An Executive Briefing and Training Manual

Managing AIDS in the Workplace

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Preface

"In 1981 the Centers for Disease Control reported five cases of pneumocystis cariini pneumonia among previously healthy male homosexuals in Los Angeles. Surprising reports of aggressive Kaposi sarcoma soon surfaced among gay men in New York. Other cases were identified as far back as 1978. These were the first glimpses of AIDS, Acquired Immune Deficiency Syndrome, an epidemic causing fear and death for thousands of people in the United States. It continues as a medical and social challenge unique in our history. One-and-one-half million people are estimated to be carrying HIV infection. By the end of 1991, 270,000 new cases will develop. (54%) of all cases now occur in New York and California, but it is estimated that by next year, more than half will occur in other states. Public and private officials are facing a crisis that is new and unpredictable."

—from the video,
"Managing AIDS in the Workplace"

An epidemic brings out the worst and best in human character. The AIDS epidemic, officially reported in 70 countries spanning five continents, has already produced real-life testimony to both.

AIDS is an emotional as well as medical issue.

As more Americans are infected, misinformation and confusion about pertinent social, legal and professional issues will increase disproportionately.

Fear is far more contagious than AIDS.

In the workplace, this is doubly true. People with AIDS are unjustifiably shunned, quarantined or fired. School administrators, frightened and misinformed about AIDS contagion, bar children with AIDS from the classroom. Tabloids print sensational and misleading stories about AIDS; news columnists demand that people with AIDS submit to tattooing. Myths and rumors abound. Instead of examining the facts, we look for scapegoats, someone or something to blame for our inability to find a quick cure.

AIDS is costly to management in terms of company production, morale, and health and disability benefit costs. AIDS not only impacts the individual, but co-workers, family members, and consumer/public relations. Ultimately, management must deal with the effects of AIDS hysteria: work stoppage, threats of mass resignation, employee petitions to supervisors, employer and union demands for automatic reassignment, quarantine or firing of suspected colleagues with AIDS—and even after his/her exit—the unnecessary reactions to sterilize and quarantine the telephones, washroom facilities and worksite of the employee with AIDS.

Even in tolerant work environments, problems appear. Management and co-workers might initially urge an individual with AIDS to continue working. Yet, when the sight of his rapid physical deterioration affects morale and productivity, management often rethinks its position.

Employers must know that such actions trigger charges of job discrimination and plunge them into legal waters. To date, New York State's Division of Human Rights has overseen settlements in which people perceived to have AIDS received thousands of dollars in more than 20 such cases. In August 1986, the United States government filed its first complaint on behalf of a person with AIDS.

Anticipating conflict and reducing risk

The legal conflict between assuring civil rights and maintaining management control puts management in a precarious position regarding its obligations to individuals with AIDS or affected by the AIDS virus.

How can a company protect its employees when it can't identify how the disease is transmitted to them? How does a company deal with the fact that an infected person does not appear sick, and may not be? What about mandatory staff testing? Is it legal? Is it even good business or ethical practice? Then what about the economics issue? Again, murky waters. What are the health care costs, how will they increase and what share of those costs will corporations pay?

Need for corporate guidelines

Because of AIDS uncertainties, an employer must develop reliable, compassionate guidelines that protect company interests, reduce workplace tension and fear, while ensuring other staff that their safety and productivity are of paramount importance.

But administrators and policy makers are deluged with reams of complicated material on this volatile subject. The problem of making daily decisions, consistent with rapidly changing insurance and legal guidelines on AIDS, is formidable.

This is the dilemma we address in this manual.

Purpose of the manual

"Managing AIDS in the Workplace" offers definitive data and procedures to lead your school or company through development of an AIDS policy suited to your organization. This executive briefing manual helps protect your institutional and corporate interests while ensuring fair employment practices. It is a human resource tool that summarizes the major issues and gives guidelines and trainer exercises on how to deal with them. It focuses on the legal and psychological, as well as medical dimensions of AIDS and helps calm this epidemic of fear. The manual's updated information helps you alter your company's employee relations policy for AIDS in the face of new legal decisions and economic criteria in order to ultimately avoid crisis management.

This manual will:

1
Establish the pertinence of the AIDS problem in every workplace, and educate managers on how to deal with it.

2
Enhance employee communication about the facts surrounding AIDS, and use feedback from this dialogue to define a policy which is based on medical testimony from recognized experts.

3
Provide reliable information to management on the latest AIDS decisions/policy/opinion/research—such as a Summary of Case Law included in Appendix I. Management, in turn, provides this updated information for staff members to foster collective awareness, and then, personal responsibility and cooperation.

4
Provide management with guidelines that protect the employee with AIDS as well as guarantee a healthy and safe workplace.

5
Provide evaluation instruments for monitoring an organization's policy effectiveness.

6
Prepare your organization to provide in-service training or to hire outside consultants who can help develop customized AIDS training programs.

Targeted audience for this manual:

- Executives, CEOs, Presidents
- Corporate Medical Director, Staff
- Human Resource, Personnel Management
- Managers
- Employee Assistance Program Directors, Staff
- Health & Safety Managers
- Union Officials
- Psychologists
- Social Workers
- Counselors

Demystifying AIDS

"Fear of catching the plague from others drove wealthy people to shut themselves inside the walls of their castles, shunning contact with servants and even loved ones . . . Wives abandoned sick husbands, parents their diseased children. The sick were left to die, and the dead went unburied. Panic began to turn to despair as hundreds and then thousands began to die. Was no one to be spared, people asked?

—Walter Olesky
The Black Plague

Walter Olesky, writing about the bubonic plague that swept 14th century Europe, might be describing our nation in the '80s. We live in a climate of fear and face a monumental health crisis for which there is no quick cure or easy social solution. Such a Dark Ages scenario should not, however, apply to AIDS. Since identification of the first cases by the Centers for Disease Control (CDC) in 1981, scientists have learned much about how AIDS is transmitted between humans. And most Americans have not reacted with the hysteria described by Olesky.

What causes AIDS?

Researchers have given different names to the virus that is linked to AIDS; HTLV-III, LAV, and now HIV, (human immunosuppressive virus) which is the name most commonly used today. There is little doubt that HIV is related to the cause of AIDS. What is not known is the exact nature of the events leading to the illness. There are other co-factors suspected in the cause of the disease. Not everyone who is exposed to the virus contracts AIDS. Most infected people remain healthy. Some may eventually become seriously ill while others only exhibit mild symptoms,and others apparently suffer no ill effects.

AIDS is among the most lethal of all immunodeficiency diseases.

Among those diagnosed as suffering from full-blown AIDS, half of all patients die before the year ends. Nearly all die within three years of diagnosis. At this time, there is no known cure. It is estimated that between 500,000 and 2,000,000 Americans have been exposed to the HIV virus, but most are not (at least not yet) suffering from full-blown AIDS.

What is AIDS? Some key definitions:

AIDS is the acronym for Acquired Immune Deficiency Syndrome. It is characterized by a collapse of the body's natural immunity against disease. A person who contracts AIDS is vulnerable to illnesses that an individual with a healthy immune system might overcome. These illnesses are referred to as opportunistic infections.

AIDS patients suffer from a host of opportunistic infections, notably (80%) from either Pneumocystis cariini pneumonia (PCP), a parasitic infection of the lungs, a type of pneumonia; and/or a rare type of cancer known as Kaposi's sarcoma (KS).

ARC is an acronym for Aids Related Complex. People who have ARC develop chronic symptoms that occur in people infected with HIV but their conditions don't meet the CDC definition of AIDS. Their symptoms are less severe than those that occur in people with AIDS, but they can be very debilitating as well.

It takes up to 2-7 years for symptoms of AIDS or ARC to develop. The symptoms may include:

- chronic fatigue
- chronic fever
- swollen glands
- chronic diarrhea
- thrush (yeast infection in the mouth)
- tendency to bruise easily
- chronic cough
- sudden major, unexplainable weight loss
- raised purple blotches on mucous membranes or skin (Kaposi's sarcoma)
- spontaneous bleeding from mucous membranes, body opening or skin growths
- body weakness/shortness of breath/general malaise

Testing can detect HIV antibodies in the bloodstream.

Testing indicates exposure to HIV virus, but generally not the presence of the live virus. A test is not available to determine that an individual actually has AIDS, nor is there any way to predict the likelihood that infected persons will develop AIDS.

Transmission of disease

AIDS cannot be "caught" like the common cold.

Unlike diseases caused by airborne viruses, AIDS cannot be acquired through casual contact between employees. AIDS is not transmitted through touching or hugging, only through the blood system and semen: direct exchange of bodily fluids. Employees cannot catch AIDS by sharing pencils, phones, even cups. Modes of transmission include: transfusion of contaminated blood; use of contaminated hypodermic needles; through sexual intercourse with a person infected with HIV virus; perinatally or through breast milk when the mother is infected; **exclusively through intimate, not casual, contact.**

In spite of the widespread myth of AIDS being contagious, AIDS is not easily transferred from one human to another. To date, there are no known cases of AIDS being acquired through the use of public restrooms, by working next to someone on an assembly line, sitting next to a person with AIDS in a public schoolroom, or eating in a restaurant employing a cook or waiter who carries the HIV virus.

In spite of rapid progress made by scientists fighting AIDS here and abroad, the workforce remains confused and misinformed, and ultimately, fearful about their own risk. Nearly half of all Americans believe they can "catch" AIDS by drinking from a cup used by a person infected with AIDS.

Again, it must be emphasized that AIDS is **not** spread via public toilets, eating from common utensils, hugging, casual kissing, swimming pools, breathing, handshakes, contact sports, telephones, drinking fountains or mosquitoes.

AIDS is not strictly a gay disease.

Although the majority of cases in America have occurred among gay communities, this is not so in other countries, and it is predicted will not long be the case in the United States. It is important to keep in mind that so far lesbians have been the least affected by AIDS, and that heterosexual IV drug users have been among the most affected. Rampant among heterosexuals in Africa, AIDS is surfacing among heterosexuals in America. An increasing number of women, heterosexual men, and children are testing positive for antibodies to HIV (this means they can probably transmit the disease even if it remains dormant in their own systems). Therefore, **the phrase "high risk group" is obsolete: there is only high risk behavior.**

People with AIDS

When developing a workplace policy, it is important to understand that the experience of people with AIDS is not just physical, but emotional as well. The psychological effects of the disease impact workplace morale as do the physical symptoms.

Besides his/her own impending death, the person with full-blown AIDS must deal with the social stigma attached to the disease. Life is changed forever, affected by fatigue, isolation, and threatened self-esteem. Other employees need to understand the true nature of the ordeal faced by the AIDS sufferer, so as to react without panic or prejudice. A similar understanding is needed for those affected by AIDS-related symptoms, and for those who are known to have been exposed to HIV virus.

The emergence of the AIDS employee in the workplace pointedly—and poignantly—tests the judgement, compassion and leadership abilities of management.

What can management do?

Fear preempts compassion, and we all lose: management, staff and the person with AIDS. But when employees are educated about AIDS, they are less fearful. This fact is clearly documented by companies who have had AIDS policies in effect for the last three years. Noticable behavior changes have come from one key activity: employee education.

Policy recommendations and guidelines for demystifying AIDS

1
Institute an employee AIDS education program that helps to alleviate the fear of AIDS while providing solid facts about how the disease is transmitted.

2
Acknowledge the fear and view AIDS as a catastrophic illness like cancer or heart disease (see discussion in chapter on "Employee Relations: An AIDS Policy?).

3
Create seminars or discussion groups to work through employees' psychological resistance and prejudice to accepting the facts about AIDS.

4
Monitor the results of your AIDS education programs that are directed at dispelling the myths surrounding AIDS. Administer pre-and post-test attitude surveys (see Appendix III in this manual).

Economic Issues

"Focusing on the economic cost of AIDS in no way devalues the human cost of physical suffering, disabling illness and premature loss of life... The costs are individually and collectively compelling but difficult to value monetarily."

—from "The Epidemiology and Health Economics of AIDS in Minnesota," March 1986.

It is estimated that by the end of 1991, 270,000 Americans will have received a diagnosis of AIDS and 170,000 will have died. The CDC calculates that for the first 10,000 cases, direct mortality costs will be 4.6 billion dollars, although this figure may be excessive.

What is going to happen is that AIDS-related employment issues will intensify over the next few years because more people will develop the disease. More people will test positive for HIV antibodies and more effective drugs to prolong life will extend the average age of employees with AIDS. They will therefore remain in the work force for a longer period of time.

Corporations will bear the burden

Direct costs

Seventy percent of the population has health insurance; employers provide it and they pay about eighty percent of the cost. These direct costs are reflected in medical treatment. They are further compounded by disability benefits, group life insurance and companies' group health plans which cover employees' dependents who contract AIDS. A recent study of *Fortune* 500 companies showed the staggering costs of all benefit claims paid to employees with AIDS. Life insurance costs ranged from a low of $40,500 upwards to $400,000 with the 50th percentile showing costs of $80,000. Disability income payments ranged from $1,689 to $100,000 with the 50th percentile at $4,391. Medical benefits ranged from $5,000 to $250,000.

Direct costs (continued)

1
Hospital care

The average hospital stay for an AIDS patient is more than 2½ weeks. A Health Science Research Survey of 167 hospitals found the average cost of a single hospitalization was $1,600. Hospital costs in New York are much higher but average reimbursement for hospitals is only $400 to $500 a day.

It is estimated that employees with AIDS will be re-hospitalized for recurring opportunistic infections at least four times a year for three to four weeks. About one-third of AIDS patients spend their remaining life in a hospital. Because physician's fees are not included in hospital costs, another $5,000 to $6,000 must be added to the above costs.

Recent testimony indicates that there is a glaring difference in average length of stay in hospitals in New York City and San Francisco. Health officials from these two cities indicated that AIDS patients in NYC public hospitals averaged 50 days, while AIDS patients in SF area hospitals averaged stays of only 12 days. The greater availability of alternative care in SF is a major reason for this discrepancy.

2
Outpatient and home care

Outpatient and home care can replace hospital care but they are often not covered by company benefit programs. The result is that employees who contract AIDS end up staying in the hospital at a greater expense to the company's health benefit program, obviously not a cost effective approach. For example, making IV drug treatment available at home could save about $25,000 a year, per patient. The problem is that many company health insurance programs don't cover this. It would be in everyone's best interests if they did.

Employers who do not cover outpatient care should revise their benefit plans and share in the savings. The average costs of outpatient care are: $50-75 a day for IV drugs; $50-75 a day for nurse visits; and $100 per week for lab services. This is still less costly than inpatient care, and by providing IV drugs at home, hospital stays can be reduced by two-thirds.

3
Litigation costs

Direct costs for employers are reflected in lengthy litigation related to AIDS discrimination suits. Examples of costly discrimination suits for corporations are many. This is exactly what you as an employer must seek to avoid by having a policy in place that deals consistently with AIDS related issues.

Case examples

A North Carolina hospital is appealing a ruling by the Department of Health and Human Services Office for Civil Rights that it violated federal law by refusing to allow a nurse with AIDS to work. After the nurse's death the hospital reached a settlement with his estate making "a substantial payment."

The finding of discrimination was upheld in the firing of a **Florida county employee**. Todd F. Shuttleworth was fired from his job as a policy analyst at the Broward County Office of Budget and Management Policy because he had contracted AIDS. The County maintained he presented a risk to co-workers. The courts disagreed. Shuttleworth's attorney sought $5 million in compensatory damages to cover lost pay, fringe benefits, embarrassment, humiliation and emotional stress. In an out-of-court settlement, Broward County agreed to rehire Shuttleworth, and pay him money and benefits estimated at $190,000. This included $40,000 in compensation, and medical costs not to exceed $100,000. They agreed to reinstate his life and health insurance and to pay his attorney $56,000 in fees and expenses.

At the end of 1986, two costly discrimination complaints were filed against **a major department store** by the Legal Aid Society of San Francisco on behalf of a 32-year-old man who was fired from his salesman job a month after he was diagnosed as having AIDS. In addition to these litigation costs, the Society's AIDS and Employment Project has called for San Francisco's gay community to boycott the company. They say that the store should not expect business from gays when it discriminates against employees who have AIDS. Boycotts lead to lost revenue that companies can ill afford. The employee has asked for reversal of his termination, reinstatement to his position, return of all lost wages and benefits, and punitive damages.

In Massachusetts, employers have been warned by the **Massachusetts Commission Against Discrimination (MCAD)** that the law "makes clear that it is illegal to fire or fail to hire or promote an individual on the basis of AIDS or to take action against an employee because of co-workers' fears of AIDS." "The fine will fit the crime," says Alex Rodriguez, head of MCAD, who emphasized that employers will be at great financial risk if they don't control their employees.

In addition to discrimination complaints brought under Federal and state laws protecting those with disabilities or handicaps, employers may be vulnerable to common law actions claiming damages for invasion of privacy, intentional infliction of emotional distress, defamation, or even assault and battery. Such suits usually demand compensatory and punitive damages.

These cases are only several examples of the millions of dollars that will be and have been incurred for unnecessary lawsuits. Companies who educate their employees, presenting the solid facts about transmission of the disease, will be less likely to find themselves in such damaging situations.

Direct costs (continued)

4
Stress related costs induced by AIDS Anxiety

Direct costs to employers are also reflected in stress related accidents on the job. When employees are fearful and anxious about working with other employees who have AIDS, or are unnecessarily afraid that they themselves may have contracted the disease, they may suffer from what is appropriately referred to as "*AIDS Anxiety.*" We know that when employees are unnecessarily anxious and "stressed out" because of lack of adequate information or support, they are unable to concentrate and accidents occur. Mistakes are made, and this is costly to employers.

Mental injury from on the job stress generated by *Aids Anxiety* may create worker compensation claims. A nine state sample of claims by the National Council on Compensation Insurance finds that mental injury from stress accounted for 9.2% of occupational disease claims in 1983—nearly double the 1980 level.

Indirect Costs

5
Equally compelling for employers are indirect costs such as absenteeism, lost productivity, work disruption costs and costs of hiring and retraining replacements. The physical and psychological well being of the employee with AIDS impacts these indirect costs.

As with any catastrophic illness, it is important that employers be concerned with helping to maintain the *quality of life* of their employees with AIDS. These employees are faced with a progressive disability with its accompanying physical pain and disruption of family, work and social life. This can precipitate feelings of fear, anxiety, and depression. Coming to terms with one's mortality is a difficult task.

It is important for employers to attend to the psychological dimension of this illness in order to keep a well trained employee for as long as he is able to function on the job. This is not only humane but financially sound. An employee with AIDS can continue to lead a productive life by helping to retrain a new employee for his position and even continue to give counsel in hospital or at home when he is no longer able to work. Employers should also consider providing other options such as unpaid leave of absence with medical benefits, or early retirement as alternatives to termination.

Employers need to consider the impact of prematurely losing valued employees who are hard to train and costly to lose.

Indirect costs (continued)

6
Attending to the morale of one's employees is good business. There are employees who, in addition to their jobs, must care for and support family members who have contracted AIDS. This dual burden is an added responsibility for certain employees. This can affect their jobs and can contribute to lost work time and decreased productivity. Companies bear the financial burden. Unfortunately, little attention has been given to the **employee caregiver,** whether he or she be a family member, friend or lover of the person with AIDS.

Companies can address this issue and reduce work disruption costs by providing these employees with counseling services in already exisiting EAP programs, personnel, or with human resource people. They can supplement individual treatment with group sessions. In this way, individuals can share information on the resources that are available in the community for people with AIDS. A case manager could facilitate and coordinate all these activities.

Policy recommendations and guidelines

1
Employers should support the availability and use of out-of-hospital care. Corporations can encourage employees to use nursing homes, hospice and outpatient facilities that offer AIDS care. They can ensure that company insurance plans cover out-of-hospital lab tests, physician's and nurse's visits and IV drug therapy—reducing lengthy, costly hospital stays.

2
Employers should work with their insurance carriers to find the most cost-effective coverage plan—one that pays for hospice or nursing home care or other proven ways of reducing AIDS bills. Health care professionals who care for AIDS patients indicate that most cases can be treated appropriately and cost-effectively on an outpatient basis. Because there is a lack of available community based options for AIDS patients in most cities, this places a severe burden on hospitals. It also contributes to prolonged lengths of stay beyond what is necessary for acute care.

3
Employee health plans should cover the cost of outpatient counseling fees for employees with AIDS or other employees whose family member has AIDS.

4
In-house counseling should also be provided by corporations in order to reduce costs associated with the devastating psychological effects of the disease.

5
Employers should avoid costly discrimination suits by incorporating an AIDS policy into existing employee relations policies before an incident occurs.

6
Employers should acknowledge a physicians' recommendations regarding the ability of an employee with AIDS or ARC to work, and provide the necessary support for them to do so.

7
In order to facilitate a comprehensive plan that will cover all areas of care for employees with AIDS, corporations should employ a case manager (who can come from existing personnel or EAP staff) to coordinate all individuals and agencies in the patient-employee care network. This manager must minimize the cost of caring for an employee without sacrificing the quality of service. Through good communication with all parties, this will ease the financial burden of the individual, the employer, the hospital and other care-giving agencies.

Internal Corporate Education for Managing the AIDS Crisis

"Education is the heart of an effective AIDS policy. One has to put the facts in some sort of perspective for the employee. To legitimately deal with their fears, one can't brush their fears off. One has to be honest and try to help them and give them the education."

—from the video,
"Managing AIDS in the Workplace"

Educating employees about the life threatening disease of Acquired Immune Deficiency Syndrome (AIDS) is in the best interest of everyone. Internal education programs for employees in the workplace will serve several purposes, including:

1) reducing economic costs

2) calming and reassuring anxious employees by providing accurate medical facts that emphasize that the disease is not transmitted through casual contact;

3) improving the overall organizational climate by supporting the continued employment of employees with AIDS who are medically fit to work.

4) teaching employees and staff alike about AIDS and how to prevent contracting it through safer sex practices.

The greatest danger AIDS represents for the workplace is the fear of the unknown. Employee anxiety and uncertainty about AIDS must be replaced by solid medical facts. Employers need to demonstrate their commitment to protecting the physical and psychological health of all employees. And, the cost for making such an educational commitment is minimal, compared to the costs that will be incurred by doing nothing.

Educational approaches

The essential ingredient guiding all AIDS education is an open communication policy supported by top level management for all employees including all managers and line personnel. Nationwide, we have found that social workers, psychologists, and human resource staff who have been educating employees about AIDS emphasize the need for such support and counsel. Open discussion of AIDS issues will dispel the very real fears employees have about AIDS and prepare an organization to reasonably and responsibly manage a "crisis" before it begins.

Organization-wide seminars

Organization wide seminars, 30 minutes to an hour in length, led by appropriate internal staff or outside consultants will assist in ventilating emotions and guard against charges of discrimination, or crisis management. It is best to encourage employees to attend these sessions voluntarily and to not make training mandatory. Incentives for attendance include advertising the benefits of AIDS education beforehand and strong encouragement and attendance by top level management. Of course, each company has to decide what best fits its corporate culture.

It is essential to keep in mind that appropriate medical knowledge needs to be conveyed in a sensitive manner. Counseling should be available for employees as well.

We also recommend trainers deal openly and honestly with issues of homophobia, drug abuse, and death as a prelude to discussions about the medical facts about AIDS. Since these are the major unspoken topics surrounding AIDS, employees will respect a willingness to be candid and direct. Emotional resistance to medical facts will as a consequence be received in a more accepting manner.

Employees will prefer that these seminars be brief, routine and regularly updated. A newsletter, employee bulletin and updated reading lists of news articles and books on the latest AIDS information are easy methods to maintain communication about the disease with current employees. In person training seminars and counseling opportunties are still essential for building and maintaining the trusting relationship which is desired between management and employees.

Three-pronged approach

A three-pronged team training approach that includes the **medical, legal and psychological dimensions of AIDS** will educate both management and employees. While all three approaches may not be included at once, all three should be covered on a routine basis. The educational message then becomes very clearly reinforced, and corporate employee relations policy continues to be unambiguous.

The multi-faceted aspects of AIDS in the workplace call for employers to continue educating staff responsible for AIDS communication for employers. It is often necessary to send one or two of these staff to **outside training seminars** to remain current with the rapidly changing medical and legal knowledge base.

Safer sex practices

We think it prudent to educate employees about "safer sex practices." The fact of the matter is, employees have a life outside the workplace that impacts the health and well being of the organization. Safer sex will help prevent the disease among employees regardless of their sexual preference.

Safer sex means taking precautions against allowing bodily fluids to enter the blood through vaginal intercourse, anal intercourse, and from being in contact with the broken skin or mucous membrane of a sex partner. Other bodily secretions—like tears or saliva—may transmit certain viruses, such as hepatitis B and CMV, but their role in AIDS disease development is minimal or non-existent.

Employees should also be aware of the dangers in blood to blood contact through sharing hypodermic needles, syringes and cookers.

A professional health educator at your organization can easily inform employees about these facts, and thereby go a long way to preventing the spread of the disease.

Accountability and evaluation

Once an educational program is in place, it is essential to develop an accountability and evaluation (see Appendices II, III) of your training regimen. These assessment tools should include:

- Interviews with EAP counselors about the state of "AIDS Anxiety" among employees.
- Evaluation of employee feelings about each seminar, bulletin and outside educational experience about AIDS.
- Each of these assessments should be graphed over time and continually monitored to form a statistical picture of the corporate health and well being of employees' attitudes and behaviors with regard to AIDS.

Case examples of education programs

Wells Fargo Bank's Employee Assistance Director, Bryan Lawton, Ph.D., views AIDS education as a responsibility of corporations which, when done properly, can avoid work disruption, improve employee morale and create an atmosphere of sympathy towards terminally ill employees.

Wells Fargo created a flow of information about AIDS in their workplace that released employee tension and improved labor/management relations. They developed an AIDS policy that included education, updated medical information, a sympathetic tone, and a willingness to allow an employee with AIDs to return to work.

Blue Cross/Blue Shield in Manhattan handles their AIDS policy under their existing policy for terminal illness and a safe and healthy work environment. They provide AIDS information to management and staff through their newsletter. Further, they tell us that their position on AIDS has been successful: they have never dismissed an employee because of AIDS; nor have they had any employees refuse to work with another employee who has, or is suspected of having, AIDS.

AT&T's treatment of the AIDS crisis has generated an employee climate of listening, learning and accepting the facts about AIDS. When two employees complained about another employee with AIDS, AT&T responded with medical facts, counseling, and films about AIDS. By treating AIDS like any other handicap, AT&T has kept employee anxiety at a minimum and they continue to keep their employees updated through information released by their medical department and by regularly showing a film on AIDS during the noon hour.

The American Council of Life Insurers has committed itself to eliminating the disease and unwarranted public fears. They have allocated $1.6 million for AIDS medical research and public education. They have provided their industry with an AIDS education kit, because it is "good business."

Summary of educational guidelines

1
Encourage an open communication policy.

2
Offer organization-wide seminars that are short, routinely offered, updated and voluntarily mandated in attendance depending on the corporate culture.

3
Deal openly and honestly with homophobia, drug abuse and death as related to the AIDS disease.

4
Offer a three-pronged team training approach that includes medical, legal and psychological dimensions of AIDS.

5
Publish AIDS information in a monthly newsletter and employee bulletin. Inform employees about an updated reading list on news articles and books on AIDS.

6
Educate employees about safer sex practices and dangerous drug use.

7
Develop an accountability system to evaluate your AIDS educational efforts.

Testing and Confidentiality

"People who are tested are making a sacrifice for the public health and what they deserve from us is the protection of confidentiality—the protection of their privacy—and they deserve for us to pay for the test . . . which should not be done in a mandatory fashion except in very unique circumstances, and that the test be available to those that need it under the conditions of anonymity."

—from the video,
"Managing AIDS in the Workplace"

It is not uncommon for employers to require some form of medical examination as a pre-condition of employment and, in certain occupations, to require such examinations on a periodic basis, depending on the nature of the job. The use of polygraphs, psychological testing and urinalysis to combat difficult personnel problems is also growing in popularity among certain employers. These tests, in and of themselves, raise serious ethical and legal concerns. These concerns are substantially heightened when one considers the question of "testing for AIDS." This chapter will discuss the nature of what has come to be known as the "AIDS test"—what it is able to detect and not detect—and the cost of the test vs. the potential benefits.

What the test is

There is no test for the presence of the AIDS virus, and there is no test that diagnoses AIDS. In the spring of 1985, a test was licensed by the Federal Food and Drug Administration (FDA), that attempts to determine the presence of antibodies to human immunodeficiency virus (HIV)—a retrovirus that is currently identified as the primary cause of AIDS. The purpose for which the test was licensed is to screen blood donated for use by blood banks. It was not designed for use by employers or for any other purpose, although the Armed Forces and some other government agencies are using it to screen applicants or employees. The test is conducted by administering an enzyme—linked immunosorbent assay (ELISA) test for antibodies to HIV. The ELISA test, however, has a substantial false positive rate.

In 1985, blood banks reported that of 16 million units of blood screened, there were 40,000 false positive test results. Based on the high false positive rate, it was the consensus of the FDA, National Institutes of Health and the CDC, that seropositivity to HIV would be defined as two positive ELISA tests confirmed by another, more sophisticated test, called the Western Blot. Of samples initially testing positive on an ELISA test, 50 to 60 percent do not repeat as positive on a subsequent ELISA or confirmatory Western Blot procedure.

In addition, the number of false positive results are substantially higher when the test is used among the general population as opposed to populations which may engage in at risk behavior. The test's primary and most appropriate purpose has been to screen blood and plasma donations in blood banks for antibodies to HIV.

What the test is not

The HIV test is not a diagnostic test for AIDS or AIDS Related Complex (ARC). Seropositivity, as confirmed by two positive ELISA tests and the Western Blot assay, is accepted as evidence of exposure to HIV and is probably indicative of the individual being infectious and capable of passing the HIV virus to others through sexual contact or blood exchange.

Current estimates indicate that within ten years of infection with HIV virus, 20 to 50 percent of persons who test positive for HIV antibodies are likely to develop AIDS. Given the test's limited predictive and diagnostic value, any broad use of the test as a screening mechanism would be misleading, deceptive and unfair. In addition, use of the test on a broadscale basis could prove relatively expensive considering the minimal returns involved. While the ELISA test is fairly inexpensive—$2 to $3—the necessary confirmatory Western Blot costs upwards of $100 each.

Is testing necessary?

Beyond questions regarding the value of the HIV test as a predictive test for AIDS, especially when used on a broadscale basis, employers must ask if such testing is necessary. The necessity of such testing in the private sector is clearly suspect, since medical evidence reported by the highly respected CDC—and discussed at length in the Employee Relations chapter—demonstrates that excluding persons with AIDS or ARC is unnecessary to protect the health of other co-workers. While insurance carriers may prefer testing to determine actuarial rates—a policy which by itself is controversial—the reliability and predictive value of the HIV antibody test should cause all corporations to reconsider the economic and legal costs of the tests.

1
Use of the test on a broadscale basis to screen current or prospective employees may unnecessarily stir feelings of employee resentment toward an employer and generally depress employee morale within the workplace.

2
Use of the test also raises serious questions of civil rights and job discrimination. These latter issues are accentuated if the test is used on a selective basis (i.e., only for individuals perceived as at risk for AIDS).

While federal law on discrimination in employment on the basis of AIDS may be unclear at the current time, a majority of states have adopted policies prohibiting discrimination against persons with AIDS. These states have declared AIDS a handicap covered under exisiting anti-discrimination and human rights laws. Several

other states, which have not yet adopted such a policy, are likely to do so in the event a specific complaint alleging such discrimination comes before the appropriate state body. **(It is therefore extremely important that employers be aware of state law on discrimination against the handicapped and its applicability to persons with AIDS.)**

3

Employers considering such a screening program should also be concerned with regard to the quality of testing in commercial laboratories. The United States Army has been conducting a widescale HIV antibody testing program for all recruits, justified in part by the unique need for each member of the Armed Services to serve as a potential source for battlefield transfusions. In the more than 1 million tests performed, the Department of the Army reports false positive rates for Western Blot assays as high as 30 percent among blinded negative control specimens in some large commercial laboratories. Even with rigorous quality control and a single commercial laboratory contract, problems continue with the Army testing program.

Several states and individual localities have enacted laws or otherwise have regulated the use of the HIV antibody test and who may be licensed to perform it. To date, California, Massachusetts and Wisconsin have enacted laws preventing employers from using HIV antibody tests for pre-employment screening or for the removal of employees who test positive. Some states, such as New York, attempt to limit which labs may perform the test through its existing licensure authority.

Aside from screening of blood and plasma donations, the test may be recommended for individuals who have engaged in high risk behavior (sharing needles in IV drug use or sexual contact with at-risk persons). Persons who test positive for exposure to HIV antibodies are counseled in ways to prevent further exposure to themselves or to others. The CDC recommends such testing on an individual, voluntary basis.

Physicians closely monitor the health status of HIV antibody positive individuals to identify any signs of immune system irregularity or other symptoms associated with AIDS. Many states and localities have established free HIV testing sites which provide anonymous testing, coupled with pre and post test counseling. These programs also guarantee confidentiality and guard against abuse or misuse of test data. The location of such test sites can easily be obtained from state or local health departments.

It is important that employers know what existing state law or regulation allows with regard to use of the HIV test as a condition of employment. Of particular importance are standards of confidentiality and informed consent on the part of a current or prospective employee before a test can be administered.

As indicated earlier, the HIV antibody test was originally meant strictly for the protection of the nation's blood supply. Our best advice is: **given the legal protection afforded employees with AIDS, companies are advised not to use the test for insurance or for employment purposes. In a word, caution is the best tack to take, especially in what is rapidly becoming a new age of AIDS litigation.**

Issues to consider before testing

To summarize, before implementing a policy of mandatory HIV testing as a condition of pre-employment or continued employment, employers should consider the following:

1
There is currently no available test which detects the presence of AIDS.

2
The existing test which identifies the presence of antibodies to HIV is primarily and most appropriately used to screen blood and plasma donations.

3
The HIV test has a limited predictive and diagnostic value; any broad use of the test as a screening mechanism would be misleading, deceptive and unfair.

4
States vary in the legal protections afforded individuals in regarding discrimination on the basis of AIDS or a positive HIV test. Be sure to know the laws in your state, or consult with someone who does.

5
State laws vary regarding who may perform such tests and the standards regarding confidentiality of test results. Be sure to know the laws in your state or consult with someone who does.

6
In order to avoid costly litigation, employers should be very strict with confidentiality laws with regard to medical information. Employers must respect the patient's right to privacy.

7
Consider the effect of a screening program on employee morale.

8
Consider the benefits you expect to gain in implementing an HIV screening program in the workplace, and whether those benefits would outweigh the substantial negative workplace implications, especially in terms of: costs, legal exposure, and reduced employee morale.

Recommendation

Considering all that has been covered in this chapter, we recommend against use of the HIV test as a mechanism to screen current or potential employees for AIDS.

Case studies

Mandatory testing is not practiced by any of the **30 American companies** surveyed by the Institute for Disease Prevention in the Workplace. A larger study by the insurance industry of 154 companies revealed that while a few companies are considering testing, over 90 percent are not testing, nor are they considering doing so.

Corporate leaders on the testing issue, like Bank America, Wells Fargo, Chevron, and AT&T, among others, have systematically guarded employee rights of confidentiality and rights to privacy, while anticipating problems related to AIDS through prevention education programs.

The military, *in contrast*, requires testing and adjudicates cases of non-compliance among military personnel. It is argued by the service that the test is "medically necessary to insure the health of military personnel."

The private sector does not have this choice to impose testing and, given constitutional challenges to privacy rights that the test represents, corporations need to consider assiduously the business advantages and negative fallout involved in imposing the test. We discourage the practice. The costs are clearly not worth the benefit.

Employee Relations: An AIDS Policy?

"The teachers brought in an employee assistance program to counsel other staff members. The district provided counseling during the school day. The teachers then provided that same counseling at cost to the union as opposed to the school district for parents, so the parents of the community would be able to learn a lot more about AIDS."

—from the video,
"Managing AIDS in the Workplace"

Recently, workers at a New England utility walked off the job when one of their co-workers—suffering from AIDS—returned to work after a 17 month absence, as a result of a court settlement with the company. The day of the walkout, the shop steward stated: "There's an epidemic of fear here. People are under incredible stress. A grown man was crying this morning because he feared giving AIDS to his invalid father or losing his job." He said the workers wanted "the company to use more of its resources to bring in experts to help them deal with the terror."

"This is a human issue, not a labor-management dispute," he said. "We support Paul (the co-worker with AIDS) as an individual and are optimistic that there is a way to make his environment positive and dignified. But we need the company to show genuine concern for all the workers and to meet us halfway."

After a meeting with doctors, arranged by the company, most fears of the workers and their families were allayed, although there was a sense that the concerns of the families had been trivialized. "They made them sound like silly fears," said one family member. "To me they're not silly."

How does an employer "Manage AIDS in the Workplace" without suffering loss in morale and productivity, and accusations of discrimination? This is not as difficult a question to answer as one might suppose. It depends on an employer's commitment to deal consistently and sensitively with the fear that surrounds the disease.

At the outset, it should be remembered that an AIDS policy in the workplace is not just for employees who may be suffering from AIDS, but also—and equally important—for employees who fear AIDS. Many people who knowingly come into contact with persons with AIDS are afraid that they, too, will develop this illness. Despite what medical authorities tell us about the transmission and prevention of AIDS, we still maintain fears that in most cases are not rational. When directly confronted with the disease, those fears—fear of the unknown—become aroused. A policy on AIDS in the workplace must confront fear with facts, but it must also acknowledge the legitimacy of fear and not trivialize it.

Chapter 1 told us that AIDS is not transmitted through casual contact, even among household members of persons with AIDS. It is not transmitted by air, door knobs or sitting next to someone who has AIDS, ARC, or who tests positive to HIV. The Centers for Disease Control (CDC) told us these facts in 1985. They also said that workers with AIDS, "should not be restricted from using telephones, office equipment, toilets, showers, eating facilities and water fountains." (see Appendix IV)

Educational programming—as discussed in a previous chapter—about AIDS in the workplace is the quickest route to allay employee fear, misperceptions, absenteeism and legal wrangles that can develop. It is the cornerstone of any employee relations program.

Why an AIDS employee relations program is necessary.

The workplace issues to prepare for through a written plan that is both practiced and understood by employees and employers alike must:

- be cognizant of the legal obligations of the employer, and the legal rights of the employee regarding non-discrimination in employment based on a handicapping condition;
- be perceived as fair to employees diagnosed with AIDS, as well as co-workers who have a fear of AIDS; and
- be able to maintain efficiency in the workplace by diffusing a potentially disruptive situation that may occur through the development of AIDS in the workplace.

Do your existing personnel policies deal with AIDS? Check the following:

If employers are to be prepared for the eventuality of dealing with AIDS in the workplace, it is important that they have written policies in place before a crisis occurs. A good place to begin is to review existing personnel policies and to apply them to a theoretical case of an employee with AIDS.

- **Most state anti-discrimination laws view AIDS as a handicap.**
  Most organizations have written policies designed to provide equal opportunity in employment to all employees and applicants without regard to race, color, religion, sex, national origin or handicap. Such policies are recommended for organizations which receive federal, state or local government funding, or which have federal contracts. Although the definition of AIDS as a handicap under existing federal anti-discrimination law may be unclear, a majority of states have adopted policies prohibiting discrimination on the basis of AIDS. This has been accomplished through the interpretation of AIDS as a handicap under exisiting anti-discrimination and human rights laws. A recent survey indicated that 34 states would take action on complaints alleging AIDS related discrimination. Other states are likely to adopt similar policies when confronted with a specific complaint.

- ***Diagnosis of AIDS cannot justify employee dismissal.***
  An employer's personnel policies may include provisions for employee performance reviews to provide periodic evaluation of employee performance in terms of job requirements. This may provide that each supervisor review the performance of employees under their supervision on an ongoing or periodic basis. The continued employment of an individual should be based on the ability of the employee to perform the required job function. Such reviews may consider the ability of a person with AIDS to fulfill a required job function—as would consideration of any debilitating condition be an appropriate consideration—but may not be used as the basis of dismissal if the condition bears no correlation to the ability to perform required tasks.

  Of course, a person with AIDS may be dismissed for any reason, other than his or her medical condition, that would otherwise warrant dismissal. The employer should be clear that the reason for dismissal is not tainted by any considerations that the employee has, or is thought to have, AIDS.

■ **If termination is necessary for reasons of an AIDS related disability, adequate severance should be provided.**
Termination of employment is usually accompanied by severance pay and an explanation as to the reasons for dismissal. As previously discussed, diagnosis with AIDS cannot justify termination of employment. In addition, existing employer policies may include provisions for the temporary extension of pension, health and welfare benefits or the ability of a former employee to continue certain benefits—such as health insurance coverage—on a temporary basis at a group rate. In certain instances, federal law or state law may require this. In any event, employers should review this issue and seek to develop a compassionate policy.

Dismissal without notice may result for reasons such as, but not limited to: gross neglect of duty, incompetency, theft and contempt of or failire to obey legitimate orders of a supervisor. Being dismissed for cause may result in forfeiture of severance pay or other benefits.

■ **Most employers provide health and life insurance coverage as a benefit of employment.**
Employers should review their existing policies and determine the extent to which they would meet the needs of a person diagnosed with AIDS.

■ **Sick leave policies should be applied in a uniform fashion.**
Are sick days limited to a specified amount per year and does illness lasting longer than a specified period require a medical certification? In its early stages, AIDS or ARC will not necessarily manifest itself in any particularly debilitating way. However, as the condition progresses, there may be periods of prolonged employee absence and debilitation. There is no justification for adopting a more restrictive policy for those who have AIDS than exists for those with other catastrophic illnesses, for example, cancer, heart disease, etc. or for those who suffer such injuries as broken legs, arms, and the like. Otherwise it will seem that AIDS and not absence from work is the real reason for denying benefits.

Five basic guidelines to manage fearful co-workers

1
Employees have a responsibility to perform their assigned tasks with a co-worker who has AIDS, or, in the case of a health care worker, with a patient suffering with AIDS. However, they won't do their jobs if they fear for their lives. The reluctant employee who comes in contact with AIDS needs to be counseled, educated and supported by a sensitive personnel manager. Employee fears must be legitimately dealt with and not trivialized or brushed off as out of hand. It is important that an employer not undermine morale in the workplace by embarking on such a course. As stated earlier, education must be a cornerstone of any employment policy. In this respect an employer might wish to designate a management level staff—someone from the EAP Department, or Human Resource Management—as a contact person on AIDS accessible to employees and their families.

2
Employers have the right to discipline an employee through their right to manage the workplace while simultaneously providing that it be a healthy and safe place to work. Cooperation with the union in determining what is a reasonable precaution should be sought.

3
If the workplace is unionized, then the question can be resolved by the collective bargaining agreement or through provisions of the National Labor Relations Act (Labor Management Relations Act, as amended, 29 U.S.C. 141 et seq.). For example, the employee whose immune system is weakened due to chemotherapy may be more susceptible to opportunistic infections that accompany AIDS. This kind of realistic concern differs qualitatively from employees who want to wear protective garments when in contact with patients. Such was the case with a group of nurses at a San Francisco hospital who were not allowed such a practice by their employer because it was not medically justifiable.

Employers should recognize, however, that the Labor Act protects from discipline employees who engage in good faith in concerted activity for mutual aid and protection. As interpreted by the courts, this might provide protection to employees who refuse to work with someone with AIDS, at least in a situation where the employer does not take steps to educate the concerned workers.

Employers should also be sensitive to the claim by employees that the Occupational Safety and Health Act protects employees from working with co-workers who have AIDS. This Act, however, is meant to protect employees who refuse to work due to a reasonable fear of imminent or serious physical injury. Thus, it is doubtful that the Act would in fact protect the recalcitrant employee.

4
Provisions should be made for medically certified groups of employees to avoid contact with people who have AIDS if they are pregnant health care workers, have open sores, or are immunosupressed and therefore more susceptible to disease. Employers should counsel these employees and consider temporarily removing them to other areas. Without being medically certified, however, an employer is legally justified in disciplining a reluctant employee to the point of removal as a last resort in extreme cases.

5
Good labor relations should lead employers to deal with the "panic and paranoia" of AIDS through written policy and a sincere effort to discuss and counsel a worried worker, not by discipline and discharge. Here, employers should practice good listening and observatory skills, on a case by case basis, to evaluate an employee's refusal to work with or serve someone with AIDS.

To date, scientific research has clearly demonstrated that no health professional has developed AIDS as a result of casual contact while caring for an AIDS patient. Nonetheless, employees in hospitals, food services and laboratories, need to understand current medical knowledge and CDC guidelines concerning AIDS. The CDC states in their November 1985 guidelines for the workplace that "no special precautions are required for personal service workers whose services do not involve a risk of blood contamination." Further, CDC continues, "No evidence exists of transmission of either the AIDS virus or hepatitis B virus during the preparation or service of food or beverages." (see Appendix IV)

It is very likely that existing personnel and employee relations policies can adequately deal with employees with AIDS and their co-workers. It would, in fact, be the ideal situation to consider those policies and their application to AIDS in the workplace, rather than to develop new policies tailored to a specific situation. After employers review their existing policies, they should communicate to their employees how those policies would apply in the workplace, both in terms of an employee with AIDS and co-workers and their families. This can be achieved either through a forum at which these issues are discussed with employees, or through existing employee communication vehicles such as internal memorandums or newsletters.

Publicizing these facts, as well as the medical facts of AIDS, through carefully designed educational programs, or other means, will help to avoid unnecessary panic and resistance to work demands and help prepare for a crisis before it occurs.

Guidelines for health care professionals

Persons working in the health care field who are called on to provide direct services to persons with AIDS may have unique concerns not found within a non-health care work environment. Unquestionably, it is more difficult to provide direct services to a person with AIDS than it is to work by his side. In addition, health care workers may also find working with persons with AIDS to be an emotionally draining experience as well. However, health care professionals are also knowingly called to a higher standard of conduct than are employees in a non-health care environment.

- Provide strong administrative support for health care professionals who are charged with the responsibility of caring for persons with AIDS.
- Deal honestly with the fears employees have by sensitive counseling through existing Employee Assistance Programs, or through other qualified personnel.
- Put the medical facts in perspective—as it applies to care providers—so they can judge the information rather than just being told or given a blanket assurance.
- Call the health care professional to the highest standards of their own profession and to their own calling, which is again the idea that people who work in a health caresetting are there because they want to help people who have illnesses—it is part of their role.

CDC guidelines on prevention of transmission of HIV in the workplace

On November 15, 1985, the Centers for Disease Control issued extensive guidelines for the prevention of transmission of HIV (or, HTLV-III/LAV, as it was then scientifically termed)—the virus which is the causative agent of AIDS—in the workplace. These guidelines remain as the most extensive and authoritative set of recommendations issued by any government agency which has been extensively involved in AIDS related research. A copy of these guidelines, published in CDC's Morbidity and Mortality Weekly Report (11/15/85, Vol. 34, No. 45), is included in Appendix IV of this manual.

These guidelines cover several issues related to AIDS in the workplace which should be reviewed by employers in both the health care field and non-health care field. They deal with issues related to:

1
Risk of health care workers acquiring HIV in the workplace.

2
Precautions to prevent acquisition of HIV infection by health care workers.

3
Precautions for health care workers during home care of persons infected with HIV.

4
Precautions for providers of prehospital emergency care.

5
Management of parenteral and mucous membrane exposure of health care workers.

6
Serologic testing of patients

7
Risk of transmission of HIV infection from health care workers to patients.

8
Precautions to prevent transmission of HIV transmission from health care workers to patients.

9
Management of parenteral and mucous membrane exposure of patients.

10
Serologic testing of health care workers.

11
Risk of occupational acquisition of other infectious diseases by health care workers infected with HIV.

12
Sterilization, disinfection, housekeeping and waste disposal to prevent transmission of HIV.

13
Considerations relevant to other workers, including: Personal service workers, food service workers, other workers sharing the same environment.

Case illustrations

Westinghouse Corporation appears to be another leader in developing an enlightened AIDS policy in the workplace. Their Corporate Medical Director, E.C. Curtis says that AIDS should be treated like any other employee disability. He adds that employees with AIDS should be allowed to work as long as they are able. Curtis maintains that employers should incorporate AIDS under "communicable and terminal disease policies, rather than developing a separate policy, so that they do not risk charges of discrimination." Strict confidentiality should be observed with all employees. Westinghouse corporate guidelines dealing with AIDS focus on complying with the law, maintaining productivity, managing costs, and retaining trust. Westinghouse has produced two corporation-wide briefing papers on "AIDS as a Workplace Issue." Curtis indicates that the Medical Director's office gives guidance about AIDS to employees on the telephone and provides in-house counseling as well, if necessary.

Commissioner Glen R. Jeffes of the **Pennsylvania Department of Corrections** has an enlightened attitude to the AIDS issue and has instituted policy accordingly. He has ordered a mandatory AIDS education program for all inmates and prison system employees. He indicates that "the department has an obligation to insure that both staff and inmates are informed about this relatively new disease." Their training program includes audio visual information, facts from the CDC and special question and answer periods. All information is updated as necessary. Commissioner Jeffes insists that "AIDS isn't just an institutional problem. It is also a community problem. By giving our employees the most up-to-date information, they will be better prepared to face the issue..both on and off the job."

The **National Restaurant Association** issued their guidelines on AIDS in 1986. They specified that NRA members who discriminate against employees who have AIDS or who are at risk for contracting AIDS, may find themselves in legal and financial difficulty. The NRA has been informed by Dr. Otis Bowen, Secretary of Health and Human Services, that restaurant employees who are infected with HIV antibodies should not be restricted from work on that basis alone. The NRA policy incorporates the Public Health Service guidelines on AIDS which state explicitly that "blood-borne and sexually transmitted infections like AIDS are not transmitted during preparation or serving of food or beverage." The NRA strongly believes that their AIDS policy prevents needless anxiety about the safety of patronizing food service establishments.

Public Relations

"Avoid speculating about the issues...get the facts...because the press is particularly looking for statements dealing with the future and treating them as if they were the present."

—from the video,
"Managing AIDS in the Workplace"

AIDS takes lives.

It has the potential of taking corporate managers with it if public relations gaffes are committed during the insensitive handling of the issues surrounding this dread disease.

Effective public relations policies, which mirror internal health education and employee policies discussed in the previous education chapter, must be created to deal with this epidemic. AIDS is, in some ways, medically different from diseases businesses normally encounter, yet daily policy decisions have to be made quickly and publicly while under attack by hostile media and the concerned co-workers of a person with AIDS. Public relations plans are complicated by this dual responsibility to both the internal and external audience. Unaddressed staff concerns can be as lethal as defensive posturing with outside media.

To deal with AIDS questions today, a company can assume that it operates in a climate of attack. Reporters often take companies to task for their stances on the environment, toxic hazards and personnel situations such as drug testing, wrongful termination and defamation of character. Remember, the media have an historical orientation towards stories about abridgements of civil liberties. And the issues surrounding AIDS are complicated by a basic conflict between civil rights as broadly conceived, and corporate hiring, firing and work practices. If you accept the premise that this conflict exists, and recent Supreme Court cases indeed confirm it, your company will be better prepared to develop new public relations strategies to deal with it. But operating in a crisis PR mode is not sufficient. When companies lack a consistent public relations posture on criticial issues such as AIDS, it is easier for attack to be generated and sustained, cannibalizing long-term corporate image gains. Yet, research by the Institute for Disease Prevention in the Workplace indicates that many major U.S. corporations have no AIDS public relations policy.

General guidelines

An effective public relations policy starts with the controlled dissemination of clear, honest and accurate information on company health policies. The policies must be promoted both through internal education programs and through the creation of good media relations.

As a policy maker, follow these general guidelines:

1
First, remember that this is a "people" issue. It is about people who are facing death and may die, and about those who are going to be affected by those dying people. Learn about the epidemiology of AIDS. Demystify it for yourself. Chapter One of this manual is a good place to start. Gather as much information as possible on the subject and digest it fully. The Centers for Disease Control have extensive publications. Management publications have much valuable information.

2
Transmit this information to your Board of Directors or public relations staff so they are completely informed. If you have no PR staff, then prepare yourself to be a knowledgeable spokesperson. Make evaluations on the AIDS question together with the Board, because support from the top is essential in maintaining a positive corporate identity and socially responsible posture.

3
With your Board, and when possible, with your unions, create a corporate policy that can be transmitted to corporate health officers, human resource personnel, and eventually to employees and outside audiences. Make sure this posture is communicated in a consistent, positive, on-going fashion that will gain and retain public support.

One public relations firm, which deals with health related issues in New York, advocates these related public relations guidelines:

4
Be prepared. Write a *contingency statement* that gives company policy on AIDS that can always be transmitted to the media or to internal audiences. The key element in this statement: strict rules of confidentiality towards the employee should be observed. Any leaks or dissemination of information to those who really do not have a "need to know" expose the company to charges of privacy infringement.

5
Let one person speak on the issue. This may be the corporate medical director, company president, human resource officer or corporate communications director, but only one.

6
Do not be afraid to buy time before addressing the issue. Don't overreact to the quick phone call from an outside source or pressure from line workers. Many organizations, when queried by the Institute for Disease Prevention in the Workplace, insisted that all questions be done in writing and that all answers would also be in writing. Set the ground rules for sensitive interviews yourself. Remember that the image of the company must always be presented fairly, even during a crisis. And AIDS is a crisis that won't go away.

7
Don't be afraid to correct media who have reported inaccurately about your policy. This makes good business sense. Create some "crisis money" in case you have to place policy statements in major media in ad form if other avenues of publicity are not open; and, remember that the worst thing you can do is put the issue off because of some unfounded fears about AIDS. Not speaking to the issue at all, issuing a "no comment," opens a PR Pandora's box.

The AIDS issue, therefore, necessitates an active public relations policy, because statistics indicate that few companies will be left unaffected by the possibility of a worker contracting the disease. There are further steps companies can take to achieve fair representation by the press:

8
Identify the press corps who cover health issues in your area and develop a working relationship with them.

9
Avail yourself of opportunities to work with the press, positioning positive stories on your progressive health practices.

10
Use the clout of directors or visible corporate leaders to position letters to the editor and "Op-Ed" pieces. Trustees represent a company both formally and informally. Their activities with the press described here are the formal response. However, their informal response is as powerful in representing the company during a crisis like AIDS. Speaking out on behalf of the organization at any given time in any setting is effective if they have the facts and are in sync with the contingency statement referred to above. The director's position in the community and industry will often provide a needed reliability for statements.

11
If the reporter who interviews you wants to tape record your responses, you can tape record his questions and dialogue. Have clerical staff transcribe these tapes and send a copy to the reporter to indicate that you are aware of the interview contents. This will ensure that what you said gets written accurately. If you "misspoke," the transcription becomes your key to finding the right answer for that tough question when the next reporter shows up.

Case studies

Labor/management and community relations

Some organizations, the **American Hospital Association** in particular, conduct live satellite teleconferences on the topic of AIDS and invite representatives of community agencies (school boards, local governments, health organizations and major employers) to view their programs.

The United Federation of Teachers, a labor union representing educators throughout New York State, feels that sharing the information relieves the problem and that training and public relations activities with their teachers and the community has given them solid grounding on the issue. They feel that labor/management/community collaborations are the only way to dispel the fears.

A school policy case study

Some school policies, unfortunately, are less enlightened. The barring of children from school in Kokomo, Indiana and Racine, Wisconsin, created media storms. An incident in Swansea (Boston) Massachusetts, where an AIDS stricken schoolboy was allowed to attend class by the State Human Services Secretary and the school superintendent—based on solid public health information—however, created little furor because the issue was honestly, accurately, and decisively dealt with by the district and state public information officers. In fact, it was handled so adroitly by these parties that the *Boston Globe* actually ran an editorial praising the courageous stance of these officials and publicly shaming those in Kokomo and elsewhere who "took the easy way out," which from a public relations standpoint really wasn't.

Hospital public relations

Hospitals are on the front lines of treating AIDS related illnesses and dealing with the issue. One of the largest organizations in the nation promoting voluntarism in health care delivery provides experts on the AIDS issue to speak at important seminars during the year and these talks are videotaped for dissemination to member hospitals. Hospital public relations translates to patient relations and that means privacy.

A **northeastern hospital** recently had their conduct, vis-a-vis an AIDS patient, examined by the state health department and subsequently by local media because of a failure to have a draft protocol for patient's rights approved by the hospital's directors and staff executive committee. Word of the transfer of an AIDS patient requiring surgery to a larger hospital, something done all the time by private physicians, leaked to the local newspaper and created adverse publicity for the hospital. One of the three citations by the health department was for failure of the hospital's medical staff to fully communicate with the patient's attending physician concerning the transfer. They also failed to communicate the move to the public relations department and administration, necessitating some hot-footing in a crisis PR situation when the press came searching for the reasons for the transfer. Failure to have a protocol ready for this type of incident resulted in some weak statements to the press on why the patient was moved, none having any real bearing on the the original motives for the transfer.

The corporate picture

As interviews by the Institute for Disease Prevention in the Workplace indicate, too many companies are waiting until a crisis occurs to do anything about it.

An incident of telephone repairmen walking off their jobs with a major telephone utility in the northeast, rather than work with a colleague who had AIDS, subsided after doctors talked to them about the disease. According to the utility's spokesperson, an employee communication program on the issue of AIDS is being incorporated into worker education programs. And the utility resolved to keep the employee on the job, no matter what, gaining some positive PR points, according to the Associated Press article about the case.

It is, however, coming after the fact. The worker with AIDS was returning to work after a year-long absence and the settlement of a $1.5 million lawsuit which alleged that the company revealed his disease to co-workers, provoking threats. The confidentiality issue raised its head. Whether true as "alleged" or untrue, lack of solid internal PR on this health issue before the fact, created external PR problems.

A positive approach

The DuPont Corporation, a multi-national corporation based in Wilmington, Delaware, has a long history of providing health programs for their workers. One of the first companies in this country to provide an alcohol treatment program for employees, they have "always had a deep concern for their people," according to a company spokesman. They also have a progressive stance towards the AIDS crisis. Their number one public relations policy guideline is *respecting the confidentiality of the worker.* They protect their worker by never releasing names. They admit that if the person wants to identify himself, that is his business. And even if a person with AIDS does come forward, strong internal public relations efforts through corporate media about the medical facts of AIDS have prevented any major PR gaffes.

One employee with AIDS did come forward in 1985 and released information about himself and the disease to the *Wilmington News Journal.* But his response was to praise the support he got from DuPont and from co-workers, some in areas of the corporation unknown to him, as they related to his illness. He said there was no overreaction by co-workers and that management was behind him completely.

Food service

A leading fast-food franchiser has a similar policy of confidentiality and feels that this policy not only protects the worker but it protects the company from possible privacy infringement lawsuits, whether they stem from an AIDS related situation or from some criminal action, or drug related incident concerning an employee. Although admitting that there are no hard, written policies concerning AIDS, the company PR office is cooperating with corporate medical directors in researching the effects of the disease in the workplace. Admittedly, they take a lower profile about the disease. Progressive employee relations programs "nip-in-the-bud" any unwanted associations between the disease and the food served in their outlets. Implied in this statement is not a restrictive screening or firing policy but a clear understanding of CDC guidelines as they apply to AIDS and food handling. They have the facts about the disease and it doesn't create unnecessary fear for them. They communicate the facts to managers through special training programs at corporate headquarters.

Some suggestions for the PR professional

Optimally an organization has a cracker-jack public relations person who already knows the general approaches to take on crisis issues. And hopefully that person is versed in the AIDS issue as it impacts his organization and is backed by solid corporate policy on employee health. The only suggestions that can be made for that person are:

- Create a CEO "bluebook," a weekly crisis briefing book which outlines the general press themes to take on a specific incident—the contingency statement that will be released by the organization's spokesperson; and,
- Get a clipping service to monitor all press releases and corporate pronouncements on the AIDS issue to ensure that the perception by the press and the general public matches the reality of the company.

Ten steps to an effective AIDS PR policy

For a company who must train other staff to deal with public issues, we suggest the following exercises:

1
Write down the scenarios that could occur during an AIDS PR "incident" at your organization, taking into consideration unique health policies you may have. Write verbal themes that could address those scenarios in a positive, non-defensive way and still maintain the public identity of your organization.

2
If you do not have a strong employee health posture, help develop one internally because PR is only cosmetic if there is no real policy to back it. Then draft a public relations response to that policy. This can simply be an 8½x11 page, single spaced, of responses to critical questions and your organization's basic profile on health issues. The themes outlined on this sheet should be disseminated to appropriate internal audiences to ensure a consistency of response, such as medical directors and human resource personnel who address the issue, as well as the PR department.

3
Practice your responses from this theme list to simple inquiries about AIDS or from mock, confrontational phone calls and try to defuse the prejudice of the inquiry with calm, clearly outlined policies and a firm, decisive phone voice.

4
Practice your response to a mock press conference situation which you might videotape, to ensure no fragmented communications and verbal "misspeaks." Review the videotape of these mock press confrontations and alter your style to meet the situation. Speaking before one person and speaking before ten reporters are two different things and require customized responses.

5
Enter your prepared responses on your organization's word processor so that when you control the interview situation and insist on written communications to an initial phone inquiry, you don't have to reinvent the wheel each time you reply with correspondence. Draw out the major verbal modules from the processor's data bank that contain your AIDS policy.

6
Prepare an article on AIDS that is researched with a doctor and a lawyer versed on the specifics of the issue and submit it to your house-organ for publication.

7
Gather information from policy training exercises with employee focus-groups; elicit emotional responses that you can flag as problems to confront later with good internal PR.

8
Write a pamphlet that summarizes the latest knowledge on AIDS, a quick, brief summary to defuse prejudices. Distribute it to staff.

9
Conduct management "train the trainers" seminars with outside experts. Training exercises are best conducted by knowledgeable outside consultants who give fresh, candid approaches to the AIDS issue and not modulated in-house positions; and,

10
Don't assume any of the above positioning strategies or earlier guidelines are cover-ups, posing, stonewalling. Return the phone calls after you are sure of your response. Write a reply backed by strong medical information. Be honest. Be accurate. But control the transmission of the important visual and verbal cues that project your organization's long-term identity.

Executive Summary of Guidelines

This manual has given you concrete suggestions for dealing with AIDS in the workplace. The basic premises from which you should develop your own policy are very simple: AIDS is an emotional issue as well as medical issue and therefore affects all levels of your organization; it won't go away by avoiding it; fear is more contagious than AIDS; and education will quell hysteria, avoid unnecessary legal problems, and prevent the spread of the disease.

In summation, we offer these guidelines, drawn from the identified chapter:

General guidelines for Demystifying AIDS

1
Institute an employee AIDS education program that helps alleviate the fear of AIDS and provides solid facts about how the disease is transmitted.

2
Acknowledge the fear and view AIDS as a catastrophic illness, like cancer or heart disease (see discussions in the chapter on *Employee Relations: An AIDS Policy?*)

3
Create seminars or discussion groups to work through employees' psychological resistance and prejudice to accepting the facts about AIDS.

4
Monitor the results of your AIDS education program that are directed at dispelling the myths surrounding AIDS. Administer pre- and post-test attitude surveys (see Appendix III in this manual).

Economic policy guidelines

1
Employers should support the availability and use of out-of-hospital care. Corporations can encourage employees to use nursing homes, hospice and outpatient facilities that offer AIDS care. They can ensure that company insurance plans cover out-of-hospital lab tests, physician's and nurse's visits and IV drug therapy—reducing lengthy, costly hospital stays.

2
Employers should work with their insurance carriers to find the most cost-effective coverage plan—one that pays for hospice or nursing home care or other proven ways of reducing AIDS bills.

3
Employee health plans should cover the cost of outpatient counseling fees for employees with AIDS or employees whose family member has AIDS.

4
In-house counseling should also be provided by corporations in order to reduce costs associated with the devastating psychological effects of the disease.

5
Employers should avoid costly discrimination suits by having an AIDS policy in place before an incident occurs.

6
Employers should acknowledge a physician's recommendations regarding the ability of an employee with AIDS or ARC to work, and to provide the necessary support for them to do so.

7
In order to facilitate a comprehensive plan that will cover all areas of care for employees with AIDS, corporations should employ a case manager (who can come from existing personnel or EAP staff) to coordinate all individuals and agencies in the patient-employee care network. This manager must minimize the cost of caring for an employee without sacrificing the quality of service. Through good communication with all parties, this will ease the financial burden of the individual, the employer, the hospital and other care-giving agencies.

Educational guidelines

1
Encourage an open communication policy.

2
Offer organization wide seminars that are short, routinely offered, updated and voluntarily mandated in attendance depending on the corporate culture.

3
Deal openly and honestly with homophobia, drug abuse and death as related to the AIDS disease.

4
Offer a three-pronged team training approach that includes medical, legal and psychological dimensions of AIDS.

5
Publish AIDS information in a monthly newsletter and employee bulletin. Inform employees about an updated reading list on news articles and books on AIDS.

6
Educate employees about safer sex practices.

7
Develop an accountability system to evaluate your AIDS educational efforts.

Testing guidelines

1
Before implementing a policy of mandatory HIV testing as a condition of pre-employment or continued employment, employers should consider the following:

1
There is currently no available test which detects the presence of AIDS.

2
The existing test which identifies the presence of antibodies to HIV is primarily and most appropriately used to screen blood and plasma donations.

3
The HIV test has a limited predictive and diagnostic value; any broad use of the test as a screening mechanism would be misleading, deceptive and unfair.

4
States vary in the legal protections afforded individuals regarding discrimination on the basis of AIDS or a positive HIV test. Be sure to know the laws in your state, or consult with someone who does.

5
State laws vary regarding who may perform such tests and the standards regarding confidentiality of test results. Be sure to know the laws in your state or consult with someone who does.

6
In order to avoid costly litigation, employers should be very strict with confidentiality laws with regard to medical information. Employers must respect the patient's right to privacy.

7
Consider the effect of a screening program on employee morale.

8
Consider the benefits you expect to gain in implementing an HIV screening program in the workplace, and whether those benefits would outweigh the substantial negative workplace implications, especially in terms of: costs, legal exposure, and reduced employee morale.

Employer guidelines to manage fearful co-workers

1
Employees have a responsibility to perform their assigned tasks with a co-worker who has AIDS, or, in the case of a health care worker, with a patient suffering with AIDS. Counsel and support fearful employees. Make education the cornerstone of any employment policy. Designate a management level staff person—someone from the EAP Department, or Human Resource Management—as a contact person on AIDS accessible to employees and their families.

2
Employers have the right to discipline an employee through their right to manage the workplace while simultaneously providing that it be a healthy and safe place to work. Cooperation with the union in determining what is a reasonable precaution should be sought.

3
In unionized workplaces, resolve questions through collective bargaining agreements or provisions of the National Labor Relations Act (Labor Management Relations Act, as amended, 29 U.S.C. 141 et seq.).

4
Make provisions for medically certified groups of employees to avoid contact with people who have AIDS if those certifiable populations are pregnant health care workers, have open sores, or are immuno supressed and therefore more susceptible to disease. Counsel these employees and consider temporarily removing them to other areas.

5
Deal with the "panic and paranoia" of AIDS through written policy and a sincere effort to discuss and counsel a worried worker, not by discipline and discharge.

Guidelines for Health Care Professionals

1
Provide strong administrative support for health care professionals who are charged with the responsibility of caring for persons with AIDS.

2
Deal honestly with the fears employees have by sensitive counseling through existing Employee Assistance Programs, or through other qualified personnel.

3
Put the medical facts in perspective—as it applies to care providers—so they can judge the information rather than just being told or given a blanket assurance.

4
Call the health care professional to the highest standards of their own profession, which is that care providers are there to help people who have illnesses.

Public relations guidelines

1
Keep your Board of Directors completely informed and insist on their "support from the top" when addressing the issue.

2
Write a contingency statement that consistently gives company AIDS policy and adheres to strict rules of confidentiality. Create a "briefing book" of potential press themes that *one* company spokesperson will address with the contingency statement. Clip all press notices to monitor reportage.

3
Don't overreact to outside pressure. Buy time before responding to sensitive questions on AIDS policy. Before an incident occurs, establish relations with reporters who cover health issues so you can position stories on AIDS. Tape and transcribe all reporter interviews. Send the transcription to the reporter to ensure accuracy. Honestly address inaccurate reporting on the issue as it relates to your organization.

4
Internally, use professional trainers and audio visual tools to educate. Write a company brochure on AIDS transmission.

5
Don't cover up or stonewall. Reply with sound medical information and honest, accurate accounts of incidents in your organization.

Summary of Current Case Law

Employers who must decide how to treat employees with AIDS should be aware of the broader legal issues which have been raised by the AIDS epidemic. On one hand, private sector employers lack powers of government; on the other hand they are not constrained by the constitutional limitations that apply to government employees. All employees, however, like the government, must reach a sometimes difficult balance between the operational needs of conducting business and protection of individual rights.

Constitutional issues

The U.S. Constitution protects the privacy of all persons against intrusion by government agencies by precluding government from conducting unreasonable searches and seizures (**Amendment IV**) and guaranteeing to all persons that their right to life, liberty and the property will not be taken by the government without "due process of law" (**Amendment V and Amendment XIV**). Nevertheless, the Constitution permits the government, pursuant to its police power, to enact laws to protect the general public from the spread of disease. Due process rights and rights to privacy are not violated by reasonable health regulations compelling vaccination, for example. **Jacobson v. Massachusetts, 197 U.S. 11 (1905).**

What is a reasonable regulation for controlling one disease, however, may not be reasonable for another. Although the Constitution does not prohibit government from acting for the general welfare against the claims of individual rights when dealing with disease control, it does require that the measures taken be rationally related to legitimate governmental ends, and that the least intrusive means be used when fundamental rights are at stake. In addition, laws which are motivated by ill will rather than by desire to accomplish legitimate governmental ends will be subject to heightened scrutiny. **Cleburne v. Cleburne Living Center, 105 S. Ct. 3249 (1985).** For these reasons, perhaps, government has not instituted mass antibody screening among the general public or the recording of the identities of those who are HIV seropositive. Such measures, rather than being rationally related to legitimate governmental ends (which can be accomplished far less intrusively), may be motivated by ill will. However, the Armed Forces, the State Department and recently the Job Corps administered by the U.S. Department of Labor have instituted mass screening programs for employees or applicants. Some of these programs will likely be challenged in court.

AIDS and employment law

Employment in the private sector has traditionally operated under the "at-will" doctrine, pursuant to which an employee who has no contract for a set term of employment can be fired for a good reason, a bad reason, or no reason at all. In most jurisdictions this is still the rule, although the common law in some states has evolved to require "just cause" to dismiss an employee. In addition, even where the "at will"

doctrine is still the general rule, employment decisions cannot be made on certain specific grounds which are prohibited by federal and state civil rights statutes and collective bargaining agreements. These prohibited criteria may include, for example, race, sex, age, religion and national origin. Of particular relevance to AIDS are statutes which in most states and many localities prohibit employment discrimination based upon handicap.

The **Rehabilitation Act of 1973, 29 USC §794**, prohibits discharges by federal agencies, federal contractors or subcontractors and employers receiving substantial federal funds based upon an employee's handicap, record of handicap, or perceived handicap, so long as the employee is reasonably able to perform the duties of the job. Many state and local statutes are modeled after the Rehabilitation Act, and they apply to the employment practices of many private employers.

There have been determinations in most states that AIDS is a condition which is an impermissible basis for discrimination under applicable state laws. Among the important jurisdictions in which such determinations have been made are California, Florida, Illinois, Maine, Massachusetts, Michigan, Minnesota, Missouri, New Jersey, New York, Oregon, Texas, Washington, Wisconsin, the District of Columbia, and the Province of Ontario. AIDS has been held to be a handicap covered by the Federal Rehabilitation Act by federal District Court judges in California (**Thomas v. Atascudero Unified School District, No. 886-609 AHS (BY) (DC Ca., November 17, 1986**), and Florida **Shuttleworth v. Broward County, 41 FEPC 406 (S.D. Fla., July 8, 1986)**, and by a state court judge in New York (**District 27 Community School Board v. Board of Education of the City of New York, Index No. 14940/85, Slip. Op. (Sup. Ct., Queens Co. February 11, 1986) (Hyman, J.)**). The Office of Civil Rights of the Department of Health and Human Services has brought an employment discrimination proceeding on behalf of a discharged North Carolina nurse with AIDS (who unfortunately died before his complaint was prosecuted) in **Doe v. Charlotte Memorial Hospital, #04-84-3096**.

What does this mean for employers? Generally, it means that discharge of an employee with AIDS and, in many states, with ARC, who is able to perform the duties of his or her job will be illegal. But beyond that general principle, the extent of protection offered by these statutes is as yet unclear. Whether there is a duty to find alternate tasks which the partially disabled person with AIDS can perform is an open question. Similarly, whether the statutes extend protection to those with ARC or those at risk for AIDS or perceived to be at risk for AIDS is a determination which may be made differently in each jurisdiction.

The Justice Department has recently urged (in an interpretation of the part of the federal Rehabilitation Act that applies to employees who receive federal funds) that under federal law it may be a defense if the employer discharges an employee with AIDS out of fear of contagion. But this position is not likely to find favor with those interpreting state laws. It was rejected, for example, by the Suffolk County (Massachusetts) Superior Court in **Cronan v. New England Telephone Company, No. 80332,** BNA Daily Labor Reporter (BNA) No. 179, D-1, September 16, 1986. There, after the telephone company lost its motion for summary judgment dismissing

the discharged employee's complaint, it agreed to reinstate Mr. Cronan, to pay him a cash settlement, and provide training regarding AIDS to its employees, who staged a one-day walkout when Mr. Cronan returned to work.

The application of federal law to chronic health conditions such as AIDS may be clarified when the U.S. Supreme Court decides **Arline v. School Board of Nassau County**, in which argument was recently heard. In a decision by the Eleventh Circuit Court of Appeals, **Arline v. School Board of Nassau County, 772 F. 2d (11th Cir. 1985)**, a teacher's discharge for tuberculosis was determined to be illegal, because that chronic condition was found to be a handicap under the Rehabilitation Act. The Court found neither Congressional intent nor statutory language to exclude disease from the scope of protected handicaps, as the School Board had urged. That will be one of the questions which the Supreme Court may answer definitively in its decision in the case.

In addition to federal and state handicap discrimination laws, there are a number of other legal issues of which the employer dealing with AIDS should be aware. Where collective bargaining agreements or the common law require just cause for dismissal, it is likely that a dismissal based on an employee's contracting AIDS will violate that standard. Reinstatement, along with back pay and damages, are among the remedies available to employees. Employees with AIDS also may have protection under the **Federal Employee Retirement Income Security Act, 29 USC §1140**, which prohibits the discharge of employees where the motivation is to deprive them of certain benefits (including health insurance benefits) which may be governed by the law.

In some municipalities, moreover, there are laws specifically protecting employees with AIDS from discrimination. Major cities in California, such as Los Angeles, San Francisco, Oakland and Berkeley have such laws, as does Austin, Texas.

Employers with information about an employee's antibody status or illness with AIDS should treat that information with extreme care and confidentiality. The failure to do so will subject the employer to actions for damages, as occurred in the **Cronan** case, where one of Mr. Cronan's claims was for breach of his privacy rights when news of his illness was disseminated in the company. Other possible common law tort actions may include defamation, assault, intentional infliction of emotional distress and malicious interference with contractual relations.

Finally, there is the perilous question of screening potential employees so as to avoid hiring those at risk for AIDS. Antibody screening may violate the laws of certain jurisdictions with specific laws prohibiting such screening: California, Maine, Massachusetts, Wisconsin and the District of Columbia. It may violate the handicap laws in those places where perception of being in a risk group is sufficient to give one protection under the law. Screening by other means, such as sexual orientation, may violate the laws of Wisconsin, the District of Columbia, and numerous municipalities across the country which prohibit discrimination based on sexual orientation. (In addition, of course, such screening is irrational: not all gay people are at risk, and many people other than gay people are at risk.) Even less rational would be screening based on marital status, which would also violate the laws of New York and numerous other jurisdictions. As noted in the text of this manual, HIV antibody screening in the workplace has little justification, may adversely affect employee morale, and may invite litigation.

Employment in health care and food handling

Guidelines for dealing with persons with AIDS in these professions should be the same as those for any other communicable disease.

In the hospital setting, the American Hospital Association recommends consideration of possible reassignments of personnel to prevent direct patient contact, especially where invasive procedures are used, and to protect the employee with AIDS from the various diseases to which one might be exposed in hospitals. The Association further recommends continued monitoring of the employee's physical condition, with an eye toward further job reassignment.

The U.S. Public Health Service has recommended that food handlers with AIDS or hepatitis B, which is thought to be transmitted in a similar manner, follow established procedures related to personal hygiene and sanitation. Unless the employee exhibits oozing open wounds or a debilitating infection, he should not be barred from work. Special procedures should be instituted to protect against infection in the course of invasive procedures.

Employment in penal institutions

No particular precautions have been identified for either prison employees or prisoners infected with AIDS other than normal personal hygiene and sanitation. While common sense and education should alleviate most concerns about AIDS, the special circumstances of a prison may lead to special results.

The case of **In re Minnesota, 86-1 Arb. §8202 (Dec. 10, 1985)**, demonstrated the problems which might result from the lack of an articulated policy for dealing with persons with AIDS. A guard was discharged after refusing to conduct pat-down searches of prisoners because he feared the disease. He was reinstated by an arbitrator (but without back pay) because the warden had refused to accommodate his fears or to permit the use of gloves for such searches, as the guard had suggested. The key to this arbitration decision was the finding that the prior administration had done nothing to educate employees about the groundlessness of fears such as that exhibited by the guard and had earlier publicized facts about AIDS that were misleading and could have contributed to the guard's fears.

In a recent California case, on the other hand, a prison guard with AIDS was refused reinstatement by a federal District Court because prisoners' fears of contact with him might endanger his own safety and create a risk of prison violence.

AIDS and worker's compensation laws

Under American law, each state passes its own worker's compensation laws. In New York, an occupational disease is covered by the law, but the disease must be job related. Thus, a truck driver who contracted tuberculosis from his co-driver was denied benefits. **Matter of Paider v. East Park Movers, 19 NY 2d 373 (1967)**. A nurse who contracted the same disease through patient contact was eligible. **Matter of Nathan v. Presbyterian Hospital, 66 AD 2d 419 (3rd Dep't. 1978), motion for leave to appeal denied, 46 NY 2d 712 (1979)**. In California, the Department of Industrial Relations has reportedly not yet classified AIDS as a work-related illness in cases where nurses with AIDS filed compensation claims. However, health care providers may expect at least some AIDS-related claims from employees; it is

doubtful that even the most liberal jurisdiction will countenance claims from other employees except in highly unusual circumstances.

AIDS and the public schools

Teachers have the same rights to continued employment and protection from discrimination as other employees. With respect to students, the applicable laws are slightly different.

Once a state provides public schools for its children, those children have a right to remain in school. That right may be removed only by following the standards of due process. Students with AIDS enjoy the same rights to education as all other children.

Due process would require that all persons with AIDS be given a hearing before they are barred from attendance. New York City has adopted a procedure where all AIDS cases come before a panel of independent health experts. The determination on attendance is made by weighing the needs of each victim, the availability of alternatives, and the possible risks to classmates and personnel. The panel tries to maintain high standards of confidentiality to prevent harassment and boycotts. A New York court, in **District 27 Community School Board v. Board of Education of the City of New York, No. 14940/85, slip opinion (Sup.Ct. Quecas Cty. Feb. 11, 1986)**, upheld this procedure, applying the Federal Rehabilitation Act to the facts before it. The National Centers for Disease Control and the states of Connecticut and New Jersey have enunciated similar policies, with the presumption in each being to allow attendance.

Automatic exclusion of students with AIDS from school would raise the same issues of handicap discrimination as previously seen in employment.

It is clear from the thrust of the school cases that the attendance of students with AIDS must be handled on a case by case basis, in confidence, and by knowledgeable unbiased medical experts. Unless there is a substantial likelihood that the student with AIDS will have an exchange of bodily fluids with others, he or she should not be excluded from school.

Appendix II

Training Exercises

The exercises below relate to specific chapters in the manual. They illustrate the following themes:

- maintaining the health, safety and dignity of all employees
- creating an open system to facilitate candid exchange and effective decision making
- avoiding costly and unnecessary litigation
- developing policies that motivate employee morale and productivity

Each exercise helps build a workplace environment where management and employee alike are stimulated to assume a proactive, shared responsibility in formulating policies that confront AIDS connected problems in their workplace.

An exercise to help demystify AIDS

Here is an exercise you can conduct with a small employee group to a) stimulate open discussion about AIDS; b) create an opportunity to refute misinformation and stereotypes; and, c) get feedback for policy development.

Distribute copies of the article on the next page to each training participant. Give instructions to read carefully. Then, after reading, ask participants to help you list, on an easel pad, the concerns of a) employer, b) fellow employees, and c) person with AIDS. Define an equitable solution for each group based on participants' present knowledge of the crisis and knowledge of their own organization's work environment and personnel policies. Then take a group vote to determine the will of the majority on policy. Next, as trainer/expert, offer feedback on legality and practicality of their original solutions based on your knowledge from this manual. Then, ask the group to list possible revisions to the majority solutions, including their rationale. This interaction will help debunk myths and give employees a feeling that they are helping to establish fair policy. **Caution:** Be careful not to offer value judgements to the response, only known facts.

Value clarification exercise

This exercise provides an easy, yet challenging opportunity for employees to clarify their own feelings about AIDS in the workplace, and to ventilate their fears and anxieties.

Ask small groups to rank, in order of importance, the following list of words, each written on separate 3x5 cards: individual esteem; employee's civil rights; health cost containment; anti-discrimination; minority rights; AIDs education; organizational image; compassion toward terminally ill; and, workplace productivity.

The groups should reach consensus on the order of importance placed on these terms.

U.S. Files First AIDS Discrimination Charge

By ROBERT PEAR
Special to The New York Times

WASHINGTON, Aug. 8 — The Federal Government has for the first time accused an employer of illegally discriminating against a person with AIDS, Federal officials said today.

The charge was made by the Department of Health and Human Services, which said that a North Carolina hospital had violated a man's civil rights by dismissing him from his job as a registered nurse and then refusing to consider him for any other job.

Letter Sent to Hospital

The Government said the Charlotte *Memorial Hospital and Medical Center* had violated the law "by discriminatorily denying the complainant individualized consideration for possible re-employment."

The charge is contained in a nine-page letter received Thursday by the hospital. Cecily Newton, a spokesman for the hospital, declined to comment. "Our legal counsel has not had an opportunity to review the letter," she said.

Thomas B. Stoddard, a lawyer for the AIDS victim, said the decision was "a hollow victory" because the man died Feb. 26. He was 27 years old.

Mr. Stoddard is executive director of the Lambda Legal Defense and Education Fund Inc., a nonprofit group that defends the rights of homosexuals. He said it was unfortunate that the Government had not acted sooner on the man's complaint, which was filed in July 1984.

The Government's action is significant because it sets a precedent demonstrating that people with acquired immune deficiency syndrome may be able to protect their rights despite a restrictive interpretation of the relevant law by the Justice Department. In addition, lawyers said, the ruling underscores the need for employers to be cautious in taking action against workers with AIDS.

An Economics exercise about AIDS

It will be good to convene benefit managers and pool their recommendations on how to develop forceful corporate policies that will urge more responsible and inexpensive *community based care. Pose this problem for their discussion and solutions:* An AIDS patient wants to go home and receive community based treatment. However, his insurance company refuses to pay for IV drug home care or counseling outside the hospital. Because he does have some insurance, Social Services refuses to intervene.

Employee relations exercises

The purpose of workplace exercises on employee relations is to ease everyone's concern on how AIDS is transmitted. Since contracting the disease means almost certain death, employees and employers alike are naturally emotional about the subject. We all tend to be less rational than we should be.

1

Confronting these emotions head on and allowing workers to air their fears and anxieties is therefore the first step toward managing employees' fear of working with co-workers who have AIDS or serving people with AIDS.

Led by a qualified AIDS trainer, we recommend asking small groups to list their greatest fears and anxieties about AIDS; then submit them to a group or individual medical expert for a simple and brief response. A short film on the basic facts of AIDS is recommended. The Red Cross has a good one as does the San Francisco AIDS Foundation.

2

It is essential to bring management into these training sessions so the corporate AIDS policy is clearly stated and uniformly endorsed by top level administration, or the head of your smaller company. A group discussion with a corporate vice president will set the record straight.

3

Managing unwarranted fear of co-workers suspected of being infected by the HIV virus is similar to dealing with sex prejudice and discrimination at work. Such practices are unlawful, But prejudicial attitudes often persist, even in the face of logical evidence to the contrary.

To help break down employee prejudice toward people with AIDS, break into small groups (5-10 people) and ask one employee to take the role of someone with AIDS. The rest of the group states their unwillingness to work with him/her. After an exchange of 10 minutes, feedback is taken from participants. The group leader should facilitate feelings of rejection, disapproval, unwarranted fears, loss of control, etc.

Public relations exercises

For a company who must train other staff to deal with public issues, we suggest the following exercises:

1

Write down the scenarios that could occur during an AIDS PR "incident" at your organization, taking into consideration unique health policies you may have. Write verbal themes that could address those scenarios in a positive, non-defensive way and still maintain the public identity of your organization.

2

Practice your responses to inquiries about your corporate AIDS policy in mock, confrontational phone calls. Try to defuse the prejudice of the inquiry with calm, clearly outlined policies and a firm, decisive phone voice.

3

Practice your response to a mock press conference situation which you might videotape, to ensure no fragmented communications and verbal "misspeaks." Review the videotape of these mock press confrontations and alter your style to meet the situation.

4

Prepare an article on AIDS that is researched with a health professional versed on the specifics of the issue and submit it to your house-organ for publication. Or, gather information from other employee training exercises on AIDS. Focus on the emotional problems that surface and write a brief pamphlet that summarizes the latest knowledge on AIDS in order to defuse prejudices. Distribute it to staff.

Scenario-Exercise 1—The Cronan Telephone Company Story

Key objectives: To help both management and employee representatives experience the forms and effects of workplace polarization; and, to help companies gain experience in conflict management and resolution.

Composition: Ten to twenty-five participants are representatives from all levels of management, rank and file workforce.

Length of scenario: *Approximately 1 hour*

Program and room arrangements: Trainer prepares individual copies of the case study of the Cronan story in advance: newspaper clippings, judge's decision on awarding damages to Cronan, editorial comment. Room should be arranged with newsprint and felt tip markers for trainer and pencils and notepaper for participants. Room should be large enough to accommodate three sub-groups in different corners without disturbing each other.

Experience flow and dynamics

Step 1—Leader explains key objectives and requests that all participants express and exchange candid comments and feelings.

Step 2—Case study documents are then distributed and read by each participant without comment.

Step 3—After reading , each participant completes a questionnaire based on the Cronan case study.

Step 4—Scoring of the questionnaire items is as follows:

I strongly agree =	5 points
agree =	3 points
uncertain =	0 points
disagree =	5 points

Scoring system is placed on the wall of the room as it is explained by trainer/leader.

Step 5—Each participant computes his own score. Fifty points are added to each score to eliminate minus scores.

Step 6—A complete tally of all score cards is quickly made that establishes the following score intervals and respective frequencies.

The tally table	Scores	Frequency
	122-131	)
	112-121	)
	102-111	) ⅓ high scores
	92-101	)
	82- 91	)
	72- 81	)
	62- 71	) ⅓ mid range
	52- 61	)
	42- 51	)
	32- 41	)
	22- 31	) ⅓ low scores
	0- 11	)

Step 7—The leader divides participants into three groups whose scores fall in either high, middle or low range.

Step 8—Each group assembles in a different corner of the large room, selects a discussion leader who is directed to achieve a consensus viewpoint and also develop a strategy for persuading the other two groups to adopt its position as it relates to a Cronan-type situation in their own workplace. This session continues for ½ hour.

Step 9—The three groups then reassemble in a setting where each group sits together, facing the other two groups. The three spokespersons state the respective group's position for approximately 10-15 minutes.

Step 10—Following the three presentations, each group reconvenes and caucuses, giving feedback and new suggestions and instructions to the spokesperson.

Step 11—All participants reconvene in the previous three-group seating arrangement where an open discussion follows for 15-20 minutes.

Step 12—Trainer/leader announces that all members will receive new ballots directing them to vote privately on which position they favor (5 minutes).

Step 13—Coffee break is held while final tally is made (15 minutes).

Step 14—Trainer/leader presents final tally noting particularly the "changes" in voting pattern between Tally 1 and Tally 2, particularly changes of the "middle range" group whose ballots are made on different color paper than other 2 groups (15 minutes).

Step 15—In the final discussion (15 minutes), trainer/leader elicits commentary from "changers" in all three groups, directed at the effects of "polarization" in the workplace, and how a company can best handle interpersonal conflicts.

Step 16—Trainer/leader asks members to discuss what kind of workplace policy might help intercept and reduce unnecessary tension generated by this AIDS connected employee problem. Members also direct attention to:

a. Improving exercise format

b. Proposing alternative problem solving strategies for comparable interpersonal problems that develop in the workplace.

c. Providing feedback on the value of this exercise.

AIDS Victim's Colleagues Walk Out

Special to The New York Times

BOSTON, Oct. 22 — An AIDS victim's return to work for the first time in 17 months, part of a settlement of a lawsuit against The New England Telephone Company, led to a walkout today by most technicians at a garage in suburban Needham.

The technicians said they were refusing to work as a protest of how the company was handling the return of the 31-year-old AIDS victim, Paul F. Cronan.

Mr. Cronan, a 12-year employee of the company, filed a $1.75 million lawsuit in State Superior Court last December. He charged that the company had discriminated against him based on a handicap, the acquired immune deficiency syndrome; had breached his right to privacy and had coerced him not to return to work.

This morning workers asked the company if they could minimize contact with Mr. Cronan by getting their daily assignments in a parking lot rather than inside a building. When the company refused to change procedure, 29 out of 39 regular technicians refused to enter the building.

The cause of AIDS, a mysterious fatal disorder that destroys the body's ability to fight infection, is not known. However, it is thought to be transmitted through sexual contact or the transfer of bodily fluids, not casual contact.

Shop Steward Describes Fears

Today, George F. Moore, a shop steward for Local 2222 of the International Brotherhood of Electrical Workers, said: "There's an epidemic of fear here. People are under incredible stress. A grown man was crying this morning because he feared giving AIDS to his invalid father or losing his job."

He said the workers wanted "the company to use more of its resources to bring in experts to help them deal with the terror."

"This is a human issue, not a labor-management dispute," he said. "We support Paul as an individual and are optimistic that there is a way to make his environment positive and dignified. But we need the company to show genuine concern for all the workers and to meet us halfway."

The company is holding talks with the union's district representatives, said Ellen M. Boyd, a spokesman for New England Telephone. "We hope the workers will come back," she said. "No disciplinary action has yet been decided upon, but they certainly will not be paid for time not worked."

The district representative declined to comment.

Case Seen as Important One

The financial terms of the Cronan settlement have not been disclosed, but attorneys for AIDS victims say rulings made by the state and Federal courts in this case could set major precedents.

Last January the telephone company asked a Federal court to take the Cronan case under the purview of Federal Labor Relations Act. Federal District Judge Walter Jay Skinner sent the case back to state court, ruling that state laws on discrimination and privacy pre-empt Federal labor law or union agreements.

This ruling enabled Mr. Cronan to bring a civil suit and ask for $1.45 million in compensatory damages. Had he been limited to filing a union grievance, he could only have asked for reinstatement and back pay, said his attorney, David C. Casey.

Also, in August, State Judge Barbara J. Rouse ruled that state law against discrimination protects AIDS victims at work, although guidelines issued by the Federal Justice Department last June say employers, particularly Federal agencies, may bar AIDS victims from work if co-workers fear contamination, even if the fear is unfounded.

Nan D. Hunter, a lawyer for the American Civil Liberties Union in New York, who monitors AIDS cases nationwide, said. "In terms of employment discrimination, this is the first time that a state court has ruled that AIDS is a disability under state handicapped discrimination law."

As Mr. Cronan was pulling his truck out of the New England Telephone Company garage today, he said: "This is a victory for me and other AIDS victims. I'm so excited I may have to pull over later for a good cry."

Fears of his co-workers, he said, are understandable. but, he added that at work "there was medical literature about AIDS that had been written over by hand and tacked up to the wall."

"It said, 'Gays and bisexuals should be shipped to an island and destroyed,' " he said. "It's bad enough I have a disease that'll probably kill me. Now I have to deal with insults."

The New York Times/Joe Wrinn

Paul F. Cronan, a victim of AIDS, at his home in Dorchester, Mass. On the table are pictures of family members and friends.

Cronan case questionnaire

Place either: (SA) strongly agree, (A) Agree, (U) Uncertain, (D) Disagree, (SD) Strongly disagree in front of the following statements:

_____ Management acted too presumptuously in firing Mr. Cronan.

_____ Cronan's fellow employees acted too presumptuously in sending an ultimatum to management "either fire Cronan or we quit."

_____ Management only relented and reinstated Cronan when he brought discrimination charges against the company.

_____ Mass media caused Cronan's reinstatement.

_____ Society is basically ambivalent about dealing with the AIDS issue—that is sympathetic at a distance, but hostile when the situation comes close to one's work or family situation.

_____ Employee's protect self interest first; consequently managements' threats regarding loss of job or cut in wages keeps people in line.

_____ Higher work force morale and steady productivity results from managements' style of recognition and reward than otherwise.

_____ The more insecure an employee is on the job, the greater the tendency to fear and blame others, like AIDS victims.

_____ Personnel policies usually are written after, rather than anticipating crises in the workplace.

_____ Personnel policies function basically as legal protection for management's self interest, a kind of "Damage Control" over potential troublemakers in the workplace.

_____ Workers' rights tend to be compromised in unusual situations that involve threats to health and safety, such as AIDS or drug users.

_____ Cronan had no right to impose his personal problem, resulting from his life style, on his co-workers.

_____ Co-workers should show more compassion and support in dealing with those who are a person with AIDS or who test positive on HIV antibody blood test.

Scenario-Exercise 2—The AIDS IQ

Key objectives: a) To identify information gaps and fears concerning AIDS in the workplace; b) to generate through brainstorming, appropriate educational strategies to be adopted by a company worker to reduce fear and ignorance of the disease.

Composition: A group of 20-30 representatives drawn equally from management, supervisory and worker levels.

Length of scenario: 1—1½ hours

Program and room arrangements: a) Trainer/leader prepares copies of 20, key, true or false questions in advance (see Appendix III) that test general knowledge of the AIDs problem; b) approximately 5 to 6 panels of mixed participants are then created and assigned to separate rooms where they discuss test results. No leadership assignments are made for these groups. Each is instructed to engage in a 20-minute spontaneous discussion focused on two issues: implications of the test results; and, what their company can do to improve contact and communication regarding the handling of the AIDS problem.

Each panel is asked to record and test all opinions, without censorship, on newspaper print with felt marker. Each group then ranks the top three suggestions that are then reported to the entire group.

Coffee break precedes final.

Each panel hangs its three suggestions on the wall. Upon opening the final session, the president announces that the company has set aside a sum of money to implement a preferred set of program recommendations that the group will submit to the rank and file for a final vote.

Trainer leads a general discussion through the following steps:

Step 1—Clarification of group is asked to eliminate overlapping suggestions as well as combine those that are natural allies and to clarify ambiguous ideas and terminology (20 minutes).

Step 2—Group is asked to make a preliminary, private ranking on paper of the top three suggestions from the entire listing on wall.

Step 3—Advocates for each of the top three suggestions give closing five minute arguments. Ten minute floor discussion follows before final re-vote.

Step 4—Closed paper balloting is made and weighed as follows:

First choice =	5 points
Second choice =	3 points
Third choice =	1 point

In case of a tie, there will be an additional ballot run off (10 minutes).

Step 5—Committee of the whole group designates its own sub group comprising representatives from all levels to draw up its priorities which are then submitted to the company's entire workforce for final approval.

Step 6—Management convenes a group to implement policy through company in-service education program, with the assistance of a professional trainer.

Evaluation

A management-worker group also performs a 6-month followup survey of rank and file opinion on the value of its educational program.

The original AIDS questionnaire is also submitted to company workforce before and after this educational exercise to gauge whether employees and management have gained from it.

Appendix III

Evaluation Instruments

20 Statements on AIDS

Indicate whether the following statments are true or false.

_____ 1. You can get AIDS by being in the same room with a person with AIDS.

_____ 2. AIDS is *only* transmitted through semen and blood.

_____ 3. Most gay people have AIDS.

_____ 4. A person who is concerned can be tested for AIDS.

_____ 5. The virus believed to cause AIDS has been transmitted through saliva.

_____ 6. Women cannot transmit AIDS.

_____ 7. AIDS is transmitted by sneezing.

_____ 8. AIDS is an easily transmitted disease.

_____ 9. There are no cases of casual transmission of AIDS to family members, roomates, co-workers, or friends who are not also sexual partners of people with AIDS.

_____10. People can look and feel healthy and still transmit this disease.

_____11. Receptive anal intercourse is the highest risk sexual activity for gay and bisexual men.

_____12. Heterosexual sex is not as dangerous as homosexual sex.

_____13. Most people who get AIDS are not responsible for contracting the disease.

_____14. If you shoot drugs with your own needle and never share it you can't get AIDS from shooting.

_____15. You can get AIDS from donating blood.

_____16. More than ⅓ of all U.S. AIDS cases are found in New York State.

_____17. The symptoms of AIDS are general and similar to the symptoms of other diseases.

_____18. Most children with AIDS are too young to go to school.

_____19. Most children with AIDS got it from a blood transfusion.

_____20. There is currently a vaccine to prevent AIDS.

Answers
1.F 2.T 3.F 4.T 5.F 6.F 7F. 8.F 9.T 10.T 11.T 12.F 13.T 14.T 15.F 16.T 17.T 18.T 19.F 20.F

Survey questions to assess "AIDS Anxiety"

See chapters on Demystifying AIDS (page 5) and Corporate Education (page 15).

1. Do you know what causes AIDS?

2. Are you comfortable working with other employees regardless of their sexual preference? Do you believe one's sexual preference causes AIDS?

3. Do you know fellow employees who use drugs? How do you feel about working with them?

4. Are you comfortable sharing pencils, phones, cups bathrooms or drinking fountains with fellow employees who are infected with AIDS?

5. Do you feel comfortable drinking from the same glass or eating from the same dishes that a person with AIDS has used?

6. Do you believe that AIDS can be contracted by touching someone who has AIDS?

7. Do you believe AIDS can be contracted from swimming with someone who has AIDS?

8. Do you believe AIDS can be contracted from handling money?

9. Do you believe that certain occupational groups are at special risk of contracting AIDS?

Recommended employee relations policy & AIDS

Questions to consider for incorporating AIDS into your employee relations policy

1. Does your written policy provide equal opportunity of employment to all employees and applicants, including people with AIDS without regard to race, color, religion, sex, national origin or handicap? Remember: Most state anti-discrimination laws view AIDS as a handicap.

2. Does your present policy include provisions for employee performance review to provide periodic evaluation for job requirements? Remember: Diagnosis of AIDS cannot justify employee dismissal.

3. Is your employee relations policy for termination accompanied by severance pay and an explanation of reasons for dismissal? Remember: If termination is necessary for reasons of an AIDS related disability, adequate severance should be provided.

4. Does your existing employee policy provide adequate health and life insurance coverage for an employee diagnosed with AIDS? Most employers provide health and life insurance as a benefit of employment.

5.Are your sick leave policies applied in a uniform fashion? Remember: AIDS and ARC in early stages will not necessarily manifest themselves in any particularly debilitating way. There is no justification for adopting a more restrictive policy for those who have AIDS than exists for those with other catastrophic illnesses.

Appendix IV

CDC Guidelines for the Workplace

Morbidity & Mortality Weekly Report, November 1985

The information and recommendations contained in this document have been developed with particular emphasis on health-care workers and others in related occupations in which exposure might occur to blood from persons infected with HTLV-III/LAV, the "AIDS virus." Because of public concern about the purported risk of transmission of HTLV-III/LAV by persons providing personal services and those preparing and serving food and beverages, this document also addresses personal-service and food-service workers. Finally, it addresses "other workers"—persons in settings, such as offices, schools, factories, and construction sites, where there is no known risk of AIDS virus transmission.

Because AIDS is a bloodborne, sexually transmitted disease that is not spread by casual contact, this document does not recommend routine HTLV-III/LAV antibody screening for the groups addressed. Because AIDS is not transmitted through preparation or serving of food and beverages, these recommendations state that food service workers known to be infected with AIDS should not be restricted from work unless they have another infection or illness for which such restriction would be warranted.

This document contains detailed recommendations for precautions appropriate to prevent transmission of all bloodborne infectious diseases to people exposed—in the course of their duties—to blood from persons who may be infected with HTLV-III/LAV. They emphasize that health-care workers should take all possible precautions to prevent needlestick injury. The recommendations are based on the well-documented modes of HTLV-III/LAV transmission and incorporate a "worst case" scenario, the hepatitis B model of transmission. Because the hepatitis B virus is also bloodborne and is both hardier and more infectious than HTLV-III/LAV, recommendations that would prevent transmission of hepatitis B will also prevent transmission of AIDS.

Formulation of specific recommendations for health-care workers who perform invasive procedures is in progress.

Persons at increased risk of acquiring infection with human T-lymphotopic virus type III/lymphadenopathy-associated virus (HTLV-III/LAV), the virus that causes acquired immuno-deficiency syndrome (AIDS), include homosexual and bisexual men, intraveneous (IV) drug abusers, persons transfused with contaminated blood or blood products, heterosexual contacts of persons with HTLV-III/LAV infection, and children born to infected mothers. HTLV-III/LAV is transmitted through sexual contact, parenteral exposure to infected blood or blood components, and perinatal transmission from mother to neonate. HTLV-III/LAV has been isolated from blood, semen, saliva, tears, breast milk, and urine and is likely to be isolated from some other body fluids, secretions, and excretions, but epidemiologic evidence has implicated only blood and semen in transmission. Studies of nonsexual household contacts of AIDS patients indicate that casual contact with salvia and tears does not result in transmission of infection. Spread of infection to household contacts of infected persons has not been detected when the household contacts have not been sex partners or

have not been infants of infected mothers. The kind of nonsexual person-to-person contact that generally occurs among workers and clients or consumers in the workplace does not pose a risk for transmission of HTLV-III/LAV.

As in the development of any such recommendations, the paramount consideration is the protection of the public's health. The following recommendations have been developed for all workers, particularly workers in occupations in which exposure might occur to blood from individuals infected with HTLV-III/LAV. These recommendations reinforce and supplement the specific recommendations that were published earlier for clinical and laboratory staffs (1) and for dental-care personnel and persons performing necropsies and morticians' services. (2) Because of public concern about the purported risk of transmission of HTLV-III/LAV by persons providing personal services and by food and beverages, these recommendations contain information and recommendations for personal-service and food-service workers. Finally, these recommendations address workplaces in general where there is no known risk of transmission of HTLV-III/LAV (e.g. offices, schools, factories, construction sites). Formulation of specific recommendations for health-care workers (HCWs) who perform invasive procedures (e.g. surgeons, dentists) is in progress. Separate recommendations are also being developed to prevent HTLV-III/LAV transmission in prisons, other correctional facilities, and institutions housing individuals who may exhibit uncontrollable behavior (e.g. custodial institutions) and in the perinatal setting. In addition, separate recommendations have already been developed for children in schools and day-care centers (3).

HTLV-III/LAV-infected individuals include those with AIDS (4); those diagnosed by their physician(s) as having other illnesses due to infection with HTLV-III/LAV; and those who have virologic or serologic evidence of infection with HTLV-III/LAV but who are not ill.

These recommendations are based on the well-documented modes ofHTLV-III/LAV transmission identified in epidemiologic studies and on comparison with the hepatitis B experience. Other recommendations are based on the hepatitis B model of transmission.

Comparison with the Hepatitis B Virus Experience

The epidemiology of HTLV-III/LAV infection is similar to that of hepatitis B virus (HBV) infection, and much that has been learned over the last 15 years related to the risk of acquiring hepatitis B in the workplace can be applied to understanding the risk of HTLV-III/LAV transmission in the health-care and other occupational settings. Both viruses are transmitted through sexual contact, parenteral exposure to contaminated blood or blood products, and perinatal transmission from infected mothers to their offspring. Thus, some of the major groups at high risk for HBV infection (e.g. homosexual men, IV drug abusers, persons with hemophilia, infants born to infected mothers) are also the groups at highest risk for HTLV-III/LAV infection. Neither HBV nor HTLV-III/LAV has been shown to be transmitted by casual contact in the workplace, contaminated food or water, or airborne or fecal-oral routes (5).

HBV infection is an occupational risk for HCWs, but this risk is related to degree of contact with blood or contaminated needles. HCWs who do not have contact with blood or needles contaminated with blood are not at risk for acquiring HBV infection in the workplace (6-8).

In the health-care setting, HBV transmission has not been documented between hospitalized patients, except in hemodialysis units, where blood contamination of the environment has been extensive or where HBV-positive blood from one patient has been transferred to another patient through contamination of instruments. Evidence of HBV transmission from HCWs to patients has been rare and limited to situations in which the HCWs exhibited high concentrations of virus in their blood (at least 100,000,000 infectious virus particles per ml of serum), and the HCWs sustained a puncture wound while performing traumatic procedures on patients or had exudative or weeping lesions that allowed virus to contaminate instruments or open wounds of patients (9-11).

Current evidence indicates that, despite epidemiologic similarities of HBV and HTLV-III/LAV infection, the risk of HAV transmission in health-care settings far exceeds that for HTLV-III/LAV transmissions. The risk of acquiring HBV infection following a needlestick from an HBV carrier ranges from 6% to 30% (12-13), far in excess of the risk of HTLV-III/LAV infection following a needlestick involving a source patient infected with HTLV-III/LAV, which is less than 1%. In addition, all HCWs who have been shown to transmit HBV infection in health-care settings have belonged to the subset of chronic HBV carriers who, when tested, have exhibited evidence of exceptionally high concentrations of virus (at least 100,000,000 infectious virus particles per ml) in their blood. Chronic carriers who have substantially lower concentrations of virus in their blood have not been implicated in transmission in the health-care setting (9-11, 14). The HBV model thus represents a "worst case" condition in regard to transmission in health-care and other related settings. Therefore, recommendations for the control of HBV infection should, if followed, also effectively prevent spread of HTLV-III/LAV. Whether additional measures are indicate for those HCWs who perform invasive procedures will be addressed in the recommendations currently being developed.

Routine screening of all patients or HCWs for evidence of HBV infection has never been recommended. Control of HBV transmission in the health-care setting has emphasized the implementation of recommendations for the appropriate handling of blood, other body fluids, and items soiled with blood or other body fluids.

Transmission from patients to health-care workers

HCWs include, but are not limited to, nurses, physicians, dentists and other dental workers, optometrists, podiatrists, chiropractors, laboratory and blood bank technologists and technicians, phlebotomists, dialysis personnel, paramedics, emergency medical technicians, medical examiners, morticians, housekeepers, laundry workers and others whose work involves contact with patients, their blood or other body fluids or corpses.

Recommendations for HCWs emphasize precautions appropriate for preventing transmission of bloodborne infectious diseases, including HTLV-III/LAV and HBV infections. Thus, these precautions should be enforced routinely, as should other standard infection-control precautions, regardless of whether HCWs or patients are known to be infected with HTLV-III/LAV or HBV. In addition to being informed of these precautions, all HCWs, including students and housestaff, should be educated regarding the epidemiology, modes of transmission and prevention of HTLV-III/LAV infection.

Risk of HCWs acquiring HTLV-III/LAV in the workplace. Using the HBV model, the highest risk for transmission of HTLV-III/LAV in the workplace would involve parenteral exposure to a needle or other sharp instrument contaminated with blood of an infected patient. The risk to HCWs of acquiring HTLV-III/LAV infection in the workplace has been evaluated in several studies. In five separate studies, a total of, 1,498 HCWs have been tested for antibody to HTLV-III/LAV. In these studies, 666 (48.5%) of the HCWs had direct parenteral (needlestick or cut) or mucous membrane exposure to patients with AIDS or HTLV-III/LAV infection. Most of these exposures were to blood rather than to other body fluids. None of the HCWs whose initial serologic tests were negative developed subsequent evidence of HTLV-III/LAV infection following their exposures. Twenty-six HCWs in these five studies were seropositive when first tested; all but three of these persons belonged to groups recognized to be at increased risk for AIDS (15). Since one was tested anonymously, epidemiologic information was available on only two of these three seropositive HCWs. Although these two HCWs were reported as probable occupationally related HTLV-III/LAV infection (15-16), neither had a preexposure or an early postexposure serum sample available to help determine the onset of infection. One case reported from England describes a nurse who seroconverted following an accidental parenteral exposure to a needle contaminated with blood from an AIDS patient (17).

In spite of the extremely low risk of transmission of HTLV-III/LAV infection, even when needlestick injuries occur, more emphasis must be given to precautions targeted to prevent needlestick injuries in HCWs caring for any patient, since such injuries continue to occur even during the care of patients who are known to be infected with HTLV-III/LAV.

Precautions to prevent acquisition of HTLV-III/LAV infection by HCWs in the workplace.

These precautions represent prudent practices that apply to preventing transmission of HTLV-III/LAV and other bloodborne infections and should be used routinely (18).

1

Sharp items (needles, scalpel blades, and other sharp instruments) should be considered as potentially infective and be handled with extraordinary care to prevent accidental injuries.

2

Disposable syringes and needles, scalpel blades, and other sharp items should be placed into puncture-resistant containers located as close as practical to the area in which they were used. To prevent needlestick injuries, needles should not be recapped, purposefully bent, broken, removed from disposable syringes, or otherwise manipulated by hand.

3

When the possibility of exposure to blood or other body fluids exists, routinely recommended precautions should be followed. The anticipated exposure may require gloves alone, as in handling items soiled with blood or equipment contaminated with blood or other body fluids, or may also require gowns, masks, and eye-coverings when performing procedures involving more extensive contact with blood or potentially infective body fluids, as in some dental or endoscopic procedures or postmortem examinations. Hands should be washed thoroughly and immediately if they accidentally become contaminated with blood.

4

To minimize the need for emergency mouth-to-mouth resuscitation, mouth pieces, resuscitation bags or other ventilation devices should be strategically located and available for use in areas where the need for resuscitation is predictable.

5

Pregnant HCWs are not known to be at greater risk of contracting HTLV-III/LAV infections than HCWs who are not pregnant; however, if a HCW developes HTLV-III/LAV infection during pregnancy, the infant is at increased risk of infection resulting from perinatal transmission. Because of this risk, pregnant HCWs should be especially familiar with precautions for preventing HTLV-III/LAV transmission (19).

Precautions for HCWs during home care of persons infected with HTLV-III/LAV.
Persons infected with HTLV-III/LAV can be safely cared for in home environments. Studies of family members of patients infected with HTLV-III/LAV have found no evidence of HTLV-III/LAV transmission to adults who were not sexual contacts of the infected patients or to children who were not at risk for perinatal transmission (3). HCWs providing home care face the same risk of transmission of infection as HCWs in hospitals and other health-care settings, especially if there are needlesticks or other parenteral or mucous membrane exposures to blood or other body fluids.

When providing health-care service in the home to persons infected with HTLV-III/LAV, measures similar to those used in hospitals are appropriate. As in the hospital, needles should not be recapped, purposefully bent, broken, removed from disposable syringes, or otherwise manipulated by hand. Needles and other sharp items should be placed into puncture-resistant containers and disposed of in accordance with local regulations for solid waste. Blood and other body fluids can be flushed down the toilet. Other items for disposal that are contaminated with blood or other body fluids that cannot be flushed down the toilet should be wrapped securely in a plastic bag that is impervious and sturdy (not easily penetrated). It should be placed in a second bag before being discarded in a manner consistent with local regulations for solid waste disposal. Spills of blood or other body fluids should be cleaned with soap and water or a household detergent. As in the hospital, individuals cleaning up such spills should wear disposable gloves. A disinfectant solution or a freshly prepared solution of sodium hypochlorite (household bleach, see below) should be used to wipe the area after cleaning.

Precautions for providers of prehospital emergency health care.
Providers of prehospital emergency health care include the following: paramedics, emergency medical technicians, law enforcement personnel, firefighters, lifeguards, and others whose job might require them to provide first-response medical care. The risk of transmission of infection, including HTLV-III/LAV infection, from infected persons to providers of prehospital emergency health care should be no higher than that for HCWs providing emergency care in the hospital if appropriate precautions are taken to prevent exposure to blood or other body fluids.

Providers of prehospital emergency health care should follow the precautions outlined above for other HCWs. No transmissions of HBV infection during mouth-to-mouth resuscitation have been documented. However, because of the theoretical risk of salivary transmission of HTLV-III/LAV during mouth-to-mouth resuscitation, special attention should be given to the use of disposable airway equipment or resuscitation bags and the wearing of gloves when in contact with blood or other body fluids. Resuscitation equipment and devices known or suspected to be contaminated with blood or other body fluids should be used once and disposed of or be thoroughly cleaned and disinfected after each use.

Management of parenteral and mucous membrane exposure of HCWs.
If a HCW has a parenteral (e.g. needlestick or cut) or mucous membrane (e.g. splash to the eye or mouth) exposure to blood or other body fluids, the source patient should be assessed clinically and epidemiologically to determine the likelihood of HTLV-III/LAV infection. If the assessment suggests that infection may exist, the patient should be informed of the incident and requested to consent to serologic testing for evidence of HTLV-III/LAV infection. If the source patient has AIDS or other evidence of HTLV-III/LAV infection, declines testing, or has a positive test, the HCW should be evaluated clinically and serologically for evidence of HTLV-III/LAV infection as soon as possible after the exposure, and if seronegative, retested after six weeks and on a periodic basis thereafter (e.g. 3, 6, and 12 months following exposure) to determine if transmission has occurred. During this follow-up period, especially, the first 6-12 weeks, when most infected persons are expected to seroconvert, exposed HCWs should receive counselling about the risk of infection and follow US Public Health Service (PHS) recommendations for preventing transmission of AIDS (20-21). If the source patient is seronegative and has no other evidence of HTLV-III/LAV infection, no further follow-up of the HCWs is necessary. If the source patient cannot be identified, decisions regarding appropriate follow-up should be individualized based on the type of exposure and the likelihood that the source patient was infected.

Serologic testing of patients
Routine serologic testing of all patients for antibody to HTLV-III/LAV is not recommended to prevent transmission of infection in the workplace. Results of such testing are unlikely to further reduce the risk of transmission, which, even with documented needlesticks, is already extremely low. Furthermore, the risk of needlestick and other parenteral exposures could be reduced by emphasizing and more consistently implementing routinely recommended infection control precautions (e.g. not recapping needles). Moreover, results of routine serologic testing would not be available for emergency cases and patients with short lengths of stay, and additional tests to determine whether a positive test was a true or false positive would be required in populations with a low prevalence of infection. However, this recommendation is based only on considerations of occupational risks and should not be construed as a recommendation against other uses of the serologic test, such as for diagnosis or to facilitate medical management of patients.

Since the experience with infected patients varies substantially among hospitals (75% of all AIDS cases have been reported by only 280 of the more than 6,000 acute-care hospitals in the United States), some hospitals in certain geographic areas may deem it appropriate to initiate serologic testing of patients.

Transmission from health-care workers to patients
Risk of transmission of HTLV-III/LAV infection from HCWs to patients. Although there is no evidence that HCWs infected with HTLV-III/LAV have transmitted infection to patients, a risk of transmission of HTLV-III/LAV infection from HCWs to patients would exist in situations where there is both (1) a high degree of trauma to the patient that would provide a portal of entry for the virus (e.g., during invasive procedures) and (2) access of blood or serous fluid from the infected HCW to the open tissue of a patient, as could occur if the HCW sustains a needlestick or scalpel injury during an invasive procedure. HCWs known to be infected with HTLV-III/LAV who do not perform invasive procedures need not be restricted from work unless they have evidence of other infection or illness for which any HCW should be restricted. Whether additional restrictions are indicated for HCWs who perform invasive procedures is currently being considered.

Precautions to prevent transmission of HTLV-III/LAV infection from HCWs to patients.
These precautions apply to all HCWs, regardless of whether they perform invasive procedures: (1) All HCWs should wear gloves for direct contact with mucous membranes or nonintact skin of all patients and (2) HCWs who have exudative lesions or weeping dermatitis should refrain from all direct patient care and from handling patient-care equipment until the condition resolves.

Management of parenteral and mucous membrane exposure of patients.
If a patient has a parenteral or mucous membrane exposure to blood or other body fluids of a HCW, the patient should be informed of the incident and the same procedure outlined above for exposures of HCWs to patients should be followed for both the source HCW and the potentially exposed patient. Management of this type of exposure will be addressed in more detail in the recommendations for HCWs who perform invasive procedures.

Serologic testing of HCWs
Routine serologic testing of HCWs who do not perform invasive procedures (including providers of home and prehospital emergency care) is not recommended to prevent transmission of HTLV-III/LAV infection. The risk of transmission is extremely low and can be further minimalized when routinely recommended infection-control precautions are followed. However, serologic testing should be available to HCWs who may wish to know their HTLV-III/LAV infection status. Whether indications exist for serologic testing of HCWs who perform invasive procedures is currently being considered.

Risk of occupational acquisition of other infection diseases by HCWs infected with HTLV-III/LAV.

HCWs who are known to be infected with HTLV-III/LAV and who have defective immune systems are at increased risk of acquiring or experiencing serious complications of other infectious diseases. Of particular concern is the risk of severe infection following exposure to patients with infectious diseases that are easily transmitted if appropriate precautions are not taken (e.g., tuberculosis). HCWs infected with HTLV-III/LAV should be counseled about the potential risk associated with taking care of patients with transmissible infections and should continue to follow existing recommendations for infection control to minimize their risk of exposure to other infectious agents (18,19). The HCWs personal physician(s), in conjunction with their institutions' personnel health services or medical directors, should determine on an individual basis whether the infected HCWs can adequately and safely perform patient-care duties and suggest changes in work assignments, if indicated. In making this determination, recommendations of the Immunization Practices Advisory Committee and institutional policies concerning requirements for vaccinating HCWs with live-virus vaccines should also be considered.

Sterilization, disinfection, housekeeping, and waste disposal to prevent transmission of HTLV-III/LAV.

Sterilization and disinfection procedures currently recommended for use (22, 23) in health-care and dental facilities are adequate to sterilize or disinfect instruments, devices, or other items contaminated with the blood or other body fluids from individuals infected with HTLV-III/LAV. Instruments or other nondisposable items that enter normally sterile tissue or the vascular system or through which blood flows should be sterilized before reuse. Surgical instruments used on all patients should be sterilized before reuse. Surgical instruments used on all patients should be decontaminated after use rather than just rinsed with water. Decontamination can be accomplished by machine or by hand cleaning by trained personnel wearing appropriate protective attire (24) and using appropriate chemical germicides. Instruments or other nondisposable items that touch intact mucous membranes should receive high-level disinfection.

Several liquid chemical germicides commonly used in laboratories and health-care facilities have been shown to kill HTLV-III/LAV at concentrations much lower than are used in practice (25). When decontaminating instruments or medical devices, chemical germicides that are registered with and approved by the US Environmental Protection Agency (EPA) as "sterilants" can be used either for sterilization or for high-level disinfection depending on contact time: germicides that are approved for use as "hospital disinfectants" and are mycobactericidal when used at appropriate dilutions can also be used for high-level disinfection of devices and instruments. Germicides that are mycobactericidal are preferred because mycobacteria represent one of the most resistant groups of microorganisms; therefore, germicides that are effective against mycobacteria are also effective against other bacterial and viral pathogens. When chemical germicides are used, instruments or devices to be sterilized or disinfected should be thoroughly cleaned before exposure to the germicide, and the manufacturer's instructions for use of the germicide should be followed.

Laundry and dishwashing cycles commonly used in hospitals are adequate to decontaminate linens, dishes, glassware, and utensils. When cleaning environmental surfaces, housekeeping procedures commonly used in hospitals are adequate; surfaces exposed to blood and body fluids should be cleaned with a detergent followed by decontamination using an EPA-approved hospital disinfectant that is mycobactericidal. Individuals cleaning up such spills should wear disposable gloves. Information on specific label claims of commercial germicides can be obtained by writing to the Disinfectants Branch, Office of Pesticides, Environmental Protection Agency, 401 M Street, SW, Washington, DC 20460.

In addition to hospital disinfectants, a freshly prepared solution of sodium hypochlorite (household bleach) is an inexpensive and very effective germicide (25). Concentrations ranging from 5,000 ppm (a 1:10 dilution of household bleach) to 500 ppm (a 1:100 dilution) sodium hypochlorite are effective, depending on the amount of organic material (e.g., blood, mucous, etc.) present on the surface to be cleaned and disinfected.

Sharp items should be considered as potentially infective and should be handled and disposed of with extraordinary care to prevent accidental injuries. Other potentially infective waste should be contained and transported in clearly identified impervious plastic bags if the outside of the bag is contaminated with blood or other body fluids, a second outer bag should be used. Recommended practices for disposal of infective waste (23) are adequate for disposal of waste contaminated by HTLV-III/LAV. Blood and other body fluids may be carefully poured down a drain connected to a sanitary sewer.

Considerations Relevant to Other Workers

Personal-service workers (PSWs). PSWs are defined as individuals whose occupations involve close personal contact with clients (e.g., hairdressers, barbers, estheticians, cosmetologists, manicurists, pedicurists, massage therapists). PSWs whose services (tattooing, ear piercing, acupuncture, etc.) require needles or other instruments that penetrate the skin should follow precautions indicated for HCWs. Although there is no evidence of transmission of HTLV-III/LAV from clients to PSWs, from PSWs to clients, or between clients of PSWs, a risk of transmission would exist from PSWs to client and vice versa in situations where there is both (1) trauma to one of the individuals that would provide a portal of entry for the virus and (2) access of blood or serous fluid from one infected person to the open tissue of the other, as could occur if either sustained a cut. A risk of transmission from client to client exists when instruments contaminated with blood are not sterilized or disinfected between clients. However, HBV transmission has been documented only rarely in acupuncture, ear piercing, and tattoo establishments and never in other personal-service settings, indicating that any risk for HTLV-III/LAV transmission in personal-service settings must be extremely low.

All PSWs should be educated about transmission of bloodborne infections, including HTLV-III/LAV and HBV. Such education should emphasize principles of good hygiene, antisepsis, and disinfection. This education can be accomplished by national or state professional organizations, with assistance from state and local health departments, using lectures at meetings or self-instructional materials. Licensure requirements should include evidence of such education. Instruments that are intended to penetrate the skin (e.g., tattooing and acupuncture needles, ear piercing devices) should be used once and disposed of or be thoroughly cleaned and sterilized after each use, using procedures recommended for use in health-care institutions. Instruments not intended to penetrate the skin, but which may become contaminated with blood (e.g., razors), should be used for only one client and be disposed of or thoroughly cleaned and disinfected after use, using procedures recommended for use in health-care institutions. Any PSW with exudative lesions or weeping dermatitis, regardless of HTLV-III/LAV infection status, should refrain from direct contact with clients until the condition resolves. PSWs known to be infected with HTLV-III/LAV need not be restricted from work unless they have evidence of other infections or illnesses for which any PSW should also be restricted.

Routine serologic testing of PSWs for antibody to HTLV-III/LAV is not recommended to prevent transmission from PSWs to clients.

Food-service workers (FSWs).
FSWs are defined as individuals whose occupations involve the preparation or serving of food or beverages (e.g., cooks, caterers, servers, waiters, bartenders, airline attendants). All epidemiologic and laboratory evidence indicates that bloodborne and sexually transmitted infections are not transmitted during the preparation or serving of food or beverages, and no instances of HBV or HTLV-III/LAV transmission have been documented in this setting.

All FSWs should follow recommended standards and practices of good personal hygiene and food sanitation (26). All FSWs should exercise care to avoid injury to hands when preparing food. Should such an injury occur, both aesthetic and sanitary considerations would dictate that food contaminated with blood be discarded. FSWs known to be infected with HTLV-III/LAV need not be restricted from work unless they have evidence of other infection or illness for which any FSW should also be restricted.

Routine serologic testing of FSWs for antibody to HTLV-III/LAV is not recommended to prevent disease transmission from FSWs to consumers.

Other workers sharing the same work environment. No known risk of transmission to co-workers, clients, or consumers exists from HTLV-III/LAV-infected workers in other settings (e.g., offices, schools, factories, construction sites). This infection is spread by sexual contact with infected persons, injection of contaminated blood or blood products, and by perinatal transmission. Workers known to be infected with HTLV-III/LAV should not be restricted from work solely based on this finding. Moreover, they should not be restricted from using telephones, office equipment, toilets, showers, eating facilities, and water fountains. Equipment contaminated with blood or other body fluids of any worker, regardless of HTLV-III/LAV infection status, should be cleaned with soap and water or a detergent. A disinfectant solution or a fresh solution of sodium hypochlorite (household bleach, see above) should be used to wipe the area after cleaning.

Other issues in the workplace

The information and recommendations contained in this document do not address all the potential issues that may have to be considered when making specific employment decisions for persons with HTLV-III/LAV infection. The diagnosis of HTLV-III/LAV infection may evoke unwarranted fear and suspicion in some co-workers. Other issues that may be considered include the need for confidentiality, applicable federal, state, or local laws governing occupational safety and health, civil rights of employees, workers' compensation laws, provisions of collective bargaining agreements, confidentiality of medical records, informed consent, employee and patient privacy rights, and employee right-to-know statutes.

Development of these recommendations

The information and recommendations contained in these recommendations were developed and compiled by CDC and other PHS agencies in consultation with individuals representing various organizations. The following organizations were represented: Association of State and Territorial Health Officials, Conference of State and Territorial Epidemiologists, Association of State and Territorial Public Health Laboratory Directors, National Association of County Health Officials, American Hospital Association, United States Conference of Local Health Officers, Association for Practitioners in Infection Control, Society of Hospital Epidemiologists of America, American Dental Association, American Medical Association, American Nurses' Association, American Association of Medical Colleges, American Association of Dental Schools, National Institute of Health, Food and Drug Administration, Food Research Institute, National Restaurant Association, National Hairdressers and Cosmetologists Association, National Gay Task Force, National Funeral Directors and Morticians Association, American Association of Physicians for Human Rights, and National Association of Emergency Medical Technicians. The consultants also included a labor union representative, an attorney, a corporate medical director, and a pathologist. However, these recommendations may not reflect the views of individual consultants or the organizations they represented.

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Appendix V

AIDS Referral Sources

Toll-free AIDS information hotlines

Nationwide
National Public Health Service
Centers for Disease Control
1-800-342-AIDS
1-800-447-AIDS
in Atlanta:
404-329-3534
404-329-1290
404-329-1295

California
Northern California
800-FOR-AIDS
Southern California
800-922-AIDS

Delaware
800-342-4012

New Hampshire
800-852-3345

New York
800-462-1884

Ohio
800-332-2437

Pennsylvania
800-692-7234

Texas
800-392-2040

State 800 listings are toll-free only within the state. The National Public Health Service listing is toll-free from anywhere in the 48 adjacent states. They will accept calls from alaska and Hawaii on 202-245-6867. The two California listings are toll free on a regional basis only.

National organizations with information on AIDS

American Red Cross
AIDS Public Education Program
Contact local chapter for information.

American Association of Physicians for Human Rights
(MD referrals)
PO Box 14366
San Francisco, CA 94114
415-673-3189

Institute for Disease Prevention in the Workplace
4 Madison Place
Albany, NY 12202
518-434-2381

National Gay and Lesbian Task Force
1517 U St., NW
Washington, DC 20009
202-332-6483
Fund for Human Dignity
212-741-5800 (Educational material)
National Gay and Lesbian Crisis Line
1-800-221-7044 (Crisis counseling)

National Hemophilia Foundation
Soho Building
110 Greene Street, Room 406
New York, NY 10012
212-219-8180

National Institute of Allergy and Infectious Diseases
Office of Research Reporting and Public Response
301-496-5717

National Lesbian and Gay Health Foundation (Health care referrals)
PO Box 65472
Washington, DC 20035
202-797-3708

National Association of People with AIDS
202-483-7979

Public Health Service
Preventive Health Services Administration (Statistics on AIDS)
202-673-3525

San Francisco AIDS Foundation
333 Valencia Street, Fourth Floor
San Francisco, CA 94103
415-863-AIDS (Hotline)

State and local organizations with information on AIDS
(If no organization is listed for a specific area, contact the local Health Department.)

California
California Department of Health Services
AIDS Activities
PO Box 160146
Sacramento, CA 95816-0146
800-367-2437 (Hotline, Northern California)
800-922-2437 (Hotline, Southern California)
TTY Number 415-864-6606

Alameda/Contra Costa
Pacific Center AIDS Project
400 40th Street, Suite 200
Oakland, CA 94609
415-420-8181

AIDS Project/Los Angeles
Direct Services:
7362 Santa Monica Blvd.
West Hollywood, CA 90046-6695
213-876-8951

Administration:
3670 Wilshire Blvd., No. 300
Los Angeles, CA 90010
213-738-8200

Palm Springs
Desert AIDS Project
PO Box 8925
Palm Springs, CA 92263
619-323-2118

Sacramento
Sacramento AIDs Foundation
2115 J Street
Sacramento CA 95816
916-488-AIDS

San Diego
San Diego AIDS Project
4304 3rd Ave.
PO Box 81082
San Diego, CA 92138
619-543-0300

San Francisco
Sand Francisco AIDS Foundation
333 Valencia Street
San Francisco, CA 94103
415-864-4376

Connecticut
AIDS Education
Department of health Services
150 Washington Street
Hartford, CT 06106
203-566-1157

Colorado
Colorado AIDS Project
PO Box 18529
Denver, CO 80218
303-837-0166

District of Columbia
AIDS Action Project
Whitman-Walker Clinic
2335 18th Street, NW
Washington, DC 20009
202-332-AIDS

AIDS Program
202-332-5939 (support group information)

St. Francis Center
2201 P St. NW
Washington, DC 20037
202-234-5613

Florida
AIDS Center
Jackson Memorial Hospital
Miami, FL 33136
305-547-6231

AIDS Education Project
PO Box 4073
Key West, FL 33041
305-294-8302

Health Crisis Network
PO Box 52-1546
Miami, FL 33152
305-634-4636

Illinois
AIDS Action Project
Howard Brown Memorial Clinic
2676 N. Halstead Street
Chicago, IL 60614
312-871-5696

Indiana
Indiana AIDS Task Force
1500 North Ritter
Indianapolis, IN 46219
317-543-6200

Louisiana
New Orleans AIDS Task Force
906 Bourbon Street
New Orleans, LA 70116
504-529-3009

Maryland
Health Education Resource Organization
Medical Arts Building
Cathedral & Read Streets
Baltimore, MD 21201
301-947-AIDS

Massachusetts
AIDS Action Committee
661 Boylston Street
Boston, MA 02116
Hotline: 617-536-7733
Administrative Services: 617-437-6200
Fenway Community Health Center: 617-267-7573

AIDS Task Force
150 Tremont Street
Boston, MA 02111
617-727-2700

Minnesota
Minnesota AIDS Project
124 Lake Street
Minneapolis, MN 55405
612-827-2821

Missouri
AIDS Project
PO Box 36372
Kansas City, MO 64112
816-474-8522

Nevada
Reno AIDS Project
PO Box 3192
Reno, NV 89505
702-355-9269

New Hamsphire
Public Health Service
Hazen Drive
Concord, NH 03301
800-852-3345

New Mexico
New Mexico AIDS Services
209 McKenzie Street
Santa Fe, NM 87501
505-984-0911

New York

Albany
AIDS Institute
NYS Department of health
Albany, NY 12237
800-462-1884

New York City

AIDS Resource Center, Inc.
(residential treatment, bereavement counseling)
PO Box 792
Chelsea Street Station
New York, NY 10011
212-206-1414

American Foundation for AIDS Research
40 W. 57th Street, Suite 406
New York, NY 10019
212-333-3118

Gay Men's Health Crisis, Inc.
Box 274
132 West 24th Street
New York, NY 10011
212-807-6655 (Direct advice)
212-807-7517 (Education)

HTLV-III Hotline
NY City Department of Health
c/o Office of Public Health Education
125 Worth Street
New York, NY 10013
212-566-7103 (literature)
212-566-8290 (speakers, public health information)
718-485-8111 (hotline)

Counseling assistance statewide:

Mid-Hudson Valley AIDS Task Force
914-997-1614

AIDS Council of Northeastern New York
518-445-AIDS

AIDS Rochester, Inc.
716-244-8640

Central NY AIDS Task Force
315-475-AIDS

Southern Tier AIDS Task Force
607-723-6520

Buffalo AIDS Task Force, Inc.
716-881-AIDS

Long Island AIDS Project
516-444-AIDS

New York City AIDS Hotline
718-485-8111

Children & Youth AIDS Project
212-430-3333

Gay Men's Health Crisis
212-807-6555

Haitian Coalition
718-855-0972 or 0973

Hemophilia Foundation
212-682-5510

For HTLV-III antibody testing statewide:

Buffalo area
716-847-4520

Rochester area
716-423-8081

Syracuse area
315-428-4736

Northeastern New York
518-457-7152

Mid-Hudson Valley
914-632-4133 ext 439

Nassau County
516-535-2004

Suffolk County
518-348-2999

New York City
718-485-8111

Oregon
Cascade AIDS Project
408 S.W. 2nd
Portland, OR 97204
503-223-8299
Hotline 503-223-8299

Pennsylvania
Philadelphia AIDS Task Force
PO Box 7259
Philadelphia, PA 19101
215-232-8055

Texas
KS/AIDS Foundation
3317 Montrose Blvd
Houston, TX 77006
713-529-3211

Utah
AIDS Project Utah
300 E. 700 South
Salt Lake City, UT 84111
801-531-9155
Hotline 801-533-0927

Washington
Seattle AIDS Action Project
113 Summit Ave. SE
Seattle, WA 98104
206-323-1229

International AIDS Resources

Canada
AIDS Montreal
1212 St. Hubert
Montreal
Quebec
514-282-9888

AIDS Committee of Toronto
PO Box 55, Station F
Toronto, Ontario M4Y1R3
416-926-1626

AIDS Vancouver
PO Box 4991 MPO
Vancouver, MC V6B 4A6

Puerto Rico
Fundación AIDS de Puerto Rico
Call Box AIDS
Louisa Street Station
San Juan, Puerto Rico 00914
809-754-9119

Appendix VI

Suggested Readings & Videos

Books/Manuals/Reports

Acquired Immune Deficiency Syndrome: 100 Questions and Answers,
New York State Department of Health, January 1, 1986. No charge. Written in a non-technical format, this fact book gives the answers to many commonly asked questions about AIDS.

AIDS in the Mind of America,
Altman, Dennis,Anchor Press/Doubleday, Garden City, New York 1986. $16.95. Written from the viewpoint of a political scientist, this book is a rational discussion of political, social and legal issues surrounding AIDS. The text is an informative but non-technical reading which traces the progress of AIDS in America.

AIDS Legal Guide: A Professional Resource on AIDS-related Legal Issues and Discrimination,
Lambda Legal Defense and Education Fund, Inc. New York, 1984. $15.00/copy—individuals; $25.00/copy—institutions. This manual focuses on New York State and federal laws and practices pertaining to AIDS. Designed to assist attorneys, this manual is also helpful to other professionals concerned with the legal issues surrounding AIDS.

The Epidemiology and Health Economics of Acquired Immunodeficiency Syndrome in Minnesota: Current Status and Future Projections,
AIDS Unit, Acute Disease Epidemiology Section, Minnesota Department of Health, Minneapolis, Minnesota, March 1986. No charge. This summary of the health and economic impact of AIDS on Minnesota residents would be useful to other organizations interested in conducting similar studies.

Mobilizing Against AIDS: The Unfinished Story of a Virus
Institute of Medicine, National Academy of Sciences, Harvard University Press, Cambridge, Mass. 1986. Based on presentations of the Institute of Medicine held in Washington, D.C. on October 16, 1985. The book summarizes the major issues associated with AIDS from epidemiology, to personal and social stress, to public health policy, among others.

Understanding AIDS: A Comprehensive Guide,
Gong, Victor, MD, Editor, Rutgers University Press, New Brunswick, New Jersey 1985. Contributions from a wide range of AIDS-related experts provide a layman's guide to the current AIDS situation. Listing of AIDS referral centers, hotlines, and health resources are included.

Articles

"AIDS: A time bomb at hospital's door."
Hospitals (Jan. 5, 1986), pp. 54-61.

"AIDS in the Workplace: The Ethical Ramifications."
Bayer, Ronald, and Gerald Oppenheimer, *Business and Health* (Jan/Feb. 1986), pp. 30-34.

Newsletters

AIDS Alert,
American Health Consultants, Inc. Atlanta, GA. (Published monthly) $79.00. Current medical experiences and research findings are presented for use by the health professional. Text language is technical,

AIDS Policy and Law,
Buraff Publications, Inc., Washington, DC. (Published bi-weekly) $337.00. Includes current information on legislation, regulation, and litigation concerning AIDS.

AIDS Update,
Lambda Legal Defense and Education Fund, Inc., New York. (Published monthly). Free. Includes information on current AIDS litigation and legislation.

CDC AIDS Weekly,
Center for Disease Control, Atlanta, Georgia. (Published weekly) $520.00 for one year. Includes current information on AIDS research, periodicals and related meetings worldwide. Of use to medical personnel, this publication is easily read by other professionals, as well.

National Coalition of Gay STD Services, The Official Newsletter,
Gay and Lesbian Press Association, Milwaukee, WI. Contains a vast amount of up-to-date information on AIDS and other sexually transmitted diseases and related issues. The alphabetized table of contents on front page makes for quick reference.
(Published every two months).

Videos

"AIDS Hits Home,"
CBS documentary with Dan Rather, CBS News, 1986. Length: 60 minutes. This documentary addresses the impact of AIDS on America, the facts about the disease, the increasing threat to heterosexuals, and the effects AIDS will have on all of us.

"Beyond Fear"
½ inch and ¾ inch, three 20 minute segments. Features facts, epidemiological studies and prevention methodologies. Produced in 1986 by the American Red Cross. Rental fee is nominal.

"An Epidemic of Fear: AIDS in the Workplace"
Produced by the Corporate Television Department of Pacific Bell (23 minutes), with the technical assistance of the University of California Medical Center, San Francisco General Hospital, and the San Francisco AIDS Foundation, 1986. This video includes case studies which capture workplace issues surrounding AIDS, and is recommended for a general employee workforce. Available in ½ inch VHS or Beta. May be purchased for $195.00.

"Managing AIDS in the Workplace"
(28 minutes). Produced by Workplace Health Communications, Corp. 4 Madison Place, Albany, NY 12202. 518/434-2381. This video includes interviews with top national experts on AIDS and raises legal, ethical and policy issues to be considered when developing employee relations policies. A good discussion starter for managers, decision makers and college students. Available in ½ inch or ¾ inch VHS. Rental fee $45.00, purchase price $150.00.

This manual and the material and data contained herein are intended only as general information to increase the public's awareness on this issue, and needs to be updated continually. This material and data are not necessarily applicable to particular industrial, commercial or institutional settings. Workplace Health Communications Corporation makes no representations as to the efficacy of use of the material or data contained in this manual in particular industrial, commercial or institutional settings: Workplace Health Communications Corporation specifically disclaims any intent to do so. Any use of this material or data in particular situations is at the user's own risk. For proper evaluation of the facts unique to your business and for proper application of the laws and the legal steps appropriate to your particular business, consult with a professionnal or attorney knowledgeable in the field.