Human Immunodeficiency Virus and the Emergency Setting: Legal Considerations

John J. Smith, M.D., J.D.
Department of Radiology, University of Virginia Health Sciences Center, Charlottesville, Virginia

The emergence of human immunodeficiency virus (HIV) has changed the atmosphere surrounding the provision of emergency medical treatment. HIV-positive patients fear denial of needed health services based on their seropositivity, whereas medical providers worry about occupational exposure. Both patients and providers have concerns regarding HIV testing and the confidentiality of test results. This article summarizes some of the many legal implications created by HIV in the emergency setting.

HIV IN THE PROVISION OF MEDICAL CARE

Human immunodeficiency virus (HIV) is an incurable viral infection that typically results in uniformly fatal acquired immunodeficiency syndrome (AIDS). It is transmitted via contact with bodily fluids, such as blood, semen, vaginal secretions, breast milk, or saliva (1–3). In the emergency setting, blood and blood products are the primary mode of transmission.

Providers exposed to HIV-infected blood via a single needlestick injury have an approximately 0.4% risk of seroconversion (4). Patients exposed to the blood of an infected provider face an undetermined risk of seroconversion, widely assumed to be lower than that faced by exposed providers (5, 6). Despite the relatively low risk of infection, the incurable nature of HIV and the fatality of AIDS have caused physicians to alter their approach to patient care, particularly where exposure to infected fluids is a possibility. Most visibly, this takes the form of universal precautions; less visible but more troubling, providers may alter treatment or even avoid treating those whom they perceive as HIV-positive (7). For their part, patients have reacted with near hysteria to risk posed by HIV-positive providers, particularly in the wake of a Florida dentist apparently infecting several of his patients (8).

Duty to treat known or potentially infected patients

Moral and ethical duty

Physicians and other health professionals have a moral and ethical duty to treat patients in need of their services, traditionally without regard to the risk those patients pose to the providers themselves. HIV-positive patients are clearly covered by this duty, as reflected in the Hippocratic Oath and numerous policy statements of leading medical organizations. However, enforcement mechanisms for such nonlegal duties are generally nonexistent, providing little incentive for a reluctant provider to treat “undesirable” patients.

Legal duty

Legal standards for patient care, enforceable in court, are far more important in the HIV setting than moral or ethical standards. Until quite recently, the legal duty to treat HIV-positive patients varied depending on the type of provider and jurisdiction involved and provided patients with uneven protection. The Americans with Disabilities Act (ADA), a recently enacted federal antidiscrimination law, largely eliminated this uncertainty (9). Title III of the ADA clearly prohibits disparate treatment of HIV-positive patients, based solely on their seropositivity, in the professional offices of a health care provider, hospital, or other service establishment.

As with any law, Title III of the ADA has exceptions. A provider may avoid liability by showing that accommodations necessary to treat HIV-positive individuals would
fundamentally alter the nature of the service being provided (10).
There is also a “direct threat” exception, applicable where a dis-
abled person’s involvement in an activity poses a direct threat to
others (11). Given that HIV is not casually transmitted, and con-
sidering the effectiveness of universal precautions, both exceptions
are nearly impossible to employ in the typical emergency setting.
This is reflected in a recent unreported federal court decision, in
which an osteopathic physician was ordered to provide therapy of
extremely questionable clinical benefit to an HIV-positive patient
who sought it (12). As a practical matter, the ADA allows a
provider to deny an HIV-positive patient medical services only if
that treatment or procedure is not performed by the provider in
question.

**Provision of health care services by infected providers**

The provision of medical services by HIV-infected health care
workers is an extremely emotional issue. Like treatment of HIV-
infected patients, issues involving these health care workers are
governed by a variety of considerations.

**Moral and ethical considerations**

Morally and ethically, physicians and other health care
providers are under an obligation to do no harm to their patients.
It is what constitutes such harm that is a matter for debate. The
American Medical Association (AMA), in a recent document, has
called for individual evaluation of infected providers by a local re-
view committee (13). This position apparently reverses an earlier
stance that called for blanket restrictions of such individuals (14).

**Federal regulatory efforts**

The federal government has made an attempt to regulate
providers infected by HIV. In July 1991, the Centers for Disease
Control (CDC) issued guidelines that amounted to general re-
strictions on infected providers, restrictions which were subse-
quently attacked by many medical organizations as unnecessary
(15). In response, the CDC retreated from these guidelines, al-
lowing state and local health departments to address HIV-infected
providers on an individual basis (16).

**Legal standards, informed consent, and practical considerations**

Although statements of the AMA and state and local guidelines
(if any) concerning HIV-infected providers may not have legal
force; they can influence the “standard of care.” Such a standard is
a practice accepted by the medical community as appropriate ac-
tion in a given situation, and it serves as a legal duty that the health
professional owes his or her patients. A practitioner who ignores
such guidelines may risk legal liability should patient injury result
from the failure to follow recommended practices. Actual trans-
mission of HIV certainly constitutes such injury; injury has also
been found where actual transmission has not occurred, such as
with simple exposure to an infected professional’s blood (17), or
even the reasonable fear that transmission has taken place (18). A
majority of courts, however, do not recognize actions where fear
of transmission is unreasonable, or no exposure is established (19).

The doctrine of informed consent poses another pitfall for an
HIV-infected provider. Most jurisdictions require such consent
before any invasive procedure can be performed, although excep-
tions usually exist for emergent procedures. Where no emergency
is present, failure to provide information that a rational patient re-
quires to make an informed treatment decision may result in liabil-
ity. Courts have recognized that a provider’s HIV status may be
implicated as such necessary information (17, 18, 20).

There are practical problems confronting HIV-positive
providers as well. Institutions fearing legal liability may hesitate
to grant such professionals privileges, particularly for invasive pro-
cedures. Compounding this situation is the reluctance of liability
insurers to assume coverage for potential patient exposure (21).
Finally, the refusal of many patients to be treated by known
HIV-positive health professionals, regardless of the service provid-
ed, makes such persons a business liability for most practices and
institutions.

**Rights of the HIV-positive provider**

HIV-infected providers are afforded some protection under the
employment provisions of the ADA, Title I, which prohibits a
“covered entity” from discriminating against a “qualified” person
with HIV in virtually any aspect of the employment relationship.
Currently, there is no definitive case law interpreting the “cov-
ered entity” language. However, courts interpreting similar lan-
guage in Title VII of the Civil Rights Act of 1964 have extended it
beyond direct employment relationships (22). This makes it
likely that Title I of the ADA covers most traditional health
provider employment relationships.

Should the employer of an infected provider be deemed a cov-
ered entity, a provider must still prove that he or she is a qualified
individual with a disability, able to perform the essential functions
of employment, with or without reasonable accommodation.
Federal courts interpreting similar provisions in the Rehabilitation
Act of 1973 have recognized that HIV-positive providers pose a
risk to others where there is a possibility of exposure to the
provider’s bodily fluids, making it unlikely that an infected
provider could successfully invoke the ADA to retain a position
where the risk of transmission exists (23). But a covered entity still
has an obligation to make a “reasonable accommodation” under
Title I, including reassignment to duties where such risk does not
exist. Reasonable accommodation is avoidable only where
“undue hardship” is involved, as determined by a fact-based in-
quiry which includes the difficulty or expense involved in making
the accommodation.

Finally, there is the “business necessity” exception to coverage
under Title I. This provision allows the use of employment qualifi-
cations that screen out or tend to screen out disabled individuals, if
the standard is job related and consistent with “business necessity.”
It is a very narrow exception as applied to infected providers, prob-
ably useful only where the provider poses a safety risk to others.

**Testing of patients and health care professionals**

Testing for HIV is an informed consent procedure in most cir-
cumstances in most states. Where consent is not forthcoming,
compelled blood testing is generally considered a search and
seizure subject to the Fourth Amendment of the United States
Constitution (24). This Constitutional protection is not absolute:
legitimate government interests may overcome an individual’s
right to privacy.