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Question: My dental assistant has advised me that she will refuse to treat any HIV-positive patients. This puts me in an intolerable position. I realize my responsibility for treating HIV-positive patients, but my dental assistant is essential in my practice. She has been an excellent employee. Nevertheless, I may have no alternative but to terminate her if she refuses to assist in treating HIV-positive patients. The problem I have is whether I would be exposed to any wrongful termination or employment discrimination action by her if I terminate her for this reason. Please advise. Answer: As your question implies, a dentist may not legally or ethically discriminate against HIV-infected patients. The law is clear that HIV/AIDS is a protected classification under the federal Americans With Disabilities Act and Michigan's Persons with Disabilities Civil Rights Act. Multiple judicial decisions have held that a dental office is subject to the federal and state legislation, and that refusal to render routine dental treatment to HIV-infected patients in an office setting when such care would have been provided to noninfected patients is a violation of the law. As the employer of the dental assistant, it is your responsibility to assure that your dental practice and staff comply with the applicable law and ethics. The American Dental Association policy is that adherence to the Centers for Disease Control and Prevention's recommended procedures results in little risk of transmission of HIV and AIDS, and that a dentist should not refuse to treat a patient whose condition is within the dentist's scope of competency solely because the patient is HIV-infected or has AIDS. An employer may legally terminate an at-will employee without cause, subject to certain conditions. There must be no employment contract precluding termination without cause, and the termination must not be based on discrimination against any class of protected persons under the state or federal discrimination laws. Applying this general rule of law, and assuming no employment contract or personnel policy to the contrary, and that the only reason for termination is the employee's refusal to treat HIV-infected patients, it can be concluded that you would not be liable for wrongful termination or employment discrimination. The fact that you as a health professional are legally and ethically bound to treat HIV-infected patients if you would otherwise treat such patients who are not infected presents a compelling reason to terminate your employee for cause. Although such a factual defense establishing cause is not essential in a case where the employee is at-will (i.e., the employee cannot establish either a breach of contract or discriminatory practice in violation of state or federal law), it is always best to present a sound reason for termination, be it to the judge or jury. If your dental practice has adopted an employee manual including progressive disciplinary procedures, including warnings, probation, etc., you should review those procedures to determine whether they may have an impact on the termination of this particular employee. Even if you have no employment manual or policy governing disciplinary procedures, it would be wise to warn your employee in advance that any refusal to treat an HIV- infected patient would result in termination of employment. It would also be wise to follow this warning in writing and make it clear that this would be the only reason for termination. This would be valuable evidence in the event the employee claimed that there was another reason that might fall within a protected classification under the federal and state discrimination laws. Since wrongful termination and discrimination litigation is fact-intensive, employers are often uncertain as to the cause for termination that may be asserted by the employee. Plaintiff-employees typically raise factual claims which fall within the discrimination laws. Based on the assumptions incorporated in this answer, however, and the applicable law, the dental assistant would not have a viable cause of action. Anyone can file a lawsuit. But, based on the facts in this case, such a suit would be summarily dismissed as a matter of law. NOTE: This column is the opinion of the author and does not constitute legal advice from the Michigan Dental Association. — 82-11 — Earlier in 1998, the United States Supreme Court ruled, in a case involving dental services, that an individual who is HIV positive, but who has no symptoms of AIDS, is disabled and protected against discrimination under the Americans with Disabilities Act (ADA).In this case, Sidney Abbott disclosed her HIV positive status to a dentist from whom she had sought treatment. The dentist refused to fill her cavity in his office, but offered to provide treatment in a hospital if Ms. Abbott paid the hospital charges. Abbott declined and sued under the ADA, claiming the dentist's refusal to provide services in his office was unlawful discrimination based on her disability, asymptomatic HIV.A. Supreme Court Decision On appeal to the Supreme Court, in Bragdon v. Abbott, Dr. Bragdon argued that (1) Ms. Abbott's asymptomatic HIV did not qualify as a disability under the ADA, and (2) the ADA permitted him to treat Ms. Abbott in a hospital because treating her in his dental office constituted a direct threat to his, and possibly others', health or safety.The ADA defines a disability to include a "physical or mental impairment that substantially limits one or more of the life activities of such individual." Thus, to obtain the ADA's protections, Ms. Abbott had to establish that her asymptomatic HIV infection was an "impairment" that "substantially limits ... [a] major life activit[y]."The Supreme Court had little trouble in finding that infection with HIV impairs an individual's hemic and lymphatic systems. The more difficult question was whether asymptomatic HIV significantly limited one or more major life activities.Ms. Abbott claimed the ability to reproduce as a "major life activity," and claimed that HIV had significantly limited her ability to bear children. The Court agreed, finding that HIV infected women who try to reproduce (1) impose a significant risk of infecting their male partners, and (2) impose a significant risk of infecting their offspring.In reaching its conclusion, the Court accepted as true Ms. Abbott's unchallenged assertion that she decided not to have children because of her HIV status. It is unclear whether the outcome of the case would have been different if Ms. Abbott had decided against having children for a different reason.The Court also addressed the "direct threat" defense raised by Dr. Bragdon. The ADA does not require a place of public accommodation, such as a dental office, to provide service to an individual with a disability if doing so creates a direct threat to the health or safety of the service provider or others.Here, Dr. Bragdon contended that filling Ms. Abbott's cavity in his office created a significant risk of transmitting the virus. He argued that treating Ms. Abbott in a hospital setting would be safer. The Court did not resolve this issue on the facts in the record, but it provided guidance on how the issue should be resolved.The Court stated that a "direct threat" defense should (1) be determined from the perspective of the individual who refuses the accommodation, and (2) the assessment of the risk must be based on medical or other objective evidence.In determining the reasonableness of the fear of transmission of HIV during dental procedures performed in an office, the Court noted that "special weight and authority" should be given to public health authorities, like the Centers for Disease Control. The Court concluded, however, that the record had not been fully developed on that issue, and sent the case back to a lower court for further consideration.B. Subsequent FindingsAfter such further consideration, on December 29, 1998, the appropriate lower court determined that treating Ms. Abbott in Dr. Bragdon's office did not create a direct threat to Dr. Bragdon's or his staff's health or safety. Therefore, such court concluded that Dr. Bragdon's denial of in-office treatment violated the ADA.C. ConclusionThe Supreme Court decision in Bragdon v. Abbott is significant in that it establishes that individuals with asymptomatic HIV are generally protected against discrimination under the ADA. Although the case is about places of public accommodation, its legal principles also should apply to employment, because the ADA prohibits discrimination not only by places of public accommodation, but also by most employers, that is, those with fifteen or more employees.The Fourth Circuit, which sets federal law in Maryland and Virginia (among other states), had earlier ruled that asymptomatic HIV was not a disability, because it neither constituted an impairment nor substantially limited a major life activity. As a result of Bragdon v. Abbott, that ruling is no longer good law.Accordingly, now the nationwide standard is that persons with asymptomatic HIV are protected under the ADA, and that they may not be discriminated against by most employers or by places of public accommodation unless there is a direct health threat. As a library, NLM provides access to scientific literature. Inclusion in an NLM database does not imply endorsement of, or agreement with, the contents by NLM or the National Institutes of Health. Learn more: PMC Disclaimer | PMC Copyright Notice J Forensic Odontostomatol. 2012 Dec 1;30(2):7–16. This paper is structured around the following: autonomy and consent, confidentiality, disclosure, knowledge of patient and provider HIV status, the right to choose whom to treat, testing for HIV and the importance of HIV policies in the workplace to guard against discrimination. The emergence of the HIV/AIDS pandemic has challenged traditional ethical values of the health care profession. These include the infectious nature of HIV, the social stigma of the disease and its ethical and legal dilemmas. This paper addresses some of the pertinent questions related to HIV infection and AIDS. The three broad principles of ethics, namely, autonomy, beneficence and justice, provide the basic framework on which this paper is based. Advances in the biotechnology of rapid oral fluid testing particularly in the detection of HIV antibodies from patients in the dental setting have raised additional ethical and legal considerations in the subsequent management of HIV infected patients to include disclosure of test results to the patient and proper referral to physicians or nurse practitioners. The oral health care worker must thus have a solid foundation in the application of bioethical principles. A clinical case scenario related to HIV testing in the dental setting is presented to illustrate how a lack of understanding and the wrongful application of ethical principles may lead to patient harm and legal liability. Given the increasing infection rate of HIV worldwide, polices must be upheld and revised as needed to protect healthcare providers, patients, and society generally against discrimination Dentists can often detect early manifestations of systemic diseases in the oral cavity and may function as gatekeepers in the healthcare system by referring patients to physicians and nurse practitioners for evaluation and treatment. Advances in the biotechnology of oral fluid testing and the direct accessibility of the oral cavity to examination may change the scope of dental care whereby the dentist can promote public health, advocate needed changes in health policy, and align dentistry more closely with medicine and nursing. That alignment was not fully realized generations ago when dentistry was largely isolated from its allied health professions and focused almost exclusively on the restoration of teeth. Advances in oral fluid testing received widespread attention when antibodies to HIV infection could be detected from oral transudate, and forever changed the erstwhile, relatively tranquil landscape of dental practice. Dentistry was catapulted into the center of the HIV/AIDS crisis. Dentists saw a major shift in their role as oral diagnosticians testing for HIV antibodies. That shift also necessitated an in-depth understanding of bioethical principles and their judicious application in clinical management. The principles of biomedical ethics from medical practice have now become even more important and integrated into dental practice. The oral health care worker (OHCW) can only examine or treat patients who have given their consent. Such consent is based on the patient's voluntary authorization of a dental procedure on his or her understanding of the relevant information provided by an OHCW. (1) Consent rests on the principle of respect for autonomy which acknowledges the ability of persons to comprehend knowledge, weigh alternatives and form judgments. Cultural differences also need to be taken into account as well as a right to respect autonomy. The doctrinal principle of informed consent and confidentiality both flow from autonomy. One important purpose of the doctrinal principle of informed consent is to protect people not only from unnecessary treatment but also all forms of unwanted treatments even if they are deemed medically necessary. Each individual who is competent has the fundamental right to control who can touch his or her body. While autonomy is a hugely important value,, the ability of teh health worker to provide care must also be respected. This leads to the crux of moral issues involved in setting limits to individual autonomy in health care. (2) The obligation of confidentiality is virtually universal in professional codes of ethics, particularly with respect to HIV/AIDS. There is an inherent conflict between a patient's interest in confidentiality and the public's interest in protection from infectious diseases. The presumption is that only patients themselves can know which disclosures to third parties will have consequences in their private, public and professional lives. (3) A person with HIV/AIDS has a right to privacy, especially with regard to the doctor-patient relationship. Deliberate breach of this right by disclosing confidential information to another, constitutes an unlawful act. Courts have awarded damages in an instance whereby a medical doctor disclosed his patients' HIV status to a colleague on the golf course without the patients' consent as in Jansen van Vuuren v Kruger. (4) From one standpoint, confidentiality is a branch or subset of informational privacy, it prevents re-disclosure of information that was originally disclosed within a confidential relationship. (5) An infringement of a person's right to confidentiality occurs only if the person (or institution) to whom the information was disclosed in confidence fails to protect the information or deliberately discloses it to someone without first party consent. By contrast, a person who without authorization enters a hospital record room or computer data bank violates rights of privacy rather than rights of confidentiality. Only the person or institution that receives the information in a confidential relationship can be charged Confidentiality is not absolute and clinical information must sometimes be shared by other health professionals. (6) In fact, no moral norm is absolute. The ethical duty of the OHCW extends not only to patients but also to other individuals whose life and safety may be affected by non-disclosure of information. The autonomy of that patient ought to then be limited accordingly. Consequential arguments thus support disclosure of confidential information such as HIV status as ethically permissible in the context of a "duty to warn", as in Tarasoff v. Regents of the University of California, if and only if the probability and magnitude of harm are major to a third party such as a patient's spouse, partner or other third party. (5, 7, 8) For the dental practitioner, however, risk is minimal to the practitioner who uses proper barrier techniques and protocol. In the absence of major risk of harm from HIV infection, disclosure is no more compelling than for any other chronic illness, e.g., diabetes mellitus. There may however be another circumstance in which it is ethically permissible to disclose a patient's HIV status without the patient's previous permission and informed consent. Let us say that while the patient was competent, he had made every effort to keep his positive HIV status strictly confidential. However, his HIV infection ultimately progressed to AIDS and disclosure of the patient's HIV status is likely to be critical in his end of life care to avoid harm or needless suffering. The advanced HIV infection may thus become the proximate cause of the patient's death. In that specific regard, Vernillo, Wolpe, and Halpern (9) proposed that disclosure of an incompetent patient's HIV status may usefully inform surrogate decision-making as much as terminal cancer may. In contrast, if a competent patient after appropriate counseling refuses to have other health care workers informed of his/her HIV status, then the patient should be told that the OHCW is duty bound to divulge this information to other health care workers who are also involved in the management of the patient. However, counseling of the patient is an absolute prerequisite to disclosure of the patient's HIV status. It is ethically unjustified to disclose the HIV status of a patient to a referring physician whether it is necessary or not without informing the patient about such disclosure. Furthermore, the disclosure is warranted only in as much as such information will primarily lessen the risk of clinical complications for the patient and not necessarily the potential for HIV exposure to the healthcare professional. Doctors have an ethical duty to disclose the patient's positive HIV status but those who wish to make such disclosures should always first have a comprehensive discussion with the patient because the patient may also refuse consent to disclose his or her HIV status. A doctor is legally bound to such a decision and the same would apply to oral health care workers. As discussed in the next section, an HIV test result particularly one confirmed by a physician or nurse practitioner from a dentist is no longer preliminary but definitive and thus represents a diagnostic finding of infection. The patient may then decide whether or not to accept medical treatment if treatment is recommended. The ethical and legal issues pertaining to HIV testing in the dental setting have been discussed previously. (7, 10) A recent qualitative study in an urban university dental clinic showed fairly consistent results and indicated relatively high levels of acceptability among dental students and faculty for implementing rapid oral fluid HIV testing. (11) Dental practice sites present unique opportunities for implementing the Center for Disease Control (CDC) recommendations for routine HIV testing. (12) The availability of rapid diagnostic test kits that detect HIV-1 and HIV-2 antibodies in oral fluid has greatly facilitated the acceptability and potential for widespread HIV testing in dental sites and elsewhere. (7, 13, 14) On July 3, 2012, the US Food and Drug Administration approved the OraQuick In-Home HIV Test, the first over-the-counter home-use rapid HIV test to detect the presence of antibodies to HIV. (15) The dentist can also play an important role in explaining the interpretation of test results to patients, given the emergence of in-home testing. However, this technological advance raises additional ethical considerations. The patient who asks his or her dentist about an in-home test must understand that a positive result does not mean that the individual is definitely infected with HIV but rather that additional testing should be done in a medical setting to confirm the oral fluid test result. Similarly, the patient must understand that a negative test result does not mean that an individual is definitely not infected. Counseling patients about test results also help ensure that patients know how to use an in-home kit properly. It is equally important for the dental patient to know that rapid oral fluid tests for HIV antibodies have had a history of persistent false positive test results (16) reinforcing the need for patients to follow-up with a medical healthcare professional. Nonetheless, advances in rapid oral fluid diagnostic technology generally may not only promote the public good but also reshape the scope of dental health care delivery and informed consent. (17) Obtaining fully informed and voluntary consent for HIV testing is absolutely critical and nowhere more so than in the dental setting. With advances in rapid oral fluid testing, the dental practitioner must have a sound working knowledge of bioethical principles to include respect for patient autonomy, confidentiality, and the subsequent management of a preliminary test result. (7) Let us consider the following case scenario in a dental practice which offers an additional ethical analysis. A dentist informs a patient that he or she will do a rapid test for HIV infection from the patient's oral fluid. The patient is fully informed about the purpose of the test and any risks and benefits as part of pre-test counseling. The patient is also told that he or she can refuse to have the HIV test (opt-out consent) without any prejudice to receiving dental care. Refusal however must be made before the oral fluid sample is obtained and tested for HIV antibodies. If the patient chooses to get tested and a sample is obtained, then the patient cannot later refuse the test result. About 10 to 15 minutes into the dental procedure, the patient says, "Doctor, I understood what you told me before but I really do not want the test result. I am frightened. You have not yet seen the test result nor have I. So, why not discard the HIV test result?" The dentist wrongfully interprets this patient's request as an exercise of his or her autonomous right and willfully discards the test result. The patient visits a physician about a year later with symptoms of fatigue and weight loss. The physician obtains a positive HIV test result from the patient who comments that a dentist had performed a rapid HIV test but agreed with the patient to discard the test result without any knowledge of the result. In the above clinical scenario, the dentist is likely to be legally liable for negligence whereby failure to use a reasonable amount of care (i.e., providing the preliminary HIV test result to the patient) may have led to harm. When the patient had requested that his or her HIV test result be discarded, the dentist should have understood the limits of patient autonomy and thereby not acquiesced to that request. If the patient had known his or her HIV test result sooner, then a physician could have treated him or her before the infection progressed to symptomatic disease. Discarding an oral fluid sample is no different than discarding a biopsy specimen. If diagnostic information is obtainable (even if preliminary), then it must be evaluated further by a physician or nurse care practitioner. The result must also be reported to the patient. Failure of the OHCW to report the HIV test result to the patient by discarding it undermines the patient's autonomy to make future decisions regarding his or her healthcare. Such an action may also represent a violation of that patient's civil rights. How then is a patient to act when he or she cannot possibly know the harm that might befall him or her? The answer in general depends upon the magnitude and the probability of harm as previously discussed. In all likelihood, the physician or nurse practitioner will assess the risk of HIV exposure through post-counseling with that patient. One study concluded that it is very ineffective to leave partner-notification to patients. (18) Perhaps, the only responsible strategy is the one proposed by the American Medical Association (AMA) Council on Ethical and Judicial Affairs: a physician who knows that a seropositive individual is endangering a third party should (1) attempt to persuade the infected patient to cease endangering a third party. If the infected patient recants on the clinician's recommendation and infects his partner, then that patient assumes the legal liability. However, the OHCW must have complete documentation in the clinical chart to show that the infected patient was persuaded to cease the practice of unprotected sex with his partner (2) if persuasion fails, notify authorities, e.g., public health officials, law enforcement; and (3) if the authorities take no action, notify the endangered parties. (19) Failure of the individual to disclose his or her HIV status to a sexual partner results in willful exposure of that third party to HIV infection and legally constitutes an act of assault. From a legal point of view, a person may act in what is termed "private defense" of another, when it appears that such person's physical integrity may be threatened by another's unlawful action. Negligently or deliberately infecting another person with HIV could give rise to civil claims as was the case in Venter v Nel in 1997. (4) Oral health care workers should always first discuss the issue of notifying patients or face possible civil claims for damages. Questions of conflicting obligations may understandably occur when an OHCW is faced with the decision of whether the status of an HIV positive individual should be disclosed to a third party without the consent of the patient. The above AMA tiered strategy (19) offers some guidance but physicians or nurse practitioners should assume the role of notifying third parties when previous steps have failed. There are grounds for such a disclosure only where there is a serious and identifiable risk to the specific individual(s) who, if not so informed, would be exposed to infection. The patient's autonomous right to confidentiality is thus trumped. Justice to a third party deems it appropriate to inform the third party who can now obtain HIV testing and medical treatment, if needed. Therefore, when a person is found to be infected, the OHCW is obliged to discuss the matter with the patient's physician who can take the lead in a post-counseling session. Some OHCW feel strongly that they should know the HIV status of high-risk patients because of fear of possible infection. Testing for HIV should only be suggested if the degree of security it affords the OHCW is substantially more than the potential harm it may cause the patient. However, as stated previously, dentists who properly use barrier technique are generally at a low risk of contracting HIV infection from patients regardless of the patient's risk status. It is the duty of the practitioner to suggest that tests be carried out. Should patients refuse to undergo testing, they should be advised to seek a second opinion. If such a test is deemed essential to the management of the patient, pre-test counseling needs to be performed by a professionally trained counselor. A doctor or dentist, whose diagnostic ability is compromised by the persistent refusal of a patient to undergo a simple investigation, is free to terminate the professional relationship. Such decisions would be taken in a spirit of compassion and understanding and every effort should be made by members of the profession to avoid such situations. (20) A caveat does exist:: if dentists insist that patients get HIV tested primarily out of concern for the practitioner's own well-being, then patients may equally insist that their dentists undergo HIV testing. Although there is no legal obligation of an OHCW to treat a patient, the issue is a complex one, because health professionals have taken the Hippocratic Oath which affirms the ethical obligation to treat and there is no need to modify dental care for HIV infected patients. Furthermore, no personal characteristics, such as race, colour, creed, sexual identity, and culture should impinge on treatment planning. (21) Williams (22)also argues that dental ethics codes make no exception to the dentist's duty to treat all patients equally to include patients with infectious diseases such as HIV/AIDS. Up to 70% of patients with HIV/AIDS have oral manifestations of the infection. OHCW are often the first to diagnose this and need to discuss their findings with their patients. Under such circumstances, an OHCW must also acknowledge the rights of patients (23) and need to take into account the ethical principles of beneficence and justice. (24) Beneficence encompasses the following: not to inflict evil or harm, to prevent evil or harm, to remove evil or harm and to do or promote good. (25) Justice has been described in terms of fairness and "what is deserved". (24) Doyal (20) argues that in the ethical management of patients with HIV, the virtues of courage, prudence, charity and hope need to be part of the approach to treatment. There are however, limits to the exercise of these virtues in the course of work. It is accepted that the courage, which is expected within professional practice must be mediated by the additional virtue of prudence. In South Africa, unless it can be shown that a job applicant's medical status could affect an inherent job requirement, pre- and post- employment testing for any medical condition is specifically prohibited by the Basic Conditions of Employment and Employment Equity Acts as being unfair and discriminatory. Unlike in previous years, the definition of "employees" includes job applicants, in as much as every person must be treated equally when applying for a job (except in as much as affirmative action policies justify discrimination). Section 6(1) of the Employment Equity Act (EEA) states that "No person may unfairly discriminate, directly or indirectly, against an employee, in any employment policy or practice, on one or more grounds, including ... HIV status ..." This section applies to all employers and employees. Notably, the omission of the word 'positive' from the phrase 'HIV status' means that discrimination on the grounds of an employee's perceived HIV status is also prohibited. Therefore it is not a prerequisite that an employee be HIV positive before he can succeed with a claim of unfair discrimination on the grounds of his or her 'HIV status'. Section 7(2) of the EEA states that 'testing of an employee to determine that employee's HIV status is prohibited unless such testing is determined to be justifiable by the Labour Court'. (4) The labor law clearly states that as long as a person is not physically ill, there is no reason for an employer to discontinue, reduce or alter the employee's duties whatsoever. The complication which clearly demarcates this from any other situation is the possibility of infecting a patient. Under normal circumstances there is no, or negligible risk. When procedures require the use of sharp instruments, then the risk increases. It will depend on the kind of action the OHCW intends to take with the patient, which should delineate various forms of treatment that may expose the patient to high or low risk. There are no compelling data to show transmission of HIV infection from a dentist to a patient when the dentist is using barrier technique to include gloves, mask, and a clinical gown. (26) Some patients in a dental office, however, may still remain suspicious of a dental health care provider and the risk of HIV transmission from that provider. The Centers for Disease Control and Prevention (CDC) and the Florida Health and Rehabilitative Service Department (HRS) initially dismissed the case in which an HIV-positive dentist, David Acer, had transmitted HIV infection to at least six of his dental patients. In the light of withheld behavioral evidence from medical records, legal testimonies, and personal interviews obtained during the investigation, the information strongly supported the conclusion that these six HIV transmissions were most likely intended by the dentist to execute a political and social agenda. (27) Nonetheless, the OHCW should seek specialist advice on the extent to which they should limit their professional practice in order to protect patients. They must act upon that advice, which in some circumstances would include a requirement not to practice or to limit their practice in certain ways. No OHCW should continue in clinical practice merely on the basis of their own assessment of the risk to patients. The OHCW must also keep in mind that he or she is prone to opportunistic infections that may be contracted from an ill patient. It is unethical for OHCW who know or believe themselves to be infected with HIV to put patients at risk by failing to seek appropriate counseling, or to act upon it when given. The doctor, who has counseled a colleague who is infected with HIV to modify his or her professional practice in order to safeguard patients, and is aware that his advice is not being followed, has a duty to inform an appropriate body that the fitness to practice of the OHCW may be seriously impaired. The Health Professions Council of South Africa (HPCSA) (28) provides a set of ethical guidelines fully cognizant of the increasing infection rate of HIV. However, differences in adherence to acts, policies, and/or ethical guidelines may exist in other countries. Universality in terms of the ethical principles of beneficence and non-maleficence as it guides the provision of healthcare does indeed exist.Polices must be upheld and revised as needed to protect healthcare providers, patients, and society generally against discrimination. Given the increasing infection rate of HIV worldwide, the financial cost of the impact of HIV/AIDS is huge and will escalate dramatically in the work force. Aside from the possible future cost of absenteeism, employers should take every precautionary step against possible labour problems, arising from HIV in the workplace. This requires the education of employees about AIDS and ensuring that the working environment is safe. Methods of education may include publishing articles in employee newsletters and on notice-boards about AIDS transmission and prevention; providing AIDS 'hotline' numbers as part of the employee assistance program; conducting meetings with medical and legal specialists on AIDS to inform employees of the syndrome and to inform management and supervisors of the rights of AIDS sufferers and other employees. (4) The multifaceted challenge of the HIV/AIDS pandemic has had a profound effect in healthcare practice necessitating a re-examination and application of the concepts of ethics, responsibility, autonomy and justice. There have been sweeping changes in social attitudes, policy and regulatory frameworks. On a global scale it took activism to new heights and raised moral concerns of social justice with regard to access to health care, basic human rights, the government's responsibility to care for its citizens, and the duty of beneficence of the developed towards the developing world. On a national level it has re-opened debates on issues of distributive justice and fairness. HIV has forced society to look at innovative ways of collectively managing the pandemic in a responsible, sustained and equitable manner. Healthcare providers including dentists, physicians, and nurses play a decisive role in the referral of patients and in the detection and treatment of HIV infection. The understanding of bioethical principles and their judicious application should ensure that patients with HIV infection are justly treated commensurate with any patient who suffers from a chronic illness.

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