SUTURING A TORN SYSTEM: HOW TO REDUCE DISCRIMINATION AGAINST HIV-POSITIVE MEDICAL CARE WORKERS

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Although HIV has qualified as a disability under the Americans with Disabilities Act (“ADA”) ever since the Supreme Court’s 1998 decision in Bragdon v. Abbott, the ADA’s “direct threat” defense has been broadly used and interpreted expansively. Although many sub-categories of individuals with HIV have meritorious legal issues that demand analysis, the complexities of the medical profession coupled with HIV’s stigma have rendered confidentiality and disclosure issues ripe in that field. For the purpose of this note I have grouped together all individuals who provide medical services into a class which I call “Medical Care Workers” or “MCWs.” More specifically, I focus on how the law currently treats HIV-Positive MCWs. I address the deficiencies of the current regulatory regime, the short-falls of medical community standards, and the legal issues that pervade. In Suturing a Torn System: How to Reduce Discrimination Against HIV-Positive Medical Care Workers, I also make several suggestions to improve the current legal apparatus charged with protecting HIV-Positive MCWs. I do so with the aspiration that I may persuade the legal and medical communities that HIV discrimination deserves further contemplation, and more broadly, with the hope that I may encourage the reader to learn more about HIV and AIDS.

¹ Any mistakes or omissions are my own. I would like to extend a special thanks to my family for their support throughout law school. I also owe a debt of gratitude to Professor Robert Rains for giving me direction on this project. Last, but certainly not least, I want to express my love and appreciation to the wonderful attorneys, paralegals, and clients at the AIDS Law Project of Pennsylvania for inspiring me to write this note.
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I. INTRODUCTION

Since scientists discovered HIV/AIDS in the early 1980s, the virus and resulting disease have had a growing influence on the current disability discrimination regime. The laws of the United States have recognized that HIV is a disability, and that those living with its effects should receive the same protections as other disabled individuals. The medical community has played a significant role in this development.

The medical community has moved past its negative history with AIDS; a period of misinformation that fed a sensationalist media by first characterizing HIV/AIDS as the “Gay-related immune deficiency”, or “GRID.” This community has developed treatments that show HIV is a disability that can be managed. The medical community has also worked with the Centers for Disease Control in establishing as a matter of law that HIV is not a “communicable disease,” which has had a significant effect on the “direct threat” defense for discriminatory practices.

Although the legal system has treated sympathetic plaintiffs such as Ryan White with candor, many issues surrounding HIV discrimination remain unresolved. Specifically, the legal system has not developed an adequate method of analysis to confront the difficult issues of confidentiality and patient safety in situations where treating medical practitioners are HIV-positive.

In this paper I evaluate current regulation of HIV positive Medical Care Workers (MCWs). I do so by exploring relevant statutes and case law, federal regulations, and professional association measures. I do not distinguish between each practice area of the medical profession; this would have the reader losing the forest for the trees. Rather, in this paper I
explore issues of discrimination against all HIV-positive MCWs, from nurses and dental assistants to cardiovascular surgeons.

After depicting the history of HIV and its effect on U.S. law, I address the issue of confidentiality, which has been at the forefront of discrimination cases. I also examine current disclosure requirements between MCWs and employers, employers and patients, and MCWs and patients, and discuss the implications of such requirements. Moving on from confidentiality, I delve into the difficulty that employers have in balancing patient safety and discriminatory practices. After tackling confidentiality and disclosure, I suggest a process whereby the rules can be clarified, patient safety can be ensured, and discrimination can be drastically reduced.

II. BACKGROUND

HIV has not only destroyed lives through its devastating physical and emotional tolls, but through a misguided public perception that has led to immeasurable consequences. Though management of the virus and resulting disease AIDS have improved drastically since they were discovered in the early 1980s, the American public has held fast to its stereotypes of the disease. Despite the force and effect of disability discrimination legislation in the form of The Rehabilitation Act of 1973 and the Americans with Disabilities Act, individuals with HIV have faced an unrelenting barrage of discrimination by a society that insists on handling them with a glove and tongs. This section will unveil the history of HIV, convey relevant disability discrimination legislation and case law, and detail the law’s treatment of HIV-positive MCWs.

A. THE HIV OUTBREAK
Doctors discovered HIV/AIDS through a series of diagnoses surrounding a rare opportunistic infection, which seemed only to afflict needle users and gay men. The infection, *Pneumocystis carinii* pneumonia (“PCP”), typically occurs in people with compromised immune systems.² On the heels of the PCP diagnoses came another series of diagnoses, this time a type of cancer known as Kaposi’s Sarcoma, which also appeared to be clustering in needle users and gay men.³ Members of the press took notice of the illnesses and began using the term “GRID,” standing for “gay-related immune deficiency.”⁴ By 1982, the Centers for Disease Control had determined that a more appropriate name for the disease was “AIDS,” or “acquired immunodeficiency syndrome.”⁵

Although the origin of HIV/AIDS was long the subject of debate, it has been widely recognized that the virus originated in West African chimpanzees.⁶ In 1999, the National Institutes of Health presented in a press release the findings of an international team of researchers charged with discovering the origins of HIV. The findings stated:


We now have chimpanzee isolates of simian immunodeficiency virus [SIVcpz] that have been shown by careful molecular analysis to be closely related to HIV-1. Furthermore, this virus infects a primate species that is 98 percent related to humans. This may allow us – if done carefully and in collaboration with primatologists working to protect this endangered species – to study infected chimpanzees in the wild to find out why these animals don’t get sick, information that may help us better protect humans from developing AIDS.\(^7\)

The experts determined that the simian immunodeficiency virus was likely introduced to the human bloodline when hunters were exposed to infected blood of the subspecies *Pan troglodytes troglodytes*.\(^8\)

Although AIDS is often known as a child of the 1980s, societal perception of the disease and maturity regarding the treatment of those affected by it has seen stunted growth. Misunderstanding and poor education regarding methods of transmission, disease management, and affected groups has plagued advocates and sufferers alike.

### B. HIV AS A DISABILITY

Disabled individuals have only had explicit legal protection of the type afforded to other vulnerable classes since 1973.\(^9\) The Rehabilitation Act of 1973 was Congress’ attempt to curb

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discrimination on the basis of handicap.\textsuperscript{10} Like The Civil Rights Act of 1964 before it,\textsuperscript{11} The Rehabilitation Act faced significant political challenges throughout the legislative process.\textsuperscript{12} Although The Rehabilitation Act’s eventual passage represented a clear shift in how the law would treat disabled individuals, its scope was far more limited than that of The Civil Rights Act of 1964.\textsuperscript{13} First, The Rehabilitation Act only extended coverage to federal agencies, grantees, and contractors, leaving the states to legislate on any uncovered avenues of discrimination, including discrimination by private entities.\textsuperscript{14} Additionally, The Rehabilitation Act was deficient in both funding and enforcement provisions.\textsuperscript{15}

Despite the Rehabilitation Act’s limitations, the United States Supreme Court held in 1987 that a school teacher with a contagious disease was a “handicapped individual” within the meaning of the Rehabilitation Act of 1973.\textsuperscript{16} In School Board of Nassau County, Florida v. Arline, a school teacher was fired solely because she was susceptible to tuberculosis.\textsuperscript{17} Writing

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\textsuperscript{10} \textit{Id.}


\textsuperscript{12} \textit{Id.} at 188-89 (detailing President Nixon’s pocket-veto, his veto of Congress’ new version and the Senate’s failed override).

\textsuperscript{13} \textit{Id.} at 189-90.

\textsuperscript{14} \textit{Id.}, (citing §501 of the Rehabilitation Act governing affirmative employment action by federal agencies, §503 governing affirmative employment action by certain federal contractors, and § 504 requiring nondiscrimination by federal agencies and federal grantees).

\textsuperscript{15} See Rains, supra note 4.


\textsuperscript{17} \textit{Id.}
for the Court, Justice Brennan explained that a teacher with a history of an upper respiratory disease (tuberculosis) that “substantially limited one or more of [her] major life activities” has a record of impairment under §504 of the Rehabilitation Act, and that allowing an employer to terminate a teacher with such an impairment would be unfair, it would contradict congressional intent, and would be contrary to legislative history.\(^{18}\) Further, the Court reasoned that allowing an employer to capitalize on the distinction between the effects of a disease on others and the effects of a disease on a patient by employing discriminatory hiring tactics is unjustifiable.\(^{19}\) The Court’s analysis resulted in the ultimate determination that Arline was handicapped under the definition of §504 of the Rehabilitation Act, and remanded to district court for determination whether Arline was “otherwise qualified” to teach.\(^{20}\) On remand, the United States District Court for the Middle District of Florida determined that Arline was an otherwise qualified individual, and that she was entitled to reinstatement and back pay.\(^{21}\) \textit{Arline} effectively extended protections of §504 of the Rehabilitation Act to individuals afflicted with a contagious disease.\(^{22}\) Although \textit{Arline} did not deal with HIV/AIDS directly, it provided analogous reasoning that would resurface in subsequent court cases.\(^{23}\)

\(^{18}\) \textit{Id.}.

\(^{19}\) \textit{Id.} at 282.

\(^{20}\) \textit{Id.} at 289.


\(^{22}\) \textit{See Arline.}

\(^{23}\) \textit{See e.g. Bragdon v. Abbott, 524 U.S. 624 (1998).}
In response to the Arline decision, Congress amended the Rehabilitation Act to reflect the Court’s holding by adding what has been called the “direct threat” defense to discriminatory practices. By adopting the Court’s reasoning, Congress acted by “prohibiting discrimination against individuals with disabilities while protecting others from significant health and safety risks, resulting, for instance, from a contagious disease.” Congress also relied on “direct threat” language in enacting the Americans with Disabilities Act of 1990, which states: “[T]he term ‘direct threat’ means a significant risk to the health or safety of others that cannot be eliminated by reasonable accommodation.”

President George H.W. Bush signed the Americans with Disabilities Act (“ADA”) into law on July 26, 1990, and in doing so made the most sweeping improvement to disability discrimination law since the Rehabilitation Act. The ADA’s five titles provided many of the protections thought to be either deficient or absent in the Rehabilitation Act by expanding its scope, enabling enforcement, and making remedies more available. The Americans with Disabilities Act did not pass without opposition, but despite outside pressure the Act eventually

25 Id. At 649.
26 42 U.S.C. 12111(3).
27 See 42 U.S.C. 12101 et. seq.
28 Id. The Americans with Disabilities Act consists of five titles: Title I, Employment; Title II, Public Entities and Transportation; Title III, Public Accommodations and Public Facilities; Title IV, Telecommunications; and Title V, which consists of Miscellaneous Provisions.
29 Id.
30 Both religious and business groups opposed the ADA’s passage. The National Association of Evangelicals opposed Title I (employment) as “…an improper intrusion [of] the federal government.” Lawton, K.A. Christianity Today, 10/8/90, Vol. 34 Issue 14, p. 71. Additionally,
survived bicameralism and presentment. President George H.W. Bush remarked upon the Act’s signature:

I know there have been concerns that the ADA may be vague or costly, or may lead endlessly to litigation. But I want to reassure you right now that my administration and the United States Congress have carefully crafted this Act. We've all been determined to ensure that it gives flexibility, particularly in terms of the timetable of implementation, and we've been committed to containing the costs that may be incurred.\(^{31}\)

George H.W. Bush’s signing of the Americans with Disabilities Act is widely considered to be one of the most significant moments of his presidency.

Even upon the ADA’s implementation, it was unclear how the law would treat individuals with debilitating diseases and medical conditions. Although the *Arline* decision was a victory for those with communicable diseases,\(^{32}\) the issue of HIV’s treatment under disability

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discrimination laws remained uncertain at the time Congress passed the ADA. That was, until the Supreme Court issued its decision in *Bragdon v. Abbott*.

Sidney Abbott was diagnosed with HIV in 1986. In 1994, Ms. Abbott went to Dr. Randon Bragdon’s dental office for an appointment. Although she was not manifesting symptoms at the time of her appointment, she voluntarily disclosed her HIV status on the patient registration form. Upon discovering a cavity, Dr. Bragdon informed Ms. Abbott that he had a policy against filling cavities of HIV-positive patients. Dr. Bragdon offered to fill her cavity at a local hospital for no additional fee for his services, but qualified his offer by holding Ms. Abbott responsible for any hospital fees she incurred. Finding this offer inadequate, Ms. Abbott pursued legal action under state law and Title III of The Americans with Disabilities Act regulating public accommodations. In pursuing her claim, Ms. Abbott relied on the language of section 302 of the ADA, which states: “[N]o individual shall be discriminated against on the basis of disability in the full and equal enjoyment of the goods, services, facilities, privileges, advantages, or accommodations of any place of public accommodation by any person who ... operates a place of public accommodation.” Although the term “public accommodation” under the ADA includes the “professional office of a health care provider,” Dr. Bragdon sought refuge

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34 *Id.*

35 *Id.* at 629.

36 *Id.*

37 Bragdon, 524 U.S. 624, 629.

38 *Id.*

in the ADA’s direct threat defense, which states: “[N]othing in this subchapter shall require an entity to permit an individual to participate in or benefit from the goods, services, facilities, privileges, advantages and accommodations of such entity where such individual poses a direct threat to the health or safety of others.” 40 The Supreme Court in Bragdon sought to determine whether an individual with asymptomatic HIV had a disability under the ADA, and if so, whether the Court of Appeals cited sufficient authority to determine that, as a matter of law, Ms. Abbott did not pose a direct threat to Dr. Bragdon. 41 The Court answered both questions in the affirmative. 42

The Supreme Court in Bragdon noted the ADA’s three subsections defining disability, 43 and determined that Ms. Abbott’s HIV infection constituted “a physical or mental impairment that substantially limits one or more major life activities” under section A. 44 Further, the Court held that because of “the immediacy with which the virus begins to damage the infected person’s white blood cells and the severity of the disease,” the impairment begins at the moment of infection. 45 Although the Court declined to hold that HIV constituted a per se disability under the ADA, Justice Kennedy concluded the opinion by stating that “[HIV]... even in the so-called

40 42 U.S.C. § 12181(7)(F), Bragdon, 524 U.S. 624, 629 (also citing §12182(b)(3) of the ADA).

41 Bragdon, 524 U.S. 624, 628.

42 See Bragdon.

43 “(A) a physical or mental impairment that substantially limits one or more of the major life activities of such individual; (B) a record of such an impairment; or (C) being regarded as having such an impairment.” Bragdon v. Abbott, 524 U.S. 624, 630, 118 S. Ct. 2196, 2201, 141 L. Ed. 2d 540 (1998) (citing the Americans with Disabilities Act, 42 U.S.C. §12102(2)).

44 See Bragdon, supra note 41.

asymptomatic phase, is an impairment which substantially limits the major life activity of reproduction.”

Although Bragdon is widely viewed as the most significant court victory against HIV discrimination, another case out of the Fourth Circuit issued the year before Bragdon was decided had the opposite effect for MCWs. In Doe v. University of Maryland, the Court of Appeals held that a hospital did not violate §504 of the Rehabilitation Act or Title II of the ADA (regulating public entities) when it terminated an HIV-positive neurosurgical resident “based upon the risk of transmission of the disease during performance of exposure-prone procedures.” In the third year of his six-year residency, Dr. Doe contracted HIV by needle-prick while working at the hospital. After testing positive for HIV, the hospital temporarily suspended Dr. Doe. Dr. Doe’s reinstatement was placed in the hands of a review panel comprised of experts on blood-borne pathogens. Despite the panel’s recommendations to allow Dr. Doe to perform surgery contingent on his compliance with a series of strict procedural safety requirements, hospital administrators permanently suspended him from surgery. Although the court recognized that the risk of HIV transmission from the resident to a patient during surgery

46 Id. at 647.

47 Doe v. University of Maryland, 50 F.3d 1261 (4th Cir. 1995).

48 Id. at 1267.

49 Id. at 1262.

50 Id.

51 Doe v. University of Maryland, at 1262.

52 Id.
was small,\textsuperscript{53} it nevertheless upheld his termination.\textsuperscript{54} The Fourth Circuit recognized that in order for Dr. Doe to prevail on his case, he had to establish: “(1) that he [had] a disability; (2) that he [was] otherwise qualified for the employment or benefit in question; and (3) that he was excluded from the employment or benefit due to discrimination solely on the basis of the disability.”\textsuperscript{55} The court determined that Dr. Doe was not an “otherwise qualified individual” because the risk he posed to potential patients could not be mitigated through reasonable accommodation.\textsuperscript{56} Although the reasoning holds if no reasonable accommodation could truly be made, the findings of the panel and recommendation of the CDC to allow Dr. Doe to perform surgery seems to undermine the Fourth Circuit’s decision in this case.

In \textit{Estate of Mauro v. Borgess Medical Center}, the Sixth Circuit Court of Appeals also held that an HIV-positive MCW’s termination was lawful by holding that he posed a direct threat.\textsuperscript{57} In \textit{Mauro}, a surgical technician was laid off once his employer became aware that he was HIV-positive.\textsuperscript{58} What is most interesting about the case, however, is not the majority opinion, but rather the dissent by Judge Boggs:

\textsuperscript{53} The Centers for Disease Control and Prevention (CDC) has estimated that the risk to a single patient from an HIV-positive surgeon ranges from .0024\% (1 in 42,000) to .00024\% (1 in 417,000). Centers for Disease Control, U.S. Dep't of Health & Human Servs., Open Meeting on the Risks of Transmission of Blood-borne Pathogens to Patients During Invasive Procedures (Feb. 21-22, 1991) (statement of Dr. David Bell, Centers for Disease Control).

\textsuperscript{54} See Doe v. University of Maryland, 50 F.3d 1261 (4th Cir. 1995).

\textsuperscript{55} \textit{Id.} (citing Gates v. Rowland, 39 F.3d 1439, 1445 (9th Cir.1994)).

\textsuperscript{56} Doe v. University of Maryland, 50 F.3d 1265 (4th Cir. 1994).

\textsuperscript{57} Estate of Mauro By & Through Mauro v. Borgess Med. Ctr., 137 F.3d 398, 407 (6th Cir. 1998).

\textsuperscript{58} See \textit{Mauro}. 
Mauro poses some risk. It is not ontologically impossible for him to transmit a disease of very great lethality. However, the chance that he will do so to any given patient is “small.” Whether we call the risk “extremely small,” “vanishingly small,” “negligible,” or whatever, assessing the risk remains a judgment that must be made by considering both the actual probability of harm and the degree of the consequences, just as the Supreme Court instructed us…That is what the District Court did not do, and that is why I would reverse its decision and remand for reconsideration under the correct standard—a full assessment of both the risk and the consequence. 59

Judge Boggs was dissatisfied with the subjective determination that this HIV-positive surgical technician posed a direct threat to patients, and argued for an objective legal determination. 60 Though Judge Boggs argued persuasively in his dissent, he was unable to sway the outcome of the case.

In keeping with the trend set by the Fourth and Sixth Circuits, the Eleventh Circuit also found against an HIV-positive MCW in a 2001 decision, Waddell v. Valley Forge Dental. 61 In Waddell, the court relied heavily on the four Arline factors 62 for analyzing risk, paying particular


60 Id.


62 “(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.” Sch. Bd. of Nassau County, Fla. v. Arline, 480 U.S. 273, 288, 107 S. Ct. 1123, 1131, 94 L. Ed. 2d 307 (1987).
attention to the fourth factor dealing with the probability of HIV transmission between MCW
and patient.\textsuperscript{63} The holding states:

In summary, several factors, when taken together, indicate that Waddell
poses a significant risk to others in the workplace: the use of sharp
instruments by dental hygienists; routine patient bleeding during dental
work; the risk that hygienists will be stuck or pricked while using an
instrument; the statements of Waddell and medical his (\textit{sic}) experts
acknowledging that there is some risk, even if theoretical and small, that
blood-to-blood contact between hygienist and patient can occur; and the
possibility of an inadvertent bite or other accident during a dental
cleaning. These “particularized facts” provide “the best available
objective evidence” that Waddell, because he is infected with the fatal,
contagious disease of HIV, is a direct threat to his workplace, and
therefore not a qualified individual under the ADA.\textsuperscript{64}

The \textit{Waddell} holding, though damning to HIV-positive MCWs, is likely the clearest articulation
of how courts view this issue, and how they will continue to decide in future cases.

Despite admission by the legal community that HIV positive individuals are disabled
under the Americans with Disabilities Act, whether experiencing symptoms or asymptomatic,
the courts have made the distinction that Medical Care Workers are subject to a much higher
level of scrutiny. Absent a successful challenge at the Supreme Court level, it appears that this
trend will go unchanged.

\section*{III. Regulation of HIV-Positive MCWs}

\begin{footnotesize}
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\item[\textsuperscript{63}] “At the heart of this case, however, is the district court’s analysis of the fourth factor
delineated in Arline, the probability of HIV transmission between a dental hygienist and
\item[\textsuperscript{64}] \textit{Waddell} at 1284.
\end{itemize}
\end{footnotesize}
What the medical profession represents is as sacred as it is universal: the preservation of life. All occupations committed to patient health have varying degrees of increased access to our most intimate information. This access comes with its own issues and responsibilities. Like lawyers, MCWs are guided by concepts of confidentiality and duty to their patient. This includes protecting sensitive information, relaying critical information, and helping patients make informed decisions. But is this relationship one-sided? Are MCWs owed a duty by their patients? By their hospital administrators? Should such duty exist? This section tackles the relationship between MCWs and patients, regulations regarding patient safety, and specific measures tailored to HIV-positive MCWs.

A. THE MCW-PATIENT RELATIONSHIP

*Primum non nocere.* First do no harm. It is a concept that is taught at every medical school and exists in every level of the medical profession. Though not appearing directly in the Hippocratic Oath, the phrase resides in many textbooks as an aphorism for one of the most essential ethical duties owed patients by their care providers. The MCW-patient relationship is not only governed by guiding principles, however, and is subject to scrutiny and evaluation by regulating bodies and the medical community itself.

The unusual case of Kimberly Bergalis demonstrates a tragic example of one dentist’s failure to adhere to these principles. In 1989, Kimberly Bergalis, a business student at the University of Florida and self-identified virgin who did not use intravenous drugs, developed

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symptoms of AIDS. Despite her lack of risk factors, Kimberly was diagnosed with the disease. In disbelief, and in search of answers, the Bergalis family, along with the Centers for Disease Control launched an intensive investigation to find out what had happened. Ultimately, experts connected Kimberly’s infection to Dr. David Acer, an HIV-Positive dentist who had removed two of Kimberly’s molars in 1987 without informing her of his HIV-serostatus. What is worse, the Florida Department of Health discovered additional HIV infections linked to Dr. Acer’s practice. Despite Dr. Acer’s adherence to recommended safety measures, including the use of gloves and a face mask, careful study of the infected patients’ viral sequences indicated that their infection had likely resulted from Dr. Acer’s treatment. Although subsequent discussion and opinions flourished as to how Kimberly Bergalis and the other patients were actually infected with the HIV virus, the relative certainty that the infection came from Dr. Acer and his use of safety measures are evidence of a failure in the regulatory regime at that time. Additionally, the case of Kimberly Bergalis is an unfortunate case study in the imbalance of power between MCWs and patients, and the importance that disclosure plays in preventing the transmission of HIV in medical procedures.


67 Id.

68 Id.


Though I do not want to devote too much time to one occupation, the doctor-patient relationship provides the best look at the issues of MCW-patient relationships because of both the width and depth of available information. Because doctors spend a significant amount of time with their patients collecting information through medical interviews and conversations, it is no surprise that this aspect of the relationship has been given significant pedagogical treatment.

The medical interview, like many legal concepts, has both substantive and procedural components. The following chart depicts those components:

<table>
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<th>Functions</th>
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<tr>
<td>1. Determine and monitor the nature of the problem</td>
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<td>2. Develop, maintain, and conclude the therapeutic relationship</td>
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<tr>
<td>3. Carry out patient education and implementation of treatment plans</td>
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<th>Structural elements</th>
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<tr>
<td>1. Prepare the environment</td>
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<tr>
<td>2. Prepare oneself</td>
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<td>3. Observe the patient</td>
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<td>4. Greet the patient</td>
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<td>5. Begin the interview</td>
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<tr>
<td>6. Detect and overcome barriers to communication</td>
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<td>7. Survey problems</td>
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<td>8. Negotiate priorities</td>
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<tr>
<td>9. Develop a narrative thread</td>
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<td>10. Establish the life context of the patient</td>
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<td>11. Establish a safety net</td>
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<td>12. Present findings and options</td>
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<tr>
<td>13. Negotiate plans</td>
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<tr>
<td>14. Close the interview</td>
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</tbody>
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72 The Doctor–Patient Relationship: Challenges, Opportunities, and Strategies

73 “The relationship between doctors and their patients has received philosophical, sociological, and literary attention since Hippocrates, and is the subject of some 8,000 articles, monographs, chapters, and books in the modern medical literature.” Id.


75 Id.
Though many aspects of this interview appear to be common sense, they reflect the necessity of establishing a trusting and open relationship so that a doctor (or any MCW) can provide the best care that they can. The relationship can be difficult to forge because of the imbalance of power between MCW and patient, and establishing this relationship is critical, particularly for vulnerable patients. These principles of confidentiality and privacy remain equally important for organizational personnel and related care providers (nurses, assistants, etc.).

Dr. Susan Dorr Goold, M.D. explains:

The expectation of privacy is one of the most important aspects of the doctor–patient relationship and influences the disposition to trust, but confidentiality is no longer solely in the doctor's control. Organizational personnel have access to patient information and must be required to keep it private, taught how to keep it private and monitored to be sure they do.

To conclude this section on the MCW-patient relationship, it is clear that the medical community understands the power imbalance between MCW and patients. But it is unclear what duty is owed to the MCW by the patient. Any place where vast amounts of medical information

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76 “Increasing data suggest that patients activated in the medical encounter to ask questions and to participate in their care do better biologically, in quality of life, and have higher satisfaction.” See Goold, supra note 62 (citing Kaplan S. Patient activation. Washington, DC: 1997. Presented at Royal College of Medicine symposium on Doctor Patient Communication).

77 See Goold, supra note 62.


79 See Goold, supra note 62

80 Id.
is stored -- including hospitals, doctor and dental offices, and psychiatric facilities -- is wrought with opportunity for both voluntary and involuntary disclosure of confidential information. Although the medical community rightfully puts the patients first, MCWs also carry around sensitive information about themselves (their own prescriptions, medical documents, insurance forms). If a patient sees a doctor take an HIV medication, what duty does the patient have to that doctor? If a patient overhears a phone call their dental hygienist just had about his CD4+ T cell count, can the patient request a different hygienist? I will address disclosure requirements presently.

B. DISCLOSURE REQUIREMENTS

The hypotheticals I just posed bring to surface a critical issue for MCW confidentiality. The American Medical Association (“AMA”) has established policies relating to physician health, confidentiality, and responsibilities of the parties involved.\(^{81}\) Specifically, the AMA has drafted several policies that are germane to the HIV-positive MCW discussion. The first states:

H-20.912(2) – Guidance for HIV-Infected Physicians and other Health Care Workers (2) Health care worker performing exposure-prone procedures and becomes HIV-positive should disclose his/her serostatus to state public health official or local review committee; should refrain from conducting exposure-prone procedures or perform them with permission of review committee and with informed consent of patient; in cases of uncertainty.\(^{82}\)


\(^{82}\) Id. at H-20.912(2).
The first clause of this policy seems reasonable at first blush. After all, all HIV-positive tests are reported to government agencies to ensure public safety, and requiring doctors to report to local public health officials is in accordance with this purpose. However, requiring an HIV-positive doctor, or MCW, to report to a local review committee could be viewed as an infringement of that individual MCW’s right to confidentiality of their sensitive medical information.

The AMA appears to backtrack from its disclosure requirement in H-20.912(7), which states:

H-20.912(7) – Liability Coverage for HIV-Infected Physicians. Our AMA will continue the dialogue with liability insurance companies to monitor issues surrounding liability coverage for HIV-infected physicians and will establish guidelines for any collection or use of HIV-serostatus data by professional liability carriers. Serostatus information should be treated with strict privacy and nondisclosure assurances. Discussions with liability insurance companies should include the position that to date there are no scientific grounds to require testing of physicians for HIV status.

This policy only refers to a future guideline regarding the use of HIV-serostatus data; the AMA explicitly withheld any position on the issue. In so doing, the AMA, consciously or not, ignored an opportunity to stand up for the privacy rights of HIV-positive MCWs. The AMA also hedged its bets in the area of physician confidentiality in another section of its policies. Section D-315.993 states: “D-315.993 – Physicians as Patients: their Right to Confidentiality. AMA will consider for possible intervention….court cases in which the principles of informed consent are inappropriately expanded to require disclosure of a physician’s impairment… or information

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83 Id. at H-20.912(7) (emphasis added).
otherwise protected by laws governing patient privacy and confidentiality.”\textsuperscript{84} Here, the AMA absolves itself of any legal duty to protect a physician’s right to privacy or confidentiality.

In a Pennsylvania court case, \textit{In re Application of Milton S. Hershey Medical Center of Pennsylvania State University}, the Supreme Court of Pennsylvania addressed disclosure requirements of HIV-positive physicians within its jurisdiction.\textsuperscript{85} In that case, the court determined that a physician who had contracted HIV\textsuperscript{86} and who could have conceivably had blood contact with several hundred patients was subject to an order by the trial court requiring limited disclosure of Dr. Doe’s HIV status for “compelling need” under the Confidentiality of HIV-Related Information Act.\textsuperscript{87} The Pennsylvania Supreme Court, recognizing the high burden of proof required by the petitioners, and balancing Dr. Doe’s privacy interests with the safety interests of the hospitals and patients involved, determined that the trial court did not abuse its discretion in granting such an order.\textsuperscript{88} Although this case has limited application because it is a state (commonwealth) Supreme Court decision, it is instructive as to the way the scales of justice will tip when courts weigh HIV-serostatus disclosure against public safety.

Although the AMA takes weak positions with respect to protecting physicians’, and likewise MCWs’ rights, their instincts are correct. HIV-positive MCWs performing invasive procedures should be subject to some form of regulation, and patient consent should also be a critical aspect to approving whether or not that MCW may perform the procedure. However,

\textsuperscript{84} Id. at D-315.993 (emphasis added).


\textsuperscript{86} Id. at 11 (stating that the method by which Dr. Doe contracted HIV was no determinable).

\textsuperscript{87} Id. (interpreting the Confidentiality of HIV-Related Information Act (HIV Act), 35 P.S. § 7608(a)(2)).

\textsuperscript{88} Id. at 13-14.
further legislative instruction at the federal level must be carefully crafted so as to correct the unbalanced disclosure requirements which place a high burden on HIV-positive MCWs.

IV. ANALYSIS

A. DEFICIENCIES IN THE CURRENT REGIME REGULATING HIV-POSITIVE MCWs

Although the previous sections laid out the deficiencies of the current regulatory regime pertaining to HIV-positive MCWs, I will briefly restate them in the order that they will be addressed in the next section. First, the Americans with Disabilities Act, despite its expansive protections for disabled individuals, has proven to be ineffective in protecting HIV-positive individuals in court. Second, courts themselves have not been sympathetic to HIV-positive MCWs. This is likely a symptom of the underlying policy to ensure patient safety. However, the direct threat defense has been used so expansively that severe limitations have been placed on what careers HIV-positive individuals interested in health care may pursue. Third, alarmist public perception and fear of legal repercussions have thrown the MCW-patient relationship out of balance, resulting in invasive disclosure requirements and a breach of the HIV-positive MCWs’ right to privacy and confidentiality in their medical information. These three issues will be the subject of my analysis.

B. RECOMMENDATIONS TO PROTECT THE RIGHTS OF HIV-POSITIVE MCWs AND ENSURE PATIENT SAFETY

With respect to the first two issues I laid out pertaining to the ADA’s deficiencies and the courts’ reluctance to side with HIV-positive MCWs, two birds can be killed with one stone:
either an amendment to the Americans with Disabilities Act or a new piece of legislation protecting HIV-positive MCWs. Because judges tend to adhere to *stare decisis*, both for consistency in applying the law and the fear of being reversed on appeal, The Americans with Disabilities Act will most likely continue to fail in federal court as defense to disability discrimination against HIV-positive MCWs. However, new legislative language tailored to this specific issue could prevent both the discriminatory practices that land parties in court, and ensure that courts are applying a fair law, and applying it fairly. For the purpose of further analysis, I will not focus on whether the changes should be made to the ADA or as a separate law.

The new legislative language must be consistent with the legislative scheme protecting disabled individuals. The Rehabilitation Act of 1973 and The Americans with Disabilities Act were both standout pieces of legislation in their time, particularly for the strength of their protections (though their scope and enforcement have often been called into question). This new legislation should extend to all Medical Care Workers, defined as “one whose duties pertaining to their occupation focus primarily on patient health, care, whether physical, mental, or emotional, including physicians, nurses, medical assistants, students of a medical field participating in the administration of care, technicians, dental hygienists, or any other occupation deemed as a matter of law to fall under this definition.” This language is intentionally broad to protect the largest class of individuals.

This class of protected MCWs must be given protection from unnecessary disclosure of their HIV-serostatus, whether this disclosure would be explicitly or implicitly required. Because of the stigma that still exists and remains attached to those with HIV, this disclosure must be
treated with the sensitivity that the disease itself requires. However, to discuss disclosure, I will move to the third issue I raised in the previous section. That is, the MCW-patient relationship.

The MCW-patient relationship must necessarily be a two-way street. It must be so to ensure effective communication, develop and facilitate the trust needed to provide proper care, and prevent doing harm. One way to restore this balance without requiring disclosure by an individual HIV-positive MCW would involve a specific HIV-waiver provided to patients. This waiver would be required by my proposed legislation. This waiver would be presented to patients much as any other waiver is presented, although there would be mandatory explanation of the waiver. Additionally, no patient would be declined care for declining to sign the waiver (I will get to this in a moment). This waiver would state, if answered affirmatively, that the patient recognizes that some MCWs at the particular facility may be HIV-positive, and that they permit any such MCWs to perform all procedures and provide all care they are licensed to perform and legally allowed. This waiver would also include facts about HIV, including the risk of transmission. This measure would establish informed consent, prevent disclosure of specific MCWs’ HIV-serostatus, and separate the issue of what procedures that MCW can perform to be determined by the medical profession in conjunction with state and federal governments.

A result of this proposed waiver would be specific MCW assignment. HIV-positive MCWs would not be assigned to patients who do not acquiesce to their treatment on the waiver. However, to implement this measure, it would be necessary for HIV-positive MCWs to register with a governing body, and administrative body within each facility. My proposal would include provisions establishing a commission with the Department of Health and Human Services (“HHS”) with local offices in charge of reporting. This commission would keep records of HIV-

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89 I have drafted a sample waiver to demonstrate necessary and relevant language that such a document would need.
positive MCWs, including what procedures they can perform. Employers in the healthcare field would have to work closely with this commission. The best way to implement this admittedly complex aspect to my proposal would be for employers to establish administrative offices in charge of MCW assignment.

V. CONCLUSION

Any proposal to make the sweeping changes that I have suggested will have flaws, and I do not shy away from mine. First, my proposal, specifically the establishment of a commission within HHS, would be wildly expensive and subject to the pork-barrel-buffet. Second, employers would be hard pressed to find the money to establish their individual administrative departments in charge of MCW assignment. Third, it would be difficult to make clear to patients that their ability to receive care did not depend on their signature of the waiver. Fourth, it would be impossible, at least at the outset, to get patients to sign such a waiver because of the HIV stigma. Fifth, this note treats all MCWs equally, when each occupation has significantly differing responsibilities and levels of access to patient information. Sixth, employers would be required to hire additional MCWs and retain HIV-Positive MCWs that would likely be doing little actual work.

However, despite my proposal’s flaws, it remains consistent with the legislative apparatus currently in place. It is consistent with the public policies to protect confidential medical information, to protect privacy, to reduce restrictions on who can perform what job, and to protect against discriminatory practices based on an individual’s actual or perceived disability. My proposal also seeks to maintain patient safety as a primary objective. Further, it is a logical
outgrowth of the current regime protecting HIV-Positive individuals from discrimination.

Hopefully my suggestions can be the first suture repairing a torn system.
TREATMENT WAIVER
Treatment by HIV-Positive Medical Care Workers

Patient Name: ___________________________  Date: ___________________________

I have been informed of the minimal risk of HIV-transmission through care by HIV-Positive Medical Care Workers. I understand that this risk varies depending on the procedures and care being provided. I have been informed generally about known modes of HIV transmission, and the relative risks thereof.

Initial: ______________________    Date: ______________________

I have been informed and I understand that my ability to receive care at [Medical Center] in no way depends on my responses on this form, and that my medical care will be provided in accordance with my wishes.

Initial: ______________________    Date: ______________________

I, __________________________, agree that an HIV-Positive Medical Care Worker is allowed to administer care while I am a patient at [Medical Center].

Please Circle:     YES   NO

If YES, please check the box next to medical procedures you would feel comfortable allowing an HIV-Positive Medical Care Worker to provide:

____ General Administrative Care (recording patient information)

____ Non-Invasive Procedures (taking blood pressure, temperature, and other similar external diagnostic procedures)

____ Minimally Invasive Care (drawing blood, taking throat swabs, other internal diagnostic procedures, surgeries medically defined as “minimally invasive” as explained by a medical professional)

____ Invasive Procedures (all remaining procedures that involve medical care administered inside the human body)

I, __________________________, have reviewed my responses to the inquiries included on this waiver and agree that it represents my wishes with respect to medical care as administered by HIV-Positive Medical Care Workers.

Signature: ___________________________  Date: ___________________________