HIV-Infected Health Care Workers: Revision of CDC Policy

In July 1990, the U.S. Centers for Disease Control and Prevention (CDC) became aware of a possible transmission of Human Immunodeficiency Virus (HIV) from a Florida health care worker, a dentist, to five of his patients. The CDC responded -- in the wake of extensive media coverage and hearings that highlighted the experience of a young woman, Kimberly Bergalis, who became HIV-positive while a patient of the dentist -- with Recommendations for Preventing Transmission of Human Immunodeficiency Virus and Hepatitis B Virus to Patients During Exposure-Prone Invasive Procedures (CDC Morbidity and Mortality Weekly Report, July 12, 1991). These recommendations include guidance on the extent to which the practice of HIV-infected health care workers should be restricted, and circumstances under which the health care worker's HIV status can be disclosed to patients.

Subsequently, in 1991, the U.S. Congress passed a law, section 633 of Public Law 102-141, requiring states either to adopt the CDC guidelines or to adopt similar guidelines of their own creation. In response, most states submitted their own guidelines to the CDC with a minority of states choosing to adopt the CDC guidelines as written. Since the guidelines were initially submitted to the CDC, some states have chosen to enact statutes codifying their guidelines or incorporating the CDC guidelines by reference. However, in the intervening years, medical facilities restricting or terminating the practices of HIV-infected health care workers – from doctors and surgeons to dental hygienists – have relied on the CDC's guidelines to buttress their arguments that these workers pose a "direct threat" to patients, even though that was probably not the CDC's intention. In many cases, these arguments have succeeded. Some qualified physicians did not disclose their HIV status – avoiding or delaying treatment, or paying out of pocket for it, rather than risking disclosure and the loss of their professional status and/or livelihood.

In February 1998, the CDC convened a meeting of experts on the medical, legal, and ethical issues related to the transmission of HIV from health care worker to patient. The purpose of this meeting was to help the CDC determine whether or not to revise its recommendations, and, if so, to what extent. Attendees, including physicians and state and national policy makers, were given the opportunity to consider three options: (1) no CDC action, (2) no revision of the guidelines, but CDC publication of a statement summarizing new scientific information, or (3) revision of the CDC recommendations. The majority of the group supported the third option, indicating that the recommendations did not reflect current knowledge, and that a revision would help end discriminatory practices against HIV-infected health care workers.

In March 1998, the CDC Advisory Committee on HIV and STD Prevention and the Hospital Infection Control Practices Advisory Committee met jointly to revisit the CDC recommendations. At the conclusion of that meeting, both committees voted in favor of revising the 1991 recommendations and drafted a list of specific issues that needed to be addressed in the revision. Two years later, no proposed guidelines revisions had emerged, and so I proposed reform of the national policy, believing it imposed human rights burdens on health care workers and ultimately forced some health care workers out of their chosen professions. (*See* A Proposed National Policy on Health Care Workers Living with HIV/AIDS and Other Blood-Borne Pathogens, 284 JAMA 1965 (2000)). At that time, I argued that it was possible to achieve high levels of patient safety without discriminating against and stigmatizing health care workers by focusing on management of the workplace. This is still possible.

It is now a decade since the CDC Advisory Committee met to modernize the agency's policy that did not fully reflect the state of the science and evidence. Unfortunately, for a variety of reasons, no progress has been made on the revision to the guidelines since 1998. It is now time to revisit this issue. As we work to advance the idea that HIV testing is always in the individual's interest, that HIV is a treatable, manageable disease, and that HIV stigma is on the decline, we must ensure that national policy reflects these ideals.

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