Acquired Immunodeficiency Syndrome: More Than a Health-Related Dilemma

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INTRODUCTION

The episodes of pandemic infectious disease that mankind has experienced over recorded history are numerous, although often incompletely chronicled. The *Yersinia pestis* plagues that decimated European populations in medieval times and Asian populations in modern times, as well as the influenza pandemics of the early 20th century, are examples of such epidemics, in which millions died. The more recent outbreaks of polio and hepatitis B, although economically devastating to those affected, were less significant in terms of human mortality.

We are now experiencing an infectious disease pandemic that manifests both a high mortality rate and economic devastation. This scourge is acquired immunodeficiency syndrome (AIDS) caused by a retrovirus, human immunodeficiency virus (HIV). In its brief history, this communicable disease has already changed the legal and social relationships that health care workers depend on for the delivery of their professional services to those seeking aid. Secrecy and stigma compromise the actions of those affected with the disease. Fear and fascination affect the actions of the physicians, scientists, and other health care professionals providing service to those with AIDS. Coincidentally, the concern and confusion of those exhibiting any signs of infection with the virus are being translated into societal reactions that involve litigation.

Litigation through the U.S. legal system is designed so that an impartial arbitrator, a judge or a jury, decides which of two parties presenting conflicting claims merits the protection of the law. The rights of one party may or may not bind the duty of another. The rights of the person(s) with AIDS (PWA), which in this paper include those with AIDS-related complex, have resulted in new interpretations of the duties assumed by those who provide health care services.

Our courts, as the arbitrating authorities, have just begun to rule on conflicts involving PWA. Legal suits involving blood banks, insurance coverage issues, employment and educational disputes, and criminal conflicts have already surfaced. In other areas, the courts are still in the process of establishing the priorities of the rights and duties of the contesting parties. Disputes concerning screening of patients or applicants for positions, diagnostic procedures for those seeking medical care, and issues of confidentiality involving identities as well as laboratory results have arisen.

The purpose of this paper is to discuss the issues that have evolved from the HIV epidemic. An overview of the societal conflicts that have arisen in both civil and criminal justice systems of the United States is also offered. No attempt has been made to detail all of the suits involving PWA; rather, only the initial cases of a specific issue are discussed. Since only 8 years have passed since the recognition of this disease, it is premature to define legal trends. Speculation, however, is included when appropriate.

PROGRESS TO DATE

In June 1981, the Centers for Disease Control (CDC) recorded five cases of *Pneumocystis carinii* pneumonia in young male homosexuals in southern California (15). This report in the weekly government disease digest *Morbidity and Mortality Weekly Report* was followed several weeks later by a report of 26 cases of Kaposi’s sarcoma diagnosed over a 30-month period in male homosexuals. Six of these men also had *Pneumocystis* pneumonia (16). In their discussion of these early reports, the CDC editors noted that the homosexual males involved seemed to have an impaired cellular immune response to systemic disease. With these initial reports of AIDS, originally called GRIDs for gay-related immunodeficiency syndrome, a new chapter in the history of communicable diseases was begun.
Concentrated research efforts, supported by federal agencies and private interest groups, have considerably advanced the knowledge of this disease. Although extensive publicity by the communication media and criticism by special interest groups often denigrated the scientific work attempted and the results obtained, published reports as of September 1988 show the following.

(i) The disease parameters have been defined (19, 22) and redefined for adults (40, 83) and children (25, 31, 38). These studies allow epidemiological tracking of the disease (13, 54, 85).

(ii) The at-risk populations have been identified (17, 18, 35, 74) and have remained constant (42). Subsequently, there has been evidence of lifestyle change among certain of these defined populations (26, 30, 37).

(iii) The methods of spread of the causative virus have been detailed (3, 9, 21, 29, 36, 39, 50, 55, 72).

(iv) The causative retrovirus has been isolated (6, 69), the pathogenesis of infection has been established (65, 78), and HIV nomenclature has been agreed upon by committee (48).

(v) Screening procedures suitable for identifying antibody to HIV in body fluids have been developed (43, 72, 81, 112, 115) and have been used for screening high-risk population members (13, 28), blood and blood products (27), military applicants (14, 44), and penitentiary populations (32).

(vi) Diagnostic procedures suitable for detecting HIV antigens in body fluids and tissues have made identification of infected patients possible (72, 89, 115).

(vii) Precautionary guides for use by health care workers in various disciplines, guides describing physical and chemical barriers to virus contact, have been developed and promulgated (20, 23, 24, 33, 34, 4).1

(viii) The need for educating members of at-risk populations about the dangers of certain specific sexual practices and the use of shared needles has been stressed locally and nationally (66, 99, 101).

(ix) As a result of efforts by the Surgeon General, the general public has been educated about the status of the disease, the mechanisms of spread, the available precautions, and the prognosis of this pandemic (123).

(x) Effective therapeutic agents have been developed, with limited success (67, 77, 89).

Although more than 80,000 cases of AIDS have been reported in the United States in the past 8 years, physicians and scientists have amassed an amazing record in identifying, surveying, and slowing the spread of the disease (124). During this process, the social and scientific literature has become enormous. The legal conflicts arising because of this disease and its brand on society will be no less voluminous if present predictions of disease spread prove correct (56, 64, 94, 95, 97).

MEDICAL AND PROFESSIONAL ISSUES

Because of the nature of most AIDS transmission routes, i.e., the elective use of illicit intravenous drugs or a history of multiple sexual partners or both, it was inevitable that AIDS would affect our nation’s legal system as no other disease in history. The dilemmas prompted by this disease caused Lars Olof Kallings to comment in his keynote address at the Fourth International Conference on AIDS that “the picture in its entirety that will develop will, in some respects, be even more frightening than we have expected” (100). Civil as well as criminal complaints are providing frightening records of social reactions that affect not only the provision of health care services but also our daily lives. The following topics address problems that have been contested by PWA in our legal system.

Blood and Blood Products as Sources of HIV Infection

The earliest noncriminal complaints were that blood or blood products had been the vehicle by which HIV was transmitted from a PWA to a recipient. Legal charges that transfusion blood was the vehicle involved in disease agent transmission were not new. Similar charges that donors and blood banks spread hepatitis B had been made earlier, but these legal suits were rarely successful (79, 96). Yet with AIDS, a similar situation, a surprisingly large number of suits were filed by PWA or their estates (3, 9, 55). Many complaints were filed after 1985, when the means to detect HIV presence in transfusion blood became available (28). Suits were filed to protest a wrongful act, to identify the person(s) or organization involved, and to seek compensation for the transmission of a disease agent during a blood transfusion process or by use of a blood product for therapeutic purposes. Three legal theories were proposed to seek liability from blood donors, blood banks providing transfusion resources, or hospitals at which blood and blood products were administered (73). These theories were that (i) the supplier has a legal duty to provide a safe product for human use and that a breach of this duty is compensable under strict product liability laws; (ii) the acceptance of blood or a therapeutic blood product by a person in need constitutes a product sale, and the transaction thereby implies dependence on a warranty of safety of the product; and (iii) the supplier was negligent in preparing the blood or blood product and breached the standard of care required. The result of this negligence is liability for the omission and the subsequent infection. These three legal theories, available to demonstrate liability for HIV transmission through blood or blood product use, are being answered by numerous state law and case rulings (73, 74).

The strict liability theory is aimed primarily at the manufacturer or processor of a commercial product. Negligence by conduct is not the issue. Rather, the nature of the product being sold in a damaged, defective, or imperfect condition is questioned. Recovery of damages by the petitioner is based more on proof that a sale, in this case, sale of contaminated blood, did occur. Most courts have ruled that the use of blood for transfusion purposes constitutes a service (107). The effect of this designation is to remove the liability from the processors, i.e., blood banks and hospitals, by granting them legal immunity from strict liability statutes. The rationale for such rulings varies from state to state but usually includes the promotion of such organizations as necessary for public health or comprehensive medical services or both. However, in some jurisdictions, blood banks engaged in the business of collecting, processing, and distributing blood for transfusion purposes have been held to strict liability standards (111). The argument concerning strict liability standards for blood banks was again addressed when tests became available to detect HIV antigens or HIV antibodies in the laboratory (27). The contention that hospitals have the final opportunity to ensure safety of the transfusion procedures used within their confines has more advocates among PWA than it did previously among hepatitis B victims, primarily because of the high mortality rate and the social stigma associated with AIDS.

In court rulings, the position that a transfusion recipient lacks any means to guard against contamination was weighed against the need to maintain a low-cost system
designed to ensure sufficient blood supplies to the public (76). In the legislatures that studied the effect of placing strict liability regulations on those collecting and distributing whole blood to the public, the issue of requiring insurance coverage instead of granting statute immunity for the service was a deciding factor. The cost of liability insurance to the organizations providing this service would have limited the availability of this resource. Immunity from liability was the legal result of these legislative studies.

In most states, processors of blood products enjoy the same statute immunity as blood banks. In a California case in which a hemophiliac developed AIDS after use of a commercially prepared clotting factor, the court rejected the plaintiff's appeal that the processor was not covered by the state statute because a sale of the product was proven (58). The court relied on a previous ruling involving a claim of hepatitis B transmission by clotting factor use (68). The same rationale that public health needs outweigh the individual's right to financial recovery for such injury was argued and used to deny strict liability.

The second theory cited to gain compensation for disease transmission by blood or blood products is that of warranty by the supplier that the fluids are safe. The Uniform Commercial Code, now followed by all states, imposes liability for the marketability of all goods sold. However, legislation specifying that blood used in transfusion procedures is provided as a service and is not a marketable item is in effect in most states. The only exceptions to this stance have occurred when blood banks were shown to be supplying the service for profit or when a hospital charged a fee for the blood in addition to the fee for transfusion (107). Rare instances of liability have resulted from such exceptions (76).

The third theory argued is one of negligence of the blood or blood product provider. To win a suit for negligence, the complaining party must show that (i) there was a relationship between the two adversaries involving a duty to provide care or service, (ii) this duty was not met, (iii) such a breach caused damage to the complainant, and (iv) the damage can be demonstrated. When a blood-based vehicle is suspected in infectious disease transmission, the duty or obligation at issue usually involves a failure of the provider (blood bank or hospital laboratory) to evaluate the quality of the processed unit. Suits claiming that hepatitis B infection followed the use of blood or blood products are similar to the early cases charging blood-borne HIV transmission. The result of these suits brought by PWA hinge on whether the enzyme-linked immunosorbent assay for HIV antibodies was available to the provider at the time of processing.

The claims of liability for negligent processing of blood or blood products are based on several factors. Failure to question the donor about past medical history, specifically, HIV and hepatitis B infections; failure to question about narcotic use; and failure to screen blood by the most reliable methods to detect antibodies against HIV or hepatitis B seem to be sufficient grounds to claim negligence of the processor. The use of any specimen identified from such a questionable human source would also be an admission of liability by the processor. Cases brought with these charges have been filed, although in Georgia and Pennsylvania, state laws were used to bar any warranty or strict liability petitions for damages. The trial results have been in favor of the defendant (59).

In Colorado, a woman with an accidental gunshot wound received HIV-contaminated blood during a transfusion. She sought $13 million from the blood bank supplier on a charge of negligence. A jury decided this early case of AIDS transmission by a blood bank product. The verdict of "no negligence" was influenced by the fact that blood-screening standards had not been developed and implemented; i.e., it was shown that she received contaminated blood before screening tests were available. Thus, the supplier was exonerated (102, 108). In the 1970s, a similar verdict was handed down in a case concerning detection of hepatitis B in blood or blood products (110). The issue in such suits is whether the plaintiff can show that the screening procedures for donors and for donated blood were available and were either used erroneously or omitted. Obviously those PWA who received blood before 1985, when the enzyme-linked immunosorbent assay was initially licensed by the Food and Drug Administration, will fail to show a breach of duty or failure to meet the standard of care.

A complication in any suit seeking compensation for blood-based HIV transmission is the identification of a specific blood donor. Such identity, although not always essential, could establish potential liability when several suppliers or providers of blood are used by the same patient. To establish liability of a specific donor of contaminated blood requires that such a donor knew of, or had reason to suspect, his or her status and still donated.

Attempts to obtain donor identity from blood banks or hospitals have met with little success in the courts. In Rasmussen v. South Florida Blood Services, the Florida courts were asked to provide the identities of a large number of donors whose blood had been transfused into a young man involved in a pedestrian-vehicle accident (110). This pre-1985 incident became the initial contest for a person developing AIDS and then seeking to identify the blood source through the legal system. In the suit brought by the estate after the recipient died of AIDS, the Florida Supreme Court ruled that the interests of society outweigh the rights of an individual; therefore, the blood provider was allowed to keep the names confidential. The court decreed that, in a system in which 95% of whole blood-used for transfusion purposes is given voluntarily, society's interest in maintaining the volunteer effort along with the donor's right to privacy surpass the recipient's interest in discovering the possible source of the disease agent. Decisions handed down through several other state courts have supported this ruling (58, 108).

Not all state courts have followed the lead of the Florida court. A district court in Texas ruled that there is not enough societal interest to override the recipient's legal right to know the source of transfusion blood (120). This court further concluded that the blood donor system is not set up to protect a donor from "annoyance, embarrassment . . . or undue burden." In allowing the plaintiff to search for the source of HIV infection acquired through the transfusion process, the court required the plaintiff to confer with the ruling judge after record discovery was concluded and before any contact with a suspected donor was made. The court insisted that further evidence would be required before any personal inquiry could be addressed to a suspected donor.

Other suits on the blood donor issue are in litigation, but many potential cases have been dismissed when the time of presumed exposure (transfusion) has been compared with the initiation of testing donor blood by enzyme-linked immunosorbent assay. Likewise, cases filed against those who donated blood before routine blood screening are often dismissed on the basis that donated blood obtained for
transfusion purposes involved a service and not product distribution.

Already litigated are cases involving hospital blood banks and the issue of blood-borne disease transmission (79, 80, 96). Hospitals as defendants in posttransfusion contests in which HIV has been allegedly transmitted by blood transfusion and AIDS has developed are judged by seeking liability from the source of the blood or blood product used by the institution to treat the patient. If the hospital has its own blood bank, the same criteria for negligence would apply as for blood banks. If the hospital receives blood from an independent source, proving negligence in the duty to evaluate blood bank-processed blood depends on the demonstration that the hospital had knowledge, somehow obtained, that the blood donor was suspected of having risk factors for HIV infection. Alternatively, evidence that showed inadequate handling of the blood by hospital personnel after it was obtained from a supplier could also be used to show negligence. Such suits involving hepatitis B have been brought, but none involving AIDS are on record (76).

Law suits of negligence for failure to evaluate each donor and to test serologically for HIV contamination in blood should decrease in the next few years. However, recent studies suggest that such negligence claims will not disappear, because of the interval between the time of infection and the appearance of detectable antibody in the donor. This “window” may be up to 3 months in duration (125). Thus, reports that seronegative donors are believed to be responsible for HIV infection of blood recipients are not surprising (43).

Blood or blood product recipients who seroconvert or even develop AIDS after the mandated routine screening of all blood donors place hospitals in jeopardy of liability. Ward et al. describe HIV transmission by seven infected donors who were negative by the screening test at the time of blood donation (125). Thirteen recipients, 12 of whom had no admitted or identifiable risk factor other than the transfusion, became seropositive. They reported that six of the seven donors had identifiable risk factors for HIV infection apparent to the processors at the donation site. Furthermore, the donors were given written materials describing reasons not to donate blood. Each signed an affixed statement that they understood this admonition. The donors affirmation of suitability of their blood, which was accepted by the hospital laboratory, and the sensitive screening test used were seen as adequate defenses for the hospital against the evidence of demonstrable risk factors in the donors which were not noted by those processing the blood. The question of when to defer or reject a blood donation offered by a prospective donor will surely be an issue if, as has been predicted, 90 persons are infected each year because of failure to detect HIV in donated blood.

Still to be litigated are instances in which persons with high-risk lifestyles, such as active homosexual males and intravenous-drug abusers who either suspect or know of their HIV exposure and infection, still seek to sell their blood to blood banks. The ability to detect HIV infection during the incubation period will continue to be a problem until methods to detect small quantities of antigen become realistic. Arguments for routine use of those techniques that now exist will be found in new trial case records (86). The ability of any paid high-risk donors to meet a liability judgment against them through personal or insurance resources is not very promising. Legal punishment for such social disregard is a possibility and is being considered by state legislatures.

Transmission of HIV to Health Care Professionals

The second legal issue confronting health care professionals concerns the liability for transmission of HIV from a patient to an employee who provides service. Although transmission from an infected health care worker to a patient is also possible, the foremost concern seems to arise from the first possibility. No instances have been reported of professional activity resulting in transfer of infectious virus to a patient, but the concern still exists in our society.

Health care workers who collect specimens of blood, body fluids, or waste, as well as surgeons and dentists whose activities bring them into contact with patient blood, seem to be at less risk than laboratory workers (84, 90). The laboratory-based health care worker who handles large volumes of blood often has limited knowledge of the source of the specimen. Needle sticks, instrument punctures, glass cuts, and open-wound contamination associated with specimen processing have each been documented as events which led a health professional to file legal complaint against a hospital or physician employer (127). The charges cited were failure to warn the employee of a disease threat. However, in most instances, confidentiality statutes led the physician involved to limit the information exchange at the time a specific laboratory analysis was ordered. These cases are similar to those in which charges of negligence were brought against a physician who failed to warn an employee or third party about the potential danger of contracting tuberculosis (62), typhoid (87), pertussis (118), or smallpox (75) from a patient. At issue in these suits was the failure to warn, as opposed to a charge to keep details of the patient’s illness confidential. Both of these responsibilities are duties of the physician or laboratory director to the respective parties (121).

Because of these early complaints about AIDS transmission events, most of which involved phlebotomy incidents, barrier practices were detailed (20, 23, 24), procedures to identify highly suspect specimens were developed (41), and general laboratory safety precautions were designed (45). Suits involving instances in which a nurse or laboratory worker had not been apprised of the precautionary means of obtaining the specimen or the appropriate measures to take following needle stick or mucous membrane exposure have not been fully litigated but are on court schedules. One prominent case, involving a nurse who cared for AIDS patients beginning in 1981 in a San Francisco hospital, has gained national attention (127). In her suit against the hospital, she alleges that she contracted both tuberculosis and cytomegalovirus disease from AIDS patients while she was pregnant because she was forbidden to use mask, gloves, or gown while performing her duties. She further alleges that hospital policy was responsible not only for her disease but also for the severe birth defects of her infant son. At issue is the adherence to initial guidelines suggested by the CDC for infection control when working with AIDS patients. Significant review and restructuring of hospital infection control policies and state health department involvement have already occurred because of this suit, which has not yet been fully litigated.

The defense of such charges will incorporate evidence about the minimal danger of health care workers developing AIDS. A risk of 0.35% has been reported by Wormser et al. in a study that followed individuals who experienced a single needle stick (129). A recent CDC study estimates the risk to be <1% and indicates that seroconversion following mucous membrane or nonintact-skin exposure is even less promising (41).
The nurse's suit described above has been cited as the first in which worker compensation was paid for transmission of disease to a health care worker via AIDS patients. While the nurse did not contract HIV disease during her professional work, other health care professionals either have seroconverted or may be incubating HIV disease (45). Should such disease develop, worker compensation cases will surely follow because of the attending disability. The proof of occupational exposure will be a demanding charge for any applicant because of studies such as that by Wormser et al. (129).

Follow-up and long-term studies of dentists (84) and surgeons and pathologists (92) should help to allay the anxiety of health care professionals who serve AIDS patients or process specimens obtained from them. Likewise, such studies should dispel the public's concern that health professionals are a reservoir of disease and are capable of spreading HIV through their professional activities.

Blendon and Donelan recently compiled data from 53 surveys to ascertain the opinions of Americans on AIDS (7). They found that, whereas only 20% of those questioned were concerned about contracting AIDS, 68% considered this disease the most important health problem in the nation. To dispel continuing concern about primary health care services, the known routes of disease transmission must continue to be stressed, i.e., sexual activity, intravenous drug use, blood and blood product use, tissue and bone transplantation, and congenital acquisition (42). Health care professionals also need to remain aware of the body fluids involved in transmission, i.e., sperm, vaginal secretions, blood, and breast milk.

**Issues Affecting Relationships between Health Care Workers and PWA**

A third area of medico-legal conflict concerns the professional relationships between health care workers and PWA (63, 64). At issue are legal relationships based on litigated rights of the patient and the corollary duties or responsibilities assigned to the health care professional by the courts. Each of the following issues regarding patient rights and professional duties have case law precedent because of a claim lodged against a health care professional in the United States. Not all of the examples of rights and duty issues involving PWA presented here have been completely litigated. Because of the short history of AIDS in our legal system, some grievances are still being contested. However, each of the following issues has been cited or is being contested by a PWA.

**Acceptance of a PWA for professional service.** Independent health care professionals or providers of service to the community have no legal duty to respond to all or any individuals who seek their care and attention (4). The formal promises that health professionals may make at the conclusion of their basic professional training carry no guarantee of their willingness to care for all who request their services. The Oath of Hippocrates (physicians), the Dentist's Pledge, the Pledge of Nightingale (nurses), and other such formal vows contain only promises of confidentiality, respect, privacy, and the proper use of knowledge, skill, and judgment by the oath taker. However, a health professional employed by a third party has responsibilities designated and assigned by the employer. Employer assignments place on the employee a duty to provide any publicly advertised service that the employee is hired to perform (63). Thus, a distinction can be drawn between the independent and the employed health care professional faced with accepting the PWA for service.

To bridge this gap of legal duty, the American Medical Association, the American Association of Academic Health Centers, the American Association of Medical Colleges, the American Association of Dental Colleges, and other professional organizations such as the Infectious Disease Society of America have adopted ethical policies that promote nondiscriminatory care for PWA (82, 90). Still, charges of failure to accept PWA for treatment and abandonment of PWA have been reported in local and national news publications (7). Most often the cases reported were never formally filed in the courts, but rather were attempts to achieve publicity for presumed denial of care. Two related concerns of health care professionals were noted early in the current pandemic. First, the fear of self-contamination while obtaining blood, cerebrospinal fluid, or biopsy material led health professionals to request transfer from assigned duties. Second, conflicts arose over the need to identify potential PWA to the health care professionals providing service (D. G. Sienko et al., A. R. Lifson et al., and T. C. Quinn et al., Letters, N. Engl. J. Med. 319:242–243, 1988). Both concerns have largely abated but have not disappeared. Once specific transmission routes were determined and high-risk patient subgroups identified, the apprehensions that health care professionals had developed over the risk of HIV contamination were eased (41). To neutralize further any hesitancy that some health care professionals have in providing service to PWA, legal duties have been proposed and promoted by professional societies to supplement the ethical and moral policies associated with health care aid (53, 106). To avoid discrimination against them, it must be stressed that PWA have the same civil rights as other citizens in regard to the need for privacy of health care (7).

**Informing a patient of possible AIDS diagnosis.** The issue of informing a patient of possible AIDS diagnosis usually involves a physician and a patient with clinical symptoms suggesting AIDS. However, because of the stages through which the disease progresses, patients with AIDS-related complex or those serologically positive for HIV antibodies may also be involved.

Health care professionals are obligated to discuss with their patients their suspicions about the cause of a physical complaint(s), suggest a tactic(s) available to affirm or dispel such a suspicion(s), and inform the patient of the time and money needed to proceed with the diagnosis and of the need to limit sexual or intravenous drug activity. The attending professional is also required to discuss alternative means of diagnosis available, if any, and the consequences of success or failure of the diagnostic procedures selected by the patient (121). Failure to so counsel a PWA or a patient suspected of having AIDS before diagnosis or treatment is initiated can lead to a charge of negligence. An early suit resulted from a physician's failure to inform the patient of the suspected diagnosis. He failed to counsel the patient about restricting sexual activities until diagnosis could be confirmed. As a result, transmission of HIV to a spouse was charged and litigation has been started (98).

**Obtaining consent to diagnose, treat, or assist in rehabilitation.** Obtaining permission from a patient before proceeding with any diagnostic, therapeutic, or rehabilitative process requires that the risks, consequences, and alternative means to accomplish an end be provided to the patient (114). Suits involving consent issues with PWA or those suspected of being infected with HIV have most often concerned screening policies and procedures. The individual who has been subjected to serological evaluation for HIV antibodies has
occasionally felt discrimination when results have been publicized. Charges of invasion of privacy and negligence due to lack of informed consent to be tested for HIV antibodies are rare but are on record (51). Federal regulations that require screening all immigrants, all new federal prisoners, all new members of the Armed Forces, all new Peace Corps and Job Corps applicants, and all foreign-assigned members of the State Department for HIV antibodies have been initiated (39). At this time, no legal rationale that would allow indiscriminate AIDS testing of the general public has been accepted. The charge of civil battery hangs over those who would collect specimens for HIV antibody testing without obtaining the permission of the person involved. The proposed testing of individuals in sexually transmitted disease clinics, blood donor programs, drug rehabilitation units, and obstetrical clinics provoked as much controversy as the serology proficiency studies for HIV antibodies conducted in 1988 in hospital laboratories around the nation (Lifson et al. and Quinn et al., Letters, N. Engl. J. Med. 319:242–243, 1988).

The importance of screening programs transcends the value of the information to the individuals screened. Such programs are the only way to gather information about AIDS in the population at large. For example, knowledge of trends in infection rates and the demographic and geographic rates of disease in high-risk population groups are important for determining the status of AIDS and estimating opportunistic disease rates in this country. The correlation of such data with societal activities and behavior is necessary to plan and evaluate control measures. These data lead to specific control measures, such as tracing infected persons and monitoring a high-risk individual’s progression from serologically positive to AIDS-related complex and then to AIDS. The ability to warn third-party contacts of the seropositive individual is also enhanced. Screening the members of high-risk populations can be easily justified. The opportunity to educate sexually active subgroups about the dangers of HIV infection and to provide sterile paraphernalia to high-risk intravenous drug users are two benefits of serological screening.

Still, fear of mass screening brings legal objection to collection of such data. In our society, the stigma of AIDS promotes discrimination not only in the medical treatment of the identified HIV-positive individual, but also in the social and economic relationships the individual enjoys (7, 91, 105). When a life-threatening disease is at issue, confidentiality of screening-test results cannot be guaranteed. The weight of such information’s value lies balanced between the interest of society and that of the individual. For the most part, the court has ruled for society, as in the blood donor searches (110).

The debate concerning how to use and analyze the results of screening programs is currently stymied by the question of how to collect such data. The need to maintain confidentiality of those agreeing to be tested is balanced against the position of not seeking identification at all. The rationale that mass testing is needed to determine the extent of HIV infection in our society is gaining favor among both epidemiologists and lawmakers. In 1989, one of every three newborns will be tested to assess the rate of HIV infection among childbearing women. Collection of heel blood to detect HIV antibodies in newborn infants, as is done to detect phenylketonuria, has been proposed. The specimens will not be identified, and no individual results will be reported; therefore, consent will not be required.

The rationale that mass HIV screening is needed for the same reason as for blood donor screening, immigrant screening, or military recruit screening has not been fully accepted by either medical or legal interests. The debate is ongoing (Lifson et al. and Quinn et al., Letters, N. Engl. J. Med. 319:242–243, 1988). It is interesting to note that the cost for screening has finally taken a back seat to the issue of confidentiality (126).

The second aspect of the consent issue deals with the question of who should be treated and how such treatment should be offered. Litigation about such questions has been limited to requests for court orders to release therapeutic agents such as zidovudine to an individual. The rationing of antiviral chemicals and the refusal by the Food and Drug Administration to allow the use of foreign-produced chemicals have been publicized and are reminiscent of earlier Laetrile contests. The question of who would be immunized should an effective vaccine be developed or who will be selected to test antiviral chemicals will be more thoroughly debated in ethical forums than in courts of law.

The question of gaining consent to rehabilitate PWA does not appear to face legal contest at this time. Hospitals, hospices, and health departments are more concerned with producing comfort and solace to PWA than in trying to habilitate the afflicted patients. Should a therapeutic tool become available, availability of facilities for rehabilitation could become contested, but for now such concern is a moot point.

Negligence by failure to provide the standard of care. Health care workers have a responsibility to act to the best of their ability when providing service to a patient (49). Since only experimental methods are used to treat AIDS, most complaints registered involve diagnostic activities.

Cases of missed diagnosis, erroneous diagnosis, failure to inform the patient of a confirmed diagnosis, and failure to control the spread of communicable disease are not new to litigation (106). Instances in which physicians or hospital infection control officers were found liable for the spread of smallpox (75), tuberculosis (62), and salmonellosis (87) date back to the early decades of this century. More recently, suits have been filed for misdiagnosis or failure to counsel the infected party who spreads a sexually transmitted disease or both. Suits charging transmission of gonorrhea (52) or syphilis (119) have been replaced by a flood of suits charging misdiagnosis or failure to counsel those with genital herpes simplex virus infection.

The diagnosis of AIDS is complicated by the large number of opportunistic infections in PWA patients and requires a thorough workup by the physician or scientist involved. To investigate the immune status of a person with Kaposi’s sarcoma or with infection caused by cytomegalovirus, herpes simplex virus, mycobacteria, Cryptosporidium sp., or Pneumocystis sp. can result in a charge of negligence in diagnosis or failure to counsel or both. The first litigated case of misdiagnosis or erroneous diagnosis was a malpractice suit filed in Massachusetts. In the suit of Ramos v. Bernstein, the plaintiff patient won $750,000 from the defendant physician because she was diagnosed as suffering from asthma when, in fact, she was suffering from P. carinii pneumonia complicating an HIV infection (109). Other complaints of misdiagnosis are on file but have not been litigated. These complaints often include, as a corollary charge, the failure to control the spread of disease.

Continuation of care. The patient infected with HIV has no less right to continued attention and service than other diseased persons. Even though no cure is available, PWA are legally justified in seeking comfort and solace from their
care providers. Such a position has been stressed not only by the professional spokesman, but also by the courts (63).

Abandonment by health care workers of any patient under their personal care is not only unethical but also unlawful (4). Such a duty is not specifically assigned to primary care physicians but binds nurses, physical therapists, and even laboratory workers who are employed to provide continuing service to those requiring their attention. Again, multiple cases of abandonment have been made but have not been litigated.

Another obligation is that professional health care workers continue to monitor their patients in order to control the spread of communicable disease. The counsel they can give and the influence they can have on any infected person are recognized as duties to society by both legal and medical professionals.

DISCRIMINATION ISSUES

In Education

The earliest publicized cases filed by PWA involved denial of access to educational facilities, especially to primary schools (11). At issue were two questions: (i) is the PWA handicapped and therefore entitled to protection under federal law and eligible for special consideration, and (ii) is the PWA a threat to classmates because of his or her infectious disease. Both issues involve civil rights aspects of discrimination.

Discrimination as a legal concept was defined in response to the question of whether “separate but equal” education facilities provided by the state to its citizens are lawful. As pointed out in 1954 in Brown v. Board of Education (12), when facilities are unequal in every sense, individuals are treated differently because of their race and not their abilities or qualifications. Since that time, unequal treatment of any citizen on the basis of sex, ethnic origin, religious belief, and even geographic birthplace has been contested as discriminatory. In response, Congress formulated the Civil Rights Acts of 1964 to deal with discrimination and the Rehabilitation Act of 1973 to deal with another group of “different” citizens, the handicapped. Section 504 of the latter act defines a handicapped person as one who (i) has a physical or mental impairment which substantially limits one or more of that person’s major life activities, (ii) has a record of such impairment, or (iii) is regarded as having such an impairment (10).

The inclusion of a person with a contagious disease as handicapped was ruled in a Florida suit (1). Ms. Airline had developed a recrudescence of tuberculosis that forced her to forego her teaching activities. After a third relapse of the once inactive disease, the school board employer discharged her, citing contagious disease as the reason for termination. After multiple court contests, the Supreme Court ruled that tuberculosis as an infectious disease is a handicap under the definition of the Rehabilitation Act. PWA were contemporaneously involved and concerned with the issue since this case concerned a contagious-disease issue.

Another early contest saw the president and members of a community school board sue the School Board of New York City to deny admission to any child with AIDS (57). The ruling court denied this application on the basis that such action would usurp the function of the Commissioner of Health as well as violate the civil rights of the identified handicapped individuals. A famous case in Indiana has allowed Ryan White to attend class and placed the duty to provide separate washroom and eating facilities on the defendant school system (114, 128).

Suits in Nebraska and New York (8, 71) contained expert testimony that children who had acceptable social and hygienic habits were not hazards to their schoolmates despite their HIV infection. Policies defining the necessary medical evaluations of such children and how to maintain confidentiality by limiting access to records of such evaluations have been developed. In these and similar cases, many of the discussions involving admission of children with hepatitis B were reargued (11).

Nevertheless, the fear of HIV transmission continues. In 1988, a Florida judge ordered that a glass-front isolation booth be built inside a classroom for a 6-year-old PWA. The child’s parents and the school board objected. The judge recognized that no cases of HIV transmission have been attributed to urine, saliva, or feces as vehicles, but he rationalized that the child’s personal habits provided a “remote theoretical possibility” which should be controlled (104). It appears that the fear of HIV transmission prompted by the stigma of disease and the lack of cure will continue to challenge school boards, educators, and parents (70, 117). Uncertainty seems to force a denial of scientific data, especially when the presumed potential for exposure involves children (117).

In Employment

Employment of a PWA has provoked litigation both before and since the Airline suit. In the United States, an employee is hired at will by an employer who is free to assign duties and responsibilities as judged appropriate. This employer has the right to discharge any employee for any reason not prohibited by law just as the employee has the right to terminate employment at will. The legal crux of this relationship develops when the reason used by the employer is not based on the employee’s qualifications presented at hiring or production at work but rather is unrelated to either. Initially, race, and later, sex, ethnic origin, and religious belief, have all become factors in employment, education, housing, and other activities that affect the quality of our lives. HIV infection may now be added to this list.

One particular suit provided a specific answer to the question of employment protection of a PWA by federal law (116). Mr. Shuttleworth was a budget analyst who was fired from county employment in 1985 when he was diagnosed as having AIDS. He sued to regain his job. On appeal, the Florida Commission on Human Relations ruled that a PWA was handicapped under the Rehabilitation Act definition and that his firing was discriminatory. Again, after multiple court hearings, a Florida Federal District court wrote in a ruling on this case, “No otherwise qualified handicapped individual shall, solely by reason of his handicap, be excluded from the participation in, be denied the benefits of, or be subjected to discrimination under any activities or programs receiving federal assistance.” The issue was further affirmed in a California case in which Chalk, a teacher of hearing-impaired children, was reassigned to administrative duties upon a diagnosis of HIV infection (47). He pleaded discriminatory treatment. The ruling court ordered his reinstatement as a teacher. The court said that a worker involved in education need not disprove every theoretical possibility of causing harm, such as disease transmission to students. It further commented that the fear or apprehension of HIV transmission on the part of students and parents was not grounds to deny the teacher an opportunity to instruct.
The Shuttleworth case in Florida and the Chalk case in California mirrored a similar case of discriminatory firing in Massachusetts (51). Mr. Cronan was employed by the New England Telephone Company for 12 years as a repair technician. In the mid-1980s, he consulted his physician on two occasions before seeking time off for a third physician’s appointment. When quizzed by his supervisor as to the need for this third visit, he admitted a diagnosis of AIDS-related complex. The supervisor reported the situation and a company physician then examined Mr. Cronan. The physician diagnosed ‘‘AIDS anxiety syndrome.’’ Company administrators informed Cronan’s co-workers that he had AIDS and would be placed on disability leave. This announcement was made without informing Cronan and in his absence. Cronan was threatened with violence when he applied to return to work. After being placed on permanent disability, he sued not only for discriminatory treatment but also for violation of privacy. The defense offered by the company was that their actions were based on legitimate business interests and the need to protect co-workers. This defense was rejected by the Massachusetts court. Further litigation is pending, although Mr. Cronan has died of AIDS.

A fourth employment discrimination case extended the responsibility of a defendant found guilty of firing an employed PWA (46). John Chadbourne was hired by Raytheon Corporation in 1980 as a quality control analyst. In 1983, he was diagnosed by his physician as ‘‘probable AIDS’’ and a company health care representative was informed. After Mr. Chadbourne’s personal physician certified his ability to return to work and confirmed that he would pose no threat to co-workers, his return was delayed by the employer. He became depressed, his health deteriorated, and he died. His estate subsequently brought a legal complaint against Raytheon. In a ruling on the complaint of employer discrimination that resulted, a California court not only awarded back pay, but also ordered the company to give formal educational instructions to all employees on the disease AIDS and its transmission. The company was further ordered to inform all employees of the California discrimination statute. These four successful suits should help prevent future discriminatory practices, especially with the continued stress on education about HIV transmission.

In Insurance

Because there is no known cure for AIDS, underwriting health or life insurance or both for young men has become a very controversial topic not only in insurance company board rooms but also in the editorial pages of our news media. Attempts to provide cost-effective health care coverage for PWA have met with significant confusion during the 1980s (88). Private insurers have refused coverage or have raised premium rates for those suspected of belonging to potentially high-risk groups. Factors used to identify such groups include age, occupation, residence zip code number, or listing as next of kin or beneficiary a person other than a spouse or child. Discrimination based on a fear of excessive financial loss extends to related financial areas such as home mortgages and loan applications. Instances in which these applications have been denied because of concern about AIDS are numerous.

Insurance trade organizations have agreed to oppose the stereotyping that has permeated the insurance application process. The policy adopted by the Health Insurance Association of America and the American Council of Life Insurance was presented in a bulletin to their members (2). This policy prohibits the use of marital status, living arrangements, occupation, beneficiary designation, or zip code to determine an applicant’s sexual orientation. The purpose of this industry-initiated policy is to limit discrimination against homosexuals. However, although laudable in design, there is no effective way of compelling compliance. The insurance industry can easily support its reluctance to accept all applicants without thorough investigation. CDC statistics show that, among PWA, 65% are homosexual or bisexual males, 16% are intravenous drug users, and 8% are both homosexual or bisexual and intravenous drug users (42). These percentages have been virtually unchanged since 1982 (42).

Legal actions by individuals to force changes in insurance application procedures have not yet reached litigation. Gay and lesbian organizations have been prompt in endorsing the insurance industry’s bulletin prohibiting discrimination. Disagreement, however, has been strenuous on another aspect of the application process, the HIV antibody test. Two states, Wisconsin and Maine, have legislated that such screening tests are permissible. As of early 1988, only six states and the District of Columbia had a policy set by the insurance regulatory agency of the state that limited or forbade the use of HIV-screening serology as part of an insurance application. Only California and the District of Columbia have written into law such a regulation (100).

The power of non-federal-government jurisdictions to enact such statutes was tested in federal court in 1986 when the District of Columbia passed such a prohibition (2). The legislative authority to do so was affirmed, with the court commenting that insurers do not have the right to use medical screening information just because it is actuarially valid. Applicant information must be collected and handled in a manner consistent with the constitutional right to privacy (60). A state court decision in Pennsylvania similarly found that the gathering of such information without limit was not justified (113). Until the economic impact of insuring a PWA can be shown to undermine the insurer’s ability to remain financially stable, few individual suits filed for rejection or denial of coverage will be fully litigated. However, as the number of PWA steadily increases, private industry health insurance coverage for many will be difficult if not impossible to attain. To date, government insurance coverage has not been enacted to meet the increasing costs of health care for PWA.

What also seem to be pertinent issues are the collection and handling of data from serological or blood chemistry panels designed by insurers. Since it is estimated that over one-half of the nation’s private insurers are using such information in their applications process, the concern for confidentiality has become real (113). The trend of state legislatures to require the reporting of positive HIV serological tests brings up again both the confidentiality issues and the counseling obligations of the health care worker. Suits of discrimination due to a breach in either obligation are foreseeable. The reporting of a positive result by assigned laboratories and physicians is not optional once the test results are available. Rather, it becomes a duty on which reduction of both risk and health cost depend. The legislatures that promote and pass such state regulations have already made this decision. In most states, the laboratory personnel who test the applicant’s specimen and evaluate the results are legally bound to report positive HIV serological tests, as are the physicians requesting the information for the insurer. The conflict between the state’s need to
control disease and the patients' perceived rights to control their privacy will continue to be contested.

CRIMINAL ISSUES

Although most complaints involving the transmission of contagious disease have been filed in tort (civil) suits and/or criminal cases, a review of the literature shows that criminal charges have also been lodged against those suspected of intentionally transmitting disease agents to a susceptible human host (52, 119). The explosion of AIDS in our society has added to the number of cases already on the increase.

Criminal charges are filed by the state against an accused offender to impose punitive sanctions rather than the compensatory rewards which flow from a verdict in a tort suit. The current legal activity in AIDS cases may show a combination of civil and criminal charges resulting from instances of AIDS transmission. The basis for an acquittal is the history of cases in which defendants were accused of or held liable for transmission of gonorrhea (61), syphilis (119), and, most recently, genital herpes (5, 85, 93). Each of these charges resulted from intentional transmission of a sexually transmitted disease, which AIDS can be. In addition to these precedent-setting cases, a new wave of state laws have made the intentional transmission of a sexually transmitted disease, specifically, the agent HIV, a felony, punishable by imprisonment (76). Various complaints resulting from intentional attempts by a PWA to transmit HIV have been reported by printed and electronic media. These instances, which as yet do not have court references, include personal injury cases.

In Texas, a soldier was convicted of murder after having sex with two other soldiers when he was aware that he was infected with HIV. Other reports involve charges of attempted murder and include situations in which (i) a known PWA bit a policeman, (ii) a man bit a female acquaintance, and (iii) a prostitute with AIDS continued to have sex with clients without informing them of her disease or using any precautions. Another report concerns a criminal charge resulting from the fear of AIDS. Recently, in a midwestern state, a mother killed her grade-school-age son because she suspected he had contracted AIDS. The 7-year-old boy had a herpes-type lesion on his chest, which led to the erroneous assumption by the mother. Manslaughter charges were contemplated (103). The decision to file these different degrees of criminal charges depends not only on the outcome of the act, but also on the knowledge and intent of the act. The reckless or negligent actions of persons who only surmise that they could have an infectious condition and yet elect to participate with others in potential disease-transmitting activities are certainly viewed differently from the actions of persons who know they have a disease and elect to participate. Intent to cause danger or place others in danger by exposing them to HIV by sexual activity or by sharing paraphernalia for drug abuse is now recognized by the courts as a felony, in some states can be upgraded to negligent homicide if the recipient of HIV dies from AIDS (122).

Currently, criminal cases involving such charges are in various stages of litigation and appeal. Because laboratory workers and infectious-disease physicians will be crucial witnesses in affirming the presence of the disease agent in a defendant and/or that the defendant knew of his or her infectious state, attention should be paid to the counseling responsibilities discussed.

THE FUTURE

With the realization that heterosexual spread of HIV may lead to several million new cases of AIDS in this country in this century, legislatures are beginning to react in many ways to challenge this spread. Sex education programs for primary-school children may be mandated on the basis that education about HIV transmission routes are more effective than slogans in slowing the spread of infection. Public health policies may be enacted to allow distribution of sterile needles and syringes to those using illegal drugs, provided they submit to serological tests and counseling for AIDS. In communities in which AIDS disease rates overwhelm the local medical facilities, city and state policies to ration hospital beds may lead to federal legislation to allow the admission of AIDS patients to Veterans Administration hospitals. Legislation by state and federal lawmakers may be passed to encourage hospice establishments for PWA. Civil rights protection through specific counseling requirements aimed at accommodating those identified as potential HIV carriers is also a possibility.

On the scientific front, blood testing for HIV antigen is expected to become economically feasible and be used routinely to evaluate blood donor specimens. This will then eliminate our inability to detect patients in the antibody "window" phase. Thus, the blood donor system should regain the confidence of the general public and of medical personnel. The need to evaluate tissue and organs used in transplantation will be legally contested when liability for transmission of HIV by such manipulation is charged. Research into the genetic basis of patient susceptibility to HIV should receive added interest.

The fear of contact with a PWA in a social, educational, or employment relationship should gradually lessen as educational efforts expand. The identification of PWA as handicapped will probably be accepted by education, employment, and health care interests. With experience gained by laboratory personnel and improved reagent sources, the serological tests used to select applicants for employment and insurance will become more accurate and available.

Quarantine for those exhibiting HIV-connected opportunistic disease or having a demonstrable deficient immune response will probably be argued. Criminalization of the spread of HIV may gain support in some states and may even evolve into a law covering such spread as a specific offense. Illegal drug trafficking should become more stringently prosecuted because of HIV spread. Health care workers in all professions will use the experience provoked by AIDS to enhance the personal service and compassion to patients which has declined in our routine health care system. This reactivated solace and comfort provided to all patients are foreseen as factors that could reduce the legal involvement burdening our health care system by promoting communication between patients and health care professionals. Communication often forestalls misunderstanding that leads to the filing of suits.

SUMMARY

Many legal issues will affect the health care worker during the AIDS pandemic. These issues are now beginning to be contested in our courts. It is certain that their numbers will continue to grow in the foreseeable future. As local, state, and federal governments design and implement new laws concerning PWA, mechanisms for surveillance, and control of AIDS, new issues are sure to arise. These will undoubt-
edly involve persons concerned with providing service to those afflicted with this illness. The direction of health care research has already been altered by AIDS. Societal relationships have been affected, as evidenced by the increasing number of legal charges filed when the question of HIV infection involves a patient, student, employee, or other citizen. Inevitably, the health care worker who has contact with PWA will be asked to participate in the mechanisms of the resulting legal contests. If the case reports cited above are an indication of the legal struggles ahead, appearance as a witness to provide scientific information as well as information about the care and treatment afforded PWA will be required of health care workers with increasing frequency.

LITERATURE CITED
22. Centers for Disease Control. 1983. Update on acquired immuno-