however, must consider not only its employees, but also its patients and the effects on the general public when it makes decisions about AIDS in the workplace.

A number of organizations, including the CDC, the American Federation of State, County and Municipal Employees (AFSCME), and the American Hospital Association (AHA), have developed guidelines to help hospitals formulate policies regarding HIV infection. The emphasis of the CDC guidelines is on the healthcare worker providing care to an AIDS patient. The CDC compares the epidemiology of HIV to that of the Hepatitis B virus and recommends that the precautions usually taken for preventing the transmission of blood-borne infectious disease also be taken with HIV infections [74].

The AFSCME guidelines focus on healthcare and prison workers. The guidelines emphasize the need for education to prevent transmission of HIV and further recommend that pregnant care providers be excused from direct care of AIDS patients because of potential exposure to an opportunistic infectious agent, cytomegalovirus, which may cause birth defects [75].

The AHA advised against routine testing of employees and patients for HIV. It recommends protective gear for those doing invasive procedures, such as drawing blood, suctioning, needle biopsy, and surgery, that involve an inherent potential for mucous membrane or skin contact with blood, body fluids, or tissues. Finally, the AHA advises against prohibiting AIDS-infected employees from working [75].

When considering whether or not to adopt these or other special AIDS policies, hospital administrators need to exercise care. One decision to be made is whether or not to adopt a special HIV infection policy. Some legal experts recommend special policies; others do not. Advocates of special policies say they are necessary and must be in place prior to the first case or suspected case of AIDS in order to protect against charges of discrimination. The concern is that if the policy is developed after the fact, it may be argued that the policy was aimed at protecting or singling out a specific individual. Those who are against special policies argue that they may simply instill more fear in the healthcare worker who is already reluctant to treat AIDS patients. They also argue that a special policy draws unnecessary attention to an illness that should be treated like any other. Accordingly, they recommend that AIDS be treated like any other illness or handicap and be included under existing policies.

When a hospital does develop special policies, the administration must defer to competent medical judgment and consider:

- How the disease is transmitted:
  Casual transmission of the AIDS virus has not been established; transmission is very difficult except through intimate contact.

- Duration of risk:
  The incubation period is very long; therefore, the duration of the risk may be substantial.

- Potential harm to others:
  If contracted, the eventual outcome of the disease is most likely death.

- Probability of transmission:
  In most cases, the probability is low. In hospitals, however, the risk is higher because of handling body fluids. Adherence to CDC-recommended precautions reduces the probability of AIDS transmission in a healthcare setting [76].

A hospital employer must also recognize its obligations to discuss any proposed AIDS-related policies with union or employee representatives. Under the terms of the NLRA, management is obligated to discuss with the labor organization representing its employees, "terms and conditions of employment" [33]. It is likely that management would have an obligation to bargain with its union over an AIDS policy [54]. In a nonunion setting, it is equally important that any proposed policy be developed with employee participation, to maximize satisfaction and compliance.

The Citizens Commission on AIDS for New York City and Northern New Jersey has suggested "Ten Principles for the Workplace" as a framework for hospitals within which to work in developing an AIDS policy [77]:

1. People with AIDS or HIV infection are entitled to the same rights and opportunities as people with other serious or life-threatening illnesses.
2. Employment policies must, at a minimum, comply with federal, state, and local laws and regulations.
3. Employment policies should be based on the scientific and epidemiological evidence that people with AIDS and HIV infection do not pose a risk of transmission of the virus to coworkers through ordinary workplace contact.
4. The highest levels of management and union leadership should unequivocally endorse nondiscriminatory employment policies and educational programs about AIDS.
5. Employers and unions should communicate their support of the policies to workers in simple, clear and unambiguous terms.

6. Employers should provide employees with sensitive, accurate, and up-to-date education about risk reduction in their personal lives.
7. Employers have a duty to protect the confidentiality of employees' medical information.
8. To prevent work disruption and rejection by coworkers of an employee with AIDS or HIV infection, employers and unions should undertake education for all employees before such an incident occurs and as needed thereafter.
9. Employers should not require HIV screening as part of general preemployment or workplace physical examinations.
10. In those special occupational settings where there may be a potential risk of exposure to HIV, employers should provide specific ongoing education and training, as well as the necessary equipment, to reinforce appropriate infections control procedures and ensure that they are implemented.

Hospitals should examine their existing policies or develop new policies consistent with these suggestions, which are both sensible and fair.

Education, training, and counseling programs should be implemented in preparation for rather than in reaction to a crisis. A proactive posture has the advantages of alleviating fear, reducing misconceptions, developing compassion for infected coworkers, reducing personal risk, and maintaining a stable work environment.

Most adults are employed. Work is not only a source of financial support, but also is important to the physical, mental, and social well-being of a person. In our society, work is a source of esteem and recognition and gives validity to life. Taking work away from a person with AIDS unnecessarily is inefficient for the employer and unfair to the affected employee. As an employer, the hospital should be prepared to provide employee assistance options to the AIDS employee. It should also be committed to keeping an employee on the job as long as possible, providing such options as extended sick leave, flexible hours, part-time work, and reassignment to less strenuous work.

A hospital should also be prepared to deal with modifications in disability benefits and insurance coverage, and counseling should be provided to help the infected employee and coworkers deal with death and dying and long-term disability. As an employer, the hospital should develop policies that are as sensitive and responsive as possible to coworkers' concerns while at the same time making reasonable accommodations for the infected employee.

CONCLUSION

As an employer and healthcare provider, a hospital is in a unique and sensitive position. It should be especially attentive to all of the medical and legal ramifications of AIDS as they relate to both employees and patients, and try to strike a fair

and efficient balance between the competing interests of both their constituencies. As it does so and develops policies that provide the necessary balance, it needs to consider existing state, federal, and local laws and regulations, the specific needs of its community, and its own special characteristics. The hospital's task is a most difficult one and requires the utmost sensitivity.

It is clear that there are many more questions than answers for hospitals struggling with the medical and liability problems posed by AIDS. The legal and ethical issues associated with the disease are complex. Thoughtful, informed policies can help protect infected individuals from harmful social and economic effects, while safeguarding the uninfected from the dire medical consequences of AIDS.

* * *

Sandra N. Hurd is an Associate Professor and Chair of the Law & Public Policy Department of the Syracuse University School of Management. Her publications appear in the *American Business Law Journal*, the *Journal of Products Liability*, the *Employee Responsibilities and Rights Journal*, and the *Oklahoma City University Law Review*. She is on the Editorial Board and is Contributing Editor of *Employment Testing*, a national reporter on drug, polygraph, AIDS, and genetic testing in the workplace and has testified before Congress on the problems of transnational enforcement of United States securities laws.

Dr. Elizabeth C. Wesman is an associate professor of human resource management and industrial relations at the Syracuse University School of Management. Her publications include articles on sexual harassment, pay equity, and due process in labor-management relations.

REFERENCES

1. Occupational Safety and Health Act, 29 U.S.C. §§ 651-678 (1976).
2. S. Murphy, *Protecting Employees With AIDS: Using Title VII to Meet an Urgent Need, The Review of Litigation, 3*, pp. 357, 364 (1988).
3. State of New York Department of Health, HTLV-III/LAV Testing in Health Care Facilities, 1981.
4. R. L. Heller, Jr., Where Did AIDS Come From?, *AIDS Inservice, 1*, pp. 1-2, 1987.
5. United States Department of Health and Human Services, AIDS: A Public Health Challenge, State Issues, Policies and Programs, (1987) [hereinafter referred to as HHS].
6. United States Department of Health and Human Services, Joint Advisory Notice, Protection Against Occupational Exposure to Hepatitis B. Virus (HBV) and Human Immunodeficiency Virus (HIV), pp. 2-4, 1987 [hereinfafter cited as *Joint Advisory Notice*].
7. Surgeon General's Report on Acquired Immune Deficiency Syndrome, U.S. Department of Health and Human Services, p. 21, 1986.

8. M. A. Fischi, Evaluation of Heterosexual Partners, Children, and Household Contacts of Adults with AIDS, *Journal of the American Medical Association, 257*, p. 640, 1987.
9. Update: Acquired Immunodeficiency Syndrome—United States, 1989, *Morbidity and Mortality Weekly Report, 39*, pp. 81, 83, February 9, 1990.
10. Estimates of HIV Prevalence and Projected AIDS Cases: Summary of a Workshop, October 31-November 1, 1989, *Morbidity and Mortality Weekly Report, 39*, p. 110, February 23, 1990.
11. D. Schobel, Management's Responsibility to Deal Effectively With the Risk of HIV Exposure for Healthcare Workers, *Nursing Management, 19*, p. 39, March 1988, (citing *AIDS Reference Guide for Medical Professionals*, C. Dale and A. Avers (eds.), 1986.
12. S. N. Hurd, AIDS and the Risk to Health-Care Workers: Old and New Guidelines, *Employment Testing, 1*, pp. 99, 100, 1987.
13. Recommendations for Prevention of HIV Transmission in Health-Care Settings, *Morbidity and Mortality Weekly Report, 36*, pp. S1-S18, August, 21, 1987.
14. R. Orthmann, AIDS in the Workplace: Summary of Recent Developments, *Employment Testing, 2*, p. 268, 1988.
15. S. N. Hurd, States Pass Work-related AIDS Statutes, *Employment Testing, 3*, p. 471, 1989.
16. N.Y. Public Health Law, § 2805(b) (1989).
17. Hospital Survey and Construction Act, 60 Stat. 1040 (1946).
18. K. Benesch and T. Homisak, The Duty to Treat AIDS Patients, Trial, pp. 23-24, May, 1988.
19. J. O'Brien, Patient's Rights, Doctor's Role Collide in AIDS Case, *The Post-Standard*, p. B1, col. 1, May 21, 1988.
20. *Vanderhale v. Berinstein*, 285 A.D. 290, 136 N.Y.S.2d 95, *modified* 285 A.D. 1089, 136 N.Y.S.2d 349 (3d Dept. 1954).
21. J. Allen, Health Care Workers and the Risk of HIV Infection, *Hastings Center Report, 18*, p. S2, 1988.
22. Update: Acquired Immunodeficiency Syndrome—United States, 1989, *Morbidity and Mortality Weekly Report, 39*, pp. 81, 82, 1990.
23. *Pennsylvania Insurance Management Company, Hospital Risk Control, Infection Control*, 1986, (citing H. P. Kaplan, Autologous Transfusion, August 1985).
24. L. O. Gostin, The AIDS Litigation Report, *Journal of the American Medical Association, 263*, pp. 1961, 1965, 1990.
25. *N.Y. Public Health Law*, §§ 225(4), 225(5)(a), 206(1)(j), 1981.
26. OSHA Communications Standard, 29 CFR 1910.1200.
27. N.Y. Labor Law Article 28 (1981).
28. *N.Y. Sanitary Code* Article 24.1 (1989).
29. 131 Cal. Rptr. 14 (1971).
30. 29 U.S.C. §§ 701-99 (1982).
31. 42 U.S.C. §§ 2000e to 2000e-17 (1982).
32. 29 U.S.C. § 1001-1461 (1982).
33. 29 U.S.C. §§ 151-68 (1982).
34. 29 U.S.C. §§ 651-78 (1982).
35. 45 C.F.R. § 84.3(2)(i) (1987).

36. 45 CFR §84.3(k)(1) (1985).
37. J. E. Brockhoeft, AIDS in the Workplace: Legal Limitations on Employer Actions, *American Business Law Journal, 26*, pp. 255, 279-281, 1988.
38. C. Applebaum, The Application of Handicap Discrimination Laws to AIDS Patients, *U.S.F. Law Review, 22*, p. 317, 1988.
39. 107 S. Ct. 1123 (1987)
40. 772 F.2d 759 (11th Cir. 1985).
41. 840 F.2d 701 (9th Cir. 1988).
42. *Thomas v. Atascadero Unified School Dist.*, 662 F. Supp. 376 (C.D. Cal. 1987).
43. *Ray v. School Dist. of De Soto County*, 666 F. Supp. 1524 (M.D. Fla. 1987).
44. Pub. L. No. 100-259, 102 Stat. 28 (1988) (to be codified at 29 U.S.C. §70 (1988).
45. C. Cooper, Assistant Attorney General, Office of Legal Counsel for the Department of Health and Human Resources, Application of Section 504 of the Rehabilitation Act to Persons with AIDS, AIDS-Related Complex, or Infection with the AIDS Virus, June 20, 1986.
46. D. Kmiec, Acting Assistant Attorney General, Office of Legal Counsel, U.S. Department of Justice, Application of Section 504 of the Rehabilitation Act to HIV-Infected Individuals, October 6, 1988.
47. Charlotte Memorial Hospital, Complaint No. 04-84-3096 (Office for Civil Rights, Region IV, HHS, August 5, 1986).
48. *West v. Butler*, 621 F.2d 240 (6th Cir. 1980).
49. *Kross v. Western Electric Company, Inc.*, 701 F.2d 1238 (7th Cir. 1983).
50. J. Fossum, *Labor Relations: Development, Structure, Process* (4th Edition), BPI, Irwin, Homewood, Illinois, p. 81, 1989.
51. *Cook County Bd. of Education*, 89 L.A. 521 (1987).
52. *Bureau of National Affairs, Basic Pattern in Union Contracts*, (11th Edition), pp. 130-132, 1988.
53. 42 U.S.C. §§ 2000e to 2000e-17 (1982).
54. K. H. Henry, The AIDS Epidemic: Implications for Healthcare Employers, *The Healthcare Supervisor, 6*, pp. 1, 4, 1987.
55. *Minnesota Dept. of Corrections*, 85 LA 1185 (1985).
56. *Grievance Guide* (6th Edition), BNA, pp. 1-2, 1982.
57. P. J. Cihon and J. O. Castagnera, *Labor and Employment Law* 81, PWS-Kent Publishing Company, Boston, Massachusetts, 1988.
58. 29 U.S.C. § 254 (1982).
59. *Employment Testing: Testing Resource Manual*, p. A:11, 1987.
60. *Whirlpool Corp. V. Marshall*, 455 U.S. 1 (1980).
61. *Minnesota Dept. of Corrections*, 85 LA 1185 (1985).
62. D. Mayer, Safety Agency Cites 7 Health Care Facilities—Poor AIDS Safeguards, *Healthweek*, April 25, 1988.
63. National Gay Rights Advocates Survey, September 1986.
64. S. N. Hurd, States Pass AIDS-related Laws, *Employment Testing, 3*, pp. 351, 352, 1989.
65. N.Y. Exec Law §296 (McKinney, 1988).
66. AIDS in the Workplace, N.Y.S. Joint Labor/Management Comm. on AIDS, p. 15, 1989.

67. *Summary of Cases 1987-1988*, Office of AIDS Discrimination Issues, New York State Division of Human Rights.
68. Los Angeles, Cal., Ordinance No. 160289 (Los Angeles, Cal., Municipal Code ch. III, art. 5.8, §§ 45.80-45.93).
69. *Bernales v. City and County of San Francisco Department of Public Health*, California Labor Commission, Nos. 11-17001-1, 11-17001-2, 11-17001-4 (September 1985).
70. 316 N.Y.S. 2d 348 (1970).
71. *N.Y. Pub. Health Law* § 2781(1) (1989).
72. D. Burda, Insurer Counsels on Preemployment Testing for AIDS, *Hospitals, 35*, September 20, 1987.
73. Citizens Commission of AIDS for New York City and Northern New Jersey, *Responding to AIDS: Ten Principles for the Workplace*, p. 23, 1988.
74. Guidelines for Prevention of Transmission of Human Immunodeficiency Virus and Hepatitis B Virus to Health-Care and Public-Safety Workers, *Morbidity and Mortality Weekly Report, 38*, pp. 1, 4, June 23, 1989.
75. R. M. Green, The Hospital as Employer and Health Care Provider: A Perspective on AIDS, 23rd Annual Personnel and Labor Relations Institute, Hospital Association of New York State, p. 17, 1986.
76. K. L. Goldsmith, Factors Critical to Dealing with AIDS in the Workplace, *Provider for Long-Term Care Professionals*, p. 50, 1987.
77. P. Pontius, *AIDS in the Workplace Seminar Series: Corporate Strategies*, The Business Council of New York State, Inc., pp. 1-3, 1988.

Direct reprint requests to:

Prof. Elizabeth C. Wesman
Syracuse University
School of Management
900 S. Crouse Avenue
Suite 500
Syracuse, NY 13244-2130