HEALTH - COMMUNICABLE DISEASES - CIVIL RIGHTS AND DISCRIMINATION - DISABILITY - TESTING OF CONTRACTUAL HEALTH CARE PROVIDERS FOR HIV - RESTRICTIONS ON PRACTICE OF HIV-POSITIVE PROVIDERS

The Honorable William Donald Schaefer

Dear Governor Schaefer:

You have requested our opinion about the legality of a requirement that contractors providing health care services in State correctional facilities determine whether any of their employees are infected with the HIV virus, which causes AIDS. The State would establish this requirement in order to impose on HIV-positive health care providers special measures for the protection of the patients in these facilities.

The ultimate answer to your question depends on a public health judgment that we are not able to make. That is, the proposed requirement would be legal only if the activities of HIV-positive health care providers present a significant risk to the health of patients in the facility. The decision about the significance of the risk, in turn, requires expert assessment of the pertinent scientific evidence.

Under federal law, a person with a disability - including a person with HIV - may not be subjected to employment restrictions because of that disability if the person is “qualified” to perform the job. In particular, a person with an infectious disease may not be subjected to special restrictions unless the risk of contagion makes the person unqualified to perform the job even after reasonable steps are taken to accommodate the disease.

HIV can be transmitted only if the blood or other bodily fluid of a person with the disease enters the body of another person. If an HIV-positive health care provider does not regularly perform invasive procedures that could result in the passage to a patient of the provider's blood or other bodily fluid, the risk to the provider's patients is essentially zero. [FN1] In our opinion, federal law prohibiting discrimination against individuals with disabilities bars an attempt to impose any special workplace requirements on this category of health care providers, even though their jobs might involve patient contact. [FN2] Moreover, because no action could lawfully be taken on the basis of a positive test result, a requirement that these providers submit to testing would also violate the Fourth Amendment to the U.S. Constitution.
The category of health care providers who regularly perform invasive procedures presents a different legal issue. In our opinion, federal law does not preclude special restrictions on this category of HIV-positive health care providers if the restrictions are justified on medical grounds. Thus, if the State is to impose by contract special restrictions on the practice of HIV-positive health care providers, an appropriate public health official must first make a reasonable determination along these lines: Based on current medical evidence and evolving standards of patient care, and taking into account feasible infection control methods, patients in State correctional facilities undergoing invasive procedures from HIV-positive providers are subject to a degree of risk that, as a matter of public health policy, is unacceptable.

*2 If such a judgment were reached on the basis of an informed assessment of the scientific evidence, the State may lawfully direct its health care contractors to take special steps to protect patients — if necessary, to forbid HIV-positive providers from engaging in invasive procedures in State correctional facilities. As a corollary, the State may require its contractors to identify the providers who would be subject to these restrictions.

I

Background

Your inquiry is a consequence of reports that two dentists who died of complications from AIDS had treated prisoners in correctional facilities in the Baltimore area. Both dentists were employees of a contractor that provides a range of health care services to the Division of Correction, consistent with the State's duty under the Eighth Amendment to provide constitutionally adequate medical care to those in its custody. Estelle v. Gamble, 429 U.S. 97 (1976).

Persons become infected with HIV when a retrovirus, the human immunodeficiency virus, enters the bloodstream. "Most persons infected with HIV are in the asymptomatic incubation stage, thus have no signs and symptoms [and] look and feel healthy . . . ." Governor's Advisory Council on AIDS, Guidelines for Control of Human Immunodeficiency Virus Infection 1 (May 1989) ("HIV Infection Control"). See also, e.g., Brandt, Health Care Workers and AIDS, 48 Md. L. Rev. 1, 3 (1989). Their diagnosis is typically established through blood tests that show the presence of antibodies formed in response to the virus's entry into the body. [FN3]

"It is presently thought that most persons who are infected will eventually develop AIDS, a stage of the infection defined by the presence of one or more of a number of infections or cancers." HIV Infection Control at 1. AIDS is a fatal illness, typically causing "a lingering death commonly resulting from opportunistic infections and often accompanied by both physical and mental debilitation." Id.

The HIV virus is transmitted from person to person "by sexual contact, by contact with contaminated needles, from mother to baby, by transfusion of infected blood or blood products, and from infected
blood or bloody body fluids in contact through breaks in the skin or mucous membranes.” Id. The Governor's Advisory Council reports “no documented spread of HIV by ordinary household, social or office contacts.” Id. See generally Friedland & Klein, Transmission of the Human Immunodeficiency Virus, 317 N. Eng. J. Med. 1125 (1987). “Thus no special precautions are required for HIV-infected workers who only come into casual contact with other persons in the job setting . . . . A risk of transmission of HIV infection from a health care worker to a patient exists in situations where there is trauma to the patient, as in invasive surgical or dental procedures, and trauma to the worker, such as a scalpel or needlestick injury.” HIV Infection Control at 21.

Health care providers have been urged by authoritative bodies like the Centers for Disease Control ("CDC") and the Governor's Advisory Council to adhere to “universal precautions.” when engaging in invasive procedures - notably, the wearing of latex gloves. HIV Infection Control at 6-8. The barrier of the gloves protects both the patient and the provider. [FN4]

*3 These precautions do not work, of course, if they are not followed. An expert in one case testified “that approximately five to ten percent of the time health care workers do not comply with recommended universal precautions.” Leckelt v. Board of Comm'rs, 909 P.2d 820, 820 (5th Cir. 1990). And even the most conscientious provider could suffer an accident - latex gloves are no match for a scalpel. “Studies indicate that surgeons will cut or puncture a glove in approximately one out of every four cases and will sustain a significant skin cut in one out of every forty cases.” Gostin, Hospitals, Health Care Professionals, and AIDS, 48 Md. L. Rev. 12, 20 (1989).

Until recently, no case of provider-to-patient transmission had been reported in the literature. In fact, several studies of HIV-infected surgeons showed no transmission: “Out of a total of 4,703 patients studied there were no documented cases of HIV transmission from surgeons infected with AIDS to their patients.” Rossi v. Estate of Almarez, Case No. 90344028 CL123396, slip op. at 4 (Cir. Ct. Balto. City May 23, 1991) (Kaplan, J.).

However, last year the CDC reported a case “consistent with transmission of HIV to a patient during an invasive dental procedure . . . .” CDC, Possible Transmission of Human Immunodeficiency Virus to a Patient During an Invasive Dental Procedure, 39 Morbidity and Mortality Weekly Rep. ("MMWR") 489, 491 (1990). See also 40 MMWR 21 (1991).

This new evidence of provider-to-patient transmission has brought into sharp focus the related issues of testing of health care providers and restrictions on those who test positive for HIV. Five years ago, the CDC discouraged routine testing "since the risk of transmission is so low." CDC, Recommendations for Preventing Transmission . . . During Invasive Procedures, 35 MMWR 221, 223 (1986). Accord, HIV Infection Control at 21 ("Routine screening of workers for HIV antibodies is not recommended as a means of preventing the transmission of HIV."). See also Gostin, HIV -Infected Physicians and the Practice of Seriously Invasive Procedures, Hastings Center Rep., Jan./Feb. 1989 at 35. Even in light of the new evidence, one commentator suggests that mandatory testing is unnecessary:
For now, given the small risk of transmission, it appears that the balance between utility and risk does not warrant mandatory testing of health care workers or reporting by them. Instead, voluntary testing and subsequent voluntary action seem to be most appropriate.


Yet in an editorial accompanying that article, the editor of the New England Journal of Medicine herself wrote that testing health care providers (and hospitalized patients too) "makes sense from several standpoints . . . . [B]ecause it is remotely possible that there could be an exchange of blood during a medical procedure, patients have a right to know whether a doctor or nurse who performs invasive procedures is infected with HIV." Angell, A Dual Approach to the AIDS Epidemic, 324 N. Eng. J. Med. 1498, 1499 (1991). [FN6]

*4 The issue of HIV-infected health care providers drew legislative attention during the past session. Chapter 535 (House Bill 194) of the Laws of Maryland 1991 provides in part as follows:

(1) The Medical and Chirurgical Faculty of the State of Maryland in consultation with the Centers for Disease Control, the Maryland Hospital Association, and the Department of Health and Mental Hygiene shall develop a practice protocol for physicians who are infected with HIV.

(2) This practice protocol shall be reported . . . to the General Assembly on December 2, 1991.

§ 18-338.1(1) of the Health-General Article (effective July 1, 1991).

II

Federal Law

A. Rehabilitation Act and Americans With Disabilities Act

State agencies are currently subject to § 504 of the Rehabilitation Act of 1973, 29 U.S.C. § 794, if they receive federal financial assistance. This statute provides in general that "[n]o otherwise qualified individual with handicaps . . . shall, solely by reason of her or his handicap, be excluded from the participation in, be denied the benefits of, or be subjected to discrimination" in the operations of such a State agency. 29 U.S.C. § 794(a).

In addition, starting next year the State will be subject to Title II of the Americans with Disabilities Act (the "ADA"), which broadly prohibits state and local governments from engaging in discrimination against persons with disabilities. "[T]itle II of the ADA is, in essence, an extension of the nondiscrimination mandate of section 504 to those State and local governments that do not receive Federal financial assistance . . . ." 56 Fed. Reg. 8538 (February 28, 1991) (Department of Justice proposed regulations). Because the basic principles governing the State's actions remain unchanged, we will discuss the two statutes together.

HIV infection, whether or not it has developed into AIDS, is a

Section 202 of the ADA provides that “no qualified individual with a disability shall, by reason of such disability, be excluded from participation in or be denied the benefits of the services, programs, or activities of a public entity, or be subjected to discrimination by any such entity.” [FN7] A “qualified individual with a disability” is one who “meets the essential eligibility requirements for . . . participation in programs or activities provided by a public entity.” § 201(2). In its proposed regulations, the Department of Justice takes the view that Title II's antidiscrimination requirements apply to a state's contractual undertakings. [FN8] Further, Title II's broad proscription of discrimination is intended to incorporate standards set out elsewhere in the ADA, including the duty of employers under Title I. H.R. Rep. No. 101-485, 101st Cong., 2d Sess. 84 (1990); S. Rep. No. 101-116, 101st Cong., 2d Sess. 44 (1990). Thus, the State could not require by contract that its contractor engage in unlawful discrimination against the contractor's employees.

*5 Under Title I of the ADA, employers may not “discriminate against a qualified individual with a disability because of the disability of such individual in regard to job application procedures, the hiring, advancement, or discharge of employees, employee compensation, job training, and other terms, conditions, and privileges of employment.” § 102(a). [FN9] An individual is “qualified” if he or she “can perform the essential functions of the employment position that such individual holds or desires.” § 101(8).

Among the examples of prohibited discrimination set out in § 102(b) is “using qualification standards, employment tests or other selection criteria that screen out an individual with a disability or a class of individuals with disabilities, unless the standard, test or other selection criteria . . . is shown to be job-related for the position in question and is consistent with business necessity.” § 102(b)(6). In addition, an employer may not “make inquiries of an employee as to whether such employee is an individual with a disability or as to the nature or severity of the disability, unless such . . . inquiry is shown to be job-related and consistent with business necessity.” § 102(c)(4)(A).

In School Board of Nassau County v. Arline, 480 U.S. 273 (1987), the Supreme Court discussed the factors to be considered in deciding whether the Rehabilitation Act affords job protection to a person with a contagious disease. Quoting from an amicus brief filed by the American Medical Association, the Supreme Court wrote that the inquiry should focus on the following:

“facts, based on reasonable medical judgments given the state of medical knowledge, about (a) the nature of the risk (how the disease is transmitted), (b) the duration of the risk (how long is the carrier infectious), (c) the severity of the risk (what is the potential harm to third parties) and (d) the probabilities the disease will be transmitted and will cause varying degrees of harm.” 480 U.S. at 288. Significantly, the Court instructed the lower courts that they “normally should defer to the reasonable medical judgments of
public health officials” about these matters. Id.

Both the Rehabilitation Act (as amended in 1988) and the ADA directly address the issue of individuals with contagious disease, and both codify the Supreme Court's focus on actual medical risk. 29 U.S.C. § 706(8)(c) excludes from the definition of “individual with handicaps” someone “who has a currently contagious disease or infection and who, by reason of such disease or infection, would constitute a direct threat to the health or safety of other individuals or who, by reason of the currently contagious disease or infection, is unable to perform the duties of the job.” Under § 103(b) of the ADA, an employer may adopt a requirement “that an individual shall not pose a direct threat to the health or safety of other individuals in the workplace.” § 103(b). A “direct threat” is “a significant risk to the health or safety of others that cannot be eliminated by reasonable accommodation.” § 101(3). The ADA's legislative history explains that, “in determining what constitutes a significant risk, . . . the employer may take into consideration such factors as the magnitude, severity, or likelihood of risk to other individuals in the workplace . . . .” H. Conf. Rep. No. 101-596, 101st Cong., 2d Sess. 60 (1990). See also H.R. Rep. No. 101-485, 101st Cong., 2d Sess. 76 (1990) (“the term 'direct threat' is meant to connote the full standard set forth in the Arline decision”).

*6 With respect to HIV, the facts about the first three Arline factors are not subject to reasonable dispute: a person is at risk of getting the disease through contact with infected blood or other bodily fluid, but not otherwise; a person with HIV is always infectious; and the potential harm to third parties is devastating.

The indisputability of the first factor means that the Rehabilitation Act and the ADA do not allow discrimination against persons infected with HIV, including health care providers, whose jobs simply do not entail any significant risk that a patient would become exposed to the provider's blood. If the risk of blood exposure is essentially zero, the provider's infectiousness in other contexts and the severity of the disease are irrelevant. See Chalk v. United States District Court, 840 F.2d 701, 706-08 (9th Cir. 1988) (applying Arline factors to teacher with AIDS).

On the other hand, if an HIV-positive health care provider routinely engages in invasive procedures, the first three Arline factors all point to a decision that the provider is not qualified. The determinative factor is the fourth, “the probabilities the disease will be transmitted” given the nature of the provider's tasks. This assessment of probabilities requires knowledge of the latest epidemiologic and clinical evidence. It is for an expert in the field to make, not the Attorney General.

Compliance with the ADA requires an additional expert judgment. If an individual with an infectious disease can safely work with “reasonable accommodation,” the employer has a duty to provide that accommodation. Arline, 480 U.S. at 288. [FN10] Conversely, “[a] person who poses a significant risk of communicating an infectious disease to others in the workplace will not be otherwise qualified for his or her job if reasonable accommodation will not eliminate that risk.” 480 U.S. at 287
“An accommodation is not reasonable, and will therefore not be required, if . . . it imposes an undue hardship upon the operation of the . . . employer.” Hall v. United States Postal Service, 857 F.2d 1073, 1080 (6th Cir. 1988). See ADA § 101(10) (defining “undue hardship”) and 102(b)(5)(A) (excusing “reasonable accommodation” duty if “undue hardship” on business operation would result). The employer's decision not to provide an accommodation to an individual with a disability must “reflect a well-informed judgment grounded in a careful and open-minded weighing of the risks and alternatives . . . .” Arline v. School Bd., 772 F.2d 759, 765 (11th Cir. 1985), aff'd 480 U.S. 273 (1987).

Except for the danger of accidental cuts or punctures serious enough to penetrate a glove, the risk to a patient posed by an HIV-positive health care provider who performs invasive procedures but who adheres scrupulously to universal precautions is negligible. Plainly, the risk increases if the provider fails to adhere to these precautions. Whether that increase reaches a medically significant level is for an expert in the field to determine.

*7 If measures to ensure compliance with universal precautions - for example, monitoring - were feasible and effective, and if the risk of a medically significant accident were very low, these measures would be the kind of “reasonable accommodation” required by the ADA, and the State could not resort to more severe measures limiting the work opportunities of HIV-positive providers. Again, the judgment whether these measures could be effective at a reasonable cost is for the appropriate public health official. [FN11]

Our focus on the legal significance of actual patient risk finds support in an official position of the American Medical Association, whose views were given decisive weight in Arline. The AMA has concluded that “patients are entitled to expect that their physicians will not increase their exposure to the risk of contracting an infectious disease, even minimally. If no risk exists, disclosure of the physician's medical condition to his or her patients will serve no rational purpose; if a risk does exist, the physician should not engage in the activity.” Council on Ethical and Judicial Affairs, Ethical Issues Involved in the Growing AIDS Crisis, 259 J.A.M.A. 1360, 1361 (1988). See also Comment, The AIDS Project: Creating a Public Health Policy - Rights and Obligations of Health Care Workers, 48 Md. L. Rev. 106, 143 (1989). [FN12]

The few reported cases involving government efforts to require HIV testing confirm our view that the ADA issue will be resolved on the strength of the medical justification for finding out a person's HIV status. In Leckelt v. Board of Comm'rs, 714 F. Supp. 1377 (E.D. La. 1989), aff'd 909 F.2d 820 (5th Cir. 1990), the courts held that the firing of a nurse, “some of [whose] duties provided potential opportunities for HIV transmission to patients,” because of his refusal to disclose the results of his HIV test did not violate the Rehabilitation Act. In light of legitimate medical concerns about risk to the patients (and to the nurse himself), the nurse “was not ‘otherwise qualified’ to perform his job . . . because of his failure
to comply with [the hospital's] policies for monitoring infectious diseases, such as HIV.” 909 F.2d at 830. See also Local 1812, AFGE v. Department of State, 662 F. Supp. 50 (D.D.C. 1987) (rejecting Rehabilitation Act challenge to HIV testing of Foreign Service officers because HIV-positive officers who could not get adequate medical care overseas were not “otherwise qualified” for the jobs).

To summarize, “[w]hether it can be established that the performance of invasive procedures or other activities within health care settings creates a significant risk of transmission to others is a question that will ultimately turn on expert medical testimony.” Hermann & Schurgin, Legal Aspects of AIDS § 12:38, at 12-47 (1991). If medical evidence supports the existence of an unacceptable degree of risk, the State may abate the risk without breach of its duties under the Rehabilitation Act and the ADA. If not, any differential treatment of HIV-positive health care providers would be unlawful.

B. Fourth Amendment

*8 Any State requirement that forces individuals to obtain HIV tests or else forfeit an employment opportunity would be subject to review under the Fourth Amendment's proscription of “unreasonable searches and seizures.” See National Treasury Employees Union v. Von Raab, 489 U.S. 656 (1989). In our opinion, however, a State requirement involving HIV testing that complies with the Rehabilitation Act and the ADA would also be constitutional, and for the same reason: The requirement would reflect a reasonable medical judgment about the steps necessary for patient protection.

The balancing test invoked by the Supreme Court for deciding Fourth Amendment claims of this kind would require, as the Rehabilitation Act and the ADA do, the State to demonstrate the medical justification for its indirect testing requirement. If that justification existed, the State's interest in protecting the health of those in its facilities would outweigh the privacy claims of health care providers and would therefore be constitutionally “reasonable.” In Leckelt v. Board of Comm'rs, 909 F.2d at 832-33, the same medical rationale that supported an HIV testing requirement under the Rehabilitation Act also sustained it under the Fourth Amendment. See also Local 1812, AFGE v. Department of State, 662 F. Supp. at 53. Cf. Plowman v. Department of the Army, 698 F. Supp. 627, 636 (E.D. Va. 1988) (“medical need to know” rendered HIV test of hospital patient constitutionally reasonable).

Another case illustrates the constitutional consequence of insufficient medical justification. In Glover v. Eastern Nebraska Community Office of Retardation, 686 F. Supp. 243 (D. Neb. 1988), aff'd 867 F.2d 461 (8th Cir.), cert. denied 110 S. Ct. 321 (1989), the state employer sought to test all patient care workers at a state facility for HIV and other communicable diseases, claiming that the facility's patients were at risk. The courts found this patient care justification to be unsupported by the medical evidence: “[F]rom a medical viewpoint, this policy is not necessary to protect clients from any medical risks.” 686 F. Supp. at 249. See also 867 F.2d at 464. Apparently the workers in question did not routinely engage in invasive procedures, and the district court characterized the risk of HIV transmission as “minuscule, trivial, extremely low, extraordinarily low, theoretical,
and approaches zero.” 686 F. Supp. at 251. Hence, the testing requirement was unreasonable under the Fourth Amendment.

In short, “employee expectations of privacy against mandatory HIV testing depend on careful judicial application of the medical authorities to the fourth amendment and Rehabilitation Act.” Note, Mandatory Testing of Public Employees for the Human Immunodeficiency Virus: The Fourth Amendment and Medical Reasonableness, 90 Col. L. Rev. 720, 743 (1990).

III

State Law

A. Informed Consent For Testing

Under § 18-336(b) of the Health-General Article (“HG” Article), health care providers are under a duty to obtain informed consent prior to testing a person's blood for the presence of HIV:

*9 Before obtaining a blood sample from an individual for the purpose of testing the blood for the presence of HIV infection, a health care provider shall:

(1) Obtain written informed consent from the individual on a uniform HIV informed consent form that the Department [of Health and Mental Hygiene] shall develop consistent with the requirements of the Department as established by regulations adopted by the Department; and

(2) Provide the individual with pretest counseling . . . .

The phrase “informed consent” invokes the physician's well-established duty to provide the patient with enough information about the benefits and risks of the procedure to render the patient's consent to the procedure an informed one. See Sard v. Hardy, 281 Md. 432, 379 A.2d 1014 (1977).

Nothing in HG § 18-336 precludes an employer from requiring an employee to be tested so that the employer can learn the employee's HIV status. [FN13] Nor does anything in this statute preclude the State from imposing a testing requirement on those with whom it contracts to provide health care services.

B. Work-Related Medical Inquiries

Article 100, § 95A of the Maryland Code limits an employer's ability to obtain medical information about an applicant for employment: “An employer may not require an applicant to answer any questions, written or oral, pertaining to any physical, psychological, or psychiatric illness, disability, handicap or treatment which does not bear a direct, material, and timely relationship to the applicant's fitness or capacity to properly perform the activities or responsibilities of the desired position.” Since HIV infection is a “physical . . . illness [or] disability,” this section would prohibit an employer who hires health care providers from asking about their HIV status unless that information was relevant to the provider's job responsibilities. [FN14]

For the reasons discussed in Part II above, a State contractor's
inquiry about HIV status would bear no relationship “to the applicant's fitness or capacity to properly perform the activities or responsibilities of the desired position” if the position did not entail routine performance of invasive procedures. If, on the other hand, the applicant was applying for a job involving invasive procedures, and if medical evidence justified special requirements for HIV-positive providers, this statute would not prohibit the employer's requiring disclosure of HIV status.

C. Human Relations Commission Act

Under Article 49B, § 16(a)(1), an employer may not “discriminate against any individual with respect to his compensation, terms, conditions, or privileges of employment, because of such individual's . . . physical or mental handicap unrelated in nature and extent so as to reasonably preclude the performance of the employment.” [FN15] HIV infection is a “handicap,” according to the Human Relations Commission. COMAR 14.03.02.02.

The Commission's regulations recognize that a person is not qualified to do a job if the person would “create a dangerous condition to life or health of self or others.” COMAR 14.03.02.05A(2). More generally, an employer may “take action otherwise prohibited under these regulations when mental and physical ability is a bona fide occupational qualification reasonably necessary to the normal operation of the particular business.” COMAR 14.03.02.05F(1).


D. Code of Fair Practices

The Code of Fair Practices, Executive Order 01.01.1987.20, contains the following provision: “Every State contract for . . . services shall contain clauses which prohibit discrimination on account of . . . physical or mental handicap . . . .” Article VI(A). The term “discrimination” is not defined or elaborated. In the absence of evidence that the term was meant to have a broader connotation than the term as used in the federal and State laws discussed above, we conclude that if an action would not violate these laws, it would not be an act of prohibited discrimination under the Code of Fair Practices.

IV

Conclusion
In summary, it is our opinion that:
1. The State may not require a contractor to restrict the activities of HIV-positive health care providers who do not regularly engage in invasive procedures, nor may the State require the contractor to ascertain the HIV status of providers who do not regularly engage in invasive procedures.
2. If public health officials reasonably determine that the protection of patients against a significant risk of transmission of HIV so requires, the State may require its contractor to impose special requirements or limitations on HIV-positive health care providers who regularly engage in invasive procedures and may require the contractor to ascertain who those providers are.

Very truly yours,
J. Joseph Curran, Jr.
Attorney General

Jack Schwartz
Chief Counsel
Opinions and Advice

[FN1]. A word about usage in this opinion: When we refer to a provider who “regularly” engages in invasive procedures, we mean that these procedures are an integral part of that provider's practice; we do not mean to imply that some minimal frequency is necessary. “Invasive procedures,” as we use the term, means procedures that afford a ready pathway for the blood or other bodily fluid of the provider to enter the patient's body: deferring to medical expertise, we do not attempt to itemize these procedures. See note 12 below. Finally, although HIV can be transmitted through bodily fluids other than blood, the medium of provider-to-patient transmission is most likely to be blood. For brevity's sake, in the rest of this opinion we will refer to “blood” only, instead of “blood or other bodily fluid.”

[FN2]. We are not here discussing persons who have infectious diseases associated with AIDS (for example, tuberculosis) to the extent that they separately pose a risk to others. See Hermann & Schurgin, Legal Aspects of AIDS § 12:38, at 12-46 to 12-47 (1991).

[FN3]. Because the antibodies might not be present in the bloodstream for weeks or months after the person has contracted the disease, a negative HIV test does not establish that the person is free of the disease.

[FN4]. Health care providers treat a patient population comprising some unknown percentage of persons infected with HIV; hence, providers must take precautions against contracting the disease from their patients. The percentage of the prison population with HIV has been estimated to be eight percent. Baltimore Sun, May 30, 1991, at B1.

[FN5]. It has been argued that mandatory testing of health care providers is a step down a slippery slope, leading to a loss of trust between physicians and patients as well as an erosion of the confidentiality commitment that has encouraged people to obtain testing and counseling voluntarily. Comment, The AIDS Project: Creating a

[FN6]. Dr. Angell coupled her recommendation about epidemiologic control with concern about the need for the protection of individual rights: “Clearly, HIV-infected persons need to be protected against discrimination and hysteria, but doing so requires social and political measures, not epidemiologic ones.” Id.

[FN7]. The State is a “public entity.” § 201(1)(A).

[FN8]. Proposed 28 C.F.R. § 35.130(b)(3)(i) states that “[a] public entity may not, directly or through contractual or other arrangements, utilize criteria or methods of administration . . . [t]hat have the effect of subjecting qualified individuals with disabilities to discrimination on the basis of disability.” 56 Fed. Reg. at 8553.

[FN9]. Title I of the ADA becomes effective in July 1992 for employers with 25 or more employees and in July 1994 for employers with 15 to 25 employees. Employers with fewer than 15 employees are not covered.

[FN10]. Proposed regulations of the Equal Employment Opportunities Commission describe a “reasonable accommodation” in part as “[a]ny modification or adjustment to the work environment, or to the manner or circumstance under which the position held or desired is customarily performed, that enables a qualified individual with a disability to perform the essential functions of that position . . . .” 56 Fed. Reg. 8578, 8588 (February 28, 1991) (proposed 29 C.F.R. § 1630.2(o)(1)(ii)).

[FN11]. If monitoring were judged effective but would be economically reasonable only if limited to HIV-positive providers, the State could require disclosure of HIV status to enable the monitoring to be accomplished.

[FN12]. If restrictions were medically justified in some circumstances, expertise is required to identify the exact circumstances. For example, although surgery is generally the most invasive of procedures, increasing use of laparoscopy renders some types of surgery no more susceptible to an exchange of blood than many nonsurgical procedures. See Guiding the Knife, The Economist, May 4, 1991, at 83.

[FN13]. Some states have expressly prohibited such employer requirements. See, e.g., Cal. Health & Safety Code § 199.21.

[FN14]. This provision is inapplicable to the State in its capacity as employer. See, e.g., Unnamed Physician v. Commission on Medical Discipline, 285 Md. 1, 12, 400 A.2d 396 (1979); Harden v. Mass Transit Admin., 277 Md. 399, 408, 354 A.2d 817 (1976). Cf. Article 100, § 95(a)(2) (term “employer” defined to include the State for purposes of that section only).

[FN15]. This provision applies to employers with 15 or more employees. Article 49B, § 15(b). The term “physical or mental handicap” is defined in § 15(g).
[FN16]. Although we are addressing the Human Relations Commission Act in order to provide you with a complete response, we recognize that interpretation of the act is primarily the prerogative of the Commission, subject to judicial review. See Commission on Human Relations v. Mass Transit Admin., 294 Md. 225, 233, 449 A.2d 385 (1982).