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TESTING HEALTH CARE WORKERS FOR AIDS*

Barry S. Reed, M.D.**

The tragic case of Kimberly Bergalis has inflamed an already heated debate which argues that: health care workers (HCWs), HCWs who are engaged in invasive procedures, or both, *plus* all patients should be tested for Human Immunodeficiency Virus (HIV) infection.¹ Epidemiologic review of Ms. Bergalis's infection has concluded that she was probably infected as a result of contact as a patient with her oral surgeon, Dr. David J. Acer.² With respect to HIV testing, one remedy suggested is extreme. If the HCW is positive for antibodies to the AIDS virus and fails to share that information with his or her patients, then the HCW should be imprisoned for ten years.³

AIDS testing does not routinely attempt to isolate the virus. Antibodies to the virus are only indirect evidence of the viral infection. Testing for the antibodies uses an immunologic technique, Enzyme Linked Immunosorbent Assay (ELISA) and is confirmed with a separate test, the Western Blot.⁴

* Opinions expressed in this Essay are those of the author and do not necessarily represent the views of the Metropolitan Life Insurance Company or its affiliated companies.

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1. Kimberly Bergalis, a 23-year-old woman, recently died of AIDS. She and four other former patients of Florida oral surgeon, David J. Acer, contracted AIDS. Acer died of AIDS in 1990. Before his death, he published an open letter to his patients advising them to be tested for AIDS. None of Acer's former patients identified by the Centers for Disease Control (CDC), has had any known risk factors for AIDS—including intravenous drug abuse, or blood transfusions. Centers for Disease Control, *Update: Transmission of HIV Infection During an Invasive Dental Procedure—Florida*, 40 MORBIDITY AND MORTALITY WKLY REP. 21, 26 (1991) [hereinafter CDC, *Update*]; see also Katherine Karker-Jennings & Michael F. Berkey, *Providers with HIV/AIDS—A New Dilemma*, 5 MED. STAFF COUNS. 39, 39 (1991).

2. CDC, *Update*, *supra* note 1, at 21.

3. *Emotion and Science: Editorial*, 122 JADA 10 (1991) (referring to legislation proposed by Senator Jesse Helms).

4. For an explanation of the procedures and accuracy of the two commonly used tests for detecting the AIDS antibody, see Patricia S. Atkins, Comment, *The Constitutional Implications of Mandatory AIDS Testing in the Health Care Industry*, 17 SW. U. L. REV. 787, 793-94 (1988); Michael D. Hagen, et al., *Routine Preoperative Screening for HIV: Does the Risk to the Surgeon Outweigh the Risk to the Patients?*, 259 JAMA 1357, 1358 (1988); Susan J. Levy, Comment, *The Constitutional Implications of Mandatory Testing for Acquired Immunodeficiency Syndrome—AIDS*, 37 EMORY L.J. 217, 227-28 (1988).

The latter identifies specific HIV proteins. An HIV positive patient who also has one or more of the complications identified in the guidelines of the Centers for Disease Control (CDC)⁵ is diagnosed as having AIDS.

The legal questions surrounding the testing of HCWs for AIDS are many and complex. Who is an HCW? Physicians, dentists, and nurses are clearly included, but what about students in training? Does the definition extend to phlebotomists, who are usually laboratory technicians? Does it extend to volunteer rescue squad members, firemen, and paramedics who have been trained to start intravenous lines? The basic issue in testing HCWs for AIDS is the dilemma of balancing the government's invasion of the rights of individuals such as HCWs with the interests of the general public. The government action has the potential to be coercive, resulting in a "taking of property"—revoking a professional license to practice and earn a living. That "taking" raises constitutional questions.

More generally, the issues range from individual rights of HCWs, patients, and HCWs who become patients to confidentiality, liability and tort, and discrimination in employment and housing. The legal issues focus on statutory concerns, including legislation ranging from the Public Health Service Act⁶ to the 1990 Americans with Disabilities Act.⁷ The scope of this Essay is intentionally narrow and will not discuss tort liability, the right to treatment of AIDS patients, or discrimination. This Essay attempts to shed some light on the issue of AIDS testing of HCWs without generating more heat. How reasonable and logical could testing of HCWs be in practice?

SCOPE OF THE AIDS EPIDEMIC

Since AIDS was first noted in 1981, there have been approximately 12,000,000 cases worldwide.⁸ The syndrome has been detected in 165 countries and it is estimated that by the year 2000 there will be 40,000,000 cases.⁹ In the United States there have been 140,000 deaths and over 210,000

5. Centers for Disease Control, *Revision of the CDC Surveillance Case Definition for Acquired Immunodeficiency Syndrome*, 36 MORBIDITY AND MORTALITY WKLY REP. 3S, 4S-6S (Supp. 1987).

6. Public Health Service Act, 42 U.S.C. §§ 201 to 300aa-13 (1988).

7. Americans with Disabilities Act of 1990, 42 U.S.C.S. §§ 12101-213 (Law. Coop. Supp. 1991).

8. Presentation by William Curran, M.D., Assistant Surgeon General, Deputy Director, HIV, CDC, Atlanta, Georgia, to the Association of State and Territorial Public Health Department Laboratory Directors, Chicago, Illinois on March 5, 1992. Dr. Curran emphasized that while the epidemic has apparently stabilized in the U.S.—now the numbers of deaths equals the number of new cases—worldwide the epidemic is skyrocketing. The public attitude towards the disease is becoming indifferent and the educational needs for the control of the spread of the disease are becoming politically ignored.

9. *Id.*

cases.¹⁰ AIDS has become the leading cause of death in the twenty-five to forty-four age group.¹¹

Because of the unique characteristics of AIDS, traditional public health measures used to contain infectious diseases, such as quarantine, are not effective.¹² A person who is infected with HIV may not show signs or symptoms of the opportunistic or malignant diseases associated with HIV for months or years. This has tremendous implications for any testing program. Do you test people who look sick or might possibly be sick? A person who tests negative today may become infected tomorrow and not become seroconverted to a positive test status nor infectious to others for weeks or months. Should persons tested once be retested again every six months? Every three months? Every nine months?

In the United States, AIDS has been particularly prevalent among homosexual men and is most commonly transmitted by anal intercourse. The fastest growing population of AIDS patients in the United States are intravenous drug abusers (IVDAs). There is little reason to presume that enactment of mandatory testing statutes relating to HIV status will change behavior or safeguard the public. Neither IVDAs nor homosexuals have traditionally won sympathy or compassion from either the public or legislators. If there is any positive result from the internationally reported revelation of the HIV infection of the superstar athlete Earvin "Magic" Johnson it would be a change in the public's perception and attitude that this is a disease which afflicts only a limited segment of society.¹³

CDC GUIDELINES FOR HEALTH CARE WORKERS

The guidelines designed to lessen the risk of the spread of HIV and Hepatitis B (HBV) were published by the CDC in July, 1991.¹⁴ The CDC recommends that HCWs who perform exposure-prone procedures should know their HIV antibody and HBV antibody status.¹⁵ Exposure-prone procedures

10. *Id.*

11. Centers for Disease Control, *Mortality Attributable to HIV Infection/AIDS—United States, 1981-1990*, 40 MORBIDITY AND MORTALITY WKLY REP. 41, 41-42 (1991).

12. See Gene W. Matthews & Verla S. Neslund, *The Initial Impact of AIDS on Public Health Law in the United States—1986*, 257 JAMA 344, 344 (1987).

13. The announcement by Johnson of his retirement from one of the most successful professional basketball careers of all time due to infection by the AIDS virus was front page news nationwide. See, e.g., Lou Cannon, *Basketball Star Magic Johnson Retires with AIDS Infection*, WASH. POST, Nov. 8, 1991, at A1; Susan Pulliam, *Fateful AIDS Test on Magic Johnson was for Insurance*, WALL ST. J., Nov. 8, 1991, at A1; Richard W. Stevensen, *Magic Johnson Ends His Career, Saying He Has AIDS*, N.Y. TIMES, Nov. 8, 1991, at A1.

14. Gary R. Noble, *HIV and Health Care Settings*, HIV/AIDS PREVENTION NEWS (CDC Atlanta, Ga.), Oct. 1991, at 1, 1.

15. *Id.*

are defined as those in which the HCW might be cut or injured and his or her blood may come into contact with a patient's body cavity, subcutaneous tissues, or mucous membranes.¹⁶ The guidelines add that HCWs who are positive for either antibody test:

[S]hould not perform exposure-prone procedures unless they have sought counsel from an expert review panel and been advised under what circumstances, if any, they may continue to perform these procedures. Such circumstances would include notifying prospective patients of the HCW's seropositivity before they undergo exposure-prone invasive procedures. The review panel should include experts who represent . . . all of the following: (a) the HCW's personal physician(s), (b) an infectious disease specialist with expertise in the epidemiology of HIV and HBV transmission, (c) a health professional with expertise in the procedures performed by the HCW, and (d) state or local public health official(s). If the HCW's practice is institutionally based, the expert review panel might also include a member of the infection-control committee, preferably a hospital epidemiologist.¹⁷

Dr. Gary Noble, Deputy Director (HIV), at the CDC, has noted that the risk of transmission of HIV infection from an HCW to a patient during routine medical procedures is zero and very small even during exposure-prone procedures.¹⁸ The following instances support Dr. Noble's position:

- (a) Of the 732 patients of Dr. Acer (Kim Bergalis's dentist) who have been tested, only five were reported to be positive for HIV. The epidemiologic review of the five "Acer" cases has not provided an explanation of the mechanism of viral transmission.¹⁹ The study noted many breaks in the sterilization practices in Acer's office.²⁰ Additionally, records of accidents were not maintained.²¹
- (b) When a Tennessee surgeon died from AIDS-related disease in 1988, HIV testing of 616 former patients was performed. These patients had been operated on by the surgeon between January 1, 1982 and September 1988, the period in which he was most likely to be infectious. Only one patient was reported to have contracted AIDS, and it is speculated his exposure to HIV was a result of

16. *Id.*

17. *Id.* at 2.

18. *Id.*

19. For similar examples of HIV positive HCWs who did not transmit their HIV infection to their patients see Dennis Hevesi, *Fury and Relief Greet AIDS Proposal*, N.Y. TIMES, Oct. 9, 1991, at B6.

20. CDC, *Update*, *supra* note 1, at 25-27.

21. *Id.* at 27.

either intravenous drug use or sexual encounters with prostitutes.²²

(c) Dr. Philip Feldman, a Long Island, New York dentist, died from AIDS-related pneumonia in June, 1991. Five hundred seventy-eight of his patients were tested for AIDS antibodies and two were found to be HIV positive.²³

(d) In a study of 9,000 patients of infected HCWs, not one other case has been traced to the care given by a doctor or dentist infected with the AIDS virus.²⁴

(e) During the entire AIDS epidemic, approximately forty cases of transmission of HIV to HCWs from patients have been reported.²⁵ The risk of transmission is calculated at 0.3% per exposure of percutaneous blood.²⁶

HCW RESPONSE TO CDC PROPOSALS²⁷

Before publication of the CDC guidelines, many medical organizations expressed their opposition to the plan for identification of "exposure-prone" procedures, asserting that there is an inadequate scientific basis for such a plan. The CDC called an open meeting in Atlanta on November 4, 1991 to enlist the help of the medical community in identifying the "exposure-prone" procedures.²⁸ Commenting on behalf of thoracic surgeons, Quentin Stiles, M.D. stated, "The question we have to ask ourselves is—is this an idea based on scientific merit or an overreactive response to political pressure?"²⁹ In response to the lack of support from the medical community, the Director of the CDC, William Roper, M.D., said, "We are anxious to proceed in a manner that builds consensus We are going to think very clearly about this in the next few weeks."³⁰

22. Ben Mishu et al., *A Surgeon with AIDS: Lack of Evidence of Transmission to Patients*, 264 JAMA 467, 469 (1991).

23. See Hevesi, *supra* note 19, at 264.

24. Lawrence K. Altman, *Unexpected Defiance Greets AIDS Guidelines*, N.Y. TIMES, Oct. 15, 1991, at C3.

25. Frank R. Lewis, *HIV Testing of Health Care Workers: The Need for Additional Data*, 76 AM. C. SURGEONS BULL. 17, 18 (1991).

26. *Id.* at 17; see also David K. Henderson et al., *Risk for Occupational Transmission of Human Immunodeficiency Virus Type 1 (HIV 1) Associated with Clinical Exposures*, 113 ANNALS INTERNAL MED., 740, 744 (1990).

27. See generally, Craig Crosby & Diana L. Madden, *Health Care Groups Show Opposition to Mandatory Testing*, THE INTERNIST, Apr. 1991, at 18 (outlining the negative reaction of HCW's to the proposed mandatory testing of all HCWs under the new CDC guidelines); Constance B. Wofsy, *HIV-Infected Workers: How Should We Proceed?*, THE INTERNIST, Apr. 1991, at 17 (evaluating whether HCWs should be mandatorily tested for HIV infection).

28. Malcom Gladwell, *Medical Groups Reject Limits on HIV-Infected Workers*, WASH. POST, Nov. 5, 1991, at A1.

29. *Id.*

30. *Id.* at A4.

Much of the theory underlying the proposed measures to limit the risk of transmission of HIV from HCWs to patients is based on experience with HBV. HBV is a far more infectious and easily transmitted agent than the HIV and many scientists and medical clinicians have questioned the scientific validity of modeling proposed HIV regulations on HBV.³¹

The New York State Department of Health stated its intention to protect the confidentiality of infected HCWs and allow them to continue treating patients in most cases. The proposed New York legislation would require a formal course for HCWs in infection control techniques. If an HCW tested positive, there would be no requirement to advise patients of the HCW's condition. Testing would be voluntary and a review panel would assess whether an infected HCW's continued practice constituted a significant risk to patients and should be restricted.³² Voluntary reliance on the infected HCW assumes that the HCW will be informed of his or her HIV status. The proposed New York legislation also presumes that the HCW is willing and able to use good judgment. Given that AIDS may primarily result in dementia, it is not clear that the HCW will always be able to exercise sound judgment. Albert R. Jonsen, M.D. suggests that medical institutions, medical professional societies, and professional organizations must act affirmatively to support HIV-infected HCWs before they can be expected to conform with the July, 1991 CDC guidelines.³³ David M. Price, Ph.D., offers a succinct summary of the recommendations to HIV-infected HCWs which he discussed at a December, 1990 conference held at Brunswick, New Jersey.³⁴ Price cautions against actions which are punitive towards HCWs and disregard their needs. Additionally, The American Dental Society reversed an earlier position supporting the idea of an "exposure-prone procedures" list, saying that such a list lacked scientific validity.³⁵ In response to protests by over thirty health care and civilian organizations, the CDC ultimately dropped its plan to identify "risk prone" procedures.³⁶

CONCLUSION—LANDESMAN SYNOPSIS

Sheldon Landesman, M.D., a clinician and AIDS researcher in the Infec-

31. *Id.*

32. Kevin Sack, *Albany Plans to Allow Surgery by Doctors with the AIDS Virus*, N.Y. TIMES, Oct. 9, 1991, at A1, B6.

33. Albert R. Jonsen, *Is Individual Responsibility a Sufficient Basis for Public Confidence?*, 151 ARCHIVES INTERNAL MED. 660, 661-62 (1991).

34. David M. Price, *What Should We do About HIV-Positive Health Care Professionals?*, 151 ARCHIVES INTERNAL MED. 658, 658-59 (1991).

35. Altman, *supra* note 24, at C3.

36. Lawrence K. Altman, *U.S. Backs Off Plan to Restrict Health Care Workers with AIDS Virus*, N.Y. TIMES, Dec. 4, 1991, at A1, C19.

tious Disease Division at the State University of New York Downstate in Brooklyn, has offered a most concise and eloquent overview of the HIV/HCW testing issue.³⁷ Reviewing the competing interests involved in the AIDS epidemic, he notes the limitations on the ability of the state to limit individuals' behavior using coercive or noncoercive means.³⁸ He comments that it is appropriate for the state to use extraordinary police powers when there is a reasonable certainty of the risks which are involved.³⁹ Nonetheless, numerous experts have estimated that the risk of an HCW transmitting HIV to a patient is close to zero.⁴⁰

In reviewing the policies which have developed over the first ten years of the epidemic, Landesman concludes that the public has accepted that AIDS is not spread through casual contact.⁴¹ Infected children attend school and infected workers are allowed to return to the workplace.⁴² However, constant vigilance is required to prevent discrimination,⁴³ Landesman laments over the lack of consensus among medical professionals,⁴⁴ pointing out that it could stir public anxiety or result in surgeons refusing to operate on HIV positive patients.⁴⁵ Landesman suggests that one of the lessons of the past ten years is renewed appreciation of the importance of universal precautions by HCWs to minimize transmission from infected patients to HCWs.⁴⁶ Conversely, the failure to observe these hygienic precautions may have played a central role in the infection of the dental patients of Dr. Acer.⁴⁷ Although he denies having answers to the question about testing HCWs, Landesman concludes with several important suggestions. First, he requires complete honesty with the public. It is important to speak of risk in real terms, because failing to be honest is a prescription for fear.⁴⁸ Second, he suggests reaching a public health consensus, although he believes it will probably not be found and may aggravate the public's confusion and distrust.⁴⁹ Next, he believes education of the HCW and general public must

37. See Sheldon H. Landesman, *The HIV-Positive Health Professional: Policy Options for Individuals, Institutions, and States*, 151 ARCHIVES INTERNAL MED. 655 (1991).

38. *Id.* at 655.

39. *Id.*

40. *Id.*

41. *Id.*

42. Altman, *supra* note 36, at C19.

43. Landesman, *supra* note 37, at 656.

44. Gladwell, *supra* note 28, at A4 (quoting William L. Roper, M.D., the Director of the CDC).

45. Landesman, *supra* note 37, at 656.

46. *Id.*

47. See *supra* notes 1-2 and accompanying text.

48. Landesman, *supra* note 37, at 656.

49. *Id.*

include education of "derivative and secondary implications."⁵⁰ He states,

If we end up with a policy that excludes infected surgeons and dentists, then the first and logical derivative policy begins with the testing of surgeons and dentists and, perhaps, students. The second derivative policy will be the testing of patients. A third very important derivative policy would be an alteration of the concept of "significant risk." If we propose exclusion of infected providers from performing invasive procedures because they pose a "significant risk" to their patients, then we have defined a level of risk wherein public action is required This level of "significant risk" could be potentially translated into testing and excluding infected food handlers, infected school children, and many others.⁵¹

Furthermore, he asserts that whatever policy is adopted should be the least restrictive, thereby minimizing the use of coercive state power.⁵² In addition, he posits the importance of taking the fear of contracting AIDS at face value. In other words, to say that fear of AIDS equals bigotry, the audience which is being addressed will not listen. Finally, he recognizes that the current debate is driven by fear which is inappropriate to the level of the actual risk, because, in fact, the exaggerated fear of infection from an HCW is almost unrelated to the actual risk.⁵³

50. *Id.*

51. *Id.*

52. *Id.* at 657.

53. *Id.*