Texas Orthopedic Surgeon Letter of Finding

[RECIPIENT'S NAME REDACTED]

Dear Dr. **[REDACTION]:**

The U.S. Department of Health and Human Services (HHS), Office for Civil Rights (OCR), Headquarters Office, received a February 22, 2005 request from the Complainant asking for a reconsideration of the January 10, 2005 OCR Region VI administrative decision in Transaction Number 00-00834. In that case, the Complainant alleged that you (the Recipient) discriminated against him on the basis of his disability (HIV disease) in violation of Section 504 of the Rehabilitation Act of 1973, as amended, 29 U.S.C. § 794, and its implementing regulations at 45 C.F.R. Part 84 (Section 504). Specifically, the Complainant alleged that the Recipient, an orthopaedic surgeon, refused to perform surgery on his knee to repair his anterior cruciate ligament (ACL) because the Complainant is HIV positive and the Recipient instead referred him to another surgeon in a different city.

On January 10, 2005, OCR Region VI issued a letter of finding ("LOF") concluding that the Recipient did not violate Section 504. After receiving Complainant's February 22, 2005 request for reconsideration and conducting a thorough review, OCR's Headquarters' Office remanded the case to OCR Region VI for additional analysis.

As detailed below, based upon our review of the original LOF and additional analysis of information received from a Centers for Disease Control and Prevention (CDC) physician expert and a second physician expert/orthopaedic surgeon, OCR Region VI finds that the Recipient violated Section 504.

Background

The Complainant is an HIV positive man. The Recipient is an orthopedic surgeon in Austin, Texas. In January 1999, the Complainant went to see the Recipient for treatment of a knee injury. During that visit, the Complainant revealed his HIV status to the Recipient. The Complainant alleges that the Recipient diagnosed his knee condition as a cracked bone, and told him that it would heal in time.

In February 1999, the Complainant re-injured his knee and went back to see the Recipient. At that time, the Recipient diagnosed the injury as a complete tear of the ACL. In August 1999, the Recipient advised the Complainant to begin an exercise program; and, if there was no improvement, to consider knee surgery.

By November 1999, the Complainant's knee had not improved. The Complainant asked the Recipient to perform knee surgery and the Recipient agreed. However, prior to the day of surgery, the Recipient informed the Complainant that he would not perform the surgery because

the Recipient feared that the splattering and aerosolizing of blood and bone particles might pose a risk of HIV transmission to him and others in the operating room.

The Recipient states that he uses the bone-patella tendon-bone technique to repair torn ligaments. That procedure requires him to use an oscillating saw to cut a wedge of bone from the patella and proximal tibia. According to the Recipient, this process showers the operating room with small particles of bone and blood. A newer method of surgery for a torn ACL is the hamstring graft technique, which does not require sawing. The Recipient contends that he is not versed in the hamstring graft technique. According to the Recipient, there is no aerosolizing of blood with that procedure, and therefore less chance of HIV transmission. In February 2000, he provided the Complainant with the name of a doctor in Galveston, Texas, who was willing to perform the hamstring graft technique on the Complainant.

Under Section 504, a covered entity is not required to treat an individual if that individual poses a significant risk to the health and safety of others and reasonable modifications will not eliminate that risk. In *School Bd. of Nassau City v. Arline*, 480 U.S. 273 (1987), the Supreme Court held that a determination of "direct threat" must rely on an individualized assessment, based on reasonable judgments given the current state of medical knowledge. "In making these findings, courts normally should defer to the reasonable medical judgments of public health officials." 480 U.S. at 288. The individualized assessment should consider: (1) the nature, duration, and severity of the risk; (2) the probability that transmission will occur; and (3) whether reasonable modifications of policies, practices, or procedures will mitigate that risk. 480 U.S. at 288.

The original LOF concluded that the Recipient "exercised reasonable medical judgment in referring the [C]omplainant to a physician who would provide the needed service while reducing the risk of infection while performing such a procedure." (LOF at 5). The conclusion was based on the opinion of a public health advisor in HHS Region VI, a physician who was asked to determine whether the Recipient's decision "was a reasonable medical judgment." (LOF at 4). According to the original LOF, the Region VI public health advisor concluded that "it is good medical judgment for a doctor to seek less risky alternatives where the invasive procedure produces the degree of risk of transmission that the bone-patella tendon-bone procedure produces." (LOF at 4).

Evidence and Analysis

The original LOF erred in framing the issue purely as one of "reasonable medical judgment," and in relying on the opinion of the Region VI public health advisor as to whether the Recipient exercised good medical judgment. As noted above, the appropriate legal standard is whether the Complainant posed a significant risk to the health and safety of others and, if so, whether that significant risk could be eliminated through some reasonable modification. As Arline noted, in making these types of assessments, courts (and, therefore, OCR) may defer to the reasonable medical judgments of public health officials. 480 U.S. at 288.

The role of public health officials in this context is to provide an expert opinion for OCR to consider as it determines, as a factual matter, the nature or level of the risk to the health and

safety of the Recipient posed by providing the knee surgery to the Complainant. OCR also must determine whether that level of risk rises to the legal standard of "significant risk." 480 U.S. at 288, n. 16. If OCR decides, based on the medical evidence, that the risk posed by the Complainant to the Recipient is significant, it may defer to reasonable medical judgments of public health officials in determining how far the risk might be reduced based on modifications to practices. The decision regarding whether the reduced level of risk meets the legal standard of eliminating the significant risk is a decision that OCR must make.

Under Section 504, recipients are prohibited from, on the basis of disability, denying a qualified individual with a disability any aid, benefit, or service provided under programs or activities that receive Federal financial assistance. See 45 C.F.R. §§ 84.4(a) and (b)(1)(i). In determining whether the Recipient discriminated against the Complainant on the basis of his disability (HIV disease) in violation of Section 504, the following issues must be considered: (1) whether the Complainant posed a significant risk to the health and safety of the Recipient; and (2) if the Complainant did pose a significant risk of HIV transmission to the Recipient, whether the Recipient fulfilled his obligation to consider if reasonable modifications of policies or procedures could eliminate or mitigate that risk.

1) Whether the Complainant posed a significant risk to the health and safety of the Recipient.

In support of its conclusion that the Complainant posed a significant risk to the health and safety of the Recipient, the original LOF quotes the opinion of a Region VI public health official and an article from the *Journal of Orthopaedic Trauma*. The Journal article stated that the "orthopedic surgeon is at a theoretical risk of aerosolized transmission of HIV via the respiratory route from equipment that could aerosolize blood and tissue," but concluded that there "is currently no biologic or epidemiological evidence that aerosolized transmission via the respiratory route has occurred." 10 *Journal of Orthopaedic Trauma* 292 (1996).

Although the *Journal of Orthopaedic Trauma* describes a theoretical risk of aerosolized transmission of HIV via the respiratory route during the performance of surgery, that risk is countered by the fact in 1996, there was no evidence of aerosolized HIV transmission via the respiratory route actually occurring.

In reconsidering its disposition of this case, OCR contacted Adelisa L. Panlilio, MD, MPH, from the Centers for Disease Control and Prevention. The expert is a physician and medical epidemiologist in CDC's Division of Healthcare Quality Promotion; has been employed by CDC for over 18 years; and has conducted and supervised several studies on the risk and prevention of HIV transmission in health care settings.[1]

Dr. Panlilio prepared a report for OCR on what was known about the risk of HIV transmission to health care personnel in 1999.[2] The report surveys research conducted by the CDC and other organizations in the area of HIV transmission and concludes that overall occupational risk of HIV transmission to health care personnel is low. In over twenty years of the HIV/AIDS epidemic, CDC has received reports of fifty-seven individuals employed in health care settings with documented HIV infection after exposure in the workplace. The highest risk of transmission

is when a health care worker is injured with a needle or sharp instrument contaminated with HIV-infected blood. In that scenario, there is an average of one infection in 300 exposures. Contamination of intact skin with blood or other infectious materials, close personal contact with infected patients, or contact with contaminated environmental surfaces has not been linked to occupational HIV transmission. Of particular relevance is Dr. Panlilio's conclusion that there is and never has been data supporting aerosol exposure as a route of HIV transmission. Specifically, Dr. Panlilio's report states that:

> The airborne route of transmission of HIV has not been documented in epidemiologic or laboratory studies. True airborne transmission would require the formation of very small particles capable of remaining suspended in the air for extended periods of time, capable of being inhaled, and capable of transmitting infection.[3]

Dr. Panlilio's report also discusses a serosurvey of U.S. and Canadian orthopedic surgeons conducted in 1991 at an annual meeting of the American Academy of Orthopaedic Surgeons. Of 3,420 surgeons tested, two were found to be HIV seropositive, and both acknowledged unspecified *non-occupational* risk for HIV infection.

In reaching her conclusions, Dr. Panlilio consulted with James V. Luck, Jr., M.D., a board certified orthopedic surgeon, who is President, CEO and Medical Director, Orthopaedic Hospital, Santa Monica–UCLA Medical Center and Orthopaedic Hospital. Dr. Luck opined that in 1999, at the time that the Complainant was seeking surgery to have his ACL repaired, orthopedic surgeons had adequate personal protective equipment (PPE) available to protect themselves from splashes of blood or irrigation fluid that could occur during the surgery. The PPE included fluid-resistant gowns, rubber aprons, face shields, gloves, goggles, or other protective eye gear. Dr. Luck continued that, if an orthopaedic surgeon chose to do so, he or she might wear what is known colloquially as a "space suit" (with its own powered air supply) to be protected against splashes and the inhalation of infectious particles. Dr. Luck concluded that such a "space suit" is probably far more protection than what would be needed for a simple ACL repair.[4]

OCR has found no scientific evidence to support the Recipient's contention that performing surgery on the Complainant would pose a significant risk to his health and safety. Given the reasonable medical judgments of the two physician experts set forth above, OCR has concluded that in 1999, the potential risk of HIV transmission that the Complainant might have posed to the Recipient during surgery would not rise to the legal standard of a "significant risk."

2) Whether, if the Complainant did pose a significant risk of HIV transmission to the Recipient, the Recipient fulfilled his obligation to consider if reasonable modifications of policies or practices could eliminate or mitigate that risk.

Assuming, for the sake of argument, that OCR had determined that the Complainant did pose a significant risk to the Recipient during surgery, Section 504 requires recipients to consider whether reasonable modifications of policies and practices would eliminate or mitigate that risk.

In 1988, CDC recommended that "blood and body fluid" or "universal" precautions be consistently used for all patients regardless of their infection status. *See Prevention of Transmission of Human Immunodeficiency Virus, Hepatitis B Virus, and Other Blood borne Pathogens in Health Care Settings*, 37 Morbidity and Mortality Weekly Report (MMWR) 377-388 (June 24, 1988). CDC maintains that the key to protecting healthcare personnel from exposure to blood and body fluids is to treat all patients as if they were infectious for blood borne viruses and to act accordingly.

According to Drs. Panlilio and Luck, there were appropriate barrier precautions in 1999, such as fluid-resistant gowns, rubber aprons, gloves, and goggles, that health care workers could use during invasive procedures to prevent skin and mucous-membrane contact with blood and other body fluids of patients. Also, in 1999, orthopaedic surgeons had a choice of wearing additional protective equipment to protect them from splashes and inhalation of infectious aerosols.

The Recipient has stated that, even though he follows the CDC's universal precautions (gowns, masks, double gloving) when performing the bone-patella tendon-bone surgical technique on his patients, his underwear is saturated with blood after performing the procedure. However, the Recipient has not presented any objective scientific evidence that the use of the CDC's universal precautions during the performance of the bone-patella tendon-bone technique would not be sufficient to eliminate or mitigate the risk of HIV transmission by the Complainant to him. Moreover, there is no evidence that an orthopaedic surgeon's use of additional precautions -- such as PPE -- would not substantially reduce any risk of occupational HIV transmission. In light of the opinions of the two physician experts set forth above, OCR has determined that, even in 1999, the use of universal precautions would have reduced the level of risk of HIV transmission by a patient to a health care worker to a level below that which is required to establish the legal standard of a "significant risk." Therefore, OCR finds that the Recipient's failure to consider whether the use of reasonable modifications during Complainant's planned surgery would have eliminated or mitigated any potential risk to his health and safety violated Section 504.

Conclusion

For the reasons stated above, OCR has concluded that there is sufficient evidence to support a finding that the Recipient discriminated against the Complainant on the basis of his disability in violation of 45 C.F.R. §§ 84.4(a) and (b)(1)(i) of the Section 504 regulations.

Opportunity for Voluntary Compliance

When an OCR investigation indicates that a Recipient violated applicable civil rights laws, the Recipient is given the opportunity to take corrective actions necessary to remedy the violation. If compliance cannot be secured by voluntary means, compliance may be effected by suspension or termination of, or refusal to grant or to continue, Federal financial assistance.

OCR is interested in working with the Recipient to resolve these violations in a cooperative and proactive manner, and in providing the Recipient with technical assistance in making changes to ensure that people living with HIV/AIDS have an equal opportunity to benefit from his services.

To this end, OCR Region VI will be in contact with the Recipient to discuss the corrective actions that will be necessary to remedy the violations in this case.

Please be advised that OCR's regulations prohibit a Recipient from harassing, intimidating, or retaliating against an individual because he or she has made a complaint, testified, assisted or participated in any manner in an action to secure rights protected by the civil rights statutes enforced by OCR. 45 C.F.R.§ 80.7(e).

Under the Freedom of Information Act, it may be necessary to release this document and related correspondence and records upon request. In the event OCR receives such a request, we will make every effort to protect, to the extent provided by law, information which identifies individuals or which, if released, would constitute an unwarranted invasion of privacy. 5 U.S.C. § 552.

If you have any questions about this letter, you may contact me at (214) 767-4056. At the same time, I would like to extend to you an invitation to contact me so that we can discuss next steps in resolving this matter. I would appreciate a response to this letter within thirty (30) days. Thank you for your continued cooperation.

Footnotes:

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1. See Dr. Panlilio's Curriculum Vitae (attached).
2. See Dr. Panlilio's expert report (attached)
3. See Dr. Panlilio's expert report at page 5.
4. See Dr. Panlilio's expert report at page 7.

Sincerely,

Ralph Rouse
Regional Manager

[**ATTACHMENTS REDACTED**]
cc: Tamara L. Miller
Deputy Director
Office for Civil Rights