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## The ethics of the AIDS-afflicted physician: The death of voluntary compliance

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# **UMI**

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**THE ETHICS OF THE AIDS-AFFLICTED PHYSICIAN:  
THE DEATH OF VOLUNTARY COMPLIANCE**

**BY**

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**A thesis submitted in partial fulfillment  
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Master of Arts in Ethics and Policy Studies

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## **ABSTRACT**

### **The Ethics of the AIDS-Afflicted Physician. The death of voluntary compliance!**

by

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This argument will examine the ethical issues, policies, and controversy surrounding the AIDS afflicted health care worker, especially the HIV positive Physician / Surgeon. The discussion encompasses evaluation of rights of the individual, natural and otherwise, with focus on the rights of confidentiality, privacy, and disability rights and related laws that pertain to afflicted individuals. The discussion will examine the ethical responsibilities of the HIV positive health care worker within the medical practice, along with issues of the patient rights of informed consent, institutional responsibility, and the policy positions of professional associations representing afflicted individuals. Protective legislation for victims of communicable disease will be balanced against the issues of public health with focus on the legislative beginnings of these protective laws, and protections offered by the various laws, common and otherwise. Policy recommendations for the treatment of these individuals and those that are affected by their actions will be offered.



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## CHAPTER 1

### INTRODUCTION

The issues of AIDS and HIV infection are on the mind of the nation. Caring for infected individuals involves the problems of how to mitigate risk and screen patients for the protection of the caregiver. The problem of HIV infected healthcare workers, specifically HIV infected surgeons, involves risk to the very individuals these caregivers are sworn to help. Yet, mitigation of these risks must also take place, and that means a call for change from current policy positions. This thesis will offer a solution to current policy problems and will base the argument for change on moral positions that are not influenced by the current practice of statistical determination of risk. A change from the status quo is often a painful and fearful process. When examining issues that appear, on the surface, to be of concern to all players, many problems arise to cloud the already murky water. Among these problems are the balance of individual versus community rights, discrimination, justice and fairness, and issues of law; each of which poses a roadblock on the way to change. An argument in favor of change must temper individual concerns against a larger community of need. A full fledged stand in favor of general utility would trounce the value of the individual. Yet by contrast, to allow a select group of individuals to dictate societal behavior ignores the value of the common good sought by those in a

particular community. To stand firmly on either side of this issue denies a sense of responsibility to those on the other side. While this may sound as political as standard fence sitting, the real answer is not to sit on the fence, but to tear it down in favor of a better, more just and equitable solution for all.

The argument of this thesis is a concise and determined effort to remove the fence of discrimination against infected individuals and to build a base of responsibility and positive action based on individual and community needs and concerns. The AIDS and HIV issue is real and a passionate subject for the public at large. It has been the subject of much debate in the classrooms, the courtrooms, the boardrooms, and the bedrooms of the nation. The subject for this argument will be the individual afflicted with the Human Immunodeficiency Virus or HIV, who is also a surgeon, a health care professional who is exposed to and potentially exposing others to the HIV infection. <sup>1</sup> Current policy regarding these individuals, that they "should refrain from performing exposure prone procedures", and the 'voluntary compliance' expected of this policy lacks the necessary strength to obligate individual acquiescence.

The AIDS epidemic is a powerful topic that has engendered an environment of fear and distrust of our fellow citizens. Fear is a powerful affliction. "From the earliest reports of a serious new illness spread through an infectious agent, a secondary epidemic of fear has accompanied the epidemic of illness and death, generating a wave of discrimination against those identified with the disease" (Burris, et. al. 1993, 297).<sup>2</sup> This pattern is well known throughout history. From the black death in Europe, typhoid fever in American cities, to the Acquired

Immune Deficiency Syndrome of contemporary society, fear has plagued society's treatment of afflicted individuals. Uniquely, the issue of contemporary societies dealings with the AIDS-afflicted individual "has not focused narrowly on those diagnosed with AIDS, but has reached out to touch asymptomatic people infected with HIV and even un-infected people suspected of being infected because of their membership in so-called high risk groups or their association with people who have AIDS" (Burris et. al. 1997, 297). Such discrimination begs the question of individual rights and argues for protection and defense.

In Chapter Two we will examine the issues of rights. The language of 'rights' has been embroiled in a bitter war of verbiage and assertions on each side of the issues. No matter which side of the fence on which one stands, each has a habit of trying to overpower the others with strong language about "their" rights and how the other person should be respectful of what is due to us. "The language of rights is the language of no compromise. The winner takes all and the loser has to get out of town. The conversation is over" (Glendon 1991, 9).<sup>3</sup> This has not been overlooked by the modern scholar or legislator. The issue of rights is very prominent within the social framework of modern society and is currently debated on several levels; here, individual rights and the rights of society are two conflicting areas of discussion. Each offers different domains of concern and although these areas are of importance, it seems that no matter which area of rights is discussed, there is a need to balance any assertion of rights by an individual or group with that of the other individuals or groups that

may be affected. In other words, an assertion of rights cannot be valid unless there is a determination of justice for those required to respect those rights.

Rights discussions are often complex and often delve into a realm of the obscure and controversial, such as the notion of “natural rights”. A discussion of natural rights is one that has had perplexing consequences for much of our societal and political thinking for many years. Some would argue that the distinct concept of “human” or “fundamental” rights is unique and identifiable. Yet, some would state that these are merely notions of convenience without which the human creature could not survive. Still others would argue that the ‘natural rights’ are derived from the *state of nature* (or our human nature or our natural condition) and are those with which mankind is endowed regardless of an individual’s place in the world. Others still would argue that these rights are divinely bestowed by their God. A dissenting opinion on the whole subject holds that the entire argument, irrespective of one’s position, is merely a semantic trap serving no useful purpose, that there are no rights but only politically conflicting claims.

Chapter Three will attempt to examine many of the existing laws and protective legislation that has been drafted. We will examine the current protection that has been offered to individuals with HIV and the strong treatment of individuals that have been deemed a possible direct threat to others. Chapter Four will examine the framing of these laws, what legal basis has been used in their formulation, and how some individuals are favored under these protective guidelines.

In many instances the issues and responses by both individuals and groups are grounded in philosophical chest thumping, which fails to offer reasonable solutions or position stances relative to their individual or group doctrine. If no solution or policy is offered, then the situation becomes disconnected and leaps into the arena of individuals and groups seeking to define what they are and the roles they are to play. If a group or individual only redefines the problem and offers no real solution, then the old adage, "if you are not part of the solution, then you are part of the problem", should be invoked. Clear policy must be proposed in any argument for or against current practices. Many players in this dilemma will seek only to acquire a protective stance for themselves or their members. But this, again, is only a form of posturing and is defensive at the best. Sometimes it appears that professional associations may be the most adept players in this posturing methodology. Chapter Five will offer what is believed to be a reasonable solution to the policy dilemma. As current policy falls drastically short in achieving its goals, that of protecting all parties involved- the policy proposed herein will attempt to give clear guidelines for implementation and alternatives to current operational deficiencies. I will also attempt to give fair representation to oppositions to the proposed policy and address expected objections in a straightforward manner.

An extended, broad based deliberation on the value of public protection policy focused on AIDS and HIV is beyond the scope of this thesis. <sup>4</sup> This present argument shall focus on a single segment of the potential afflicted population, that of HIV positive physicians, specifically HIV positive surgeons,

and their extended risk to the general population via exposure-prone surgical procedures performed in the operating room theater.

This argument has many sides: The afflicted surgeons will claim that their positive status is not statistically relevant in the area of significant risk. They will also claim disability status under long-standing, and more current laws, and protection under the veil of privacy extended to all “medical patients” about their personal medical history. Patients will take them to task on the issues of autonomy and choice, as well as identifiable and significant risk. Patients are now questioning the HIV status of the provider and the resultant scream of disability rights from the infected individual providers is deafening. One side bellows “patient rights” in the realm of informed consent and protection from harm, and the other shrieks “privacy protection” of confidential information and the rights of disabled individuals. Neither gives any whisper of responsibility to the other or to their concerns. Patients feel the surgeons’ position is a violation of the public’s belief, justified or not, that, in all instances, the physician must place the patient’s welfare above his own. Both will rely on the epidemiology of disease transmission for the support of their individual positions. Each will also offer policy positions that are categorically unacceptable to the other. Here the problem arises. Each side is entirely correct in its assertions. If both sides are correct then the issues that are being argued must be removed from the bargaining table and a search for common ground must be initiated. Here is the reason for undertaking to propose an ethical policy position which will attempt to appease the anger on both sides.



What issues may be able to effectively solve the dilemma? The policy position to be offered here is ethically based and will dismiss much of the scientific statistical argument, as outlined in Chapter Three, as not relevant to the discussion because it supports both sides of diametrically opposed positions. The policy will also offer a reasonable approach to a solution that involves all players in the discussion and may lead to a gradual rebuilding of public trust and confidence in a health care system fraught with chaos and infighting. It should be viewed as the ultimate compromise seeking to bring the sides together and offer each a solution to their own concerns that is at least palatable to the other. We do not claim that this is the only solution, but that it is one that will try to consider the positions of each side and look for common ground. We also do not claim to be able to please all of the players. Some individuals will undoubtedly be offended, affected, and harmed. This is because some individuals' rights, justified or not, may be ignored in favor of the greater "community of need". The issues of public health that surround this pandemic problem must not be ignored because of any one group of individuals, even professionals. The issues of "community" will be the grounding for the philosophical support for the policy offered. Any ethical determination must stand on the basis of the "broad community of need" rather than solely on individuals and groups. Chapter Six will show that the communitarian stand is rational and objective in its approach to the problems we have outlined. When addressing a pandemic problem, as the issue of HIV and HIV infection have been determined to be, aggressive and decisive policy

must be enacted to offer the public the protection and confidence in the health care system that so succinctly defines pandemic. Anything short of aggressive policy appears weak and ineffective in addressing the concerns of the community as a whole.

Chapter Seven will offer a supporting ethical stand based on the surgeon's ability to seek and achieve well-being under the current approach to the problem and the current "should refrain from the performance of 'invasive procedures'" edict. The chapter will also examine the concept of justice as it relates to the patient / surgeon relationship and how the existing policy offers an injustice to the patient.

The conclusion will attempt to pull the entire argument together for a final examination.

## Chapter Notes

1. The terms 'AIDS afflicted', 'HIV infected', and the like, will be used generically throughout this work to refer to individuals that test positive for the virus that causes Acquired Immune Deficiency Syndrome.
2. Scott Burris and others, *AIDS Law Today: A New Guide for the Public*, (New Haven: Yale University Press, 1993), 297.
3. Mary Ann Glendon. *Rights Talk, The Impoverishment of Political Discourse*, (New York: The Free Press, 1991).
4. see: for example; Amatai Etzioni, ed., *The Essential Communitarian Reader*, (Lanham, Rowman & Littlefield, 1998), xxv, 131; Amatai Etzioni, *Rights and the Common Good, The Communitarian Perspective*, (New York, St. Martins Press, 1995) 20, 75.

## CHAPTER 2

### RIGHTS

Individual rights and responsibility seem to go hand-in-hand, but no matter where one goes today, he or she hears claims and assertions of rights but rarely a whisper about responsibility. When individuals place “rights” above the welfare and concern for others, they make the most grievous of all errors, that of trying to be a moral exception. This is not to say that individual rights and liberties are unimportant. On the contrary, but rights claimed and liberties demanded is a one-sided logic counter to the concept of “respect for all”.

We all make declarations and contentions about “our” rights. Very often the debate ends up with the “claims that whatever right is under discussion at the moment trumps every other consideration” (Glendon 1991, 8).<sup>1</sup> Many times we do so without discussing the implications of these claims and the ultimate fallout associated with the positions taken. “My rights” are of extreme importance in the discussion, whereas “your rights” are important only as long as they do not compete with “my rights”! The assertion of rights may be made by individuals, or by groups on behalf of individuals. They can be discussed in a framework that is legal or ethical, and the goal of any group attempting to assert a right is that there is established a legal framework within which to assert that right, thereby giving a certain amount of justification for the assertion. This framework

may use arguments that are thought of as *prima facie*, or “on the face of it”, and that will require no further explanation other than the stating of the right and the claim of the “human experience”. Some of these will be asserted as “natural” or “God given”, those that cannot be taken away regardless of that which befalls the offended individual. A common question asked about the existence of fundamental moral rights may be answered by the simple reasoning from the facts of human nature (Wellman 1985, 170-71). <sup>2</sup> Certain facts about human nature, that all human beings seek to prolong life and shun injury or pain, seem to imply, *de facto*, that all humans have a natural right to life and a moral right not to be injured.

### Natural Rights

Natural Rights have always been in the background for scholars and individuals in their declarations of rights. They have been called ‘inalienable’, “fundamental”, ‘common’, and even “divine” rights. Thomas Jefferson in his writing of the Declaration of Independence based the entire document on the concept that all men are “endowed by their creator with certain inalienable rights; ... life, liberty, and the pursuit of happiness”. “The term ‘natural rights’ is generally restricted to those [rights] which are conceived of as more fundamental than others, from which the others may be deduced, or to which the others are only auxiliary” (Ritchie 1952, 80-81). <sup>3</sup>

The defense of the natural rights is easier in a group. When a man is attacked and his life is in jeopardy, is it not easier to defend one’s life with the

help of others? Men bind together in commonwealths for “the foresight of their own preservation”, the protection of their most basic natural right, that of life itself (Hobbes 1651, Chap. 17). <sup>4</sup>

Much of the grounding for the assertion of rights for individuals lies in the philosophical case for the concept of rights claims. Self preservation, that of the continuation of life, is one of the pillars in the rights discussions.

Thomas Hobbes stated that, “Man has, through the use of his own power and will, the freedom to preserve his own nature; that is to say of his own life; and consequently, of doing anything, which in his own judgment, and reason, shall conceive to be the [means of the preservation]” (Hobbes 1651, Chap. 14). <sup>5</sup> For Hobbes the issue that made it a fundamental natural right was that man was also bound and forbidden to do “that, which was destructive of his life.” The endeavor to be and to continue to be is not granted by human artifice but is natural to all living beings. He believed that man had the right to his life (nature) and was bound by the law of nature in the preservation of that life. Hobbes also professed to a natural equality among men. By equality he meant, not just physical equality (which he often acknowledged as a false assumption), but in aspects of power relative to a consensual social contract. That is, we are equal in that no one of us is willing to go without consideration, and anyone can be outdone by others if this is allowed. Hobbes claimed that moral action, and constraint, is only possible as long as this “political equality” existed. Hobbes continues with the ‘community’ aspects that appear to be so important. Civil

rights pertain to the concept of community, or to use Hobbes' term:

commonwealth. These, *unlike* natural rights, are granted by mutual agreement.

As a result of man's formation of the commonwealth, the power behind the individual in the enforcement of the natural rights and civil rights (the covenants, or agreements among men, for Hobbes) become instituted.

The concept of 'social contract' does have its limitations. What happens when a man refuses to submit to the social collective will, "to march to the beat of a different drummer", if you will? The distinction must be drawn between Natural rights and Civil rights. While the line is wide and gray, it nevertheless does exist and is the basis for much of the law in the world today. Natural rights pertain to man in his person or existence; the right of a man to be secure in his intellect, to act as an individual for his own comfort and happiness, but always with the respectful awareness that his actions are not injurious to others and their (equal) natural rights. The natural rights of man cannot be taken from him. The power of the intellect, the rights of the mind, his religious beliefs, self-preservation, are all within the power of the individual; these he never surrenders. These 'natural rights' when asserted as a group and acknowledged by the group as rights that are applicable to all is a basis on which the group of civil rights is then made enforceable by laws. Many would argue that this community of rights is a natural and obvious evolution of the nature of things and the often sought pursuit of happiness.

A collateral condition of the pursuit of happiness, not made by Hobbes except as a generality, is the concept of man having his basic needs met

without restriction and to not be subjected to gratuitous pain or suffering. The concept of basic needs includes the right to adequate food, water, clothing, shelter, and medical treatments. (Hobbes 1651, Chap. 27). <sup>6</sup> The issue of not merely suffering pain is simply regarded as benign treatment by others. This will all fall into the Hobbesian definition or classification of the broad concept of justice. These are the common core or the fundamental rights that all human creatures experience. Michael Freeman notes that these rights are a fundamental part of the human experience and that the denial of these rights is a direct affront to the concept of being human: "Those rights cannot be denied without a potentially critical loss of what constitutes being human" (Ritchie, 27). This holistic view of the human condition regarding natural rights is consistent with the views expressed by Hobbes, but carries with it a form to be considered; to wit, that a basic part of being human is an essential right to "a hope by their industry" of obtaining the aforementioned fundamental human needs, wants, and desires (Hobbes 1651, Chap. 13). <sup>7</sup> These are an essential part of the human organism and cannot be denied, neglected, or rejected by anyone least of all the individual himself.

Natural rights, as shown by Hobbes, cannot be given to or taken from the individual, regardless of the circumstances. The most essential element for the purposes of this essay is the concept of life and the protection of that life. As we have shown, life is a right which man may defend under all offenses designed to relieve him of that right. But the concept of 'natural rights' is not without its detractors, and Jeremy Bentham was one of the most eloquent.



## Jeremy Bentham

Bentham rejected the concept of natural rights as an elusive concept created by man. When a man asserts he has natural rights he creates a situation where he expresses a need for some consideration relative to his life and possible happiness. His inability to express this need in any tangible way gives rise to the claim of natural rights: when a man has no political power in his possession or no support of the political system, he asserts he has a natural right. He creates a reason for the wanting or wishing for natural rights, the want of happiness. He may also assert his 'natural rights' when faced with the elements of oppression, injustice, or tyranny. But merely wishing that something is true or real does not make it so; "wishings for rights, are not rights; - a reason for wishing that a certain right were established, is not that right - want is not supply - hunger is not bread" (Bentham, 1843).<sup>8</sup> The argument can be persuasive, though. When a man has been beaten out of political grounding for his rights assertion he will cling to the thread of natural right, "that which has been bestowed by that kind goddess and governess of Nature, an indisputable legitimacy. If he can convince you, or get you to acknowledge, the existence of this or that 'natural right'" he has "the hope of getting you to acknowledge the existence of a corresponding political right, and in getting your assistance in enabling him to possess it" (Ogden 1932, 121).<sup>9</sup>

Rights do not stand alone for Bentham. Obligations are an integral part of the equation that must be accounted for. Bentham stated that, "for every right which the law confers on one party....it thereby imposes on some other party a duty or

obligation" (Bentham, 1789). <sup>10</sup> For Bentham, rights and obligations must go hand-in-hand. Those charged with the handing out of these corresponding benefits and burdens must be aware that any conference of rights in the interest of liberty also is a restriction of the same concept. "According to the principle of utility [a legislator] ought never to impose a burden except for the purpose of conferring a benefit of *a clearly greater value*. It is impossible to create rights, to impose obligations, to protect the person, life, reputation, property, substance, liberty itself, except at the expense of liberty." "The law [government] cannot create rights except by creating corresponding obligations. It cannot create rights and obligations without creating offenses. It cannot command nor forbid without restraining the liberty of individuals. It appears, then, the citizen cannot acquire rights except by sacrificing a part of his liberty" (Bentham 1864). <sup>11</sup>

Some may confuse this with Hobbes. When Hobbes spoke of man losing his liberty, he was speaking of "laying down" or giving up a right; thereby divesting himself of the liberty. Bentham, on the other hand, was speaking of the acquisition of rights, thereby creating obligations and offenses, leading to the loss of liberty. Bentham's argument that rights can only be conferred by positive law neglects the issues of what it is to be fundamentally human:

You hear a multitude of professors, of jurists,... of philosophers, who make the *laws of nature* echo in your ears. ... The phrase is sometimes modified, and we find in its place, *natural right*, *natural equity*, the *rights of man*, etc. They are, at the bottom, only the arbitrary principle... . The object is, to make our opinions triumph without the trouble of comparing them with the opinions of others. ...It is no longer the moral sense- it is the *common sense*... and common sense is a sense which belongs to everybody; [and] then he will take good care in speaking for everybody [and] make no account of those who do not think as he does (Bentham 1864). <sup>12</sup>

This strong criticism of natural rights is extreme, even for Bentham, but does show the fervor with which the rights argument is often put forward and attacked. He neglects the issues of human self-preservation and the natural instinctive traits this self defense invokes. Contemporary philosophers have continued in the discussion, but much current work is an examination of the interdependency of rights and responsibilities. One leading example is the work of Mary Ann Glendon.

### Glendon and the Communitarians

#### Contemporary Viewpoints

Natural Rights are also asserted to have a form of precision or finality in the discussion. If I have a 'natural right' then there is nothing you or anyone else can do to relieve me of that right. Mary Ann Glendon asserts: "The exaggerated absoluteness of our American rights rhetoric is closely bound up with its other distinctive traits--a near-silence concerning responsibility, and a tendency to envision the rights-bearer as a lone autonomous individual" (Glendon 1991, 45). This silence concerning responsibility is a concept that weakens any talk of 'inalienable' rights. If the concept of natural or inalienable rights is to survive, then the concept of responsibility must also play in the discussion. One cannot confer preference without conferring a corresponding limitation. Glendon continues with, "people are well aware of their rights but fail to grasp the other half of the democratic equation... [that of] meeting personal responsibilities, serving the community, and participating in the nation's political life" (Glendon

1991, 76). The concept of community service and community standards regarding moral codes brings in an argument for a community perspective.

The seeking of the 'common good' is the gauge that is used when the community examines moral codes and rights that seek to be upheld. This might be the Supreme Good, as in the polis for Aristotle, the 'most good' for the utilitarian; but the focus and definition of the moral good outlined here is really not at stake. What is the issue is the assertion of rights and obligations by individuals that conflict with the common good, however it is defined. "A true moral right is one that is demonstrably justifiable by relation to the common good, whether it is actually recognized or not [and] ... individual[s] have no moral rights which conflict with the common good" (Hobhouse 1965, 40). <sup>13</sup> [For the purposes of this thesis we will stipulate that the issues of tyranny, oppression and injustice can only be classified as "against" the common good and can only be viewed as moral evils.]

In this way, 'the common good' can become a general common ground for coordinating rights with duties. One can argue that the education of school children serves the common good, that a national patriotism also serves this aim; each may have a certain function to perform thereby creating an obligation of society to facilitate or maintain conditions under which these functions can best be fulfilled. Rights, as they have come to be understood, have an individualistic tone that makes them inconsistent with the community aspects on which we all depend.

And a community may be said to exert a form of its own rights.

Communitarian philosophy has “made the question of balance between individual rights and social responsibility, between autonomy and the common good, a major concern”. Amitai Etzioni, a strong voice in the Communitarian movement, states that “there is a gap between rights and rightness that cannot be closed without a richer moral vocabulary - one that invokes principles of decency, duty, responsibility, and the common good, among others” (Etzioni 1998, xi). <sup>14</sup> A right to the freedom of speech does not make all forms of speech ‘right speech’. A right to shout ‘nigger’ at African Americans, or ‘Jew’ at those of Jewish descent, does not make it a *right thing* to do. The corresponding right also does not give the holder a “sufficient reason to perform” that right (Etzioni 1998, xxxiii).

### Autonomy

Arguments about autonomy often involve solely-individual thinking but may also be seen to involve community rights via the preservation of choices for the commonwealth. As we have stated, individual moral rights cannot conflict with the community of good, but part of the community of good may be said to involve individual freedoms and control.

Around the core of any ethical right clusters an assortment of associated ethical liberties, claims, powers and immunities. What ties these ethical elements together into a single right is the way in which each associated element contributes some sort of freedom or control... with respect to the possessor of the right. Because freedom and control are two aspects of autonomy, any ethical right can be thought of as a system of ethical autonomy (Wellman 1985, 329).

Problematic to the whole discussion of autonomy is the question where to draw the line between individual autonomy, the rights associated with this concept, and the point where the “allowance” of these rights infringes on the rights of others, on *their* autonomous individuality? The respect for the autonomous individual is central to the good that will be derived from this respect for the whole of the community group. If you respect my autonomy now, then when the time comes, I will respect yours. What I do not say at this point in my assertion of these rights is that my respect *then*, will be predicated on the concept of your not violating any of my perceived rights at *that* time. This collective benefit that is asserted is often termed a form of social contract or agreement by which persons live within a community.

This sense of autonomy, or the ability of individuals to be masters of their own fate or to control their own destiny, is essential to the formation of rights by both individuals and groups. The problem with (literally) autonomous decision making is the ability of the individual (or group working on behalf of the individual) to neglect a sense of fairness with respect to other individuals. Respect for the individual is not lost with the medical community and the autonomous patient is at the forefront of many medical ethics discussions. This will involve many issues, one of which is patient decision making and control over decisions that were historically left to a more paternalistic physician community. Patient autonomy has left the medical community with a patient population that is more informed (whether actually or legally informed) and

prepared, no, really, demanding, to have a say in the care that they receive or do not receive, and who does or does not provide the care.

Autonomy is an issue central to health care and will never be out of the discussion as it is a basic tenet afforded to patients. Part of the discussion of autonomy is within the disability rights issues that arise out of the concept of the infected individual health care workers who are also at the same time "patients" in their own right - and who therefore are afforded all of the same rights as other patients (i.e. autonomy, confidentiality, privacy, etc.). The control discussed earlier is a legal ability on the part of the claimant to force compliance with the asserted right thereby affirming an ethical autonomy for the individual.

### Conclusion

As we have already shown, one cannot create or assert the concept of 'rights' without assigning, creating, and obligating responsibilities. Responsibility places each member of the community in a 'double relation'. "He has a share in it. That is the sum of his rights. He has to contribute his share. That is the sum of his duties. Rights and duties thus rest on the same ethical foundation" (Hobhouse 1965, 39).

The issues of the rights for the infected health care workers will also focus on existing political rights that have been clearly established. Currently, as we shall see, there are strong protections for the infected individuals under existing disability laws. Yet, while the protections are powerful, the laws are not without areas of dispute or areas that are vague and ambiguous. This scenario will

always lead to judicial challenges to the laws, or claims and assertions made in court settings that are *not* definitely within the scope of the law, but were “clearly within the spirit of the law”. The disabled individuals within our society have, as of late, begun to receive what has been considered to be their appropriate participatory societal opportunities. These disabled ‘rights’ have been at the forefront of recent legislation, namely the Americans with Disabilities Act <sup>15</sup> and many a case is pending in the court systems of this nation with the assertion of these *new* ‘rights’. The courts have been challenged in the enforcement of these ‘rights’ and in their efforts to achieve a sense of equity for these individuals often create a form of common law that augments or modifies the ambiguous laws handed down from the legislature. While the issues of the law pertain to the rights of these individuals, they are better reviewed within the realm of a discussion on justice than on rights. (See Chapter 7)

Any argument by surgeons in favor of any “right” that does not accept the necessary responsibilities that correspond to that right on the other side of the spectrum, will fail. Patients subjected to potential grievous harm by the assertion of the rights of the physician, without the patients’ consent, will ultimately fall victim to the rights debate. One could fall back to a Hobbesian analysis and say this would violate the patient’s right to self preservation by placing the physician’s rights above his or hers with the result being a loss of the patient’s life. Physicians seeking to advance their own rights over those of the patient, particularly at the expense of the patient’s well-being, will lose the



trust of a public, already unsympathetic to the rights of wealthy individuals who, at least perceptually, may be viewed as only seeking to preserve their wealth.

## Chapter Notes

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13. Leonard T. Hobhouse, *The Elements of Social Justice*, (London: Ruskin House, George Allen & Unwin, 1965), 40.

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## CHAPTER 3

### DISABILITY LAW

With almost as much fervor and passion as was exhibited in the 1960s in the battle of minority citizens for their civil rights, the 1990s has become the battleground for the disabled. The difference between the two issues is wide but the approach and subsequent confrontations in and out of the courtroom are inexorably linked. This chapter will examine the current disability laws that exist and the areas of each that are applicable to the AIDS afflicted individual. Terms used in the laws are similar. Specifically we will concentrate on what constitutes disability, the 'otherwise qualified' and 'direct threat' portions of these laws, and examine the concept of risk regarding infected healthcare providers. We will also explore some of the case law that has been handed down by the courts regarding these persons, and examine policy positions taken as a result of this case law.

The disabled individual, classically, has been viewed as one who, through some unfortunate accident either from birth, trauma, or other mishap, has been rendered less than 'complete' (or less than 'perfect') as an organism. The result of this perception is that, for years the "imperfect" individuals of our society were sheltered or shut away from the mainstream of the population. This was done for many reasons and is grounded in the long tradition of *humanity*. In some

ancient cultures “deformed infants were sometimes slain as monstrous; even in such advanced societies as that of ancient Greece, the abandonment of infants could be tolerated.”<sup>1</sup> This has been a common practice in many civilizations where the survival of the tribe or clan was dependent on the overall health and strength of tribal members. When an individual became a burden on others, they were cast aside and left to fend for themselves. For the elderly and the disabled or sickly, this was often a death sentence. This still occurs in the modern world. While this historical background is not essential to this particular study, the wide swing of the proverbial pendulum may have come back to haunt those that would have considered the disabled as anything less than ‘complete’. This sense of ‘completeness’ was true of the civil rights movement with formation of the concept of affirmative action, and it will also be true with the treatment of the disabled in the Rehabilitation Act of 1973, and more recent the Americans with Disabilities Act of 1990 [ADA].<sup>2</sup> The broad implications that have arisen since the passage of these two key pieces of legislation will impact society for many years to come. As will be seen in the pages to come, just as the civil rights movement sought to raise the social conscience regarding African Americans and wound up with an broad minority definition that included women, Hispanics and others; so the quest for the rights of the disabled will see the broad sweep of the brush of inclusion regarding what is, and is not, handicapped. No longer will disabled status apply only to the victim of cerebral palsy or the wheelchair-bound accident victim. The concept of disability will include those with unseen disabilities. People with mental handicaps,

recovering abusers of both alcohol and drugs, persons with communicable diseases, in fact, any person who has a physical or mental problem that “substantially limits one or more of his/her major life activities” is now considered disabled. This determination allows unique protection and special treatment under the current laws of the nation much as the actions created by the civil rights movement were used to correct past injustices.

Much could be written on this broad subject and the need to narrow the focus for this work seems essential. Current discussion will concentrate on the unseen disability of the communicable disease and the impact on society for providing inclusion regarding this type of individual. This is not meant to be a sociological discussion, merely an examination of the evolution for inclusion of these afflicted individuals on the nature of ‘disability’, and how that was accomplished through the current legislation and subsequent court challenges that have arisen. This work will attempt to examine these issues and will concentrate on the effect that this determination will have on Acquired Immune Deficiency Syndrome-afflicted individuals, specifically the approach to the AIDS afflicted surgeon and student and their ability to participate in health care programs. <sup>3</sup>

The beginning of the disability revolution started with the Rehabilitation Act of 1973 which states in section 504 (hereinafter, “section 504”) that:

No otherwise qualified individual with handicaps in the United States... shall, solely by reason of his handicap, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance or under any program or activity conducted by any Executive Agency.

The key wording of "otherwise qualified" is a phrase that means to set aside the affliction of the individual and examine his status of performance if he were not so afflicted. If the individual is "otherwise qualified" then he must be afforded the opportunity to participate irrespective of his handicap. Section 504 is limited in its jurisdiction. The limitation involves activities that receive federal funding or are actual programs sponsored by a governmental or executive agency.

Implementation and jurisdiction over the act fell to the U.S. Department of Health, Education and Welfare (later transferred to the Department of Health and Human Services in 1980) which issues the implementation regulations.

The determination of what constitutes a handicapped person is generally defined in both the act and section 504 to mean:

Any person who (i) has a physical or mental impairment which substantially limits one or more major life activities, (ii) has a record of such an impairment, or (iii) is regarded as having such an impairment.<sup>4</sup>

The regulations further define the terminology of 'physical or mental impairment' to be:

(A) any physiological disorder or condition, cosmetic disfigurement, or anatomical loss affecting one or more of the following body systems: neurological; musculoskeletal; special sense organs; respiratory, including speech organs; cardiovascular; reproductive, digestive, genito-urinary; hemic and lymphatic; skin; and endocrine; or (B) any mental or psychological disorder, such as mental retardation, organic brain syndrome, emotional or mental illness, and specific learning disabilities.<sup>5</sup>

Acquired Immune Deficiency Syndrome falls under the Act in the physiology of the immune system which is a part of the lymphatic system. The definition will also cover persons who test positive for the virus but who have not presented with symptoms. The inclusion of 'asymptomatic' individuals is a wide step from

the traditional concept of 'disabled' and a clear expansion of the classical interpretation.

The first challenge to the provision of the Act on the basis of contagious disease involved a schoolteacher in Florida who sued the local school board for discrimination based on Section 504. In *School Board of Nassau County v. Arline* (1987), the local school board attempted to terminate the employment of a classroom teacher with TB. <sup>6</sup> Gene Arline, the school teacher, claimed handicapped status under the provisions of the Section 504 and sued for unlawful discharge. At the District Court level the plaintiff's motion was denied with the court stating that It was "difficult... to conceive that Congress intended contagious disease to be included within the definition of a handicapped person" (Turner 1988, 2, 23). <sup>7</sup> That finding was overturned by the Court of Appeals which stated that the Section 504 clearly included individuals with a contagious disease but remanded the case for additional finding on the status of Arline's risk of (cross) infection and of that risk, precluding the plaintiff from being "otherwise qualified" (11th Cir. 1984). <sup>8</sup> This also brought in the issue of the school board being able to make "reasonable accommodation" for the plaintiff to resume her duties as a classroom teacher. In a landmark decision in *Arline* (1987), the United States Supreme Court held that the Court of Appeals should be affirmed and that the plaintiff was a handicapped individual under the meaning of Section 504. Writing for the seven-justice majority, Justice Brennan spoke of protecting the handicapped not only from simple prejudice, but from "archaic attitudes and laws" (Turner 1988, 2 ,1).



The Supreme Court used the general definition of handicapped individual in assessing the plaintiffs case and found (i) that one or more of her major life activities were limited, due to her earlier hospitalizations for said disease, and (ii) that this clearly established that the plaintiff had a record of such an impairment. The justices further assessed the plaintiff for the physiological inclusion under section 504 and clearly found that the plaintiff's tuberculosis clearly constitutes a respiratory condition. In its arguments before the Court, the school board conceded that contagious disease could fall under the stipulations of Section 504, but further argued that this was irrelevant since the plaintiff had not been discharged for *having* the condition, but for the threat that she posed to others. This was dismissed by Brennan and the Court as more of the same prejudiced, ignorant attitudes and fears. It did move the Court to attempt to determine if the plaintiff is "otherwise qualified " and if the school board should be required to adopt an accommodation for the handicapped individual. These further fact findings were remanded to the district court who adopted a set of factors presented by the American Medical Association (hereinafter, AMA). In an *amicus curiae* ("friend of the court") brief, the AMA stated the assessment should be based on:

(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 (Turner 1988, 2, 2).

The criterion sought by the court, and eventually adopted by the Supreme Court, was if the individual offers a significant risk and that reasonable

accommodation will not eliminate the risk, then the individual is not “otherwise qualified” under Section 504. Brennan wrote, “ the fact that *some* persons who have contagious disease may *pose* a threat to others under certain circumstances does not justify excluding from coverage of the Act *all* persons with actual or perceived contagious diseases” (Turner 1988, 2, 2).

As a result of this decision by the Court, the US Solicitor General, also in an *amicus curiae* brief, raised the question as to whether a person can be contagious without having a physical impairment and could this ever constitute discrimination based on handicap? The Court skirted the issue stating that the argument was misplaced since the facts in *Arline* had given rise to a physical impairment. As a result of this judgment by the Court and its apparent reluctance to take a stand on the issue of asymptomatic AIDS patients, Congress moved swiftly to, in essence, legislatively reverse the Court. In a proposed amendment to the Civil Rights Restoration Act (hereinafter, CRRA), which had passed by overriding a presidential veto, Senators Tom Harkin and Gordon Humphrey introduced the concept of “direct threat”. The amendment states:

...Section 504 does not include those who, because of a contagious disease, “would constitute a direct threat to the health or safety of other individuals” (Gerry 1988, 182). °

The Senators were quick to add in the discussion that the amendment would not change the current law regarding “reasonable accommodation”. The problem with this amendment to the CRRA is that it left the possibility of broad judicial interpretation of the “direct threat” language and, depending on the level

of judicial scrutiny applied to an individual case, might find certain persons outside the scope of Section 504. The implication is clear and the inference is strong that persons with HIV or AIDS might be left out (Gerry 1988, 183). The courts were soon to solve this very problem.

Even though the Supreme Court had opted not to decide the issue of discrimination involving the AIDS afflicted individual the year before, the decision in *Arline* was a clear guideline for the treatment of all individuals with a contagious disease.

In *Chalk v. United States District Court* (1987) this exact issue was brought before the bench.<sup>10</sup> The issues in *Chalk* are much of the same issues raised in *Arline*, but the difference is that it involved the AIDS virus and factors in all of the paranoia, prejudice, and hysteria that has surrounded this disease. The courts have, in certain instances, participated in this hysteria. In fact the whole basis for *Chalk* involves a propagation of this hysteria. Vincent Chalk, a teacher of hearing-impaired students, was removed from his classroom duties by his employer (and offered an administrative position) due to the fear of apparent risk Chalk imposed. In the district court, the plaintiff's motion for a preliminary injunction barring his employer from excluding him from the classroom was denied. While the presiding judge stated that he believed that the plaintiff could ultimately win the case, he also stated that his own skepticism and uncertainty regarding the current state of medical knowledge with respect to AIDS resulted in the denial of the plaintiff's plea to the court for relief. He wrote:

It seems to me the problem is that we simply do not know enough about AIDS to be completely certain. ...and I do not in any sense mean to be an

alarmist... I think it's too early to draw a definite conclusion ...about the extent of the risk (Turner 1988, 3, 3-4).

The judge further stated that there was a significant risk of transmission at some point, because of the "almost inevitable mutation" of the virus (Turner 1988, notes, 33, 28). The district court further stated that the plaintiff had failed to show that he had suffered irreparable injury (due to the fact that he had been offered an administrative position without loss of income or benefits), and that the teacher's injury was 'outweighed by the fear' likely to be produced in the classroom.

On appeal, the Ninth Circuit reversed the lower court ruling. In regard to the plaintiff's pleadings, the court ruled that the district court had failed to follow the guidelines set forth in Section 504 and the those in *Arline*. While addressing many of the issues in *Arline*, the district court had failed to follow the precedent set in *Arline* and had improperly shifted the burden of proof (regarding apparent risk) to the plaintiff. The Ninth Circuit stated that "little in science can be proved with complete certainty, and Sec. 504 does not require such a test." It further reasoned that the lower court had 'improperly relied on speculation and had rejected the overwhelming consensus of medical opinion' (Turner 1988, 3, 4).

The appeals court decision was not without other case law to support the issues in the classroom. During this time there were many cases that had appeared on the court dockets that involved school children, afflicted with the aids virus, being allowed to attend regular classroom instruction. The clear difference between these cases and *Chalk* is not the science but the jurisdiction. School children, specifically handicapped children, are covered

under a separate piece of legislation than was to be applied to the decision in *Chalk*. This difference in jurisdiction did not matter to the court as the assessment of the risk would be the same, teacher or student. <sup>11</sup>

The issues in the *Arline* and *Chalk* decisions confirmed that the issue of AIDS would be covered in the language of Section 504, but the impact of AIDS afflicted individuals participating in much of the benefits of society would not be without its limitations. In the employment and education contexts, all casual contact is ruled out as a contributing factor, and the 'reasonable accommodation' language applied to all handicapped individuals. This would not go without a rigorous test in other areas.

Even though the issues appeared clear regarding employment and school attendance, other factors came into play when the issues came into the health care area, in both the employment and education settings. While it has been a creed of the health care practitioner to help, treat, and when possible cure the disease ridden and injured patient, the AIDS afflicted individual raised a concern among health care workers that was already sweeping the country.

While I will not attempt to argue for the AIDS patient in the context of patient rights to adequate health care (as that is a subject for another forum), the general ethical stand is that *all* patients have a right to receive treatment, regardless of the nature of their individual affliction. This treatment includes for the patient the tenet of "keeping them from harm" in the course of their treatment (Edwards and Graber 1988, 40). <sup>12</sup> Health care providers must address the issue of AIDS affliction within their own ranks and assess the problems that this

creates. The issue spans both the employment and education spectrums and the issues are unfolding even as this thesis goes to print.

In the case of *William Behringer, M.D. v. The Medical Center at Princeton* (1991),<sup>13</sup> a New Jersey court upheld a medical center's right to restrict surgical privileges of an HIV positive physician. The way that this case developed and the resulting decision regarding breach of confidentiality of information and a disabled person's *rights* are important to the issues being raised. While the issues of confidentiality are not central to this discussion, the resultant actions are. William Behringer was a practicing surgeon at the Princeton Medical Center who sought and received medical treatment for an undisclosed condition. In the course of the treatment and inpatient stay at the medical center, the physician was diagnosed as being HIV positive and through a lack of structured policy regarding the confidentiality of such information, this knowledge was communicated to the staff of the medical center. The issue may not have been a problem for the average patient, but the fact that the patient was a member of the medical staff led the court to determine that the hospital's confidentiality policy was insufficient to protect the rights of ALL patients. When the information reached the president of the medical center, Mr. Dennis Doody, he immediately suspended the physician's surgical privileges by canceling all pending surgeries planned by Dr. Behringer. While the doctor privately notified the Chief of Surgery of his diagnosis, he stated that he wished to continue his practice of surgery.

The position taken by the surgeon in question and the then current (1987) information from the public health agencies was placed before several committees and was ultimately passed on to the Board of Trustees of the medical center. The issues presented to the Board involved the facts that there were no known cases of transmission of the HIV virus from infected providers to patients, and that the public health agencies recommended that "individualized decisions" should be made regarding the continued practice of infected providers. The Board concluded after examining all the issues presented and assessing the ambiguity of the public health recommendations (that of stating that "operating room precautions were expected to prevent HIV transmission"), and the concerns of the hospital's president and legal departments regarding the reputation of the medical center and the litigation possibilities due to the public fear of AIDS (reasonable or not), that adopting a policy of requiring patient informed consent would be the best course of action. The policy would require that all patients preparing to undergo surgery by an HIV positive surgeon, be informed, in writing, about this status. While adopting this policy for the protection of the institution, all parties involved in the decision agreed that "in the absence of patients willing to undergo invasive procedures by HIV positive surgeons, this was a 'de facto prohibition' from surgical practice" (McIntyre 1991, 8).<sup>14</sup>

Dr. Behringer sued for damages for two separate and distinct issues: 1) that the hospital had failed in its duty to protect the confidentiality of patient information and 2) that as a result of the subsequent policy conditions on his

practice of surgery he was discriminated against in a violation of the New Jersey Law Against Discrimination. <sup>15</sup> Dr. Behringer claimed that the medical center's breach of confidentiality of his HIV status had the result that "his ability to practice was impaired, so significantly, that his medical practice was damaged, if not destroyed". The court found for the plaintiff in the argument of confidentiality of information and determined that the Medical Center was liable for damages.

On the issue of the policy conditions regarding his right to practice surgery, the court took a stand that has been a hallmark for health care providers who perform invasive procedures. The court used many pieces of information in formulating its decision. It was determined that surgeons (and dental practitioners) frequently injure their fingers in the course of providing treatment. "Most injuries are minor, but severe and unusual injuries sometimes do occur" and surgical glove cuts and cuts to the fingers, while not common place, were not unheard of (Keyes 1989, 19). <sup>16</sup>

This issue-whether or not AIDS afflicted health care providers or students in the health sciences should be allowed to practice or train in the discipline-is a problem that has been characterized as a "witch hunt" by some and a necessity by others. The Center for Disease Control (hereinafter CDC) has specific guidelines for the treatment of the AIDS afflicted patient and for the treatment of the health care worker (hereinafter HCW) afflicted with the AIDS virus. The use of "Universal Precautions" has been recommended against blood and other body secretions by the use of gloves, masks, gowns, eye protection and other



methods of 'barrier protection'. Many of these have been used since the early days of infection control, particularly in the surgical theater. These original precautions were for the protection of the patient, most health care providers, outside the operating room, merely used 'good hand washing' as the best defense against contracting disease from the patient. Routine patient contact was considered casual contact and the skin provided adequate barrier from the vast majority of patient conditions, with specific exceptions. From a patient care standpoint, the CDC responded in 1985 with guidelines stressing the use of the universal precautions with all patients with whom there is a chance of contact with blood or other infectious body fluids. In other words, all patients are to be considered infected until proven otherwise.

With regard to infected HCWs several studies, all of them retrospective in nature, have been performed. Most of these have involved 'look-back' statistical examinations of the patients of AIDS afflicted surgeons. Without going into the analysis of the data, much that has been concluded is that "although a precise, quantifiable risk to patients (from undergoing surgical procedures by AIDS infected health care workers) is not yet possible, the risk is most likely quite low" (Barnes, et. al., 1990, 313).<sup>17</sup> Responding to the potential for HCW to patient transmission the CDC guidelines in 1985 also stated:

[A] risk of transmission of (AIDS) infection from HCWs to patients would exist in situations where there is both (1) a high degree trauma to the patient that would provide a portal of entry for the virus (e.g., during invasive procedures) and (2) access of blood or serous fluid from the infected HCW to the open tissue of the patient, as would occur if the HCW sustained a needlestick or scalpel injury during an invasive procedure. (CDC 1985)<sup>18</sup>

**This determination of a potential risk to patients from HIV infected HCWs performing invasive procedures was a profound statement considering that the only clearly identified infectious risk to patients, and one that medicine has diligently fought to minimize since the discovery in the early days of surgery, was bacterial infection.**

**In the 1985 guidelines the CDC also stated that testing of HCWs performing invasive procedures should be considered and there was no clear reason to restrict HIV infected HCWs from performing non-invasive procedures “unless they have evidence of other infection or illness for (which they) should be restricted”. This apparent restriction is to protect the HIV infected HCW as these conditions are immunosuppressive in nature and the risk to the immune suppressed HCW from ill and infectious (other than HIV) patients is increased. This has been one of the major complaints from HCWs regarding all of the fervor regarding patient risk.**

**Medicine traditionally has been in the forefront in the battle to prevent the patient from acquiring so called “in-house” infections. Aseptic technique is religiously followed and the general consensus among HCWs is that real risk is not to the patients but to the workers. While all of this may be true for the patients- that the risk to the patient of not having the invasive procedure or of expiring from the procedure itself (almost all invasive procedures of a surgical nature carry a mortality risk of one form or another) is profoundly greater than acquiring an infection from the HCW- this does not change the political wind which often blows the way of public opinion.**

In *Behringer*, the plaintiff argued that “the risk of transmission of HIV to [a] patient is too remote...” (McIntyre 1991, 8). Aside from this, the case still remains that there is a ‘potential risk’ of transmission to the patient. The American Medical Association (AMA) in response to the CDC issued its own guidelines in 1988 for the employment of the HIV infected physician. The guidelines are fraught with ambiguities. This is probably due to the fact that there is no general agreement among physicians as to the real risk. But the ethical message is clear. It states:

patients are entitled to expect that their physicians will not increase their exposure to the risk of contracting an infectious disease, even minimally... if a risk does exist, the physician should not engage in the activity (JAMA 1988). <sup>19</sup>

The AMA followed these guidelines in 1991 with an affirmation of this policy by stating that:

...the “medical profession... should err on the side of protecting patients” and that HIV infected physicians “have an ethical obligation not to engage in any professional practice which has an identifiable risk of transmission” to the patients (AMA 1991). <sup>20</sup>

This “no identifiable risk” standard set forth by the AMA is not clearly thought out and is not universally applied. A “no risk” standard is a standard that is not attainable. At any one time all health care workers are infected either with simple colds or other viral infections that will have little impact on a patient’s health, or with infections or bacteria that are considered indigenous or normal to the body. The standard sets even minimal or remote danger levels that may disqualify all providers. This was never the intent of the AMA and the enforcement of these guidelines and its ‘non-application’ of these standards

(the stumbling block used is the debate over Hepatitis infected providers) to the aforementioned disabilities (as classed by Sec. 504) places the AIDS infection at a *higher* standard than other disabilities. This may be inconsistent with the *amicus curiae* brief submitted by the AMA and used in the *Arline* decision. It might also be inconsistent with the Fourteenth Amendment's Equal Protection Clause and may not satisfy the minimum scrutiny of a differential rational basis test. If two groups are to be treated differently (infected vs. non-infected providers), they must be truly dissimilar. "For the classification to be valid the risk of transmission to the patient would have to be unacceptably high. If the risk of contagion were inconsequential, the equal protection clause would not permit differentiating between HIV-infected and non-HIV-infected providers" (Keyes 1989, 16). Having established that the chance of transmission of the disease from HCW to patient is possible, albeit remotely so (even remotely would be considered 'unacceptably high'), the minimum scrutiny of rational basis is satisfied. In the *amicus* brief the AMA used severity of risk, that of the risk to third parties as one of the criteria for analysis. In this determination of severity, with the potential for ultimate death of an individual from HIV infection, if contracted, the potential for harm has clearly been established. While some HCW and patient interaction will carry no greater risk than casual contact, those who perform invasive procedures may pose a risk that is of consequence. The CDC defines invasive procedures as:

Surgical entry into tissues, cavities, or organs or repair of major traumatic injuries 1) in an operating or delivery room, emergency department, or outpatient setting, including both physicians' and dentists' offices; 2) cardiac catheterization and angiographic

procedures; 3) a vaginal or cesarean delivery or other invasive obstetric procedure during which bleeding may occur; or 4) the manipulation, cutting, or removal of any oral or perioral tissues, including tooth structure, during which bleeding occurs or the potential for bleeding exists (CDC 1987). <sup>21</sup>

The focus must now shift to the “otherwise qualified” issue under the Rehabilitation Act. In order to effectively assess “otherwise qualified” one must weigh the risk posed against the benefit provided. “From the point of view of risk, an HIV-positive provider threatens an interest upon which society and the law place a high premium - life. Life-threatening behavior is unacceptable whenever the risk out-weighs the benefit” (Keyes 1989, 22). The concern is raised about the best available surgeon to perform the procedure to maximize the potential benefit, and is this particular practitioner otherwise qualified over others to perform the procedure. One must use tort law to assess the risk balanced against the utility.

(a)While society must protect the availability of vital services, there is no need to protect the services of any one provider. Generally, there will be many non-infected providers to replace those who have been restricted from performing invasive procedures... (b)restrictions due to HIV positivity will only interfere with the provision of a very small fraction of the total... these services can be adequately provided by non-infected practitioners... (c)[and] the extent that such interest [eliminating the likelihood and severity of harm] can be adequately advanced or protected by another, less dangerous course of action (Keyes 1989,22). <sup>22</sup>

Much of the debate about AIDS afflicted individuals has involved public fear. To combat this fear and to make clear law against the discrimination toward these individuals, the Americans with Disabilities Act (hereinafter ADA) was enacted in 1990. <sup>23</sup> Here the definition of the handicapped individual included specific mention of the AIDS infected individual. While the substance of the

definition was consistent with Sec. 504, the ADA served to remove all doubt about the AIDS inclusion. While the Court's decision in *Arline* had defined "significant risk" as the standard for persons with infectious diseases, the ADA expanded the concept of the terminology with the use of the term "Direct Threat". Title I, sec. 1630.2(r) states:

An employer may require, as a qualification standard, that an individual not pose a direct threat to the health and safety of himself/herself or others. If, however, an individual poses a direct threat as a result of a disability, the employer must determine whether a reasonable accommodation would eliminate the risk or reduce it to an acceptable level. If no accommodation exists that would either eliminate or reduce the risk, the employer may refuse to hire an applicant or may discharge an employee who poses a direct threat. The employer, however, is not permitted to deny employment ... merely because of a slightly increased risk. The risk can only be considered when it poses a significant risk, i.e., high probability, of substantial harm; a speculative or remote risk is insufficient (ADA 1990). <sup>24</sup>

The wording in the ADA seems to eliminate the possibility that a remote chance of infection by an infected HCW to a patient would be criteria sufficient for the imposition of the concept of 'direct threat'.

The year after the enactment of the ADA and the same year as the decision in *Behringer*, an orthopedic surgeon in Philadelphia filed suit under Title I and Title III of the new law. In this case the issue of risk was again placed before the courts after an HIV positive surgeon was placed under the same restrictions as were used in *Behringer*. Dr. Doe was first suspended by the hospital and then reinstated after the hospital's medical staff concluded that Dr. Doe posed 'no significant risk' to patients. The hospital board overruled the physicians and applied a requirement of informed consent for all related patients as in

*Behringer*. The doctor filed suit. In *John Doe M.D. v. Mercy Health Corp.*

(1993), the issue of direct threat v. a perceived threat was addressed. Scott Burris, the attorney representing Dr. Doe, argued that the if risks of complications, other infections as well as disclosure of surgical success are not being disclosed to patients, *then* a different standard is being applied. This would be in violation of the law according to Mr. Burris (McCormack 1993, 1). <sup>25</sup>

Lawrence Gostin, executive director of the American Society of Law, Medicine, and Ethics, worries that the courts are setting bad precedent in these cases. The issues in *Doe* (and used in *Behringer*) regarding informed consent are “a perversion of the doctrine” according to Gostin. “Recognizable risk not remote risk” is the tenet of the doctrine of informed consent. “Either Dr. Doe is dangerous and shouldn’t be allowed to practice, or he is not dangerous and his human rights should be respected”, says Gostin. “If the courts apply a different standard to physicians with HIV than they do to other disabled people, it will eviscerate the ADA”, said Gostin (McCormack 1993, 2). Gostin’s point is that the courts have, within the healthcare setting, applied the conditions of risk to a higher standard. In *Arline* and under Sec. 504, the standard was “significant risk”, where the ADA sought to end the subjective angle of this terminology and implemented the concept of “direct threat”.

While much of the health care community remains divided on the potential for cross infection of the HIV virus from provider to patient, the political realities and the potential for accidental exposure in the course of a procedure remain. The studies that have currently been completed <sup>26</sup> still continue to show that the risk

for acquiring HIV from an infected HCW are much less than the risk to the HCW from the patient. They also show that, from an epidemiological perspective, that the transmission potential is far less than for other infectious conditions (i.e., Hepatitis B [HbV]) that have no such scrutiny and no such requirements.

Practicing health care providers are only part of the concern. What of the aspiring surgeon, the graduate physician who is performing surgical residency in order to become a full-fledged surgeon? Is there not a risk of those HIV positive doctors "in-training"? Would the risk be increased, both occupational for the physicians, and for the patient population? While much of the discussion up until this point has focused on the applications of the various laws that have followed the rights of the disabled regarding employment, the dialogue, or dispute, must shift to the educational area. The employment issues are governed under the ADA by Title I and are enforced by the Equal Employment Opportunities Commission (EEOC). Under the educational aspects the regulations and the enforcement are different. For the purpose of this discussion, we will concentrate on the public education area, not because an argument cannot be made to include private education within the scenario, but merely that the lines are more clearly drawn within the public sector and that the private inclusion within these guidelines is not central to the issue at hand.

In addressing the educational issues regarding AIDS and the inclusion of these individuals as disabled, there has been national discussion since Ryan White's mother first attempted enrollment of an openly HIV positive child in an Indiana school district. While the Ryan White case made national headlines,



there were clear laws on the books to back up his claim to an education within a traditional setting. In fact, the courts have had little sympathy with school districts seeking to bar students from the classroom indiscriminately. Since 1975 the inclusion of handicapped children in regular classroom activities has been the law. Under the Education for All Handicapped Children Act (EAHCA), children of school age could not be excluded from participation in regular classroom activities due to a disability.<sup>27</sup> The act applies to children 5-18 years of age and has some inclusion of young adults under age 21 involved in post-secondary education. The act states: "disabled children are to be integrated into the regular [mainstream] school program, without creating significant risks to students".

The act received vigorous testing in several cases and has also used *Arline* as a basis for much of the finding. In the case of *Martinez v. School Board of Hillsborough County*, a federal district court judge ordered the placing of seven year old Eliana Martinez, a severely mentally handicapped child infected with the AIDS virus, in a "glass cage", a specially constructed room within the regular classroom (*Martinez* 1988).<sup>28</sup> In vacating the district courts judgment in *Martinez*, the Eleventh Circuit Court cited *Arline* as the authority that only "significant risks of transmission" will justify isolation. "*Arline* is the leading opinion on contagious disease under the Rehabilitation Act. As such it provides guidelines for the treatment of AIDS issues in the public education setting" (Jarvis 1991).<sup>29</sup> In the use of *Arline* in making a determination in *Martinez* and others, the courts created an intricate relationship between the EAHCA and

Sect. 504. The thought would not be lost in the subsequent creation of the ADA and the Title III issues relating to education.

Under the ADA many of the same issues raised in Martinez and Sect. 504 relating to “places of public accommodation” are applicable to Title III of the ADA. Places of public accommodation under the ADA are numerous and exhaustive, but schools are clearly listed under Title III-1.2000 (10) as “places of education” (e.g., nursery schools, elementary, secondary, undergraduate, or post graduate private schools). <sup>30</sup> As a result of the schools being considered places of public accommodation, then individuals with disabilities may not be denied “full and equal enjoyment of goods and services offered” by these places (III-3.1000). Under the ADA a person may not be discriminated against or denied participation merely because of their disability (III-3.2000).

While the implication may be clear for participation in mainstream education (by mainstream I mean regular classroom, didactic education, e.g., elementary and secondary classroom education, and all classroom activities of a casual contact nature), the ADA does not demand equality of achievement. The ADA “does not guarantee that an individual with a disability must achieve an identical result or level of achievement as persons without disabilities” (III-3.3000). Therefore, although individuals with disabilities have the right to actively participate, there are clear limitations as to what must be done from both a reasonable accommodation standpoint and fundamental alteration of the nature of the goods and services being offered. According to the ADA, a fundamental alteration is “a modification that is so significant that it alters the

essential nature of the goods, services, facilities, privileges, advantages, or accommodations offered" (III-4.3600).

In light of these limitations, would an educator have to significantly alter or adapt "academic standards" to accommodate the disabled individual? The answer appears to be "no", that this would be "unreasonable". While a disabled individual is guaranteed the right to participate, he is not guaranteed the right to pass a particular course *because* of his disability. He must still meet all essential academic performance standards, given that the attending institution has made all reasonable accommodations (architectural, auxiliary aids, etc.) to assure a disabled individual is afforded the opportunity to pass. But what of the AIDS afflicted individual wishing to participate? In mainstream education the answer appears clear. There is not a "significant risk" to prohibit participation as it is determined that only casual contact exists in this classroom setting.

But this standard begs the all important question of "significant risk" in the education of health care workers. The education process involves the potential for failure and in many areas the failure process is just as essential as the process for success. Overcoming failure is often the application of experience, practical repetition and confidence, particularly in the training of performance skills. Health care requires many skills that can only be learned through intensive practical repetition and experience. In essence, one learns by doing. One cannot learn to perform intravenous therapy out of a book. Unless one has experienced the tactile feeling of a needle piercing actual tissue, one cannot effectively learn the procedure-at least to the standard that one would be

allowed to actually perform the procedure on a real patient, whose very existence may depend on the success or failure of the skill. All the practice on all the rubber arms (a common educational tool for teaching the basics of the intravenous therapy procedure) in the world will not satisfy nor substitute for the requirement of living tissue in the educational process. One can learn the procedure, but not the skill without living tissue.

As has been seen in the *Behringer* case and in *Doe*, the potential "direct threat" to the patient has been established, regardless of the standard, but these are cases that involve experienced professionals already possessing clinical proficiency. But the issue of the health care student is unique, as no clinical proficiency exists. If the standards applied in the previous cases are applied to the student, the question arises, "can someone who is HIV positive earn a medical, nursing, dental, paramedic or other health care degree that involves 'invasive or exposure prone' procedures?". Officials at The Medical College of Georgia believe that "a student in training is more likely to injure himself while providing treatment, and thus may pose a greater risk of transmission (of the HIV virus) than an experienced practitioner" (Koelbl, 1991, 235).<sup>31</sup> There appear to be no clear laws, other than the EAHCA, regarding these students and the issue is left up to individual institutions for risk determination within the clinical performance arena.

This chapter has extensively covered the various positions of disability law as they pertain to the HIV positive healthcare provider. In examining the issue of what it means to be considered 'otherwise qualified' and absent of 'direct

threat', the healthcare community has a problem with a statistical reality of "identifiable" v. "potential" risk. As in the *Behringer* argument, and subsequently in *Doe*, plaintiffs argued from an ambiguous position regarding this risk. The issues of student performance in the invasive area has been sidestepped by the medical community, but obviously has ominous overtones.

With the inclusion of HIV in the status of "handicapped", the laws have become exhaustive as to their scope and protection. The formulation of these laws, and the specific Congressional testimony regarding the contents for inclusion will be examined in the next chapter titled, "The Framers".

## Chapter Notes

1. *Colliers Encyclopedia*, (New York: Macmillan 1992), s.v. "infanticide".
2. The Rehabilitation Act of 1973, 29 USC §794.
3. The term "AIDS" shall be used generically throughout as to include all related areas including AIDS, AIDS Related Complex {ARC}, and positive tests for the antibodies to the virus that causes the AIDS disease.
4. C.F.R. § 84.3(j)(1) (1987).
5. C.F.R. § 84.3(j)(2)(i) (1987).
6. *School Board of Nassau County v. Arline* (1987), 107 S. CT. 1123.
7. Ronald Turner, "Arline, Chalk, the Civil Rights Restoration Act, and the AIDS handicap", *AIDS and Public Policy Journal* , 3, no. 3 (summer 1988): 2, 23 .
8. Ibid, notes: See 772 F. 2d 759, 764 (11th Cir. 1984).
9. Martin H. Gerry J.D., "Section 504 of the Rehabilitation Act, HIV and AIDS: Legal Implications", *Issues in Law and Medicine*, 4, no. 2, (1988): 182, quoting Sen. Humphrey in 134 Cong. Rec. § 256 (daily ed., Jan. 28, 1988).
10. *Chalk v. United States District Court*, 832 F. 2nd 1158 (9th Cir. 1987).
11. See *Thomas v. Atascadero*, (1987), United School District , 662 F. Supp. 376 (C.D. Cal.), and later, *Honig v. Doe*, (1988) 108 S. CT. 592, and *Martinez v. School Board of Hillsborough County*, (1988) 11th Cir. 861 F. 2nd 1502. *Thomas* and others were cited by the Ninth Circuit in reaching the decision in *Chalk* under the provisions of Sec. 504. *Martinez* while also under Sec. 504 also relied on the Education for all Handicapped Children Act of 1975 (EAHCA). The combination of Sec. 504 and the EAHCA assured school children classroom attendance. *Social Issues Resources Series*, 2, no. 5, as taken from *Phi Delta Kappa* (Apr. 1989): 646-648.
12. Rem B. Edwards, Glenn C. Graber, *Bio-Ethics*, (n.p., Harcourt Brace Jovanovich 1988):*The Hippocratic Oath*, 2, 40.
13. *Estate of William Behringer, M.D., Plaintiff, v. The Medical Center at Princeton, Dennis Doody, and Leund Lee, M.D. Defendants.* (1991) N. J. Super, (Docket #L88-2250, Superior Court of New Jersey, Law Division - Mercer County. Decided 25 Apr., 1991.

14. Russell L. McIntyre, Th.D., *Info Trends: Medicine Law and Ethics*, 6, no. 4 (Summer 1991), 8.
15. New Jersey Law Against Discrimination (LAD), N.J.S.A. 10:5-4.1.
16. Gordon G. Keyes (1989), "Health Care Professional with AIDS: The Risk of Transmission Balanced Against the Interests of Professional and Institutions", *Specialty Law Digest:-Health Care* (June 1991): 148, 19.
17. Mark Barnes, Nicholas A. Rango, Gary G. Burke, Linda Chiarello, "The HIV Infected Health Care Professional: Employment Policies and Public Health", *Law, Medicine and Health Care*, (Winter 1990): 18(4), 313. There appears to be no more current (than 1990) statistical research regarding ability to determine a quantifiable 'risk' for HIV transmission from provider to patient.
18. Ibid., as quoting the CDC, *Morbidity & Mortality Weekly Report* (Nov. 15, 1985): 34, 681.
19. Ibid., 314, as quoting the AMA in "Ethical Issues Involved in the Growing AIDS Crisis", *J. Am. Med. A. (JAMA)*, (March 4, 1988): 259, 1360.
20. Ibid., 314, as quoting the AMA in *Statement on HIV Infected Physicians* (Jan. 17, 1991).
21. Keyes 1989, see notes 96,19, As quoting the CDC, *Morbidity & Mortality Weekly Report* (1987): 36, no. 2S at 6S.
22. Keyes 1989, 22, as quoting, Restatement (Second) of Torts § 293(a)(b)(c).
23. Americans with Disabilities Act (1990), Pub. L. 101-336.
24. Americans with Disabilities Act (1990), Pub. L. 101-336, Sec.1630.2(r) "Direct Threat", Appendix B, (B-28).
25. Brian McCormick, "Violation of Disabilities Act? HIV-infected doctor says hospital cut privileges", *American Medical News*, v.36, 25 (January 1993), 1; see *John Doe, M.D. v. Mercy Health Corp.*, (1993) U.S. Dist. LEXIS 13347 (E.D. Ps 1993) no. 92-6712.
26. See C. Fordham von Reyn, et. al., "Absence of HIV Transmission from an Infected Orthopedic Surgeon, A Thirteen Year Lookback Study", *J. Am. Med. A. (JAMA)*, (April 14, 1993): 269, no. 14, 1807-1811; Audrey Smith Rogers, et. al., "Investigation of Potential HIV Transmission to the Patients of an HIV-Infected Surgeon", *J. Am. Med. A. (JAMA)*, (April 14, 1993): 269, no. 14, 1795-1801; Ban Mishu, et. al., "A Surgeon with AIDS, Lack of Evidence of

Transmission to Patients", *J. Am. Med. A. (JAMA)*, (July 25, 1990): 264, no. 4, 467-470. This list is not exhaustive.

27. Education for All Handicapped Children Act (EAHCA)(1975), Pub. L. No. 94-142 89 Stat. 774, Codified @ 20 U.S.C. §1401-1461.

28. *Martinez v. School Board of Hillsborough County*, (1988) 11th Cir. 861 F. 2nd 1502.

29. Robert M. Jarvis, et. al., *Aids Law in a Nutshell*, (St. Paul MN, West Publishing 1991).

30. Americans with Disabilities Act (ADA), U.S. Department of Justice, Civil Rights Division, Title III Technical Assistance Manual. *Note:* all citation from the ADA will be listed within the document and will be from the Title III Technical Assistance Manual unless otherwise noted.

31. James J., Koelbl, "AIDS at the Medical College of Georgia- A study in Institutional Ethics", *Journal of Dental Education* (Apr. 1991) 55, no. 4, 235.



## **CHAPTER 4**

### **THE FRAMERS**

Where the Rehabilitation Act of 1973 fell short in the protection of the disabled, the Americans with Disabilities Act attempted to take up the slack. This chapter will probe into some of the specific testimony regarding the formulation of this law. Experts in the field of public health argued for inclusion of HIV infected individuals in their fight to curb a worldwide health problem. We will examine the positions of the Justice Department regarding inclusion of 'asymptomatic' individuals, and the reasoning for that inclusion, based on expected future court challenges that may arise and policy positions expressed by the Surgeon General.

Implementation and jurisdiction over the Americans with Disabilities Act fell to the U.S. Department of Health Education and Welfare (later transferred to the Department of Health and Human Services in 1980), which issues the implementation regulations. Acquired Immune Deficiency Syndrome falls under the Act in the physiology of the immune system which is a part of the lymphatic system. The Act's covering definition will also include persons who test positive for the virus but who have not presented with symptoms. The inclusion of 'asymptomatic' individuals is a wide step away from the traditional

understanding of what constitutes a disability and a clear expansion of the established viewpoint. The courts soon resolved this very problem.

An essential reason for the act that is not mentioned in any of the specific language of the law is the nation's approach to managing and mitigating or controlling the epidemic of Human Immunodeficiency Virus. In the Senate hearings, one of the key testimonies of the impact of discrimination on the ability of public health officials to fight and potentially track and control the epidemic came from the Chairperson of the President's Commission on the Human Immunodeficiency Virus Epidemic, Admiral James Watkins. Admiral Watkins expressed to the committee the need for the inclusion of the AIDS afflicted individual on a basis that had not been addressed in previous laws that mandated inclusion. In *Arline* and in *Chalk*, the issues had been about the individuals in the cases and had involved the discrimination that had been perpetrated against them. The cases had been precedent setting, but taking the real step of arguing that inclusion of individuals with a contagious disease in an anti-discrimination law would help to fight the epidemic, this was a new concept. Admiral Watkins, in his prepared statement before the combined House and Senate Committees, wrote, "HIV related discrimination is impairing this nation's ability to limit the spread of the epidemic.... as long as discrimination occurs....individuals who are infected with HIV will be reluctant to come forward for testing, counseling, and care" (U.S. Congress, House / Senate 1988, 104).<sup>1</sup>

In Watkin's testimony before the joint committees he described the public health problem:

Crucial to this effort [to limit the spread of the epidemic] are the epidemiological studies to track the epidemic... . Public health officials will not be able to gain the confidence and cooperation of infected individuals or those at risk for infection if such individuals fear... discrimination based on a positive HIV antibody test (U.S. Congress, House / Senate 1988, 104).<sup>2</sup>

The debate was far from over, and hearings on both sides of the capitol would continue.

A year later, in committee hearings before a house sub-committee, impassioned testimony was brought by the Rev. Scott Allen, Commissioner of the National Commission on AIDS out of Washington, D.C. Mr. Allen, in a earlier statement before the same committee, agreed that, "all persons with symptomatic or asymptomatic HIV infections should be clearly included as persons with disabilities" and stated that "exclusion would be a tragic mistake". He further argued "that subsequent acts of irrational discrimination that occur [toward these individuals] has been one of the unfortunate landmarks of our Nation's response to the HIV epidemic" (U.S. Congress, House 1989, 58).<sup>3</sup> In his prepared statement presented to the committee, Mr. Allen stated, "people living with AIDS and HIV infection, and those regarded as such, deserve the same discrimination protections as all people with disabilities. Such protections from discrimination are not only necessary to enhance the quality of life for people, they are as the Presidential Commission and the Institute of Medicine have reported, the linchpin of our nations effort to control the HIV epidemic" (U.S. Congress, House 1989, 58).<sup>4</sup>

The issue then presented to the committee was one of public health battling the epidemic, not just the acts of discrimination perpetrated against individuals.

Here the actors involved have done what policy analysts call issue re-definition. Baumgartner and Jones have argued, generally, that this type of re-definition is an effort by the actors to expand the scope of conflict. Formerly, this issue had been seen by the American public as a homosexual problem and a problem of drug addicts, both undesirable components of the American population. Several outspoken Christian ministers had even called the AIDS epidemic "God's revenge on the homosexual community". To re-define the issue as a public health problem and not some moral evil is a tactic that solidified the agenda placement of the issue of AIDS and HIV, and mandated inclusion in the subsequent legislation. This mobilization caused the issue to be expanded beyond the individual concerns that had been addressed in *Arlene* and *Chalk* and made the public health problem a better focus to concentrate on. That did not stop opponents to the inclusion from expressing their views but gave real grounding as to the magnitude of the issues. This also allowed a partial dismissal of the bias associated with the view of the issue being only a homosexual or drug abuse issue (Baumgartner and Jones 1993).<sup>5</sup>

In the formulation of this new law Congress seemed to leave 'no stone unturned' in its search for a policy that could survive the intense courtroom dissection that may be in the offing. The legislature had countless hours of hearings from multiple committees delving into the nature of disability rights and issues of possible real and perceived discrimination.

In committee hearings in the House of Representatives, many persons testified and presented material to assist the legislature in the policy formulation

process. Congressman William E. Dannemeyer from California questioned many individuals regarding the nature of the rights of the disabled and those proposed for inclusion in the ADA. Upon questioning Mr. Peter Adesso, a wheelchair-bound representative of the Paralyzed Veterans of America, Mr. Dannemeyer asked Mr. Adesso if "the proponents of this legislation... were seeking to extend the coverage of the benefits of the protection that's desired... for groups of people that the American public I'm not sure is willing to extend that benefit for" (U.S. Congress, House 1989, 58). <sup>6</sup> Mr. Adesso replied, "Personally, I feel that we shouldn't discriminate against anybody." Mr. Dannemeyer continued, "What I am suggesting sir, is that I suspect that there may be groups seeking the coverage of this act that go far beyond what sensibilities and sympathies of the American public are willing to do in the way of accommodations for persons who have suffered genuine disabilities" (U.S. Congress, House 1989, 58). <sup>7</sup> The hearing testimony is not quoted in full; it was interspersed with questions about AIDS and some of the medical complications associated with the disorder. The point of citing it is that, irrespective of all of the court cases that had been litigated and judicial opinions handed down, Congressional opposition to an inclusion of the AIDS afflicted individual and all persons with communicable diseases was present. Further questioning later in the committee session illustrates this fact.

Mr. Chai R. Feldblum, legislative counsel for the American Civil Liberties Union, was subjected to a series of questions by Mr. Dannemeyer. Mr. Dannemeyer in the course of the 'interrogation', demanded 'yes' or 'no'

answers to complex questions regarding inclusion of certain individuals in the proposed legislation. Mr. Dannemeyer directly asked Mr. Feldblum, "if we strike out the [inclusion] of persons with communicable diseases, would you still support the act?". Mr. Feldblum replied, after an exhausting and futile attempt to explain some of the intricacies of the provisions within the act, with an emphatic, "No" (U.S. Congress, House 1989, 58).<sup>8</sup> They further discussed the issue of 'direct threat' as addressed in the CRRA by the Humphrey-Hawkins amendment as it applies to the ADA. Here Representative Dannemeyer showed clear ignorance of the totality of the previous laws and previous actions by Congress itself, with regards to the CRRA and section 504. Mr. Dannemeyer stated:

... there are opportunistic diseases present in persons with HIV....that are a direct threat to co-workers. For this country to adopt a law that extends the coverage of what this act seeks to do to persons in that class is a major policy step... [without any] idea of the implications of what this law seeks to do.

Mr. Dannemeyer's comments, on the face of it, appear uninformed and biased. If one were to examine a possible policy process scenario, the principle of charity might lead us to view them in a different light. Mr. Dannemeyer's comments appear to be seeking an alternative to a possible policy that he and his constituents find distasteful.<sup>9</sup> Kingdon outlines the methods that policy makers often rely on when faced with steps that they fear create too large a change. "As policy makers consider the alternatives from which they will choose, they repair to ideas and approaches with which they are familiar" (Kingdon 1995, 82).<sup>10</sup>

Mr. Dannemeyer was clearly seeking an alternative to that portion of the policy being debated that he finds to be too far reaching (its inclusion of the homosexual and the drug addicted community) and inclusive of those unfavorable groups. The ease with which it is possible to fall back on an approach that is unfavorable to specific groups borders on bigotry and is a slippery slope that the Congressman should have wanted to avoid. With his specific exclusion of the homosexual and active drug abuse group members from the disability category, the question of group discrimination based on membership is brought to the forefront. Yet, as he should have known, this is exactly the type of discrimination that has been outlawed in the Fair Housing Act Amendments of 1988 and the Civil Rights Act of 1964. It is this discrimination that the ADA addresses in the provision of "those regarded as having the disease" when the discrimination is purveyed to an individual based on group membership rather than on proof that the disability or disease actually exists. Unfortunately for Mr. Dannemeyer, his comments in search of a reasonable alternative to a policy he considered too broad and sweeping in its inclusive nature, appear uneducated and antiquated. It is exactly this type of thinking that the ADA and many of the discrimination laws are geared to fight. Mr. Dannemeyer may have proved the point of the whole process in a backward sort of way.

In the face of all the previous judicial and administrative rulings that had taken place prior to the start of the hearings for the ADA, it is not unreasonable to expect the officials in the Congress and the various departments responsible

for the drafting of the legislation to carefully examine the precedents. This is what was done by the Justice Department in the form of a memorandum drafted by then Acting Assistant Attorney General Douglas W. Kmiec. Mr. Kmiec, in the memo for Arthur B. Culvahouse, Jr., Counsel to the President, presented the views of the Justice Department on the various court rulings and administrative and Congressional amendments of the applicable laws.

Much of the ADA wording has been directly taken from section 504 of the Rehabilitation Act of 1973, specifically the definition of what constitutes a disabled individual and the areas of 'otherwise qualified' and 'reasonable accommodation'. In the areas that had been less than well defined, the Justice Department, by way of this memo, attempted to clarify the administration's position regarding the inclusion of the symptomatic and asymptomatic HIV afflicted individual.

The Supreme Court decision in *Arline* clearly identified the symptomatic contagious disease carrier to be under the coverage of section 504. In fact the issue in *Arline* had not been the nature of the affliction that caused her the problem and subsequent dismissal, but her risk of 'contamination' to her students. The court ruled clearly that "the fact that a person with a record of impairment is also contagious does not suffice to remove that person from coverage under § 504. Contagiousness by itself, does not obviate the existence of a handicap for purposes of section 504" (Department of Justice 1988). "



Since the issue of contagiousness had been resolved to the satisfaction of the Justice Department the issue of the asymptomatic individual, which had been effectively dodged by the High Court, was an issue that had to be addressed. Shortly after the decision in *Arline*, then-Surgeon General C. Everett Koop informed the Justice Department, via letter, that the asymptomatic HIV infected individual is physically impaired, stating that "from a purely scientific perspective, persons with HIV infection are clearly impaired. They are not comparable to an immune carrier of a contagious disease such as Hepatitis B" (Department of Justice 1988).<sup>12</sup>

In response to Koop's letter the Justice Department made the following recommendation. "In our view, the type of impairment described in the Surgeon General's letter fits the Health and Human Services definition of "physical impairment" because it is a "physiological disorder or condition" affecting the "hemic and lymphatic" systems. We therefore believe that, in light of the Surgeon General's medical assessment, asymptomatic HIV-infected individuals, like their symptomatic counterparts, have a physical impairment" (Department of Justice 1988).<sup>13</sup> This is the first part of the determination for the status of 'handicapped'. The second and possibly more important is the effect on 'major life activities'. One could argue that the absence of any physical symptoms precludes inclusion under this criterion.

The question with respect to asymptomatic HIV-infected individuals is more difficult because such individuals would not appear at first glance to have disabling physical effects from their infection that substantially affect the type of life activities listed in the HHS regulation. ...Nevertheless, we believe it is likely that the courts will conclude that asymptomatic HIV-

infected individuals have an impairment that substantially limits certain major life activities. ...This conclusion, we believe, may be based on the effect that the knowledge of infection will have on the individual or the effect that knowledge will have on others" (Department of Justice 1988). <sup>14</sup>

This distinction is essential and Kmiec makes clear a differentiation that the list in the CFR is not to be considered an 'exhaustive' one and was of the opinion that at least some of the courts might see certain activities that might be affected directly by the knowledge of HIV-infection or a positive test .

Perhaps the most important [of] such activities are procreation and intimate personal relations. Based on the medical knowledge available...the life activity of procreation ...is substantially limited for an asymptomatic HIV-infected individual...[and] because of the infection... they will be unable to fulfill this basic human desire" (Department of Justice 1988). <sup>15</sup>

Kmiec continued a discussion of the 'intimate relations'. "The life activity of engaging in sexual relations is threatened and probably substantially limited by the contagiousness of the virus" (Department of Justice 1988). <sup>16</sup>

This outlines the Department's opinion on how the knowledge of the presence of the infection affects the carrier. But how does the knowledge of the infection affect the reactions of *others*? This will involve the section of the definition of 'handicapped' which states that an "individual [may be] regarded as having such an impairment" (CFR 1987). <sup>17</sup>

The problem with the "regarded as having an impairment" element of the statute is that much of the issue involves one person's perception of another. Due to continued prejudice against infected individuals and individuals who are members of groups with an abnormally high risk for the infection, the need to expand the definition to be inclusive of these individuals was apparent to the

Justice Department. Reactions of others to the knowledge of the presence of an HIV-infected individual have ranged from mild displeasure to outright hysteria. Reference the Ryan White school attendance issue and the family of three HIV-infected boys who were burned out of their home because of community fear and ignorance. While these cases made national headlines and were ultimately decided on issues other than disability law, community reaction is often one based on an unfounded fear that has been used to discriminate against individuals so afflicted (EAHCA, 1975).<sup>18</sup>

This reaction was not out of the scope of the Justice Department's concern. The decision in *Arline* gave clear perspective that the handicapped definition includes someone who is regarded by others as having a limitation of major life activities, whether they do or not. The literal reference is to actual infected individuals who do not show any outward signs and not to the mis-perception of disability based on prejudice. This literal interpretation is precisely the issue that Representative Dannemeyer was addressing when questioning Mr. Addesso. If an individual is being discriminated against because of a perceived infection, does he fall under the protection of the ADA? Does this mean, as Representative Dannemeyer asserted, that members of high risk groups *may* be included under the handicapped criterion, if the 'perceived infection' was the reason for the discrimination? The answer appears to be 'yes', even though mere membership in a high risk group itself is not a cause for inclusion. This is an issue that will ultimately be decided in the courtroom as no precedent exists on this issue. The Supreme Court has stated that the coverage of §504 *does*

include persons "who as a result [of being incorrectly regarded as handicapped] are substantially limited in a major life activity" (*Davis* 442 US 397, 1979).<sup>19</sup>

"The effect of this interpretation is that the perceived impairment need not directly result in a limitation of a major life activity, so long as it has the indirect effect, due to the mis-perception of others, of limiting a life activity." That is, the law must not sanction exclusion based on mis-perception.

In *Arline*, the perception of a physical disability by others "does not have to include the belief that the perceived condition results in a limitation of major life activities, but simply that the perception of the condition by others in itself has that effect" (Department of Justice 1988).<sup>20</sup> It is clear (as clear as fog can be) that this might be used as a possible argument if an individual, by virtue of membership in a high risk group, were perceived to be infectious, thereby having a major life activity limited, would be so covered under the provisions of the ADA. There would have to be a clear case that the individual was not claiming coverage as a member of the high risk group and had a *prima facie* case of discrimination based on the perception of others. The issue of the discrimination against these individuals does not go without limitation. This was addressed by the court in *Arline* with the "otherwise qualified" wording, and in the Humphrey / Harkin amendment of "direct threat" in the CRRA, later incorporated into §504.

In the areas of "otherwise qualified" and "direct threat", the framers of the legislation were careful to make allowances for the afflicted in the first case and protection of others in the second. While the concept of "otherwise qualified"

was used in the decision in *Arline* and is a standard in the determination of the qualifying of the disabled, it is often coupled with the "reasonable accommodation" caveat that also accompanies "direct threat". Since the wording in the laws, of both §504 and the ADA, remain unchanged with regards to "otherwise qualified", we will eliminate that wording from the discussion as the framers saw no reason to change or alter the treatment of this section. Since the Harkin / Humphrey amendment to the CRRA (later incorporated into §504), the concept of "direct threat" and "reasonable accommodation" were included in the debates on capitol hill. In the Kmiec memo, the Justice Department outlined the basic tenet of the "direct threat" component and specifically addresses the AIDS issue.

[A] person who poses a significant risk of communicating an infectious disease to others... will not be considered otherwise qualified ... if reasonable accommodation will not eliminate the risk. Persons infected with the AIDS virus will not be otherwise qualified to perform jobs that involve significant risk of transmitting the virus to others (Department of Justice 1988).<sup>21</sup>

The risk of viral transmission can be obviated by making reasonable accommodation to eliminate the risk, but the Justice Department, in the Kmiec memo, stated there might be cases where there may be a justification for treating the HIV-infected individual differently than non-infected individuals. This appears to be done on a case by case basis with the determination of 'otherwise qualified' and 'direct threat' applied to each scenario. Persons found otherwise qualified (in general) but unable to eliminate the direct threat to others would be considered *not* 'otherwise qualified'. The language is very specific in this memo. Kmiec wrote:

Courts may find in certain specialized contexts that an HIV-infected individual is not otherwise qualified at any stage of the disease because infection in itself presents an especially serious health or safety risk to others because of the nature of the position (Department of Justice 1988).<sup>39</sup>

The need to place the responsibility on a case by case basis was the framer's attempt to not violate any provision of the Acts themselves, but to also subject the inquiry to the equal protection requirements in the 14th Amendment. The Justice Department outlined several areas where an infected individual may not be otherwise qualified. Depending on the stage of the disease, those responsible for public safety such as air traffic controllers or pilots, policemen or bus drivers, may not be covered. The outlined areas also specifically mention surgeons in teaching hospitals that may have surgical privileges restricted or be prohibited from performing invasive procedures. The Justice Department specifically stated: "it may not be possible to make reasonable accommodation ... where the risk of injury is great". Kmiec concludes the discussion with a re-statement of the provisions of §504 and the concept of direct threat.

The proponents of the ADA were seeking to codify existing laws as they pertained to the handicapped. They were also seeking to further define and re-define existing language as it pertains to contagious disease and risk imposed on the public by the existence of these diseases. The ADA could be called a "garbage can" law. It involves so many existing laws and statutes that it really seeks to pull all of the decisions into one area.

One of the big problems associated with the ADA is its far reaching application that is left for the courts to sort out. The framers, in the drafting of the act, clearly did not know what all of the implications may be, because the

science related to these infectious conditions lags behind the public necessity for action. Representative Dannemeyer, in his opposition to the amendment of the CRRA may be entirely correct when he stated: "If this bill is passed, as presently written, employers will be required to accommodate victims of this fatal disease despite potential health threats to other employees."<sup>23</sup>

Realistically, the Congressman's comment is probably not in-step with the science, but so much is still unknown about the virus that many are unwilling to discount the possibility that he could be correct, and the nation has set itself up for a major public health problem. The Congressman believes that the act is a leap of faith that should not be made in haste.

The unique aspect found in this inquiry was the ability of the representatives of the various agencies to transform the item from a homosexual and drug abuse disease into a public health fighting tool. This issue re-definement is an essential component of the act and Admiral Watkins' testimony before the joint House and Senate committees is the most profound element discovered so far. It is clearly plausible, as referenced in the Admiral's comments and prepared statement, that any discrimination against HIV-infected individuals would force the virus, and those infected with it, to go underground. This would cause the ability of the public health agencies to track, report, and fight the "unseen enemy", to virtually disappear overnight.

This has been the case from the very beginning. The AIDS virus, due to its deadly nature and method of transmission, has caused heightened concern among the population. Those afflicted by the disease, whether symptomatic or

asymptomatic, have been reluctant to seek treatment and counseling for fear of societal reprisals and discrimination. This above-board treatment of the afflicted individual, within the confines of the provisions of the ADA, can only seek to relieve the burden of secrecy that has so plagued these individuals.

As we have examined in this chapter, exhaustive testimony and clarification has been sought by the various framers of this law. We have seen the reluctance, by individuals and agencies, to place within the law any portion that would extend disability protection to undeserving persons. We have also seen the strength of the medical argument, as referenced by the comments of the Surgeon General to the Justice Department for inclusion. Clear interpretation by the Justice Department has also supported the exclusion of individuals who have been determined to *not* be 'otherwise qualified' because of their inability to show they are absent of 'direct threat'. Congressional testimony aside, the re-definement of the issue into a public health crisis helped solidify the circumscription of asymptomatic individuals afflicted with HIV within the confines of disability law.

The following chapter will outline a plausible policy designed to address concerns raised by the Framers of these complicated laws and to offer alternatives to existing policy and procedures that are fair and just to all.



## Chapter Notes

1. Congress, Joint hearings, House, Committee on Education and Labor, Sub-committee on Select Education, Senate, Committee on Labor and Human Resources, Sub-committee on the Handicapped: 100th Congress, 2nd. Session on S.2345, *Americans with Disabilities Act of 1988*, 27 September, 1988, Serial No. 104, (Washington D.C.: U.S. GPO, 1990) Adm. James Watkins prepared statement, 44-45.

2. Ibid., Watkins, committee testimony, 39-40.

3. Congress, House, Committee on the Judiciary, *Americans with Disabilities Act of 1989*, Hearing on H.R. 2273, 101st. Congress, 1st. Session., 3 August, 1989, Rev. Scott Allen testifying, Serial no. 58, (Washington D.C.: U.S. GPO, 1990) 170-173.

4. Ibid., Allen, prepared statement, 175-176

5. Frank R. Baumgartner, Bryan D. Jones, *Agendas and Instability in American Politics*, (Chicago: The University of Chicago Press, 1993), 89.

6. Congress, House, Committee on the Judiciary, *Americans with Disabilities Act of 1989*, Hearing on H.R. 2273, 101st. Congress, 1st. Session., 3 August, 1989, Mr. Peter Addesso testifying, Serial no. 58, (Washington D.C.: U.S. GPO, 1990) 1877.

7. Ibid., Addesso, committee testimony, 1878.

8. Congress, House, Committee on the Judiciary, *Americans with Disabilities Act of 1989*, Hearing on H.R. 2273, 101st. Congress, 1st. Session., 3 August, 1989, Mr. Chai R. Feldblum testifying, Serial no. 58, (Washington D.C.: U.S. GPO, 1990) 1894.

9. Mr. Dannemeyer's comments might seem aimed at homosexuals and those dependent on drugs. He seems to be saying that inclusion of the AIDS afflicted individuals, many of whom fall into the these population groups, is a protection for homosexuals and drug abusers. These are clearly eliminated from specific inclusion by group status and are also eliminated in the 'direct threat' language outlined in the CRRA and later incorporated into section 504. Without calling Mr. Dannemeyer homophobic and insensitive to the rights and needs of those afflicted with debilitating conditions and addictions, his comments appear not in step with contemporary political viewpoints, contemporary science, and the general spirit of the laws upon which these hearings are based.

10. John Kingdon, *Agendas, Alternatives, and Public Policies*, Second Edition (n.p.: HarperCollins College Publishers), 1995, 82.

11. Department of Justice, *memo to Arthur B. Culvahouse, Jr., Counsel to the President* (September 27, 1988), from Mr. Douglas W. Kmiec, Acting Assistant Attorney General, submitted to the Committee on the Judiciary, House of Representatives, 101st. Congress, 1st. Session on H.R. 2273, Americans with Disabilities Act of 1989, August 3, 1989, Serial no. 58, (Washington D.C.: U.S. GPO, 1990), 343.

12. *Ibid.*, 345.

13. *Ibid.*, 345-346.

14. *Ibid.*, 346-347.

15. *Ibid.*, 347.

16. *Ibid.*, 348.

17. C.F.R. § 84.3(j)(1) (1987).

18. Education for All Handicapped Children Act (EAHCA)(1975), Pub. L. No. 94-142, 89 Stat. 774, Codified @ 20 U.S.C. §1401-1461.

19. See: *Southeastern Community College v. Davis* (1979) 442 U.S. 397.

20. Department of Justice, *memo to Arthur B. Culvahouse, Jr., Counsel to the President* (September 27, 1988), from Mr. Douglas W. Kmiec, Acting Assistant Attorney General, submitted to the Committee on the Judiciary, House of Representatives, 101st. Congress, 1st. Session on H.R. 2273, Americans with Disabilities Act of 1989, August 3, 1989, Serial no. 58, (Washington D.C.: U.S. GPO, 1990), 343, quoting for the *Davis* and *Arlene* courts.

21. *Ibid.*, 351.

22. *Ibid.*, 353.

23. *Ibid.*, 360.

## **CHAPTER 5**

### **POLICY**

**In proposing any new policy for a stated problem, a clear and concise reason must be given to justify the change. As the previous chapters have outlined, we are faced with a continued public health issue that will not go away. The previous chapters have shown the issues that have become problematic as a result of current practices. This chapter will examine some of the flaws that current practices and policies have allowed and will propose a plausible alternative policy that is workable under current disability laws. The public grows weary with continued protective legislation that ignores the concerns of the general well-being in favor of select individuals and groups. Protection from discrimination is very important and must never be ignored. But when the protection, reasonable or not, infringes on the health and welfare of the community as a whole, real common good and autonomy is lost.**

**Personal autonomy, privacy, and professional growth are central to the philosophical, legal, ethical, and policy positions of professional associations responding to the Acquired Immune Deficiency Syndrome. Current policies are clear in many aspects but ambiguous in others. The apparent goal of the associations is to outline a standard of conduct consistent with available**

scientific information and to offer their members a format of performance relative to their patients, their practices, and themselves.

Professional associations have traditionally asserted that they are the best guardians of their own affairs as no one else is capable of fairly judging elite professionals other than their own peer groups. It is said that the general public, and those outside the particular area of expertise, do not have enough knowledge to fairly arbitrate that which they do not fully understand. This claim has been asserted in many areas including medicine, law, and some of the public sector including police agencies. While the "public lacks knowledge" claim is effective in many areas, it has also been equated with "hiring the fox to watch the hen house". Professional groups and associations have knowledge and they have an inherent obligation to protect association members from harm, real and perceived. This obligation cannot be taken lightly but it also can be disguised to the general public by the use of scientific data, flowery verbiage, and technical language designed to lose anyone but the most learned professional colleague. Hence, public respect for self-governing professionals can deteriorate.

This criticism of professional associations and their policy analysts may be too strong and bordering on the unfair. We would like to believe that these associations are aware of their moral obligation to act in the best interests of the public at large. But the argument is designed to show that there may be some flaws in the peer review process and that sometimes the process itself should be questioned. Clear policy from professional associations would give their

members guidelines on which to base their behavior and build public confidence in a health care system which has been accused of being elitist and unresponsive to public fears and concerns about safety. The issue is not whether the public fears and concerns are justified, merely that the system has been unresponsive to the public perception that the health care community has placed the rights and needs of its members above those of the patients and the public.

Professional associations, specifically the American Medical Association (hereinafter AMA) and the American Dental Association have developed policies and standards of conduct for their members that try to balance the professional obligations of their memberships in performance against the rights of their members to be treated as equal citizens relative to personal rights and freedoms. This has been a difficult task. This delicate balance has come under fire for not taking into consideration moral obligations of these professional groups that are central to their own philosophical basis.

The AMA's ethics policy, *Principles of Medical Ethics* (1980), guides its members' ethical responsibilities. The policy states that physicians must recognize their obligations, not only to the patients, but also to society at large. It does not state that physicians must "keep their patients from harm" as stated in the Hippocratic Oath, but speaks of medical competence, compassion, and human dignity. Statements in defense of the 4th century, BCE. oath of Hippocrates would be inappropriate as much has changed within the current scope of medical practice and the relationship of physician and patient is

dramatically different in the modern era. The principles of this ethics policy outline acceptable actions for physicians. They are charged with honest dealings with patients and colleagues, respect for patient rights, advancement of scientific knowledge, making relevant information available to patients, and using the talents of other health professionals when indicated (Mappes and Zembaty 1986, 54-55).<sup>1</sup> Basic medical ethics are essential for professional conduct and it appears in the policy that obligations of the medical practitioner are clear regarding patient rights. The controversy comes in the application of the principles, the interpretation of the obligations, and the extent to which these obligations are applicable.

On the issues of Acquired Immune Deficiency Syndrome and HIV infection, professional associations have a problem relative to their members and their professional conduct. On the one hand, physicians are charged with providing care and minimizing risks, on the other hand they must respect the rights of their own group as individuals. Since the identification of the HIV virus in 1985, scientific information has been compiled about methods of transmission of the virus from host to recipient. While the complete epidemiological profile for transmission is not relevant to the discussion at hand, the blood to blood transmission has implications for the medical community both as an occupational risk for the healthcare worker (often abbreviated HCW) in dealing with the infected patient, and as patient safety from the infected healthcare worker.<sup>2</sup>

The Centers for Disease Control (CDC) has defined the risk of exposure for patients to involve only invasive procedures (*MMWR* 1991, 40 [No. RR-8], 1-9) <sup>3</sup> and that all other care of a non-invasive nature poses no risk of transmission of HIV or HbV (Hepatitis B virus) to the patient. The term 'invasive' has proved unworkable as it appears that only certain invasive procedures of a surgical and dental nature have been implicated in transmission of HbV. These and other invasive procedures have been redefined as "exposure-prone" and the CDC states that "performance of exposure-prone procedures presents a recognized risk of percutaneous injury to the HCW, and - if such an injury occurs - the HCW's blood is likely to contact the patient's body cavity, subcutaneous tissues, and/or mucous membranes" (*JAMA* August 14, 1991, 774-775). <sup>4</sup> The CDC also states that "HCWs who adhere to universal precautions pose a small risk for transmitting HbV to patients". <sup>5</sup> They further state that "HIV is transmitted much less readily than HbV" (*JAMA* August 14, 1991, 771). They conclude:

Investigations of HIV and HbV transmission from HCWs to patients indicate that, when the HCWs adhere to recommended infection-control procedures (universal precautions), the risk of transmitting HbV from an infected HCW to a patient is small, and the risk of transmitting HIV is likely to be even smaller (*JAMA* August 14, 1991, 775). <sup>5</sup>

While the CDC has defined the term 'exposure-prone procedures', identification of which procedures are exposure-prone was sidestepped. They state that "exposure-prone procedures should be identified by medical/surgical/dental organizations and institutions at which the procedures are performed." They further state that there is "no basis for recommendations to restrict the practice of HCWs infected with HIV or HbV who perform invasive

procedures not identified as exposure-prone". This policy stance by the CDC places the weight of the problem directly on the professional organizations. The CDC's reluctance to take a stand on which procedures should be deemed exposure-prone placed the associations in a position such that may have far reaching implications to their members. In the strongest position yet taken, the CDC recommends that,

HCWs who are infected with HIV or HbV... should not perform exposure-prone procedures unless they have sought counsel from an expert review panel and have been advised under which circumstances, if any, they may continue to perform these procedures. ... Such circumstances would include notifying prospective patients of the HCW's seropositivity before undergoing exposure-prone procedures (*JAMA* August 14, 1991, 775).

The CDC also states that if professional practices of infected HCWs are modified or restricted, appropriate retraining and career counseling should be encouraged to promote continued use of the HCW's skills. This policy position, while workable in theory, has not been feasible in the practical sense. In the *Behringer* court case, the New Jersey Supreme Court upheld an institution's right to restrict surgical privileges of an HIV infected surgeon by requiring the surgeon to get informed consent from patients about his seropositivity prior to surgery.<sup>6</sup> This would seem consistent with the CDC recommendations but may conflict with subsequent legislation regarding disability rights as outlined in the Americans with Disabilities Act and the term 'Direct Threat' (Americans with Disabilities Act [ADA], 1990).

The determination of risk and what constitutes identifiable risk, significant risk, and acceptable risk, has not gone without debate, both in medicine and business. Deborah A. Stone, in her work *Policy Paradox and Political Reason*,<sup>8</sup>



discusses the concept of security. "In many current policy debates, people are said to have needs based on the condition of 'being at risk'." This risk is for a "potential harm" or harm that has not yet happened and exists only in the future. She states that "future needs often have a political potency far greater than actual needs." She further argues that the human imagination is capable of creating strong emotional terror and fervent arguments seeking protection and safety even in the face of statistics that do not support the needs (Stone 1988, 77). Stone also determines that risk is calculated if the potential harms are predictable and that the "probabilistic association of harmful outcomes with human actions is widely accepted as a demonstration of cause-and effect relationship" (Stone 1988, 156).

In other words, real predictable harm such as the death of a patient during or after surgery, even for events that may have no statistical basis on an individual case, may constitute an identifiable risk. These identifiable risks are exactly the type of risks that are disclosed to patients and discussed with them prior to the commencement of any surgery. While the risks are different for each and every procedure, all procedures carry some amount of risk that the physician discusses with the patient. This is called informed consent. Here the physician informs the patient of the identifiable risks and tries to balance them against the rewards that the necessary (or elective as the case may be) procedure will provide. In many cases the risks are deemed negligible, or if real and possible, may not involve a real risk of patient demise. Some risks may be real and patient survival may be at stake and these can be either side of the spectrum,

having or not having the procedure. Regardless of the extent of the probability, or on which side of the position one stands, it is the patient that must ultimately make the decision to accept the risks and have the procedure performed, or to not accept the risks and choose a different provider, or live or die with the consequences. In all instances a prudent person will seek to reduce his risk of mortality while achieving the maximum benefit available. We wear seat belts to reduce risk, we look both ways before crossing the street, we comply with prescribed medications to get healthy and reduce mortality. All constitute our ability to reduce risk by prudent and calculated actions. We are, or try to be, fully informed of the consequences of inaction and take steps to avoid exposure and thereby diminish risk.

On the subject of risk, the AMA has adopted a set of terms that are used within their membership and in their association policies. In response to the HIV and HbV transmission concerns of the patient population, the AMA has replaced the term 'identifiable risk' with that of 'significant risk' and states that "a risk is significant if it is real and would change the actions of a reasonable person." "There must be demonstrated risk of transmission, along with some impact on decisions from knowledge of transmission probability, to meet the standard of 'significant risk'" (AMA 1992, 91).<sup>9</sup> Due to a lack of documented cases of transmission from physician to patient at this time, the AMA states that this "transmission cannot, in general, be said to present a significant risk." This is somewhat clear in what the CDC has stated earlier that the risk is lower than HbV transmission, but nowhere do any of the associations say that the risk is

zero or statistically zero. In the transmission statistics for HbV, studying multiple patient infection groups, even with modification of the practiced universal precautions (i.e.. double gloves, restriction of high risk procedures), certain HbV transmissions still occurred even though they were limited in scope. The CDC states, "however, the limited number of recent reports does not preclude the occurrence... of transmission [and] routine use of gloves does not prevent most injuries caused by sharp instruments and does not eliminate the potential for exposure of a patient to a HCW's blood and transmission of HbV" (*JAMA* August 14, 1991, 774, quoting the CDC). This assertion is that the risk of transmission of HbV cannot be eliminated by routine universal precautions and modified precautions. Then by using the CDC's 'small risk' terminology for HbV and the 'much less' (than HbV) term for HIV, indicates that the ambiguous language makes the scientific information currently available indeterminate at best.

The AMA offers this statement on transmission and patient rights in their policy compendium:

Physicians, other health care providers and patients must recognize their personal responsibility to prevent transmission of HIV disease in all situations. ... When the scientific data are unclear, it is mandatory that the rights of the patient take precedence over those of the physician. In all instances, physicians strive to "do no harm" to patients (AMA 1992, 91).

AMA policies do not identify which procedures are exposure-prone. Neither does the American Dental Association. In one assertion the AMA states that the risk of HIV transmission is immeasurably low (transmission risk as determined by the American Dental Association is listed as "infinitesimal"), and much less than HbV, yet in policy they call for voluntary compliance for seropositivity

determination and offer a policy for monitoring of HIV-infected physicians (American Dental Association 1991, 21). The policy offers two reasons for monitoring: First, "to control the use of procedures with a significant risk of HIV transmission to patients" and second, to "maintain a high standard of practice of infection control". They further state:

Any HIV-infected physician should disclose his/her serostatus to a local review committee. ...This review committee may restrict the physician's practice, if they believe there is a significant risk to patients' welfare. One such restriction may be the disclosure of physician seropositivity to patients and obtaining consent prior to a procedure deemed to pose a significant risk (AMA 1992, 94).

This statement, in light of the previous assertions that the risk of HIV transmission was remote at best, appear to be a contradiction in the association's policies. Either there is a significant risk of transmission during certain procedures or there is not. They do state within the policy that "this risk is only theoretical in that no such transmission has so far been documented", but this statement does not relieve the contradiction. The contradiction is not present in the Current Policies of the American Dental Association. The dental community has long advocated universal precautions for the prevention of disease transmission and address the issue of HIV positive practitioners. They state:

HIV infection alone does not justify the limiting of professional duties, or automatically mandate disclosure, unless the dental health care worker poses a risk of transmitting infection through non-compliance with universal precautions, [or] a lack of infection control competence... (American Dental Association 1991, 21).

The American Dental Association also advocates peer review for compliance with the listed items and also recommends voluntary compliance with seropositivity determination, but the policy, on the face of it, appears consistent.

The whole problem with the risk management policies of the professional associations is that we are forced to *choose* which course of action is acceptable; either one that uses such vague terms as “infinitesimal” and “remote at best” to describe the risk of transmission; or one that will side with caution, prudence, and the public interest. “Errors are inevitable in such cases, and contemporary philosophy of logic and applied mathematics has no alternative available to a conscientious person under these conditions. The uncertainty cannot be hidden or ignored, one of (the) two kinds of errors will be committed” (Walton 1998). ”

Dr. Craig Walton, Professor of Philosophy and Director of the Institute for Ethics and Policy Studies at the University of Nevada, Las Vegas, argued in a recent paper the dangers of the DoE proposal on deep geological burial of high-level at Yucca Mountain, NV, that there are two types of uncertainty calculi: Type I (scientifically conservative) and Type II (morally conservative) errors. Dr. Walton states:

Type I errors involve saying, in effect, “if we must admit some errors into our scientific base, let us prefer to reject a true hypothesis not yet actually confirmed [here, that there is some risk to patients with HIV positive HCWs performing ‘exposure prone’ procedures], rather than accept a false hypothesis, not yet actually falsified” [that the risk is not relevant because no patients have been infected]. (Walton 1998).

Here the physician community would have us accept that it is better science to allow infected providers to continue to practice because the patients have “not

yet" been infected, rather than eliminate the risk because it is only "remotely" possible. Walton continues concerning Type II errors:

Type II errors, by contrast, involve saying, in effect: if we must admit some errors into our science, let us prefer to include an hypothesis not yet confirmed, because of the meaning it has for public health and safety, rather than excluding it because we are not able to prove a high likelihood that it will in fact happen" (Walton 1998).

What Dr. Walton is saying is that we should never take a policy position based on something that is possibly false (but not yet falsified) in the face of something that is possibly true (but not corroborated). Walton sums it up best when he stated:

Type II logic is chosen when the public health and safety is at risk...if error is likely... than we err on the side of caution rather than... saying, "that danger has not been proven to be highly likely, so we can ignore it". (Walton 1998).

When the issues of risk management deal with a given amount of uncertainty and probability cannot establish clear parameters upon which to base policy decisions; then prudence of action is the best response. Since we must choose one of these two approaches (Type I or Type II) it is the latter that offers the most cautious and prudent course of action.

The question now arises, "is the public willing to accept these risks or increase in risk, or not?" If we are unable to accept this increase in risk and prefer to mandate patient rights and full disclosure in the format of informed consent, what is the impact on the polis as a whole? If we mandate patient rights over that of the disabled individual, do we impinge on the rights of the infected person?

The problems of identifying select members of groups as outlined in association policies without taking a discriminatory stance are challenging at best, but from a solution standpoint they appear defensible. Handicapped regulations as outlined in the ADA and Section 504 of the Rehabilitation Act of 1973 do not permit this dissimilar treatment if the person can show that they are "otherwise qualified". There are several criteria used to satisfy the "otherwise qualified" standing but if the afflicted individual cannot get past the concept of "direct threat" then they cannot prove that they are otherwise qualified. The ADA expanded the concept of the terminology; which states:

An employer may require, as a qualification standard, that an individual not pose a direct threat to the health and safety of himself/herself or others. If, however, an individual poses a direct threat as a result of a disability, the employer must determine whether a reasonable accommodation would eliminate the risk or reduce it to an acceptable level. If no accommodation exists that would either eliminate or reduce the risk, the employer may refuse to hire an applicant or may discharge an employee who poses a direct threat. The employer, however, is not permitted to deny employment ... merely because of a slightly increased risk. The risk can only be considered when it poses a significant risk, i.e., high probability, of substantial harm; a speculative or remote risk is insufficient (ADA 1990). <sup>12</sup>

The wording in the ADA seems to eliminate the possibility that a remote chance of infection by an infected HCW to a patient would be criteria enough for the imposition of the concept of 'direct threat'. Court cases such as *Behringer* and *Doe* seem to prove, or least affirm, that the concept of direct threat *would* include surgical intervention. On the issue of the policy conditions regarding the plaintiff's right to practice surgery the *Behringer* Court took a stand that has been a hallmark for the position on health care providers who perform exposure-prone procedures. The Court used many pieces of information in

formulating its decision. It was determined that surgeons (and dental practitioners) frequently injure their fingers in the course of providing treatment. "Most injuries are minor, but severe and unusual injuries sometimes do occur" and surgical glove cuts and cuts to the fingers, while not commonplace, were not unheard of (Keyes 1989, 19).<sup>13</sup> In fact, these events do appear to be commonplace. In a three month study at a Connecticut hospital of operating room personnel cataloguing breaks in infection control procedures and universal precautions, there were a reported 331 instances. Of these 331, 70 (21%) were from sharp injuries that caused direct pain to the individual. We must remember that these statistics are from a single hospital and only over a three month period. Even with the principle of charity and the assumption that they 'had a bad three months', the significance cannot be overstated. If we were to reduce the numbers by 90%, taken against the whole of the nation, in ALL of the hospitals and operating rooms (and these were only statistics generated within the surgical environment, not including other areas that may have some invasive performances, i.e. emergency rooms) the numbers are at least significant and alarming at the worst (Wright, et. al. 1991).<sup>14</sup>

Norman Daniels, a philosophy professor at Tufts University, argues that the benefits of identifying and subsequently removing or restricting the practices of infected providers will in no way justify the costs involved. Dr. Daniels, in what appears to be a standard cost-benefit analysis, argues that the costs are not only monetary but societal as well. The cost of 'switching' or the act of changing practitioners due to HIV status affords a cost that is prohibitively high for all. The



switching creates the need to identify the afflicted individuals when the costs of the identification are prohibitive from a monetary standpoint at best. This causes money that may have been better spent elsewhere (i.e. education, improving compliance with infection control measures, research, and monitoring) to be allocated to the discovery of infected practitioners. This is a long term cost that Daniels says we should be unwilling to pay as the costs do not outweigh the benefits (Daniels 1992, 1368-1371). <sup>15</sup> Daniels also states that the costs would also be reflected in an increase in the discrimination against AIDS patients because of the occupational risk inherent to HCWs. If physicians were to face loss of their livelihood because of occupational seropositivity, they would be less likely to want to treat AIDS afflicted patients.

Daniels makes an excellent argument in support of this concept and this occupational risk alone is worthy of debate. His concept of using a statistical analysis for surgical proficiency as opposed to seropositivity (designed to eliminate the less skilled surgeon based on mortality and surgical success) is also valuable.

But overall, I disagree and I think Daniels refutes his own argument when he discusses the costs of fear. Dr. Daniels wants to keep the discussion within a framework that is purely objective in nature and to dismiss the subjective concepts of patient rights on a limited scale. "It is only because employers or other workers try to hide behind their subjective views of risk in order to deny equality of opportunity to handicapped workers that we must insist on objective assessments of risk" (Daniels 1992, 1370).

Fear and stress are recognized problems within the medical community, often cited as causing patient illness and exacerbating existing conditions. A patient switching from an infected surgeon to a non-infected one may achieve no measurable benefit except to alleviate his or her own fear. This fear may be exaggerated by prejudice and stigma, but the costs of living with this fear may be more than the switching. It may be a rational risk-benefit analysis that the patient has examined, even when we tend to ignore comparable risks in other contexts (Daniels 1992, 1369). I think that Dr. Daniels also neglects, when discussing risk, that in any situation where mortality exists I will seek to reduce my risk by contemplating alternative actions. I reduce my risk in the automobile by wearing a seat belt. I wear a helmet when bicycling. If, in any situation, I can reduce my mortality, even only fractionally, then through the process of deliberation, I can reduce my risk, or choose not to. The resultant amount of tolerated risk then becomes a personal choice and is not based on a statistical analysis. The resultant costs of fear become the price that we are not willing to pay.

It is difficult to take a position that appears discriminatory, alarmist, and paranoid. It is also difficult to argue against the scientific information and statistics that seek to prove that the “real risks” of infection transmission are extremely low. Above these issues, there appears to be universal agreement that research efforts and money should be allocated to increase the ability of the medical community to combat infection transmission from an occupational exposure, and I agree. This can help, not only from the occupational end but

also from the patient protection angle. The medical community must also explore the possibility of re-inventing some of the accepted surgical techniques to relieve the surgeon's risk from being too close to instruments that may cause percutaneous injury to the surgeon. Until that becomes a readily acceptable alternative, exposure-prone procedures will not diminish in risk and the need for further actions will be indispensable.

Immediate action is necessary to restore public confidence. The medical community *must* collaborate, debate, and decide which procedures are 'exposure-prone'. Without the medical and professional associations participation the legislators can have no clear framework from which to proceed. In the absence of a definition of 'exposure prone', the less accurate term of 'invasive procedures' should be employed and the legislative branches should act to enforce mandatory testing. Alternatively, if the medical community can identify exposure prone procedures, then only those physicians who wish to participate in these procedures will need to be monitored. Monitoring tactics should include HIV seronegativity results to be submitted with license renewals.<sup>16</sup> This should be monitored on the national level, preferably by the CDC, and a central data base should be compiled. The CDC is the natural choice since they already track the virus. This would eliminate the problems with state to state reciprocity and repetitive efforts of tracking and testing. Complete participation by the medical professional is the only way we can assure fair treatment for all parties concerned.

While one might object that submission with license renewal will not identify all infected individuals due to the serologic time window for infection to become identifiable on lab results, I counter with the positive results of elimination of currently infected individuals, proactive self-monitoring by the surgical community, and ultimate catch-up with the seroconversions that happen in the interim.

Another objection might accuse me of taking a stance that is truly discriminatory against defined handicapped individuals, - which would be against the law. As I have shown by the application of common law (as in *Behringer*), however, these individuals cannot show they are 'otherwise qualified' and absent of 'direct threat'. If they are not 'otherwise qualified', it is not discrimination.

I also argue that my approach, while dependent on the action of the professional associations, is not in and of itself discriminatory. I do not argue mandatory testing. A physician *only* has to submit lab results if wishing to perform exposure-prone procedures. Those who do not wish to submit results may move into areas of clinical practice that do not involve these procedures, thereby avoiding diminishing their ability to earn a living. Those who submit lab results that are positive and still seek to participate in these procedures will be mandated to obtain informed consent from their patients. Disability insurance and other monetary protections for physicians that seroconvert from occupational hazard should be afforded to all those practicing in the operating theater, as the occupational hazards are real and should not be understated.

As the physician community continues to argue for increased protections from occupational exposure, an additional possibility could be offered.

As more and more seropositivity from the surgical community comes to the forefront, a 'bank' of HIV seropositive surgeons may be created to achieve a decrease in occupational exposure for the non-infected. When circumstances and time allows, the 'AIDS surgeon' could be brought in to perform exposure-prone procedures on patients that are identified as HIV positive. With growing numbers of the general population becoming HIV seropositive, this may be a long term solution that may help relieve some of the occupational concerns. These 'banks' could be regionally located so access to the patients would not be inordinately delayed.

An objection might be raised that this approach further "isolates" the disabled and HIV positive community. This is not my intent. I argue for the concept of 'AIDS surgeons' from a purely practical and protective angle. If HIV positive surgeons can assist their colleagues and reduce the risks of further seropositivity from occupational exposures by performing the exposure prone procedures, then the general risk of further infection has been diminished. The goal of any public health pandemic program is to stop the spread of infection. This objective can only further help to stem the tide of an overwhelming situation.

This entire policy position should also be recognized as not being limited in scope. The entire argument may be further expanded to include other health care practitioners involved in 'exposure prone' procedures such as surgical

technicians and operating room nurses. It is also not limited by the specific viral agent. It may be expanded to include those individuals that are HbV positive as well, since HbV has been clearly shown to be more virulent than HIV. The medical community has traditionally taken the leadership role in matters of patient autonomy, safety, and public education. An active, positive approach from the scientific community, seeking alternatives that are workable and clearly definable is needed, now.

The moral defense for the aforementioned policy will follow in the next two chapters. The ethical conduct and responsibility of these healthcare practitioners is central to the justification for making a change. When the statistical relevance of the scientific information has been brought into question, the ethical platform is much firmer ground upon which to stand.

## Chapter Notes

1. Thomas A. Mappes, Jane S. Zembaty, *Biomedical Ethics*, (New York: McGraw-Hill, 2nd Edition, 1986), 54-55.

2. This thesis will not consider the occupational risk, as this is an issue that has a different scope, similar in approach, but focused from a different perspective that is not relevant.

3. *"Mortality and Morbidity Weekly Report" (MMWR)*, Centers for Disease Control, Atlanta, GA, 40, No. RR-8 (1991): 1-9. "An invasive procedure is defined as surgical entry into tissues, cavities, or organs or repair of traumatic injuries associated with any of the following: 1) an operating room or delivery room, emergency department, or outpatient setting, including both physicians' and dentists' offices; 2) cardiac catheterization and angiographic procedures; 3) a vaginal or cesarean delivery or other invasive obstetric procedure during which bleeding may occur; 4) the manipulation, cutting, or removal of any oral or perioral tissues, including tooth structure, during which bleeding occurs or the potential for bleeding exists" (reprinted from the *MMWR*, 36, suppl. no. 2S, (1987): 6S-7S).

4. "Recommendations for Preventing Transmission of Human Immunodeficiency Virus, Hepatitis B virus to Patients During Exposure Prone Procedures", *Journal of the American Medical Association (JAMA)*, (August 14, 1991): 266, no. 6, 774-775.

5. Universal Precautions are defined as "appropriate use of hand washing, protective barriers, and care in the use and disposal of needles and other sharp instruments".

6. *Estate of William Behringer, M.D., Plaintiff, v. The Medical Center at Princeton, Dennis Doody, and Leund Lee, M.D. Defendants.*, --N.J. Superior Court, (Docket #L88-2250, Superior Court of New Jersey, Law Division - Mercer County. Decided 25 Apr., 1991). See also, *John Doe, M.D. v. Mercy Health Corp.*, 1993 U.S. Dist. LEXIS 13347 (E.D. Pa 1993)(no. 92-6712).

7. Americans with Disabilities Act, Pub. L. 101-336, Sec.1630.2(r) "Direct Threat", Appendix B, (B-28).

8. Deborah A. Stone, *Policy Paradox and Political Reason*, (n.p.: HarperCollins, 1988).

9. "AMA Policy Compendium" (1992), American Medical Association, 515 North State Street, Chicago, IL 60610, Policy 20.948.

10. "Policy on HIV-infected Dentists", (1991:592), American Dental Association, 211 East Chicago Avenue, Chicago, IL 60611, Current Policies, adopted 1954-1994.

11. Craig Walton, "High-level Ethical Risk: Morally Unsound Practices at Yucca Mountain", *Science, Technology, and the American West. The Halcyon Series*, Stephen Tchudi, ed. (Reno: University of Nevada Press, 1998), vol. 19, 215-237.

12. Americans with Disabilities Act, Pub. L. 101-336, Sec.1630.2(r) Direct Threat, Appendix B, (B-28).

13. Gordon G. Keyes, "Health Care Professional with AIDS: The Risk of Transmission Balanced Against the Interests of Professional and Institutions", 1989; *Specialty Law Digest:-Health Care* (Mon.), (1991 June): (148) :7-39,19.

14. James G. Wright, Allison J. McGeer, Douglas Chyatte, David F. Ransohoff, "Mechanisms of Glove Tears and Sharp Injuries Among Surgical Personnel", *JAMA*, (September 25, 1991): 266, no. 12, 1668-1671.

15. Norman Daniels, "HIV-Infected Professionals, Patient Rights, and the 'Switching Dilemma'", *JAMA*, Special Communications, (Mar. 11, 1992): 267, no. 10, 1368-1371.

16. see: "Mandatory HIV Testing of Surgeons and Dentists 'Inevitable'; Senate Supports Legislation", *AIDS Alert*, (September 1991): v9, 165-184; Denise C. Singleton, "Nonconsensual HIV Testing in the Health Care Setting: the Case for Extending the Occupational Protections of California Proposition 96 to Health Care Workers", *Loyola of Los Angeles Law Review*, (June 1993): v26, 1251-1290.; Christine Huebner, "Mandatory Testing of Health-Care Workers for AIDS: When Positive Results Lead to Negative Consequences", *New York Law School Law Review*, (Fall 1992): v37, 339-382.



## CHAPTER 6

### Communitarian Justification

The concept of a community of people, banded together to enforce rights and obligations, is not a contemporary theme. Aristotle, in the first line of his work *The Politics*,<sup>1</sup> states that: "Every state is a community of some kind, and every community is established with a view to some good; for everyone always acts in order to obtain that which they think is good" (POL. 1252 a 1 - 1254). This chapter shall discuss the issues of the greater community and its good balanced against the individual needs that may arise within it. We will discuss individual responsibility as related to the community as a whole and the rights of that community regarding its members and their responsibilities.

The sense of community is what binds people together in search of the common good based on their views of what that good may be. It is a principle ascribing to all humankind a vested interest in one another's moral, intellectual, and even physical perfection, to be defined by each claimant according to his or her own standards (Feinberg 1986, 215).<sup>2</sup> Hobbes discusses the concept of community, or to use Hobbes's term, commonwealth, at great length in *Leviathan*.<sup>3</sup> As a result of man's formation of the commonwealth, the power behind the individual in the enforcement of the natural rights and civil rights (the covenants, or agreements among men) are made possible. The defense of the

natural rights is easier in a group. When a man is attacked and his life is in jeopardy, is it not easier to defend one's life with the help of others? People bind together in commonwealths for "the foresight of their own preservation", the protection of their most basic natural right, that of life itself (Hobbes 1651, 17, 109). <sup>3</sup> The commonwealth is said to exist when a multitude of men "agree and covenant, *every one with every one*,... to live peaceably amongst themselves, and be protected against [the intrusion or attack of] other men" (Hobbes 1651, 18, 113).

Mutual agreement was also a concept of Rousseau's. As Abraham Edel quotes Rousseau, in his 1762 work, *Social Contract*, "the undertakings which bind us to the social body are obligatory only because they are mutual; and their nature is such that in fulfilling them we cannot work for others without working for ourselves" (Edel, Flower, and O'Connor 1989, 280). <sup>4</sup> Edel also quotes Thomas Paine who stated, in *Rights of Man* (1789), that 'civil rights' are those that are deposited within a common stock of the society of which he is an equal proprietor. The power of the civil right is made up of an aggregate of the natural rights that he has *shared* with the other members of the community (Edel, Flower, and O'Connor 1989, 280). The power of the individual, with respect to those shared natural rights, along with the added power of the civil rights, are based in what has come to be known as Law.

As a result of the formation of the commonwealth certain rules must be established for the conduct of its members. These are what civil laws are all about. Law, as outlined by Locke, "is the standard of right and wrong, and the

common measure to decide all controversies between them” (Locke 1690, §124). Locke professes that given the human predisposition to look out for oneself and to violate the rights of others, it was necessary to set civil governments to enforce the social contract of civilized society. This is a society of free individuals assenting to a collective will and all must live within the boundaries as set up by the civil government. This is the agreement given by individuals for the privilege of living in the society. Laws are also part of the social contract agreed to by people and among persons within the community in which they reside for the extension of the common good. Hobbes broadens the definition slightly when he says,

Civil Law is to every subject, those rules, which the commonwealth hath commanded him, by word, writing, or other sufficient sign of the will, to make use of, for the distinction of right, and wrong; that is to say, of what is contrary, and what is not contrary to the rule (Hobbes 1651, 16).

While the overall general issue of community may be of some significance, the issue of what are the requirements for the individuals within that community must be grounded in responsibility or obligations. This organized conduct with a view toward the ‘common good’ is what the concept of community is all about. Rights and obligations then are not conditions limiting the common good, but conditions of the varying situations of the intermingled relations of persons within their community (Hobhouse 1965, 43).<sup>6</sup> Rights talk is also mandatory performance and brings up connotations of *enforcement* as well as of voluntary compliance.

Responsibilities, on the opposing side, seem grounded in a voice of accountability and encouragement. These two positions each offer a different

perspective on individual performance within a community atmosphere. One says, "I have rights that you must respect," while the other speaks of "the good that would be achieved by your thoughtful consideration of others in the community". One is a coercive or demanding tone, while the other has a persuasive and reciprocating tone. A side effect of the rights / responsibilities discussion is the way the person who is the objective focus of the discussion will respond. If the person is compelled to act they may become embittered, whereas a person that is persuaded to fulfill a responsibility, may make the actor view the response to the higher impulse, a more noble action (Etzioni 1995, 41). <sup>7</sup> Amitai Etzioni, in his conscription of communitarian values states that:

The exclusive pursuit of one's own self-interest is not even a good prescription for conduct in the marketplace; for no social, political, or moral order can survive that way. Some measure of caring, sharing, and *being our brother's and sister's keeper* is essential if we are not all to fall back on an ever more expansive government, bureaucratized welfare agencies, and swollen regulations, police, courts, and jails (Etzioni 1995, 16).

The concept of community must also be viewed as an entity in itself. If we are to believe in the concept of community then the rights and obligations of that entity must be allowed to exist. "The community itself may be said to have rights, that is just claims upon its members and all of its constituent elements" (Hobhouse 1965, 41). It has been critically stated that the Communitarian Philosophy insists that "rights have to be balanced by responsibility, [and] that they seem more interested in the responsibility of the community as a whole- 'its responsibility', say to the least fortunate members, than in the responsibility of individuals" (Etzioni 1995, 65). This criticism is of no value as the

communitarian, while committed to individual self worth and respect, serves a higher group responsibility that is created by individual actions. A more realistic approach is that modern society, as a result of the rights onslaught, has created a paradox. This situation calls attention to the fact that “as a community we may care more about the suffering of a few persons whose fate we confront directly than about the many thousands for whom we may be more distantly responsible” (Etzioni 1998, 114).<sup>8</sup>

The issues related to the public health are also a part of the communitarian philosophy. Etzioni best sums it up when he states:

When it comes to public health, people who carry [blood borne transmitted] diseases, especially when the illness is always fatal, such as AIDS, should be expected to disclose their illness ... and to inform all health care personnel with whom they come in contact. It is their contribution to help stem the epidemic (Etzioni 1995, 21).

The health care worker must also be responsible to the community at large, not to place them at risk, to assist in the fight of a communal public health epidemic, and to assure the safest possible health care environment.

Since the AMA policy statement that “physicians who are HIV infected should refrain from performing exposure prone procedures”, physicians that are NOT responsive to the policy could be said to be in violation of their ‘responsibility’ as both physicians and members of the community. This objective determination of responsibility, based on the AMA conscription of “refraining from performing exposure prone procedures”, is anchored in a community value. When the “physician community” feels that the best course of action is a

policy of restraint of individuals, than the general community may wish to affirm the obligation. Etzioni states:

This is not primarily a legal matter. On the contrary, when a community reaches the point at which responsibilities are largely enforced by the powers of the state, it is in deep moral crisis. If communities are to function well, most members most of the time must discharge their responsibilities because they are committed to do so, not because they fear lawsuits, penalties, or jails. Nevertheless, the state and its agencies must take care not to harm the structures of civil society on which we all depend. Social environments, like natural environments, cannot be taken for granted (Etzioni 1995, 22).

It is the community's responsibility to its members that will be the foundation for the assertion of the previous policy chapter. "Responsive communities define what is expected of people...and it is communities that introduce and sustain these commitments (Etzioni 1995, 22). It will fall to the individual members of the community to respect the individual needs for privacy, confidentiality, and autonomy as well as to assure that the duties and obligations of the individual member are articulated by the community. The duty of the individual physician, HIV infected or not, is to assure that inadvertent transmission of the disease does not occur to unknowing individuals. In this same vein, Bayer and Toomey discuss the professional ethic:

From the perspective of the ethics of the clinical relationship, those who may have been placed at risk unknowingly have a moral right to such information. The moral claim of those who have unknowingly been placed at risk entails the correlative moral duty of the clinician to ensure that the unsuspecting party is informed (Etzioni 1995, 84).

Physicians have a duty to the community. Duty to the medical community consists in stemming an out-of-control public health epidemic by assistance, at every turn of the wheel, to curb the AIDS epidemic. Duty to the community at

large is to not place the public at a risk of infection *that could be avoided*, despite the assessment of risk potential. In the absence of the above, the general public must be allowed to choose who will, or will not, place them at risk. It is the physician's obligation to the community. It is a fundamental right of the community, medical or general, to expect their members to live up to their obligations. The practice of medicine is not a right, but a privilege extended to members of the community. That privilege is extended to members that observe and live up to obligations that correlate to that privilege. It is the community's right to demand obligatory performance in certain areas. This is well grounded in law. The moral duty is owed by the physician to the community, for the privilege of practicing medicine within that community.

This section has presented a moral argument grounded in Communitarian Philosophy. The 'greater community of good', however that is established, is the foundation for this justification. Individual and community concerns must be balanced in order to achieve an overall social well-being. Without upholding the moral obligation the physician owes to the community, he places himself in a position where he jeopardizes, not only the community's, but his own welfare. In the next chapter, we will argue, from an Aristotelian viewpoint, how the physician risks his own well-being by not seeking a conciliatory position.

## Chapter Notes

1. Aristotle, *The Politics*, ed. Everson, Stephen, (Cambridge: Cambridge University Press, 1988). (Text citation will be POL, and the line number unless otherwise noted).
2. Joel Feinberg, Hyman Gross, *Philosophy of Law*, Third edition, (Belmont CA: Wadsworth Publishing, 1986)
3. Hobbes, Thomas, *Leviathan*, (1651), ed. Oakeshott, Michael, (Oxford: A.R. Mowbray, 1955).
4. Abraham Edel, Elizabeth Flower, Finbarr W. O'Connor, *Morality Philosophy and Practice*, (New York: Random House, 1989).
5. John Locke, *Second Treatise of Government*, (1690), ed. C.B. Macpherson, (Indianapolis Hackett Publishing, 1980).
6. Leonard T. Hobhouse, *The Elements of Social Justice*, (London: Ruskin House, George Allen & Unwin, 1965).
7. Amitai, Etzioni, *Rights and the Common Good, The Communitarian Perspective*, (New York: St. Martins Press, 1995).
8. Amitai Etzioni, ed., *The Essential Communitarian Reader*, (Lanham: Rowman & Littlefield, 1998).



## CHAPTER 7

### Well-being Justification

The conflicts that seem to arise within the medical community itself are more than just how to deal with the AIDS-afflicted health care worker and his or her ability to deliver safe and effective treatment to patients entrusted to their care.

The argument in this chapter will show that by *not* choosing a position that assures the appropriate moral conduct for the individual surgeon, he or she risks their own moral destruction. The chapter will argue for conduct that assures that this destruction does not occur. It is the true "high moral ground". When actions of an individual serve both the community aspects of right moral conduct and also serves to assure the ultimate 'well-being' of the individual by this conduct, then a truly virtuous or morally whole person has arisen. This is the ultimate moral argument - that of an individual, acting in his or her own behalf, and contributing to the 'common good'.

The physician, specifically the surgeon, is mandated by the most recent Code of Professional Ethics, published by the AMA, and the recommendations set down by the Centers for Disease Control in Atlanta, to refrain from the performance of 'invasive procedures' on patients if the doctor or surgeon is infected with AIDS.<sup>1</sup> The problem arises when the surgeon refuses to refrain from these procedures.

Many arguments have been brought forth in favor of the surgeon's discretion. These arguments, in the language of protection from discrimination through the Americans with Disabilities Act (ADA), and the fact that the health care worker, in general, is more at risk of acquiring the disease from the patient than the patient is from acquiring it from the health care worker, only seek to divert the real issue of protecting the patient from further or greater harm. None of these arguments circumvent the ethical responsibility of the surgeon not to subject his patients to any more risk than is reasonable and to inform them completely of any and all such risks. While the risk of acquiring AIDS from an infected surgeon may be remote, the catastrophic consequences warrant disclosure. Disclosure is tantamount to suspension of surgical privileges and will, in essence, remove the surgeon's ability to earn a living from surgery. The result is that the AIDS-afflicted surgeon has been driven 'underground' with his affliction by not disclosing. By doing this he or she has removed all available efforts and resources of support, both emotional for dealing with the affliction, and governmental in the protective legislation now in effect. He has effectively isolated himself from all elements of his society, his colleagues, his patients, and possibly even his family and friends. This legislation, albeit broadsweeping in nature, protects those infected with a communicable disease from many forms of discrimination including, but not limited to, employment, and housing (Rehabilitation Act of 1973, and the ADA). Disclosure assures that the afflicted physician receives all the available protection that the law will afford him.

Achieving well-being is the end and meaning of the concept of being human; it is the fullest realization of the human function as outlined by Aristotle in the *Nicomachean Ethics*.<sup>2</sup> The function of a man is to be actively exercising the rational faculties of the 'soul'; the function of the good man is the activity of the soul in conformance with virtue or excellence of standards. Just as the harp player's function is to play the harp, the good harpist's function is to play well; therefore, the good *man* is distinguished from man, in general, by his conformity with excellence or virtue in his actions (N.E. I. vii. 14-15).

Virtue, as defined by Aristotle, is the observance of the moral mean, the state between two vices, that of excess and deficiency, and it is a middle point in feelings and actions. "This is why it is a hard task to be good, for it is hard to find the middle point in anything". For in observing the mean, the actions and emotions have to be focused on the right person, at the proper time and in the right amount, in the correct way, and for the proper purpose (N.E. II. vi. 16, II. xi. 2). If at any time the surgeon were to focus the actions and emotions of a particular decision on anyone *other than the patient*, the physician risks committing an unethical act.

The effort of the good man must also occupy a lifetime and not merely be a passing activity. For the physician/surgeon whose life's function is dedicated to the health of his patients, the inability to fulfill his function in life must make him truly unhappy (N.E. I. vii. 16). This is not to say that all AIDS-afflicted surgeons are unhappy. Those that focus the activity away from direct patient care or invasive procedures, may be able to fulfill their human function well, for "no

supremely happy man can ever become miserable" and the "truly good ...man will bear all kinds of (mis)fortune... and will always act in the noblest manner that the circumstances will allow" (N.E. I. x. 13). This makes poignant the examination of the case of the AIDS-afflicted surgeon who refuses to refrain from the performance of invasive procedures, and therefore participates in harmful or base actions. Such a person would become a supremely unhappy man, unable to fulfill his function as a human.

The discrepancy between why certain afflicted surgeons achieve well-being and others do not, lies in the approach each uses to the activity. Aristotle argues for three general human character dispositions, two of vice and one of virtue (N.E. II. viii. 1). Virtuous actions constitute achieving the 'mean', the point between the vices of excess and deficiency, those of neither too little nor too much. The two dispositions of excess and deficiency are what the good man seeks to avoid. By the mean, Aristotle would also say that the concept is relative to each individual. (This is opposed to the mathematical mean between any two quantities.) As in the amount of exercise needed for the body - too little and the body may atrophy, too much will cause injury - so too, any expert in any art will seek to avoid the excess and deficiency and seek and adopt the mean, relative to that individual in that kind of action (N.E. II. vi. 6,7,8.). For the AIDS-afflicted surgeon there must be a moral mean by which he is able to fulfill his life's work and protect the health and welfare of the patient population as well.

The vices of this individual appear clear, although each may be argued at either end of the spectrum, of excess or deficiency. In the deficiency, the

physician would refrain from all practice of medicine and learn another art that may satisfy his needs for well-being as a human. While this appears, on the surface, to be an acceptable course of action to the patient population, the surgeon would ultimately see his life's work destroyed and be unhappy. As in the despair of the writer told that he can no longer write, or the artist told that he can no longer paint or sculpt, so the physician is subjected to his own destruction.

We can also argue that deficiency of action constitutes vice. For the physician who refuses to suspend or modify his existing practice, in deference to patient safety, practices a deficiency of the morally right action. There is no firm ethical basis by which this physician can claim to be acting in a virtuous manner, for if seeking the mean constitutes virtue and the mean lies between excess and deficiency, there can be no mean in the vices themselves (N.E. II. vi. 20.). By refusing to act, the physician has committed a base action for no deficiency can have a mean.

On the other side of the mean, the surgeon who continues to practice could be considered to participate in excess. In this model the surgeon continues to operate without interference and reaps all the benefits of maintaining his surgical practice including the monetary rewards and prestige associated with being a surgeon. By assuming that he must give up all the associated benefits that go with being a surgeon, he refuses for selfish reasons to disclose his affliction, and participates in reaping an excess of that to which he is entitled.

We can also argue moral excess from the other end of the spectrum. The surgeon who completely suspends the practice of medicine (because he feels that he can no longer provide for his patients in a safe manner) also can be said to participate in a form of the vice of excess. From an epidemiological standpoint, this is a true excess of action. For the reality of the nature of the disease and the transmission of same would not involve severing *complete* contact with patients, only contact that could be deemed invasive or any other manner that may compromise the patient's safety. Using an Aristotelian example of Cowardice and Rashness, the physician who totally refuses to disclose his affliction in his own self interest could be considered a coward and he who totally suspends the medical practice, rash. The mean for the afflicted physician would be the Courage to find some form of medicine that does not involve 'invasive' patient care. For the surgeon it may be research or teaching, as there are many avenues of medical practice that do not involve 'invasive' patient care. In fact the vast majority of the practice of medicine does *not* involve 'invasive procedures'. It further fits Aristotle's definition in the fact that the cowardice of inaction is greatly more opposed than the rashness of complete suspension. Complete suspension would be a safer course than that of inaction, and therefore the rashness is closer to the mean of courage and the cowardice of inaction more opposed (N.E. II. viii. 5-8).

## Justice

The discussion must also contain the aspects of justice, that of a universal concept of the whole of virtue, and the universal concept of the whole of vice. The sense of fairness, or justice, has a history that dates to pre-Socratic Greece. "Justice (*δικε*) consisted in everything [having its own assigned place and] staying in it's assigned place, and not usurping the place of another" (Feinberg and Gross 1986, 333).<sup>3</sup> We will dismiss the aspects of justice in a distributive (monetary or lawful) sense as irrelevant to the discussion at hand, since they offer no impact on the central issues being examined. Although the monetary aspects of the highly paid surgeon might be discussed, they are best saved for another forum.

The practice of virtue toward someone else is the concept of universal justice, and the contrary of the practice of vice toward another is universal injustice. Aristotle defines particular justice in two forms, that of distributive justice and corrective justice. It is the latter that will be examined first in this discussion, although a distributive argument will be offered later in the chapter. Corrective justice will only consider "the nature of the damage done, treating the parties as equal, and merely asking whether one has done and the other suffered injustice, whether one has inflicted and the other has sustained damage" (N.E. V. iv. 3).

This model is applicable to the physician / patient example we have been using, although the application will be strained. For the physician who infects a patient, although the resultant infection was not of a deliberate nature (this is an

assumption that must be made because the ethical platform would never support the concept of murder), the patient is harmed as a result of the doctor's actions. This is an injustice on the part of the physician, one that is presumably uncorrectable from an equity standpoint, and so must fall into the universal category of injustice, that of vice toward another. For the concept of this form of particular justice to apply, the assumption that both parties be considered equals must be upheld. But this equity cannot be assumed from a pure moral standpoint. This equity assumption could be a reasonable attack within a civil court of law, but even then, the universal injustice of vice toward another will apply because of the special (some would say even intimate) relationship between doctor and patient. The physician is placed in a position of trust, that he or she will stand by their oath and seek to preserve the health and welfare of their patients. When the physician places the patient at risk, a risk that could have been avoided or completely eliminated, he violates his basic oath as a physician and commits the most heinous of injustices. "Justice is that quality in virtue of which a man is said to be disposed to do by deliberate *choice* that which is just" (N.E. V. v. 17).

In order adequately to examine the concept of choice, the actions must first be determined to be under the control of the individual committing the acts. If the physician were to argue that the actions, that of participating in the invasive care of the patients, were compulsory and involuntary in nature, he would have to argue that the action or the reason for the action lies outside of the agent committing the act. To argue that societal blackballing and the monetary



hardship imposed on the AIDS-afflicted physician makes his actions based on compulsion is not a view that holds up under scrutiny. For no matter how much this hardship could be, it does not meet the criteria for acts under compulsion. It is not outside of the control of the agent, he does not have a fear of a worse alternative, other than his own displeasure, and the given circumstances do not warrant the deliberate choice of the base action; for the base action, that of placing the patient at risk, is worse than the hardship argued for the compulsion. For the actions to be considered of a mixed nature (also intrinsically involuntary in scope), the actions must pose too great a hardship or strain for the agent to endure (N.E. III. i. 7). The hardship (monetary or otherwise) imposed on the physician, that of the suspension of surgical practice, has been clearly shown to be not one of the virtuous choices but one of the vices. The choice of the physician to claim to have to substitute one vice for another in the defense of his actions is clearly choosing the worse of the two by continuing to practice. As has been shown, cowardice is further from courage than rashness.

Yet these actions do seem to fall under the class of 'mixed' actions, for "there seem to be some acts which a man cannot be compelled to do, and rather than do them he ought to submit to the most terrible death" (N.E. III. i. 8). The physician who claims that his actions are involuntary and blames external influences and claims no origination for the action argues from the absurd. He refuses to take responsibility for falling easy prey to his own passions and desires, and tries to blame the disgraceful actions on the temptations from external forces. The actions of this nature are clearly voluntary in nature for the

nature of the action originates within the agent. It is the choice of the physician, knowing the particular circumstances in which he is acting, that will constitute the virtue or the vice ( N.E. III. i. 11, 20).

Choice is defined as "voluntary action preceded by deliberation" (N.E. III. ii. 17). The deliberative aspects are related to things which are within our control. We do not deliberate about insensible things as the fool or the madman, about regular or irregular occurrences, or about chance items or those that are eternal. "We deliberate (only) about that which is in our control and is attainable by action" (N.E. III. iii. 7). Since the action is an essential part of the deliberative process (for no one would deliberate about things that are unattainable for that would be mere wishing), it must follow that it is the means upon which deliberation is focused, as opposed to the end. The end is just that, the end, and no action is attributed to the end. "A doctor does not deliberate whether he is to cure his patient", he deliberates about the actions that will achieve the goal of curing him and these actions must be attainable or reasonable (N.E. III. 1.11,15). This deliberation must not be without correctness, for deliberation that arrives at wrong or improper conclusions or aims at misdirected goals is said to be deficient of excellence.

Deliberative excellence involves a process of investigation and calculation and, by the action of choice, arriving at something good. For deliberative excellence to be achieved, what qualities must be attributed to the process? First, the deliberation must span a certain amount of time, for no true decisions are made on the spur of the moment (except by trained habit). We must reach

the right conclusion for, obviously, if we reach the wrong conclusion there has been a fault within the deliberative process; and it follows that we must reach it on the right grounds and at the right time. Improper grounds, or the wrong reasons, render the reasoning flawed as decisions delayed are often decisions and opportunities lost. For a man to judge whether his deliberation is good (deliberative excellence) he employs understanding or the capacity to judge rightly. He must also be considerate or forgiving of others and be able to judge rightly what are the equitable solutions essential to achieving the action necessary to reach the proper conclusion. This is the prudent man. One who through the correctness of deliberation and consideration of others, arrives at an equitable solution on the right grounds, at the right time, and in the right manner is said to be prudent. Prudence is the action employing all of these features and the correct action is said to be the virtuous one if employed with prudence. One does not achieve prudence easily for many factors contribute to the acquisition of this nature.

It should suffice to say that experience, consideration, deliberative excellence, and equitable judgment are the marks of the prudent man. So in the case of the physician who reaches for the solution to the dilemma of continuing his medical practice and placing his patients at risk, or to seek some reasonable alternative and still achieve the human function, the complete process must conform to a set of actions determined by a principle as defined by the prudent man. This is how the process of choice is determined, and correct choice leads to the correct actions. These actions, correctly deliberated,

considered, and judged to be equitable, will produce a virtuous end (N.E. VI.).

The rights of special individuals, those of disability rights, and aspects of autonomy must be taken into account. The quandary produced when the moral theories and these 'rights' come into conflict is readily apparent in contemporary society. The concept of equity as a form of fairness, and perceived injustices based on the violation of the aforementioned rights is the basis for much of the discussion.

Now we must look at the aspects of distributive justice as they apply to the practical workings of moral theory. The issue central to the disabled community with regards to legislation is the 'equal' opportunity to participate in the vast amount that society has to offer all other individuals not so afflicted and to be afforded the necessary accommodations to facilitate this participation. This equity, as the disabled community would view it, is something that is long in coming. This equity is the mean against a slew of continual injustices that has always plagued the disabled community.

The Aristotelian view is that "Justice is a mode of observing the mean...", and for the disabled individuals they live a form of injustice because "Injustice is related to the extremes" (NE, V. v. 17). That is, disabled living is an extreme when 'normal' functioning is prohibited due to curbs at the sidewalk and stairs in a building. This may be best viewed as a function of and within the realm of Political Justice. The application of political justice for the disabled individual is the scrutiny of the basic inequities of opportunity that exist by convention. The "administration of law" and the deciding of "what is just and what is unjust" is the

application of political justice (NE, V. vi, 4). Paul Schollmeier states it best when he relates the concept of well-being associated with political justice.

Both lawful men and fair men wish for and act for the well-being of others. And to wish and to act for the [well-being] of others is the first mark of friendship. What is lawful aims at the actions required for the [well-being] of others, and what is fair aims at the distribution of goods necessary for the [well-being] of others or at the rectification of the distribution of these goods (Schollmeier 1984,104). <sup>4</sup>

Prof. Schollmeier continues with the assertion that both justice and political friendship have the same motives and objects of focus. “Just people are thus other selves to one another, numerically different and morally the same” and “people find the [well-being] of one another to be an object of pleasant apperception” (Schollmeier 1994, 104). This reciprocal good feeling toward one another and recognition of individual worth (autonomy) coupled with a mean that is similar in substance (between justice and friendship) is the basis for political justice and friendship (Schollmeier 1994, 105).

This chapter’s discussion has revolved around correct actions of the prudent man and that of the complete performance, man’s proper function, a kind of activity inherently fulfilling, “ευδαιμονία” or well-being. Using the process of choice, the informed physician (and about disease, whether infected or not, the physician must be considered informed) by choosing the path of either non-disclosure or the complete suspension of practice chooses vice and therefore will not accomplish the human function at its best, that is, his own well-being. Choosing to suspend practice would only impact the physician and while it will not lead to well-being, it is probably the lesser of two evils. Yet the physician who continues to practice without the knowledge or consent of his patients

commits an injustice of the greatest sort, an injustice against his fellow man, a universal injustice. When a man, properly informed, through the process of deliberation, chooses an action that could only be considered base, he contributes to his own moral self-destruction. When he is fully aware of the situation, of the risks, consequences, and resultant potential outcomes, yet he still chooses vice, then he can never be truly happy. One can go even further and say that being in a position of trust, the physician has the moral obligation, based on his oath as a physician, and the true intimacy of the physician / patient relationship not to practice actions considered dangerous or to place the patient at risk to situations that can be avoided. This is far superior to the common risks associated with surgical procedures, as those are informed risks and the patient is fully aware of these and they are outlined and discussed prior to the performance of any invasion. Here the physician stands on the soapbox of epidemiology and makes the argument that he is only obligated to inform the patient of any 'significant risks', and that the risk of his transmitting the disease is too remote to be considered significant. He fails in this analysis because he does not let the patient achieve the same level of choice, through the deliberative process, that he has been allowed to pursue. He has, in essence, chosen to focus the action and emotional reasoning on the "wrong" person. He does not allow the patient's needs to take precedence over his own and therefore cannot be morally justified. If he informed the patient of the remote chance of cross infection and the patient chose to keep the surgeon, both choices would be morally justifiable.

One additional argument in our discussion of the ethically whole person is that the physician who has AIDS might be obligated to refrain from the practice of medicine entirely because of the possibility that the practitioner may infect the patient, and such an act would be in itself base. For a surgeon *willfully* to subject a patient to the potential risk of death without the expressed written consent of the patient would constitute either malice or even murder if the patient were to become infected. These are actions that have no possible moral mean to observe, and are by their very nature, evil actions. Blatantly evil actions cannot be tolerated, much less recommended. They would be a true, universal injustice, not only from the level of activity, but from the level of one's entire being. Such a physician would be an evil individual. <sup>5</sup>

Finger pointing at this stage in the argument would be ill-timed, and I do not wish to make a case for murderous actions. This is brought out only as an aside that is most ugly at best. Some individuals have been charged with attempted murder of police officers for biting and scratching these officers when they are known HIV positive cases. A similar action could be brought against individuals who place someone at risk of great bodily injury without their 'informed' consent. It is a trap that the medical community should wish to avoid at all costs.

A strong advocacy of complete suspension from practice would also be inappropriate now, given all that has been said in the previous pages, but we must make one distinction clear - there can be no morally justifiable decision regarding HIV infection that leads to willfully risking patient safety without informed consent. Moral integrity is concomitant with moral well-being. Afflicted

and non-afflicted physicians alike would have to deliberate on the risk of infecting a patient with HIV. This deliberative excellence is essential for the morally whole individual to effectively choose 'right' action. They owe it to themselves, their profession, and the community at large to give this important topic its just and rightful merit. Individual surgeon's choices are personal on first reflection, but are also constitutive, each in its way, of the moral quality of the community as well. Thus community well-being and a morally cooperative and supportive community needs just moral choices from its members, including physicians. This cooperative effort, that is strictly dependent on the just moral actions of the individual, is the key to the well-being of the community at large.



## Chapter Notes

1. The term 'physician' and 'surgeon' shall be used interchangeably as all surgeons must be physicians and all physicians are trained as surgeons. Specialty surgeons may have greater training in specialized areas, but this does not impact the discussion or this qualifier. The term 'AIDS' shall be used generically to refer to all individuals who have AIDS, are HIV positive, or are afflicted with any disturbance to the immune system associated with the Human Immunodeficiency Virus (HIV).

2. Aristotle, *The Nicomachean Ethics*, trans. H. Rackham, (Cambridge: Harvard University Press, 1926). All notations within the text will be from this edition and will be referenced by (N.E., followed by the text citation).

3. Joel Feinberg, Hyman Gross, *Philosophy of Law*, Third Edition; (Wadsworth Publishing, 1986), 333.

4. Paul Schollmeier, *Other Selves, Aristotle on Personal and Political Friendship*, (Albany: State University of New York Press, 1994).

5. See: Dennis L. Breo, "The dental AIDS cases-Murder or an unsolvable mystery?", *J. Am. Med. A. (JAMA)*, (December 8, 1993), v. 270, no. 22; reference also: Kimberly Bergalis / David Acer, D.D.S.

## **CHAPTER 8**

### **Conclusion**

**This thesis has centered around the surgeon who is HIV positive. We have attempted to show the need for a real change in current policy because of four main arguments. When a public health epidemic causes concern over the risks of disease transmission, then corrective action that is reasonable, sensible, and plausible must be offered. This work has attempted to do just that. There are many objections to what has been offered in this thesis and I have attempted to address those objections in a straight-forward manner, but in no way did I try to appease all of the players involved. I have merely tried to be as fair-minded as possible given the real problem within the healthcare arena. Fear of disease transmission on both sides of the spectrum, whether it is from the occupational side of the provider or from the patient side, has brought a degree of paralysis to the healthcare system.**

### **Rights and Responsibilities**

**Rights and responsibilities must always go hand-in-hand. One without the other leaves its counter hanging by a thread of accountability. As we have shown, people have a natural right to life and this right can never be**

taken away from them. The issue of a patient's right to this life is the firm ground on which healthcare is based using the autonomy model. Those seeking to violate these rights negate their responsibility to the patient. Patients cannot be relieved of this autonomous consideration. The medical community cannot decide for the patients what is best for them. This paternalistic treatment is contrary to autonomous consideration of the patient and makes the patient only an object of the physician's orders. This is unacceptable.

If HIV positive healthcare providers seek to practice in an 'exposure prone' environment, then they have a moral responsibility not to cross-infect their patients. The responsibility is dual. They have a duty to the patient for his or her life and a duty to the community in fighting the epidemic. The community's rights cannot go understated and are part of the strong moral tone of this work. We, as members of society, have a strong moral obligation to require that those who have the privilege of practicing medicine in our society, do not risk our lives when given this privilege, regardless of their intent. Rights, or privileges, without correlative responsibilities, or duties, cannot be justified.

### **Disability Law and Legislation**

We have attempted to give fair treatment to current disability laws. We also believe that the current laws are more than complete in the protections of the HIV positive community; their rights against discrimination must be guarded zealously. Court decisions in *Arlene* and *Chalk* have succeeded in this protection. This also has shown that these HIV positive individuals, while

included in §504 and the ADA, cannot show that they are 'otherwise qualified' and absent of 'direct threat' in specific areas, particularly in the surgical theater. The use of common law in *Behringer* and *Doe* show that the courts are unwilling to allow the potential risk of transmission to be subjected to unwilling patients. Canons of 'informed consent' have been applied to surgeons seeking to continue to practice and it has been argued that this doctrine is discriminatory against handicapped individuals. The counter argument considered in Chapter Three has been based on the assessment of risk and what constitutes real risk from an epidemiological basis. The failure of this argument is in the statistical analysis where the effort to totally eliminate the risk of mortality due to disease transmission cannot be accomplished. Remote or not, transmission is possible and given the pandemic nature of the problem and the real percutaneous injury risk to surgical practitioners, they cannot be considered to be absent of 'direct threat'. This is also applicable to the student surgeon and raises even a stronger risk from the inexperienced or surgical trainee.

When drafting these laws, legislators raised concerns about inclusion of individuals based on membership in high risk groups. While these arguments may feed the hysteria surrounding this disease, they are truly misplaced. In general, the wording of the laws *may* allow inclusion of these individuals if they are "perceived as having the disease", but this inclusion has no real impact on the overall effect of the legislation. The current laws have enough flexibility to assure fair and unbiased treatment for *all* infected individuals, physicians and

surgeons included, will be afforded given the current trend of cases testing these pieces of legislation.

The rights of disabled individuals must be observed so as not to drive the afflicted underground and into hiding because of their infected status. This does not relieve the community from protecting its constituents. The continued, above-board approach to the tracking of the virus must be lasting and the public health agencies must be afforded the tools and the resources to facilitate this effort.

### Policy

All of this said in no way offers a different course of action than the proposed change in policy presented in Chapter Five. The proposed policy has four different components;

- I) Professional associations, specifically the American Medical Association and the American Dental Association, must collaborate with their scientific colleagues to specifically determine which procedures in healthcare delivery are determined to be 'exposure prone'.

The professional associations, as well as the Centers for Disease Control, have not defined which procedures are to be considered 'exposure prone'. This lapse in official policy must be corrected. If the associations are to continue to argue that they are the best guardians of their own affairs then they, and only they, can determine what is considered 'exposure prone' and what is not. I also argue that, in the absence of action by the professional association, the CDC should take the lead and make this determination. The reluctance by the CDC

is based on the close and necessary participation by the associations in the overall goals of the Centers. This does not relieve their moral obligation.

II) Professional associations must place into their individual policy, procedure, and ethical platforms specific guidelines for HIV positive physicians and surgeons as to when they can and when they cannot perform procedures on patients.

The ambiguous language in the AMA's policy compendium regarding actions that the afflicted surgeon *should* do and what a local review committee *may* do serves no useful purpose except to offer alternatives that step away from sound moral judgment. When the AMA policy dictates that "when the scientific data are unclear [regarding the real risk of transmission], it is mandatory that the rights of the patient take precedence over those of the physician", it is difficult to understand why a stronger stand has not been taken regarding what the HIV positive surgeon *will* do regarding continuation of a surgical practice involved in 'exposure prone' procedures.

III) Surgical licensure to perform 'exposure prone' procedures shall be tied to HIV testing. Any qualified provider may apply for licensure, but those testing positive to HIV (and possibly HbV) will be required to obtain 'informed consent' from the patients undergoing the aforementioned 'exposure prone' procedures.

The proposed policy's mandate of surgical licensure tied to testing does not argue mandatory testing for all surgical providers, only those who wish to participate in exposure prone procedures. This is a critical distinction that underscores the need for the existing ambiguity to be eliminated regarding that performance. The tracking and clearing should be done using a national data base (so as to eliminate the need for state to state reciprocity and tracking) as a cost effective measure. It is possible that the professional associations may be

charged with this duty, but the effort could be better handled by the Centers for Disease Control. Not only would this help in the tracking of the HIV epidemic, it would also track, as part of the disease control, another occupation that may be shown to be "at risk" for the acquisition of the virus.

IV) Create a "bank" of HIV positive physicians and surgeons. Each "bank" will be regionally located to be called to perform 'exposure prone' procedures on known HIV positive cases, if time will permit.

When proposing the concept of a 'bank' of HIV positive surgeons, the model has two sides and offers possibilities to those HIV positive surgeons still wishing to contribute. The first is for the surgeons still to be able to practice their craft and help their patients, and second, for the HIV positive surgeons to assist their colleagues in preventing further occupational contamination. This conceptual model can be well funded by governmental dollars and is a reasonable alternative when time allows. They must also be extremely well paid, eliminating the need to go underground for monetary reasons.

### Moral Justification

The moral justification for this argument has taken on two different concepts, both logically sound. Community concerns and rights are central to the issues. We as a community have the right to demand that physicians live up to their moral obligations. It is our duty, then, to see that this happens, regardless of their reluctance to do so. The community has the right to be protected from potentially dangerous individuals seeking to place their rights above their responsibilities. We are not unsympathetic to their predicament, only to their

attempt to become a “moral exception”. Their unique status will not relieve them of their moral obligation to the community good. Their ‘professional’ status only reinforces this concept. The proposed policy also protects the HIV positive individual surgeon and places his welfare at the forefront with the creation of the HIV positive ‘bank’ of providers. He or she is given an avenue by which effectively to contribute as active members of the community. This is a desirable component of community membership, to contribute to the good of the polis.

The Aristotelian moral justification in Chapter Seven shows how the surgeon, by not refraining from risk orientated behavior, contributes to his or her own moral destruction. The physician’s moral choices, relative to his or her alteration of their medical practice in deference to patient safety is critical to their own moral well-being. Individual healthy moral foundation is an essential component and cannot be allowed to deteriorate, especially when more is at stake than the individuals themselves. The community, also, should not condone this - moral destruction of the individual will ultimately lead to the destruction of the moral fabric of the whole community. The community’s fight is ongoing in this area as we fight crime and substance abuse, and seek to promote education and social responsibility. This is the larger moral argument, both from a personal standpoint and a community of good. Community rights aside, this moral obligation of the community must prevail in the defense of its members. It is the only possible outcome that serves the moral good of the membership.



## Epilogue

I have attempted to offend no one. But this policy stand obviously will. My intent is to seek a workable alternative to existing policy, which is woefully inadequate. I take the moral high ground because the quagmire of the statistics and laws has obscured the vision of 'right action' in the given scenario. The stand I take is based on what actions physicians should do based on a moral obligation to themselves and to the community as a whole. When they attempt to avoid or side-step this moral obligation, we as a community must see that they face these responsibilities. This thesis has undertaken to argue for that policy and moral judgment.

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### **Publications:**

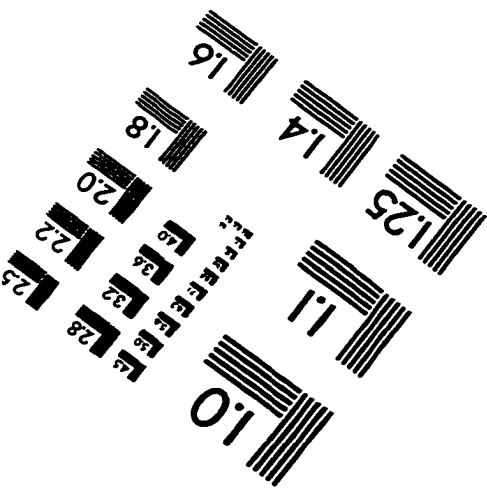
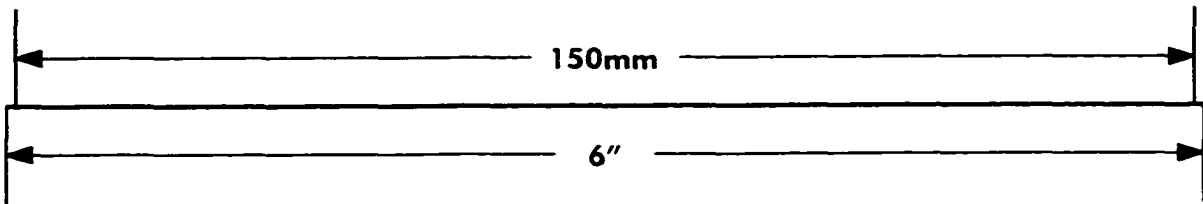
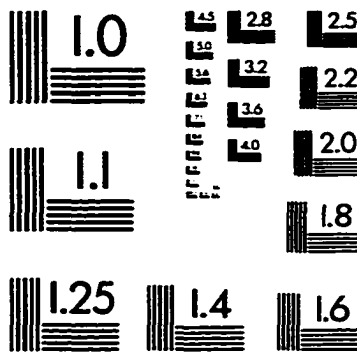
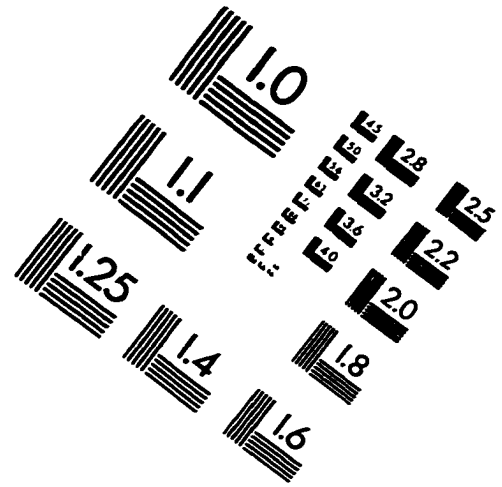
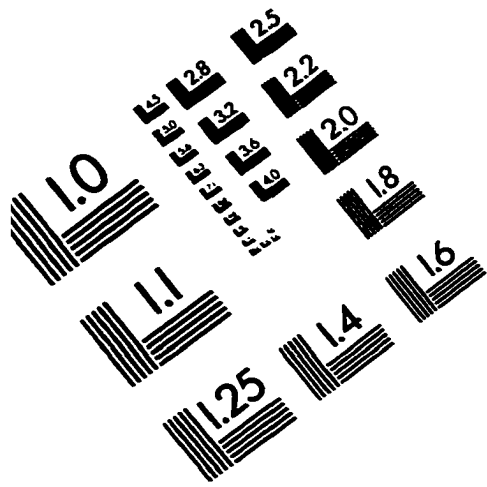
**EMS Columnist  
*Industrial Fire World Magazine*  
College Station, Texas**

**Thesis Title: The Ethics of the AIDS-Afflicted Physician. The death of voluntary  
compliance!**

### **Thesis Examination Committee:**

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Committee Member, Dr. Jerry Simich, Ph.D.  
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