FOIA Number: 2018-0756-F

FOIA MARKER

This is not a textual record. This is used as an administrative marker by the William J. Clinton Presidential Library Staff.

Collection/Record Group: Clinton Presidential Records

Subgroup/Office of Origin: National AIDS Policy Office

Series/Staff Member: Kristine Gebbie

Subseries:

OA/ID Number: 8302

FolderID:

Folder Title:
[Essential Excerpts from a Law Review Article] [loose]

Stack:	Row:	Section:	Shelf:	Position:
S	66	5	2	1

HCR

Essential Excerpts from a Law Review Article

* Instructor, Harvard Medical School; Lecturer, Harvard Law School; Research and Teaching Scholar, American College of Physicians.

ENSURING ADEQUATE HEALTH CARE FOR THE SICK:

THE CHALLENGE OF THE ACQUIRED IMMUNODEFICIENCY SYNDROME AS AN OCCUPATIONAL DISEASE.

Duke Law Journal, February, 1988

II. BEARING THE COSTS OF OCCUPATIONALLY RELATED AIDS

A. The Costs of Accidents.

If a health care worker contracts the HIV at his workplace, he will [*48] probably be seropositive for life. n101 In addition, the infected worker stands about a 70% chance of developing AIDS within seven years. n102 The first manifestations may be subtle impairment of the central nervous system. n103 Once the clinical manifestations of AIDS develop, the mean survival is approximately two years, with five-year mortality approaching 100%. n104

Tremendous costs will be associated with these accidents -- both in economic and emotional terms. n105 The total economic cost of providing medical care for a person with AIDS has been estimated at $ 147,000. n106 Once this person dies, his family and dependents will need financial support. n107

Determining who will bear these costs is vitally important to guaranteeing access to health care for those who are seropositive. If those [*49] who are infected at the workplace are expected to bear the costs, they may seek safer employment elsewhere, thus driving up labor costs for hospitals and creating new incentives for hospitals to discriminate against seropositive individuals. Moreover, if physicians believe they and their families will not be financially protected if an occupational HIV infection occurs, they will insist on testing patients or refuse to care for those who are seropositive.

The costs of accidents traditionally have been allocated by private insurance and tort law. n108 Health, life and disability insurance are purchased by

individuals or by third parties such as employers who provide benefits for employees. Private insurance partially defrays the cost of accidents, but in no way supplants tort litigation. While the tort system remains the main arbiter of such costs, a no fault administrative approach supplants torts in most jurisdictions in cases of workplace injury. n109 Workers' compensation laws cover about 87% of the work force in the United States. n110 Thus, because they can allocate the costs of occupationally-related AIDS accidents, a discussion of private insurance, tort law and workers' compensation is needed to assess the manner in which the costs of these accidents can be properly diffused within society.

B. Private Insurance.

People who contract HIV can expect to go through several stages of disease development, with at least a theoretical possibility that the disease may arrest in any one stage. First, they will experience an asymptomatic period in which they merely carry the virus. Then a period of chronic fatigue and lymphadenopathy called the AIDS Related Complex intervenes. Finally, full-blown AIDS occurs, often manifested initially by neurological changes.

These various stages would require different types of insurance if insurance were to help shift the cost of an occupational HIV infection from the health care worker. The asymptomatic carrier stage may disable a person whose occupation creates the risk that others could contract the disease. This would be the case of a surgeon, who would then turn to disability benefits. During the AIDS Related Complex stage, most people would be disabled, and would also begin to seek medical [*50] care, creating a demand for benefits under health insurance. Finally, during the AIDS stage, health, disability and eventually life insurance benefits would be required.

Does insurance provide more than a theoretical answer to the problem of the costs of HIV accidents for health care workers? The answer is a provisional yes. While more than 75% of Americans have some form of health insurance, and many have life insurance, many fewer have disability insurance. n111 Thus health care workers would not necessarily be covered for all the economic repercussions of HIV infection. Hospitals could, however, broaden the coverage they offer as terms of employment and provide disability and life insurance for employees as a benefit. It would be prudent for hospitals to take this last step in the near future.

The insurance approach works as long as the insurance is available and the benefits are at an appropriate level. One would expect underwriters to develop policies along these lines for hospitals if the occupational risk is small and the insurers' actuaries are able to assess risk. Indeed, one would hope that actuaries would be immune to irrational fears, and that the insurance approach would be a cornerstone of a reasonable approach to shifting the costs of

accidents.

One still must ask what will happen if the estimate of the occupational risk continues to grow, and insurers grow uncertain about the policies they have been underwriting. Would it be possible for insurers to refuse to write new health, disability or life insurance policies for health care workers? Again the answer is a provisional yes, depending on how the state governments react, and the manner in which the state courts view such decisions.

Insurers, their decisions about coverage, and the rates they set are governed by the various states. Since the late 1940s, most states have had insurance commissioners or other state agencies that oversee the insurance business. n112 Most state insurance regulatory agencies are guided by the National Association of Insurance Commissioners' model statute, which requires insurers to set rates that are not inadequate, excessive or unfairly discriminatory. n113 With regard to life and disability insurance, and generally health insurance, n114 the insurers are guided by this general [*51] language rather than specific statutes.

If insurers refused to write health, life or disability policies for health care workers because of uncertainty about risk of contracting HIV in the workplace, aggrieved health care workers would thus have to rely on the model statute's general prohibition against discrimination. Specifically, health care workers would have to argue that the limitations on the policies represented discriminatory risk refinement. Courts' decisions on such cases depend on the specific judiciary's attitude toward insurers as well as the risk estimates upon which the insurers relied. n115 It is difficult to predict the outcome of such litigation if the occupational risk of contracting HIV continues to grow. n116

In summary, private insurance is one way to shift the costs of accidents away from health care workers who contract HIV at the workplace. It could, however, be a less than adequate answer in some states if insurers grow wary of writing appropriate policies for health care workers. Moreover, the availability of private insurance will not prevent tort litigation and workers' compensation claims, the subjects to which we now must turn.

C. Tort Law and AIDS in the Workplace.

As noted above, a physician has recently sued Johns Hopkins University Medical Center as a result of his infection with HIV at the workplace. n117 This suit sounds in tort, as the physician alleges that his confidentiality was breached and that the support he was promised has not been forthcoming. n118 The author is unaware of other tort actions for occupationally related AIDS, and the one noted above is still in the early stages of litigation.

Even if the exclusivity doctrine prevents health care workers from suing

their employers, they may still bring tort actions by suing the patients who infected them on a battery or intentional tort line of reasoning. Although there have been several suits against people who have allegedly caused others to become infected with the HIV, n127 none have involved health care workers who had been infected by patients. Such suits would be difficult to win for a number of reasons, but especially because many AIDS patients in hospitals may be incompetent. n128 Additionally, such suits may not even be brought because most AIDS patients lack a "deep pocket."

It seems unlikely that there will be a large number of successful tort actions arising out of occupationally related AIDS cases. First, most health care workers, including support staff, nurses and doctors employed by hospitals, will probably be eligible for workers' compensation benefits, n119 and thus will be prohibited by the exclusivity doctrine from [*52] suing their employer for a workplace injury. n120

Intentional tort is the typical exception to the exclusivity doctrine, and most jurisdictions have been unwilling to lower the high thresholds set for this exception. n121 Most hospitals have instituted the CDC guidelines for prevention of occupational spread of HIV -- a policy that the OSHA now requires by law. n122 Given compliance with these guidelines, it is doubtful that a court would find that a health care institution acted with gross negligence. It is also difficult to imagine how or why a health care institution would intentionally infect a worker with AIDS. Therefore, it seems unlikely that health care workers would be able to overcome the exclusivity doctrine to sue their employers in tort.

Another way to bring a tort action for a workplace injury is to bring a third party suit against the manufacturer of a product that was casually related to the accident and injury. For example, much of the asbestos litigation is based on the doctrine of product liability. n123 White this is an area of the law that is presently undergoing great expansion, n124 it is again [*53] difficult to imagine how a health care worker might use it to circumvent the exclusivity doctrine. Perhaps product liability suits concerning hypodermic needles or body fluid containers such as plastic bags might be initiated. n125 Most accidents concerning blood or body fluids, however, are attributable to human error and not to product failure. n126

Some health care workers, especially self-employed doctors who are affiliated with the hospital but are not hospital employees, will not qualify for workers' compensation. Therefore, they can sue the health care [*54] institution directly without having to circumvent the exclusivity doctrine. Such direct suits probably will represent the majority of tort suits brought against health care institutions as a result of exposure to HIV. Will they succeed?

As the first-year law student knows, the plaintiff in a tort suit must prove

four elements: (1) a duty of care; (2) a breach of that duty as defined by a failure to reach a certain standard of care; (3) an injury that is compensable; and (4) a causal connection between the injury and the breach of the standard of care. As mentioned above, a hospital will probably be able to argue that it has met its standard of care as long as it complies with the CDC guidelines for prevention of transmission. n129 Thus the tort litigant will have an initial, large hurdle to overcome. Unfortunately, some hospitals will not carefully enforce the CDC guidelines and thus will fail to attain the standard of care.

As noted, though, the tort litigant must prove more than hospital negligence. He or she also will have to prove injury. Given the natural history of the disease, however, HIV seropositivity alone is probably enough to demonstrate injury. n130 Even if the hospital argues that HIV seropositivity is not damage in and of itself, the seropositive health care worker clearly will be able to establish her fear of the development of disease and the necessity of monitoring for any new medical symptoms. n131 Thus demonstration of injury will not be a difficult issue for a private doctor who sues a hospital.

Causation will be the major problem. The overwhelming majority of HIV transmission occurs as a result of sexual contact, intravenous drug abuse or blood transfusions. n132 Of the nearly 50,000 cases of AIDS [*55] reported in this country thus far, only 13 involve health care workers infected through workplace exposures. n133 As a result, any health care worker who becomes HIV seropositive will have to prove that his or her exposure occurred in the workplace.

The concept of causation in occupational and environmental disease-related tort claims has been the subject of much academic and judicial discussion in the past five years. n134 Some commentators have argued that diseases such as occupationally related cancer are best understood in terms of epidemiology. n135 The causal connection in such cases is probabilistic, not deductive in a Newtonian sense. n136 Courts are much more at ease with the latter kind of thinking about causation because it comports better with the sense of cause usually employed by judges and lawyers. n137

This preference for deductive, causal chain paradigms will play an important role in the determination of causation in health care worker tort claims about occupationally-contracted HIV. If these health care workers could rely on statistical notions when trying to prove causation, they might argue that, in the absence of other risk factors, the greatest risk for contracting HIV was at the workplace. n138 Because courts are not [*56] comfortable with this kind of reasoning, however, they probably will insist that each health care worker define a single incident in which the infection occurred. n139 Given the latency period between contracting the HIV and the development of AIDS, the health care worker likely will be unable to recall the specific incident, and thus will have difficulty proving causation. n140

Of course, even if courts do accept causal arguments based on probabilistic reasoning, the tort litigant will have to prove that she has no other risk factors for contracting the HIV. Unless the plaintiff has previously tested negative for HIV antibody, this proof will require a significant inquiry into her personal life and habits. This kind of scrutiny may dissuade health care workers from pursuing litigation even if they otherwise had excellent claims. Indeed, even those who can recall a specific incident that led to an infection will have to demonstrate that other potential sources of infection did not play a role. n141

What would be a health care worker's best case? A health care worker will have the greatest likelihood of success in proving causation if he or she has recently tested negative for HIV antibody, sustained a needlestick or other kind of signature exposure in the workplace, and then turned antibody positive within three to four months. Remember, however, that the worker also will have to prove that the hospital negligently employed safeguards to prevent transmission, that its negligence (or the manufacturer's) led to the transmission, and that the exclusivity doctrine does not apply because that particular worker is not eligible for workers' compensation.

[*57] Even in an era of expanding tort litigation, this is a great deal for a plaintiff to prove. Therefore, it seems unlikely that a majority of health care workers who contract HIV at the workplace can expect to gain compensation for their accident through tort litigation. Many more may be compensated through workers' compensation, so to that subject we now turn.

D. Workers' Compensation and Occupationally Related AIDS.

To assess the efficacy of workers' compensation as a means of ensuring that the cost of occupationally related AIDS does not fall solely on the infected employee and her or his family, three questions must be answered. First, is workers' compensation available to all health care workers? Second, will HIV infection be a compensable illness under workers' compensation statutes? And third, will the available compensation be appropriate and provide the necessary reassurance to support the decisions of health care workers who continue to care for all patients regardless of disease status?

Workers' compensation is generally available to all salaried workers in a given state who suffer an injury or contract an occupational disease at the workplace. Occupational disease is defined as "any disease arising out of exposure to harmful conditions of the employment, when those conditions are present in a peculiar or increased degree by comparison with employment generally." n142 An employee is defined by most workers' compensation statutes to include every person under contract or hire. n143

Many health workers are eligible for workers' compensation: maintenance workers, transport personnel and laboratory technicians are employees within the standard definition. The same is not so clear for nurses and physicians, including doctors in training who are employed by hospitals. Many courts distinguish between employees and nonemployees in terms of the amount of professional discretion retained by each. Thus, at times, certain hospital employees are deemed employees eligible for workers' compensation benefits and at other times the same employees are deemed professionals not covered by workers' compensation. n144 [*58] Arthur Larson argues that this distinction is impractical and that if a professional person is regularly at the disposal of the employer, he is an employee for compensation purposes regardless of his professional discretion. n145

Nonetheless, there appears to be tension in the manner in which courts treat physicians employed by hospitals, especially physicians on the housestaff. n146 Some courts have awarded interns workers' compensation without questioning their employment status. n147 In other contexts, however, courts have questioned whether housestaff members are employees and should be awarded employee protections, or are students and are not due certain labor protections. n148 Thus, nurses and doctors who are employed full time by hospitals and receive a straight salary, as well as housestaff members, probably will be eligible for workers' compensation.

Will AIDS or HIV seropositivity be compensable under workers' compensation statutes? Some occupational diseases can be classified as accidents for purposes of compensation. n149 Aside from this classification, [*59] coverage for occupational disease is defined by three kinds of statutory schemes. n150 One scheme schedules all the occupational diseases the state will compensate. Another schedules the diseases, but also has an open-ended and general definition of "occupational disease." The third scheme uses only the open definition, centering on the "arising out of" definition noted above. The trend, according to Larson, is toward the last approach. n151 Yet individual states still vary in their approaches to AIDS as an occupational disease. n152

No matter which approach is used in a given state, the largest problem with compensating occupational disease under workers' compensation statutes is that compensation for occupational disease analysis has been grafted onto a system designed to deal with traumatic injuries. n153 Workers' compensation boards are used to dealing with injuries they can easily understand and to which Newtonian concepts of causation are readily applicable. Many occupational diseases, however, are best understood through probabilistic notions of causation and have thus been poorly processed and compensated by boards. n154 As noted above, these concepts of probabilistic causation will apply in part to AIDS as an occupational disease. n155

Another problem caused by workers' compensation boards' unfamiliarity with

disease issues is that of latency periods. n156 The usual notice and filing limits for workers' compensation are one to two years from the date of infection. These and other limitations have confounded compensation for occupational diseases with long latency periods. n157 For example, some health care workers probably will become aware of seropositivity for HIV before AIDS or AIDS Related Complex develops. After [*60] the virus has infected the body, there could be a latency period of between three to ten years before AIDS develops. n158 During this time, the employee will not necessarily be handicapped, although she may be unable to work her usual job because of legitimate fears of contagion. n159 Thus, considerations of notice requirements and compensation will have to be addressed before the full-blown syndrome develops. Otherwise, the HIV-infected employee will face a double bind -- she is aware of the potential for developing AIDS within the notice period but develops the disease only after the notice period has lapsed.

Boards will face another problem with the definition of disease and the relation of that definition to a syndrome. Workers' compensation statutes refer to diseases. AIDS is not a disease, but a syndrome, because it is defined through a combination of risk factors and seropositivity. n160 Workers' compensation statutes thus will have to be interpreted to include the syndrome as a disease. n161

If workers' compensation boards can be properly educated on these issues, they will be able to consider AIDS as an occupational disease. This does not necessarily mean that they will find individual cases of AIDS compensable under their enabling legislation. In each individual case, workers' compensation boards will have to address the causation problem -- the relation of the disease to the workplace.

Fortunately, there are analogies upon which boards can rely in determining causation. AIDS is an infectious disease in the broadest use of that term, as it is caused by the HIV. Other infectious diseases have been compensated and can act as a model for HIV-related compensation. As noted, some states address such diseases as accidents. n162 To meet the definition of "accidental," an infectious disease must be unexpected, and the time of contraction must be definite. n163 The requirements of unexpectedness [*61] and definiteness fit an infectious disease into a traumatic accident rubric and invoke deductive notions of causation with which a board should be quite comfortable. Be this as it may, some infectious diseases might be expected occupational hazards, and the time of their contraction might be indefinite. As a result, the applicability of the accident rubric is rather limited.

In recognition of this limitation, more states are adopting an occupational disease approach to infectious diseases. Some states list infectious diseases generally under their schedules. n164 Others use the open-ended definitions of occupational disease. n165 Under the open-ended rubric, courts have approved

compensation for a wide variety of occupational diseases, n166 most frequently for hepatitis n167 and tuberculosis. n168

Hepatitis is an especially good analogy to AIDS because the transmission of this disease is biologically similar to HIV transmission. n169 In some hepatitis cases, courts have had to address the critical causation issue of hepatitis contracted by a health care worker who did not recall a specific incident and thus had to rely on the probabilistic notion of increased risk to prove causation. For example, in Booker v. Duke Medical Center, n170 a laboratory technician who experienced daily episodes of [*62] spilling blood on his fingers eventually contracted hepatitis and died of liver failure. The court noted that an ordinary disease of life, like hepatitis, could be an occupational disease, n171 that the disease probably arose out of the technician's employment because his employment increased the risk that he would contract the disease, n172 and that the "circumstantial" or probabilistic evidence of increased risk was sufficient. n173

The other kinds of hepatitis are Hepatitis A, which is spread through fecal-oral contact, and non-A, non-B hepatitis, which is spread mainly through blood transfusions. See Dienstag, Wands & Koff, Acute Heptatitis, in 2 HARRISON'S PRINCIPLES OF INTERNAL MEDICINE 1325, 1329-30 (11th ed. 1987)

The significance of this kind of decision for health care workers should not be underestimated. n174 It demonstrates that courts may not require proof of a single event in which exposure to a virus occurred, but instead will rely on probabilistic notions to prove causation. Courts will still deny compensation if there is insufficient proof of increased exposure preventing the inference of increased risk. n175 Nonetheless, solid precedent demonstrates that health care workers do not need to prove a single incident of infection to gain compensation for hepatitis. n176 Because the transmission of HIV is quite similar, it is safe to assume that compensation boards and reviewing courts will not hold health care workers with occupationally-related AIDS or HIV seropositivity to a Newtonian or corpuscularian standard of causation. n177

Tuberculosis cases have set a different kind of important precedent for occupationally associated AIDS. Tuberculosis and AIDS are similar in that both have a screening test available to determine whether a person has been exposed to the causal agent. n178 Some courts have accepted a negative pre-employment screening test for tuberculosis as threshold evidence [*63] of occupational exposure. n179 Courts may also accept as threshold evidence a health care worker's negative test for HIV antibody at the initiation of employment. n180

The first and second questions posed at the outset of this section can be answered only with limited affirmative replies. Workers' compensation is available to some but not all people who work at health care institutions; and HIV probably will be a compensable illness or accident. With some trepidation,

we can move to the third question and ask whether this compensation will be sufficient to nurture the workers' ethical duty, by ensuring that they and their family will not have to bear the full economic cost of occupationally related AIDS. The answer to this is, not unsurprisingly, rather complicated.

A health care worker who contracts AIDS will suffer significant disability and probable death. n181 The disability will begin once it is clear the worker is seropositive for HIV. At that point, she will have to be removed from any patient contact that poses a threat of nosocomial infection for the patient. After a fairly long latency period, the AIDS most likely will develop and the worker's further disability will depend on the kind of opportunistic infections she develops. Once the AIDS diagnosis is made, death will occur an average of three years later.

The efficacy of workers' compensation for dealing with these disabilities is probably fairly marginal, especially if we concentrate our attention on death benefits. Most death benefits are based on out-of-date levels that have not been adjusted for inflation. n182 As a result death benefits are really quite low, ranging from $ 189 per week in Arkansas to $ 1108 per week in Alaska for the maximum payment. n183 The maximum time of payment is usually about 500 weeks. n184 In addition, the average death benefit for families of accident victims is approximately $ 57,000, whereas the survivor benefit for victims of occupational disease averages $ 3500. n185 This disparity suggests that those who die of occupational diseases [*64] receive inadequate compensation. Thus victims of occupationally induced AIDS will be particularly affected, because many, if not all, victims will die of the disease.

A further problem with death benefits, and indeed all workers' compensation benefits, is that they are tied to the amount the person is earning at the time of injury. n186 This relationship particularly will affect student nurses and physicians who are members of the housestaff. These individuals are earning relatively small amounts while they are in training but usually expect a large salary increase once their training is finished. n187 Workers' compensation thus will systematically undercompensate trainees. n188

State workers' compensation boards may try to adjust their policies to avoid this undercompensation, but it is doubtful that the insurance carriers who underwrite workers' compensation are prepared financially for the burden that occupationally induced AIDS could create. Indeed, many insurance carriers will take a very hard line on such compensation n189 and argue that other risk factors for AIDS must be ruled out before the occupational exposure can be taken seriously. n190 Emphasis on multiple causation will reinforce the causation problems noted above n191 and lead to further delays in the adjudication of compensation claims.

All of these problems with workers' compensation, both in terms of coverage

and available benefits, suggest that workers' compensation alone cannot be the answer. Workers' compensation benefits will not be adequate to shift the costs from health care workers to deeper pockets and, as a result, will not provide proper reinforcement for the ethical duty to treat all patients that is recognized by some health care workers. In fact, the elements of the law that might help ensure access to health care for all patients, including those with AIDS, in reality present a [*65] safety net with gaping holes. Material is available to mend those holes, but this will require some creative use of the available legal tools.

III. CONCLUSION: ENSURING ACCESS TO HEALTH CARE FOR PEOPLE WHO ARE SEROPOSITIVE FOR HIV

To approach a solution to the problem I have raised, let us imagine a worst case scenario. Suppose that the number of infected health care workers increases from 13 in 1987 to 50 in 1988 and to 150 in 1989. At this point, many health care workers might begin to believe that the risk, while quantitatively small, is not insignificant. Many doctors might begin to insist on testing before they will conduct invasive procedures on patients. Some might even refuse to treat seropositive patients. Hospitals will face clamor from their medical staffs to institute testing for HIV antibody, a request that might be supported by nurses, doctors and other health care personnel. Patients with AIDS might begin to have trouble finding hospitals that will treat them.

At this point, lawyers and civil rights activists will review the same law I have examined in part II of this article and initiate suits to enforce patients' rights to treatment. It seems clear that both statutory and common law grounds will support a right to emergency treatment. n192 Thus emergency rooms will establish elaborate procedures for avoiding worker contact with patient blood and other body fluids. In addition to emergency care, both common law abandonment doctrines and certain state and federal statutes will prevent dumping of seropositive patients before their condition is stable. n193 The law will provide little else, however, especially as hospitals satisfy their Hill-Burton responsibilities. n194

Federal, state and local antidiscrimination statutes will prevent irrational treatment of people who are HIV seropositive, especially if AIDS or HIV seropositivity is treated under the statutes as a handicap. n195 However, as the perception grows that there is truly a risk to health care workers of contracting HIV at the workplace, any policies designed to decrease that risk will seem more rational. As Wendy Parmet has noted, "[u]ltimately, however, the question of how much risk is acceptable cannot be separated from an understanding of the social context in which the differential treatment occurs." n196

Small hospitals will argue that they and their staffs are not as well

equipped to prevent HIV spread as are large urban hospitals that deal [*66] with more seropositive patients. They will also argue that accepting HIV seropositive patients would create a risk that one of their staff members could become silently HIV seropositive and infect other patients over the course of several years. Courts will find it difficult to declare these kinds of arguments irrational and probably will accept concentrating care for AIDS patients and seropositive individuals at urban hospitals. Many of these urban hospitals will be municipal or publicly owned institutions where antidiscrimination laws will be more potent. n197

These hospitals probably will be staffed by individuals who believe they have a duty to help provide health care for all people, including those with a potentially fatal infectious disease. Many physicians will argue that this duty issues from their professional code of ethics. Nurses may make a similar argument. Support personnel and laboratory technicians will not make the same kind of arguments but undoubtedly will have some kind of altruistic motivations.

As the perception of risk grows, however, fear of disease may wear down this moral integrity. Additionally, it is possible that life and disability insurance carriers will cancel the policies held by people who work at such hospitals. n198 As noted above, workers' compensation probably will be available for workers who contract HIV at the workplace, but the compensation may not be considered adequate by many workers. n199 Thus the central urban hospitals may have difficulty finding adequate numbers of health care workers.

What can be done to avoid this situation" I suggest that as the protection provided by antidiscrimination law begins to crumble, we need to support the ethical duty to treat with a generous system of compensation for individuals who contract HIV at the workplace. In other words, we must nurture the ethical duty to treat by shifting the costs of an occupational HIV accident from the worker to the government through a compensation plan. This compensation plan would be administered best through a system similar to workers' compensation, but with some novel attributes. An outline of this proposed system follows.

If the risk of occupationally induced AIDS begins to grow, care for AIDS patients probably will begin to centralize in certain urban hospitals committed to such care or required to provide such care as public institutions. Indeed, [*67] state health departments might provide incentives for hospitals to become AIDS centers, as is happening in New York City. n200 These incentives might consist of extra revenues or subsidies in return for provision of care for all AIDS patients. In addition to providing care for patients with known AIDS, these institutions either would have no required testing for HIV or would require testing only if an invasive procedure were to be done -- and that invasive procedure would be completed regardless of the result of the screening test. In effect, these hospitals would provide care independent of HIV antibody status. Of course, special precautions would have to be enforced to minimize

the risk of occupational transmission. n201

To make these hospitals a more attractive place to work, higher wages must be offered. In addition, a compensation scheme that shifts the cost of occupationally induced AIDS should be offered to support health care workers' sense of an ethical duty to treat all patients regardless of disease status. This compensation would be broadly similar to workers' compensation, but should include some changes that overcome the deficiencies of workers' compensation that are noted above. n202

First, the compensation should be 80% of the weekly wage earned by the health care worker who becomes disabled as a result of occupational exposure to HIV. This represents a slight improvement on the typical workers' compensation benefit. Moreover, this weekly wage should reflect the increase in earnings that a trainee can expect after completion of training. For instance, a medical house officer would be compensated 80% of her current salary for the years she would have been in training, then 80% of the average internist's wage for the next 20 years. The time limit on compensation also should be increased to 1000 weeks. This level of compensation would reflect society's commitment to health care for all and adequately support doctors' and other health care workers' ethical decisions.

To avoid potential problems with proving causation, a presumption should be created that any health care worker who has AIDS or who is HIV seropositive contracted HIV at the workplace. To institute this policy, however, it will be necessary to screen those health care workers who want to be eligible for the compensation plan. Any worker who tests negative and then becomes positive over the course of employment would be eligible for compensation. This presumption would minimize the risk of emotionally and financially draining litigation.

[*68] On the other hand, this presumption raises the problem of screening. As mentioned above, n203 screening is not necessarily cost-effective and may lead to false positives and discrimination. The CDC has not recommended screening for health care workers. n204 Moreover, pre-employment or employment testing for HIV could lead to significant discrimination. n205 In response to this potential discrimination, some states have prohibited any kind of workplace testing. n206 In addition, case law developing around the concept of AIDS as a handicap has suggested that workplace discrimination based on HIV status is illegal. n207

There is little doubt, however, that screening must be completed for any AIDS occupational disease compensation program to function properly. Without screening, the program would be unworkable. Creating a presumption that any health care worker with AIDS or HIV seropositivity qualifies for a special compensation system would make employment in the health care industry very attractive to anyone who is already seropositive. For those who want to care

for AIDS patients but who are loath to undergo screening tests, employment still will be possible, but these individuals will not qualify for the compensation scheme. Thus the screening is a quid pro quo for eligibility for the compensation program. In this light, the screening is not mandatory unless one wants to qualify for the special benefits.

Those who agree to screening and are antibody negative will be rescreened on a periodic basis to ensure seroconversion has not occurred. n208 The results of these tests should be maintained in strictest confidentiality. Any health care worker who does seroconvert will be [*69] removed from patient contact that could jeopardize seronegative patients. n209 Once incapacities associated with AIDS begin to develop, the compensation system should start to provide weekly payments.

Who will pay for this compensation system? It would be optimal to put the cost of the system on those who are best able to prevent the spread of HIV. Because I cannot imagine which group this would be or how the financial burden could be so placed, I think the bill for the occupational AIDS compensation system should fall on the deepest pockets -- the state and federal governments. Unfortunately, this may be a sizable bill -- especially given the generous compensation I have outlined -- and will add to the growing costs of the epidemic.

This cost, however, is one that must be met. By shifting the costs of accidents from health workers to "deeper pockets," society can encourage the workers to continue to care for peoplw who are HIV seropositive. We are not yet at the stage where such a plan is needed, but we are at the stage where meaningful discussion of this and other contingency plans should occur. n210 As the president of the Institute of [*70] Medicine, Dr. Sam Thier, points out, the AIDS epidemic is now a national emergency and we must begin to think creatively about the problems it poses. n211

I have no good answer for this except to say that access to health care is a very important value in our country. Many people may be willing to accommodate the injustice of a special compensation system for health care workers to maintain access to health care for those who are sick with HIV-related diseases.

One alternative method of keeping health care workers on the job is the police power of the state. For instance, as a quid pro quo for licensure, doctors could be forced to serve specified terms in AIDS hospitals. This alternative fails for two reasons. First, it is probably not politically feasible in a state that values individual liberties. Second, it is doubtful that coerced employees would muster the compassion and diligence that is necessary for patient care. One could only hope we do not reach the threshold of this alternative.

- - - - - - - - - - - - - - - - - -Footnotes- - - - - - - - - - - - - - - - - -

n101. See Zagury, Bernard, Leonard, Cheynier, Feldman, Sarin & Gallo, Long-Term Cultures of HTLV-III-Infected T Cells: A Model of Cytopathology of T-Cell Depletion in AIDS, 231 SCIENCE 850 (1986).

n102. See Goedert, Biggar, Weiss, Eyster, Melbye, Wilson, Ginzburg, Grossman, DiGioia, Sanchez, Giron, Ebbesen, Gallo & Blattner, Three-Year Incidence of AIDS in Five Cohorts of HTLV-III-Infected Risk Group Members, 231 SCIENCE 992 (1986) (34.2% in cohort of homosexual males in Manhattan, 14.9% in other four cohorts). Almost all those infected have a two to three year quiescent period in which they are infectious but asymptomatic. Melbye, Biggar, Ebbeson, Neuland, Goedert, Faber, Lorenzen, Skinhoj, Gallo & Blattner, Long-Term Seropositivity for Human T-Lymphotropic Virus Type III in Homosexual Men Without the Acquired Immunodeficiency Syndrome: Development of Immunological and Clinical Abnormalities, 104 ANNALS INTERNAL MED. 496 (1986).

n103. Goudsmit, Wolters, Bakker, Smit, VanderNoordaa, Hische, Tutuarima & Van der Helm, Intrathecal Synthesis of Antibodies to HTLV-III in Patients Without AIDS or AIDS Related Complex, 292 BRIT. MED. J. 1231 (1986); Grant,

Atkinson, Hesselink, Kennedy, Richman, Spector & McCutchan, Evidence for Early Central Nervous System Involvement in the Acquired Immunodeficiency Syndrome (AIDS) and other Human Immunodeficiency Virus (HIV) Infections, 107 ANNALS INTERNAL MED. 828 (1987).

n104. Because the epidemic has not yet matured. it is difficult to estimate the survival for the various risk groups that make up the AIDS patient population. However, we do know that as of January 1, 1986, AIDS patients diagnosed before 1983 had a 77% mortality, those diagnosed in 1983 had a 73% mortality, those diagnosed in 1984 had a 61% mortality, and those diagnosed in 1985 had a 31% mortality. Castro, Hardy & Curran, The Acquired Immunodeficiency Syndrome: Epidemiology and Risk Factors for Transmission, 70 MED. CLINICS N. AM. 635, 639 (1986).

n105. I will not be able to discuss in detail the emotional costs of contracting AIDS. For a closer examination, see Cassens, Social Consequences of the Acquired Immunodeficiency Syndrome, 103 ANNALS INTERNAL MED. 768 (1985); Nichols, Psychosocial Reactions of Persons with the Acquired Immunodeficiency Syndrome, 103 ANNALS INTERNAL MED. 765 (1985).

n106. Hardy, Rauch, Echenberg, Morgan & Curran, The Economic Impact of the First 10,000 Cases of Acquired Immunodeficiency Syndrome in the United States, 255 J. A.M.A. 209, 210 (1986).

n107. The cost of replacing a healthy working person's income over the course of his expected life span is substantial. See P. Weiler, Legal Policy for Workplace Injuries 44-50 (Aug. 1985) (tentative draft report for the American Law Institute). The problem of infection spread by asymptomatic hosts is not yet appreciated. The Public Health Service estimates there are between 1 and 1.5 million carriers of the HIV. See Young, Letter From The Commissioner, 17 FDA DRUG BULLETIN 14, 14 (1987).

n108. See W. KEETON, D. DOBBS, R. KEETON & D. OWEN, PROSSER & KEETON ON THE
LAW OF TORTS 5-6 (5th ed. 1985) [hereinafter PROSSER & KEETON]. See generally G. CALABRESI, THE COSTS OF ACCIDENTS: A LEGAL AND ECONOMIC ANALYSIS (1970); R.
POSNER, ECONOMIC ANALYSIS OF LAW @@ 6.1, 6.10-.14 (3d ed. 1986).

n109. For a history of the development of workers' compensation, see generally Friedman & Ladinsky, Social Change and the Law of Industrial Accidents, 67 COLUM. L. REV. 50 (1967).

n110. J. CHELIUS, WORKPLACE SAFETY AND HEALTH: THE ROLE OF WORKERS'
COMPENSATION 20 (1977).

n111. See K. ABRAHAM, DISTRIBUTING RISK, 227 (1986).

n112. The United States Supreme Court held, in United States v. Southeastern Underwriters Ass'n, 322 U.S. 533 (1944), that sale of property insurance was interstate commence and thus subject to antitrust laws. Id. at 553, 560-62. The next year Congress enacted the McCarran-Ferguson Act so states could set up insurance regulations exempt from antitrust law.

n113. See generally J. MINTEL, INSURANCE RATE LITIGATION (1985).

n114. The exception in health insurance is the Blue Cross insurers who have always been highly regulated, largely because of their monopolistic position. See, e.g., Hospital Service Corp. v. West, 112 R.I. 164, 308 A.2d 489 (1973).

n115. Courts have come out quite differently on cases regarding risk refinement. See, e.g., Anzinger v. O'Connor, 109 Ill. App. 3d 550, 440 N.E.2d 1014 (1982); Pan Pacific Trading Corp. v. Dep't of Labor & Indus., 88 Wash. 2d 347, 560 P.2d 1141 (1977).

n116. States could of course force insurers to write such policies if they want to continue to write other kinds of policies in the state. This sort of requirement was necessitated following the malpractice crisis of the 1970s to ensure the availability of malpractice insurance. See P. DANZON, MEDICAL MALPRACTICE ch. 2 (1986).

n117. See supra note 17 and accompanying text.

n118. See Brennan, supra note 14, at 581.

n119. See infra text accompanying notes 142-51.

n120. See, e.g., Peoples v. Chrysler Corp., 98 Mich. App. 277, 279-82, 296 N.W.2d 237, 238-40 (1980) (affirming that workers' compensation is exclusive remedy for worker injury at workplace). The exclusivity doctrine was part of the critical compromise reached when workers' compensation was instituted.

n121. See 2 A. LARSON, WORKMEN'S COMPENSATION FOR OCCUPATIONAL INJURIES AND
DEATH @ 68.10 & n.4 (1987). But cf. Millison v. E.I. du Pont de Nemours & Co., 101 N.J. 161, 501 A.2d 505 (1985) (Using the "substantial certainty" of risk test, the court allowed injured worker to sue employer for aggravation of occupational disease under the intentional wrong exception where employer fraudulently concealed knowledge that worker had contracted the disease.).

n122. Centers for Disease Control, Recommendations for Preventing Transmission of infection with Human T-Lymphotropic Virus Type

III/Lymphadenopathy-Associated Virus during Invasive Procedures, 35 MORBIDITY & MORTALITY WEEKLY REP. 221 (1986) (operative, obstetric and dental procedures); Centers for Disease Control, Recommendations for Preventing Possible Transmission of Infection with Human T-Lymphotropic Virus Type III/Lymphadenopathy-Associated Virus in the Workplace, 34 MORBIDITY & MORTALITY

WEEKLY REP. 682 (1985) (general health care worker precautions). OSHA finally took notice of the risk to health workers in the late summer of 1987 when it decided to enforce the CDC guidelines. Gianelli, AIDS Protection Now Required, Am. Med. News., Aug. 7, 1987, at 1, 41; see also DEP'T OF LABOR & DEP'T OF HEALTH & HUMAN SERVS., JOINT ADVISORY NOTICE: PROTECTION AGAINST OCCUPATIONAL
EXPOSURE TO HEPATITIS B VIRUS (HBV) AND HUMAN IMMUNODEFICIENCY VIRUS (HIV) 5-10
(1987) [hereinafter JOINT ADVISORY NOTICE]. The American Nursing Association had asked for an emergency temporary standard, a move opposed by the AMA and the American Hospital Association. Id. Failure to comply with the guidelines could result in fines up to $ 10,000. OSHA has now announced plans to undertake a formal rulemaking.

n123. See, e.g., Borel v. Fibreboard Paper Prods. Corp., 493 F.2d 1076 (5th Cir. 1973) (strict liability action), cert. denied, 419 U.S. 869 (1974); see also Special Project -- An Analysis of the Legal, Social, and Political Issues Raised by Asbestos Litigation, 36 VAND. L. REV. 573, 582 (1983) (describing the traditional litigation theories of products liability used by plaintiffs).

n124. See generally Delgado, Beyond Sindell: Relaxation of Cause-In-Fact Rules for Indeterminate Plaintiffs, 70 CALIF. L. REV. 881 (1982) (discussing creative tort theories to permit plaintiff recovery where proof of exact causation is difficult); Pierce, Encouraging Safety: The Limits of Tort Law and Government Regulation, 33 VAND. L. REV. 1281 (1980) (summarizing the limits of tort law and proposing a new legal approach to reducing accident costs); Trauberman, Statutory Reform of "Toxic Torts": Relieving Legal, Scientific, and Economic Burdens on the Chemical Victim, 7 HARV. ENVTL. L. REV. 177 (1983) (proposing model statute to effect reforms in private liability system's allocation of social costs of toxic substances).

n125. Product liability has been the main area of expansion within the toxic torts area. Cf. Schwartz, Products Liability, Corporate Structure, and Bankruptcy: Toxic Substances and the Remote Risk Relationship, 14 J. LEGAL STUD. 689, 692-705 (1985) (contending that tort law should not expand to impose remote risks); Schwartz, Foreword: Understanding Products Liability, 67 CALIF. L. REV. 435 (1979) (discussing strict liability for products where the "norm is danger"); Wade, On the Effect in Product Liability of Knowledge Unavailable Prior to Marketing, 58 N.Y.U. L. REV. 734 (1983) (analyzing effect on product liability cases of increase in knowledge about product between time of

distribution and time of trial, particularly with respect to new scientific or technological developments that have occurred since the product was marketed that could make the product safer).

n126. Understandably, there is not an abundance of literature on the epidemiology of accidents with serum, blood or other body fluids in hospitals. Those of us who work in hospitals are well aware of the not infrequent episodes in which we stick ourselves with needles or get sprayed with body fluids from sick patients. The ubiquity of such episodes is the source of the concern health care workers have about AIDS. See Staver, Fear of AIDS: Physicians, Nurses Cope with Concerns about Infection, Am. Med. News, Oct. 2, 1987, at 1.

n127. See, e.g., Rasmussen v. South Fla. Blood Serv., Inc., 500 So. 2d 533 (Fla. 1987). For a discussion of tort law and infection, see Note, Liability in Tort for the Sexual Transmission of Disease: Genital Herpes and the Law, 70 CORNELL L. REV. 101 (1984); see also Hermann, Torts: Private Lawsuits about AIDS, in AIDS AND THE LAW, supra note 11, at 153 (discussing AIDS-related tort litigation relating to sexual transmission, to provision of blood, and to medical malpractice).

n128. For a discussion of the neurological deficits that accompany AIDS, see Grant, Atkinson, Hesselink, Kennedy, Richman, Spector & McCutchan, Evidence for Early Central Nervous System Involvement in the Acquired Immunodeficiency Syndrome (AIDS) and Other Human Immunodeficiency Virus (HIV) Infections, 107 ANNALS INTERNAL MED. 828, 832-35 (1987) (concluding that findings "strongly suggest that HIV is principally responsible for neuropsychological deterioration in patients with AIDS who are free of other brain disease").

n129. See supra text accompanying note 122. This assumes that some sort of "state-of-the-art" defense will be allowed in future tort litigation. Basically, hospitals will argue that given our present understanding of the transmission of the HIV, following the CDC guidelines offers excellent and appropriate protection. The future of the state-of-the-art defense is not clear at present. See Beshada v. Johns-Manville Prods. Corp., 90 N.J. 191, 202-08, 447 A.2d 539, 545-49 (1982) (state-of-the-art as negligence defense unavailable in strict liability; failure to warn case); see also Abraham, Individual Action and Collective Responsibility: The Dilemma of Mass Tort Reform, 73 VA. L. REV. 845, 856-57 (1987) (plaintiff faces significant difficulties in defeating state-of-the-art defense); cf. Mitchell v. Sky Climber, Inc., 487 N.E.2d 1374, 1376 (1986) (no duty to warn required when accident unforeseeable).

n130. See supra notes 1-5 and accompanying text.

n131. This theory has been used successfully by some toxic tort litigants. In New Jersey, a group of plaintiffs were granted damages for the costs of future medical surveillance to monitor the effects of exposure to a toxic

landfill. Ayers v. Township of Jackson, 189 N.J. Super. 561, 572-73, 461 A.2d 184, 190 (1983), aff'd in part, rev'd in part, 106 N.J. 557, 525 A.2d 287 (1987); see also Note, Future Medical Surveillance: An Award for Toxic Tort Victims, 38 RUTGERS L. REV. 795 (1986) (discussing Ayers and possible trend toward awarding future medical surveillance damages).

n132. See Update: Acquired Immunodeficiency Syndrome -- United States, 35 MORBIDITY & MORTALITY WEEKLY REP. 757, 759 (1986) (Of the first 28,098 cases of
AIDS, 18, 162 occurred in homosexual or bisexual men, 4723 in intravenous drug users, 2165 in homosexuals who were intravenous drug users, 240 in hemophiliacs, 505 in transfused individuals, 1056 in heterosexual partners of members of other risk groups, and only 853 in people without identified risk factors.).

n133. See OSHA Begins Rulemaking on AIDS and Hepatitis B, Health and Safety on the Job, Dec. 19, 1987, at 4; supra note 122.

n134. See, e.g., Brennan & Carter, Legal and Scientific Probability of Causation of Cancer and Other Environmental Disease in Individuals, 10 J. HEALTH POL. POL'Y & L. 33, 35-55 (1985) (analyzing basis for scientific concepts of causation and means of incorporating epidemiological and statistical evidence of causation into the legal process); Robinson, Probabilistic Causation and Compensation for Tortious Risk, 14 J. LEGAL STUD. 779, 779-98 (1985) (proposing further consideration of risk-based or probabilistic liability); Rosenberg, The Causal Connection in Mass Exposure Cases: A "Public Law" Vision of the Tort System, 97 HARV. L. REV. 849, 861-87 (1984) (proposing proportionality rule of causation in which manufacturer liable for proportion of total injuries attributable to its product).

n135. See, e.g., Brennan, Causal Claims and Statistical Links: Some Thoughts on the Role of Scientific Uncertainity in Hazardous Substance Litigation, CORNELL L. REV. (forthcoming).

n136. I have characterized the difference in the two approaches to causation in science as "Corpuscularian" and probabilistic. Brennan, Untangling Causation Issues in Law and Medicine: Hazardous Substance Litigation, 107 ANNALS INTERNAL MED. 741, 741-42 (1987) (Corpuscularianism is the "characterization of causation as collisions that follow the physical laws defined by mathematics." Probabilistic analysis explains causation by "defin[ing] uncertainty and provid[ing] the basis for hypothesis building."). Probabilistic models have, in the past twenty years, superseded corpuscularianism in explaining causation in science.

n137. Id. at 743 (Legal causation "relies on a positivistic-corpuscularian notion of causation" and courts frequently distrust statistical analysis.).

n138. But see Hirsch, Worsger, Schooley, Ho, Felsenstein, Hopkins, Joline, Duncanson, Sarngadharan, Saxinger & Gallo, Risk of Nosocomial Infection With Human T-Cell Lymphotropic Virus III (HTLV-III), 312 NEW ENG. J. MED. 1, 3 (1985) (The risk of developing HIV seropositivity for health workers is quite low.); Weiss, Seringer, Rechtman, Gricco, Nadler, Holman, Ginzburg, Groopman, Goedert, Markham, Gallo, Blattner & Landesman, HTLV-III Infection Among Health Care Workers: Association With Needle-Stick Injuries, 254 J. A.M.A. 2089, 2092 (1985) (health care workers are a low risk group); see also Vlahov & Polk, Transmission of Human Immunodeficiency Virus Within the Health Care Setting, in 2 OCCUPATIONAL MEDICINE: STATE OF THE ART REVIEWS 429 (1987) (Some commentators estimate that at most 3 out of 929 health care workers with a defined occupational exposure became seropositive.). Thus, the risk is small, but definite.

n139. Because AIDS is an infectious disease, courts are going to be especially prone to Corpuscularian reasoning -- since the paradigm of person-to-person spread based on personal contacts informs much of infectious disease. There is, however, at least one case of apparent nosocomial transmission of HIV without a specific incident of exposure. See Vlahov & Polk, supra note 131, at 437. Such sporadic cases may become more frequent in the future.

n140. In this regard, the latency period will play much the same disruptive role that it has in litigating hazardous waste cases. See Ginsberg & Weiss, Common Law Liability for Toxic Torts: A Phantom Remedy, 9 HOFSTRA L. REV. 859, 940 (1981) ("[I]t is difficult to prove that the cause of a disease is an unseen substance unknowingly ingested at an indeterminate time.").

n141. It is doubtful that any type of Sindell proportionate liability could be imposed in these cases. See Sindell v. Abbott Laboratories, 26 Cal. 3d 588, 612, 607 P.2d 924, 937, 163 Cal. Rptr. 132, 145 ("Each defendant will be held liable for the proportion of the judgment represented by its share of that market unless it demonstrates that it could not have . . . caused plaintiff's injuries."), cert. denied, 449 U.S. 912 (1980). For a discussion of the Sindell approach to multiple causation cases, see Robinson, Multiple Causation in Tort Law: Reflections on the DES Cases, 68 VA. L. REV. 713, 717-69 (1982).

n142. 1B A. LARSON, WORKMEN'S COMPENSATION LAW @ 41.00 (1987).

n143. 1C id. @ 43.00. Larson cites several factors that distinguish employees, including the extent of control the master may exercise over the details of work, the skill required, the length of time employed, the method of payment, and the extent to which the parties believe they are creating an employee/employer relationship. Id. @ 43.10 (citing RESTAMENT (SECOND) OF AGENCY @ 220 (1957)); see Hill v. King, 663 S.W.2d 435, 439-45 (Tenn. Ct. App. 1983) (discussing factors that constitute professional employment).

n144. See 1C A. LARSON, supra note 142, @ 45.32(a) (citing Sutherland v. New York Polyclinic Medical School & Hosp., 273 A.D. 29, 75 N.Y.S.2d 135 (1947), aff'd, 298 N.Y. 682, 82 N.E.2d 583 (1948)).

n145. 1C A. LARSON, supra note 142, @ 45.32(a).

n146. "Housestaff" refers to the physicians in training at a teaching hospital who are also referred to as residents. First year residents are known as interns. As one progresses through one's medical training, the resident is given more and more responsibility. Senior members of the housestaff in many hospitals operate with little supervision and use a great deal of discretion in their practice. Thus, according to the professional discretion distinction, these housestaff members may become less and less like employees as they advance.

n147. See Higgins v. State of Louisiana, Dep't of Health & Human Resources, 458 So. 2d 951, 952 (La. Ct. App.) (intern awarded compensation for viral encephalities contracted at Charity Hospital), cert. denied, 460 So. 2d 607 (La. 1984); Victoria Hosp. v. Perez, 395 So. 2d 1165, 1166-67 (Fla. Dist. Ct. App. 1981) (house physician denied compensation due to inadequate proof of causation, but no question about eligibility).

n148. See Regents of the Univ. of Cal. v. Public Employment Relations Bd., 41 Cal. 3d 601, 715 P.2d 590, 224 Cal. Rptr. 631 (1984). This case concerned an unfair labor practice charge brought by a housestaff association against the university hospitals in California. The university had decided to treat housestaff as students following passage of a new higher education employer/employee relation act. Id. at 633, 715 P.2d at 592, 224 Cal. Rptr. at 633. Concurring in the Court of Appeal's comparison of the amount of time housestaff spent at educational tasks with that spent on employee functions, the California Supreme Court concluded that housestaff were students, not professional employees. Id. at 618-23, 715 P.2d at 602-04, 224 Cal. Rptr. at 643-45; see also St. Clare's Hosp., 92 L.R.R.M. (BNA) 1001, 223 NLRB Dec. (CCH) P163 (1976); Cedars-Sinai Medical Center, 91 L.R.R.M. (BNA) 1398, 223 NLRB Dec. (CCH) P157 (1976); Albert Einstein College of Med. of Yeshiva Univ., 33 NLRB Dec. (CCH) No. 86 (1970). Just because housestaff generally have not been accorded collective bargaining rights does not necessarily mean they will be classified as students and not as employees for workers' compensation purposes. Nonetheless, these cases do raise some concerns about housestaff eligibility for workers' compensation.

n149. See Molony, When Death by Occupational Disease May be Considered Accidental Injury, 35 S.C.L. REV. 5, 5-11 (1983) (discussing Marquard v. Pacific Columbia Mills, 295 S.E.2d 870 (1982)).

n150. See generally Locke, Adapting Workers' Compensation to the Special

Problems of Occupational Disease, 9 HARV. ENVTL. L. REV. 249 (1985).

n151. See 1B A. LARSON, supra note 142, @@ 41.00-41.10. The problem with scheduling is that the legislatures have been chronically behind in recognition of new occupational diseases.

n152. I shall proceed according to the open-ended analysis. To the best of my knowledge no state has specifically defined AIDS or HIV seropositivity as an occupational disease.

n153. See generally P. BARTH & H. A. HUNT, WORKERS' COMPENSATION AND WORK-RELATED ILLNESSES AND DISEASES (1980); D. BERMAN, DEATH ON THE JOB:
OCCUPATIONAL HEALTH AND SAFETY STRUGGLES IN THE UNITED STATES 44 (1978);
Assistant Secretary for Policy, Evaluation & Research, U.S. Dep't of Labor, An Interim Report to Congress on Occupational Disease (1980) (discussing difficulties of compensation for occupational disease under workers' compensation system).

n154. See Brennan & Carter, supra note 134, at 59; see also Barth, Compensation for Asbestos Associated Disease: A Survey of Asbestos Insulation Workers in the United States and Canada, in DISABILITY COMPENSATION FOR ASBESTOS
ASSOCIATED DISEASE IN THE UNITED STATES (I. Selikoff ed. 1983).

n155. See supra text accompanying notes 135-41.

n156. See P. BARTH & H. A. HUNT, supra note 153, at 62-70; Locke, supra note 150, at 258.

n157. See Kutchins, The Most Exclusive Remedy Is No Remedy at All: Workers' Compensation Coverage for Occupational Diseases. 32 LAB. L.K. 212, 219-20 (1981).

n158. See supra text accompanying notes 1-4.

n159. See infra text accompanying note 208.

n160. Council of State and Territorial Epidemiologists, AIDS Program, Center for Infectious Diseases, Centers for Disease Control. Revision of the CDC Surveillance Case Definition for Acquired Immunodeficiency Syndrome, 36 MORBIDITY & MORTALITY WEEKLY REP. 1. 6-7 (Supp. No. 15, Aug. 1, 1987) ("AIDS"
does not refer to a particular disease; the term is "intended only to provide consistent statistical data for public health purposes."). Some diseases occur

so infrequently without the presence of the HIV that they alone are sufficient for the diagnosis of AIDS. Other diseases must occur with proof of HIV seropositivity before AIDS is diagnosed.

n161. It may well be that the AIDS-related complex can be severe enough to incapacitate a worker. This will have to be addressed on a case-by-case basis.

n162. See supra note 149 and accompanying text. As Larson notes, "[t]he contraction of disease is deemed an injury by accident in most states if due to some unexpected or unusual event or exposure. Thus, infectious disease may be held accidental if the germs gain entrance through a scratch or through unexpected or abnormal exposure to infection." 1B A. LARSON, supra note 142, @ 40.00.

n163. Id. supra note 142, @ 40.10; see also Connelly v. Hunt Furniture Co., 240 N.Y. 83, 87-88, 147 N.E. 366, 368 (1925) (classifying disease as accident where sudden and catastrophic).

n164. See, e.g., VA. CODE ANN. @@ 65-1-46 to -46.1 (1987) (No ordinary disease of life shall be compensable except when it is an infectious or contagious disease contracted in the course of employment in a hospital or sanitarium.).

n165. Larson argues that the distinction between accident and occupational disease is losing its significance. 1B A. LARSON, supra note 142, @ 41.31. Many states are no longer requiring that claimants specify accidents or occupational diseases. Id. @ 41.31.

n166. See, e.g., D'Angona v. County of Los Angeles, 27 Cal. 3d 661, 664, 613 P.2d 238, 241, 166 Cal. Rptr. 177, 180 (1980) (physical therapist at hospital awarded workers' compensation for meningococcemia contracted at workplace); Wilson Foods Corp. v. Porter, 612 P.2d 261, 263-64 (Okla. 1980) (workers' compensation claim based on brucellosis contracted at an abattoir).

n167. See Pommeranz v. State, 261 N.W.2d 90, 91 (Minn. 1977) (per curiam) (hospital switchboard operator awarded workers' compensation for hepatitis); Barr v. Pasack Valley Hosp., 155 N.J. Super. 504, 506, 382 A.2d 1167, 1168 (App. Div. 1978) (noting that nurse awarded compensation in earlier proceedings for permanent disability after contracting hepatitis at workplace).

n168. See Middleton v. Coxsackie Correctional Facility, 38 N.Y.2d 130, 136-37, 341 N.E.2d 527, 531-32, 379 N.Y.S.2d 3, 8-9 (1975) (corrections officer at state prison awarded workers' compensation for developing tuberculosis after prisoner with tuberculosis coughed on him); Quallenberg v. Union Health Center, 280 A.D. 1029, 1029, 117 N.Y.S.2d 24, 25 (1952) (finding tuberculosis compensable through workers' compensation), appeal denied, 281 A.D. 776, 117 N.Y.S.2d 919 (1953).

n169. When courts speak of hepatitis, they often do not specify what type of hepatitis they mean. Hepatitis B is most similar to HIV in its mode of transmission. Both viri can be transmitted by sexual contact, especially oral-anal contact, as well as by blood transfusions and sharing of needles. Moreover, Hepatitis B is a well-recognized occupational health hazard. Fortunately, there is a potent vaccine for Hepatitis B. See JOINT ADVISORY NOTICE, supra note 122, at 1. [hereinafter HARRISON'S MEDICINE].

n170. 297 N.C. 458, 256 S.E.2d 189 (1979).

n171. ID. at 470-71, 256 S.E.2d at 197-98.

n172. Id. at 474, 256 S.E.2d at 199-200.

n173. Id. at 476, 256 S.E.2d at 200-01.

n174. For a long discussion of Booker, see Note, Workers' Compensation -- Redefinition of Occupational Disease and the Applicable Compensation Statute -- Booker v. Duke Medical Center and Wood v. J. P. Stevens & Co., 16 WAKE FOREST L. REV. 288 (1980).

n175. See, e.g., Arkansas Dep't of Correction v. Chance, 271 Ark. 472, 477-78, 609 S.W.2d 666, 668-69 (1980) (denying compensation for tuberculosis to man who worked in remodeling of prison hospital but did not come near patients); City of Fort Lauderdale v. Lindie, 496 So. 2d 168, 169-70 (Fla. Dist. Ct. App. 1986) (paramedic denied compensation for herpes simplex because of lack of proof that patient to whom she was exposed had herpetic lesion), cert. denied, 506 So. 2d 1042 (Fla. 1987); Esposito v. N.Y.S. Willowbrook State School, 38 A.D.2d 985, 985, 329 N.Y.S.2d 355, 356 (1972) (cafeteria worker denied compensation for hepatitis).

n176. See Sacred Heart Medical Center v. Carrado, 92 Wash. 2d 631, 635-36, 600 P.2d 1015, 1018 (1979) (citing various cases demonstrating trend toward use of increased risk doctrine).

n177. Cf. Brennan, supra note 136, at 742-43.

- - - - - - - - - - - - - - - - -End Footnotes- - - - - - - - - - - - - - - - -

n178. The tuberculosis test is a simple skin test in which denatured tuberculin baccilus is injected subcutaneously. If a person has been infected with tuberculosis, an immunological reaction will be mounted and some redness and inflammation will develop. The AIDS screening test is for antibody to the HIV. See supra text accompanying notes 4-5. Unlike HIV, the tuberculin baccilus can be warded off by the body, and those with positive skin tests are not necessarily infected or infectious. See Daniel, Tuberculosis, in 1 HARRISON'S MEDICINE, supra note 169, at 625, 630.

n179. See Florida State Hosp. v. Potter, 391 So. 2d 322, 322-23 (Fla. Dist. Ct. App. 1980) (denying compensation because of positive tuberculosis skin test before employment); Hayes v. St. Mary's Hosp., 285 A.D. 914, 914, 137 N.Y.S.2d 409, 410 (1955) ("powerful and almost incontrovertible proof" that claimant contracted disease while employed).

n180. See infra notes 205-06 and accompanying text.

n181. See supra notes 1-2 and accompanying text.

n182. See Locke, supra note 150, at 267.

n183. See 4 A. LARSON, supra note 142, app. B table 16 (Death Benefits: July 1987). Benefits are calculated on the basis of the state's average weekly wage. Most states use the figure of 66 2/3% of the worker's salary for calculation of the death benefit. Many states make provisions for continued support of children if a spouse dies. While few states provide protection against inflation in award of death benefits, the benefits are not subject to taxation.

Id.

n184. Id.

n185. See P. BARTH & H. A. HUNT, supra note 153, at 174.

n186. Tort law has been much more liberal in compensating victims of accidents by providing for their future earning potential. See generally PROSSER & KEETON, supra note 108, @ 127, at 949-54.

n187. For example, the average fellow in cardiology earns about $ 20,000 per year. Once his training is finished, his salary could increase within three years to $ 200,000 annually. Personal communication with Andrew Beamer, M.D., Cardiology Fellow at Brigham and Woman's Hospital (April 20, 1988).

n188. See Otten v. State, 291 Minn. 488, 40 N.W.2d 81 (1949) (student nurse contracting tuberculosis receives her former monthly stipend under workers' compensation).

n189. While many academic writers are concerned about the inadequacy of workers' compensation, just as many commentators argue that economic reality is such that the connection of a disease to the workplace must be very clear before compensation is awarded. See, e.g., LaDou, Mulryan & McCarthy, Cumulative Injury or Disease Claims: An Attempt to Define Employers' Liability for Workers' Compensation, 6 AM. J.L. & MED. 1, 20 (1980) (economic operation of workers' compensation requires providing "adequate benefits" only for "truly work-related injuries or diseases").

n190. This multiple causation problem has played a leading role in tort litigation in the last ten years. See generally Delgado, supra note 124.

n191. See supra notes 170-71 and accompanying text.

n192. See supra notes 44-54 and accompanying text.

n193. See supra note 70 and accompanying text.

n194. See supra notes 56-58 and accompanying text.

n195. See supra notes 65-66 and accompanying text.

n196. See Parmet, supra note 65, at 69.

n197. See Staver, supra note 71 at 33 (discussing the concentration of care for AIDS at certain hospitals in New York City); supra note 61 and accompanying text.

n198. While California, Maine, Wisconsin and the District of Columbia have passed legislation banning the use of HIV antibody tests for insurance purposes, see Scherzer, Insurance, in AIDS AND THE LAW, supra note 11, at 191, some commentators argue that it is neither unethical nor improper for insurance companies to deny life insurance to people who are HIV antibody positive or who have risk factors for developing AIDS. Id. at 193-94.

n199. See supra notes 185-86 and accompanying text.

n200. See Staver, supra note 71, at 33.

n201. Epidemiologist and infectious disease control teams must begin to consider precautions for health care workers that go beyond the CDC guidelines. See supra notes 122-23.

n202. See supra notes 142-82 and accompanying text.

n203. See Barry, Cleary & Fineberg, supra note 27, at 264-66.

n204. See Recommendations for Prevention of HIV Transmission in Health-Care Settings, 36 MORBIDITY & MORTALITY WEEKLY REP. 3, 15 (Supp. No. 2 1987) ("Since
transmission of HIV from infected health-care workers performing invasive procedures to their patients has not been reported and would be expected to occur only very rarely, if at all, the utility of routine testing of such health-care workers to prevent transmission of HIV cannot be assessed.").

n205. Indeed, numerous reports tell of discrimination against people with AIDS. See, e.g., Roth, Many Firms Fire AIDS Victims Citing Health Risk to Co-Workers, Wall St. J., Aug. 12, 1985, at 21; see also Bayer & Oppenheimer, AIDS in the Work Place: The Ethical Ramifications, BUS. & HEALTH, Jan.-Feb. 1986, at 30.

n206. These states include California, Florida and Wisconsin. CAL. HEALTH & SAFETY CODE @@ 199.21(f), 199.38 (West Supp. 1988); FLA. STAT. ANN. @ 381.606(5)
(West 1986); WIS. STAT. ANN. @ 103.15(2), (3) (West Supp. 1987).

n207. See, e.g., Shuttleworth v. Broward County, 639 F. Supp. 654 (S.D. Fla. 1986) (referring to Florida Commission on Human Relations' ruling that employee fired because of AIDS was discriminated against because of handicap); Cronan v. New England Tel. Co., 41 Fair Empl. Prac. Cas. (BNA) 1273 (Mass. Super. Ct. 1986) (AIDS is a handicap under Massachusetts Fair Employment Practices Act and thus employment discrimination is not permitted.).

n208. Diana Brahams has reviewed the excellent reasons for maintaining the

test results in strictest confidentiality. Brahams, Medicine and the Law: Confidentiality for Doctors Who Are HIV Positive, 2 LANCET 1221, 1221-22 (1987).

n209. Many health care workers maintain that there is little risk of a seropositive individual passing the infection along to a patient. See Gianelli, Protect Patients From HIV, Health Care Workers Told, Am. Med. News, Nov. 20, 1987, at 1. Nonetheless, a great deal of hysteria surrounds those HIV seropositive doctors who continue to practice medicine. See Little, Pediatrician Selling Practice in Wake of AIDS Hysteria, Am. Med. News, Oct. 9, 1987, at 9; Meyer, AIDS Job Bias Growing Fast in Health Industry, Am. Med. News, Feb. 27, 1987, at 34. Because the urban hospitals that act as AIDS centers will undoubtedly care for patients with other diseases, it will be necessary to limit patient contact for those health workers who become seropositive for HIV.

n210. There are many deficiencies of the plan I offer. Perhaps the largest is a matter of justice. One can argue that workers have died for years as a result of diseases contracted at the workplace and all that was available to them was the inadequate workers' compensation system outlined above, see supra notes 162-82 and accompanying text, and can question why health workers, and especially doctors, should be accorded special status now that they too face an occupational disease.

n211. The shifting of the costs of accidents may prove insufficient to keep health care workers on the job. Indeed, people may be so risk-averse that benefits, programs and higher wages will not be adequate. Cf. Viscusi, Magat, & Huber, An Investigation of the Rationality of Consumer Valuations of Multiple Health Risks, 18 RAND J. ECON. 465, 465, 477-78 (1987) (reporting the results of a study of "risk-dollar tradeoffs for the risks associated with using an insecticide and a toilet bowl cleaner," and consumers' valuation of risk reduction).