

A LEGACY OF *JOHNSON CONTROLS:* *ARMSTRONG v. FLOWERS HOSPITAL*

Daphne Planto Sipes*

I. INTRODUCTION

Many commentators hailed *International Union, UAW v. Johnson Controls*' as the most important employment law decision of the decade.² Several pointed to the expected pressure that employers

* Associate Professor, The University of Texas at San Antonio; J.D., 1978, University of South Carolina; BA., 1975, University of South Carolina.

¹ In *International Union, UAW v. Johnson Controls*, 499 U.S. 187 (1991), the United States Supreme Court held that the employer policy excluding fertile women from the workplace because of potential fetal hazard was a sex-based violation of Title VII and the Pregnancy Discrimination Act (PDA). *Id.* at 200. Moreover, the exclusionary policy was not justifiable as a bona fide qualification, business necessity, nor for cost effectiveness. *Id.* at 206-07.

² See, e.g., David L. Kirp, *Fetal Hazards, Gender Justice, and The Justices: The Limits of Equality*, 34 *Wm. & MARY L. REV.* 101 (1992); Matthew F. Weil, *Protecting Employees' Fetuses From Workplace Hazards: Johnson Controls Narrows the Options*, 14 *BERK. J. EMPLOY. & LAB. L.* 142 (1993); Stephen F. Befort, *BFOQ Revisited: Johnson Controls Halts the Expansion of the Defense to Intentional Sex Discrimination*, 52 *OHIO ST. L.J.* 47 (1991); Louise B. Moses, Comment, *Title VII: Fetal Protection Does Not Justify Gender Based Employment Discrimination*, 25 *SUFFOLK UNIV. L. REV.* 1196 (1991); Joel P. Peller, *Fetal Protection Policies: An Employer's Struggle to Comply with Title VII*, 19 *OHIO N. UNIV. L. REV.* 801 (1993); Andrew Evan Bernstein, *UAW v. Johnson Controls: A Final Word on Fetal Protection Policies and Their Effect on Women's Rights in Today's Economy*, 9 *HOFFSTRA LAB. L.J.* 451 (1992).

would bear to rectify workplace hazards.³ Still others called for the reform of pregnancy and gender discrimination regulations affecting U.S. women workers.⁴ Only a few took issue with the actual longterm effects of the Court's refusal to recognize fetal rights in the workplace.⁵

In *Armstrong v. Flowers Hospital*⁶ the effect of *Johnson Controls* was felt by a young home health care nurse in Alabama who refused to work under what she perceived to be a fetal hazard. Because of obvious neglect of her professional duty to treat an infectious patient, the nurse was promptly fired. Both of the courts reviewing her termination pointed to the legacy of *Johnson Controls* and reached a swift pronouncement that Nurse Armstrong had no grounds for relief.⁷ Despite court approval of her employer's policies and termination decision, the reliance upon *Johnson Controls* is distinguishable, especially in light of the current goals recently promoted by the Americans With Disabilities Act ("ADA") and Family Medical Leave Act ("FMLA").

Long-term versus short-term workplace risks for pregnant health care workers and for other at-risk workers in U.S. employment are frequently undeterminable, adding to the flux of fetal protection policies. *Armstrong* provides fertile ground for renewing the debate about justifiable rights of expectant mothers to avoid perceived and real risks of harm in their workplaces. Other legal and ethical issues linger in Nurse Armstrong's situation and call for a reconciliation of

³ Theresa M. Scannell, Note, *Fetal Protection Policies No Longer a Bona Fide Occupational Qualification Defense?*, 75 MARQUETTE L. REV. 489 (1992); Meredith L. Jason, *International Union v. Johnson Controls, Inc.: Controlling Women's Equal Employment Opportunities Through Fetal Protection Policies*, 40 AMER. UNIV. L. REV. 453 (1990); Elizabeth A. Phillips, *The Status of Sex-Specific Fetal Protection Policies*, 57 Mo. L. REV. 951 (1992).

⁴ Samuel Issacharoff & Elyse Rosenblum, *Women and the Workplace: Accommodating the Demands of Pregnancy*, 94 COLUM. L. REV. 2154 (1994); Pendleton Elizabeth Hamlet, Note, *Fetal Protection Policies: A Statutory Proposal in the Wake of International Union, UAW v. Johnson Controls, Inc.*, 75 CORNELL L. REV. 1110 (1990); Michelle M. Braun, *The Battle Between Mother and Fetus: Fetal Protection Policies in the Context of Employment Discrimination*, 14 HAMLINE L. REV. 403 (1991); Jennifer Morton, Comment, *Pregnancy in the Workplace—Sex-Specific Fetal Protection Policies—UAW v. Johnson Controls, Inc.—A Victory for Women?*, 59 TENN. L. REV. 617 (1992); Christine Neylon O'Brien, et al., *Employer Fetal Protection Policies at Work: Balancing Reproductive Hazards with Title VII Rights*, 74 MARQUETTE L. REV. 147 (1991).

⁵ E.g., Kirp, *supra* note 2; Eva M. Auman, *Excluding Women From the Workplace: Employment Discrimination vs. Protecting Fetal Health*, 55 Mo. L. REV. 775 (1990).

⁶ 812 F. Supp. 1183 (D. Ala. 1993), *aff'd*, 33 F.3d 1308 (11th Cir. 1994).

⁷ See *Armstrong v. Flowers Hospital, Inc.*, 33 F.3d 1308, 1316 (11th Cir. 1994) *aff'd* 812 F. Supp. 1183, 1192 (D. Ala. 1993).

equal opportunities and the consideration of child bearing and child rearing. Many experts who reviewed *Johnson Controls* have called for U.S. society, particularly its female work force, to define the gender policies, just as the nation is facing other societal concerns such as gun control, crime, and affirmative action programs. This call puts the onus undoubtedly on women to generate a more robust debate about work, career, family, and discrimination, although it is evident that the policies also affect men as fathers, husbands, employers, and employees. This article proposes a state-created exception paralleling the ADA's accommodation feature. The proposal offers due process for both the employer and the employee, while preserving the obvious societal goods of mothers in the workforce and regard for fetal risks. Moreover, the proposed solution offers employers an institutional experience base upon which increased productivity, efficiency, and avoidance of liability are gained.

II. A Legacy of *JOHNSON CONTROLS V. ARMSTRONG*

In December of 1990 Nurse Armstrong was assigned to her first HIV- positive patient⁸ after six months of employment as a home care nurse with the Home Care Services ("HCS") division of Flowers Hospital. The patient had been diagnosed with cryptococcal meningitis, an infectious disease common among AIDS patients, and the patient had also been vomiting. The assignment would require blood draws for lab work. Special bags would be provided for contaminated materials and Sharps containers for the used needles. Nurse Armstrong informed her supervisor that she did not believe that she should treat the patient since she was in her first trimester.⁹ She specified that it was not the presence of AIDS that posed a risk to her fetus, as much as the infections commonly present in AIDS patients, such as chicken pox. The policy of HCS was not to make exceptions and not to reassign patients. Any nurse who refused to treat a patient was subject to ter

⁸ The distinction between being merely HIV infected and having AIDS is relevant when focusing on certain legal protections. For example, under the ADA an HIV-positive applicant for employment is not by status alone eligible for accommodation. 42 U.S.C. §§ 12102(a), 12112(a) (West Supp. 1994). In terms of access to health care, however, an HIV-positive patient and an AIDS patient have equal rights. Nurse Armstrong did not argue that mere HIV infection posed a greater risk to her fetus than did AIDS; she merely argued that in either situation there were more infectious diseases than she perceived tolerable for her condition.

⁹ After her termination by HCS, Nurse Armstrong did not seek re-employment until after the delivery of her child in June of 1991. *Armstrong*, 812 F. Supp. at 1187.

mination, per the written policy of HCS. After being given two days within which to reconsider her decision, Armstrong chose to be terminated. It was her determination that a higher duty to avoid harm to her fetus superseded her duties as an employee and as a professional health care giver.

The Equal Employment Opportunity Commission (“EEOC”) found no reasonable determination of a violation under Title VII of the Civil Rights Act. In January of 1992, Pam Armstrong filed a wrongful termination suit alleging a violation of the Civil Rights Act of 1964 (“1964 CRA”), as amended by the 1978 Pregnancy Discrimination Act (“PDA”),¹⁰ asserting both disparate treatment and impact types of discrimination. Her basic argument was that the employer’s refusal to reassign her away from a patient whose opportunistic infections could harm her fetus constituted a violation of the PDA, the employer’s own policies, and the 1964 CRA. Nurse Armstrong never gained access to a trial because the courts ruled that she was not entitled to a preferential assignment.

She based her theory on *Johnson Controls* which, she claimed, stands for the proposition that an employer cannot force a woman to choose between her job and her fetus. “In other words, women as capable of doing their jobs as their male counterparts may not be forced to choose between having a child and having a job.”¹¹ Both of the federal courts reviewing her claims disagreed. “In that case, the employer had denied women who were capable of becoming pregnant the opportunity to work in certain jobs. A comparable situation would exist if Home Care Services had denied Armstrong the right to work in home health care solely because she was pregnant. Armstrong would then be forced to choose between having a child

¹⁰ 42 U.S.C. § 2000e(k). That section provides:

The terms “because of sex” or “on the basis of sex” include, but are not limited to, because of or on the basis of pregnancy, childbirth, or related medical conditions: and women affected by pregnancy, childbirth, or related medical conditions shall be treated the same, for all employment-related purposes, including receipt of benefits under fringe benefit programs, as other persons not so affected but similar in their ability or inability to work, and nothing in section 2000e-2(h) of this title shall be interpreted to permit otherwise. This subsection shall not require an employer to pay for health insurance benefits for abortion, except where the life of the mother would be endangered if the fetus were carried to term, or except where medical complications have arisen from an abortion: *Provided*, That nothing herein shall preclude an employer from providing abortion benefits or otherwise affect bargaining agreements in regard to abortion.

¹¹ *Johnson Controls*, 499 U.S. at 204.

and having a job.”¹² Of course, Nurse Armstrong was not contending that HCS was excluding her from the work place, only that the risk was intolerable in her condition, which she claims was a denial of her civil rights.

The thrust of Nurse Armstrong’s argument was that the employment practice impacted pregnant nurses with an unfair differential result because male and nonpregnant nurses would not face the risk of being fired by refusing to work with an infectious patient who posed a fetal risk. However, the Eleventh Circuit stated that all employees, regardless of gender or pregnancy status, equally faced the risk of being terminated for refusing to treat an assigned patient. Although the risk of harm to a fetus would only necessarily result to a nurse who was pregnant, all employees equally faced the same work rule. Both the court of appeals and the district court examined the impact of losing employment, not the impact of a risk assignment, as the crucial determinant. “The only disparity in the impact between pregnant and nonpregnant nurses is the potential risk of harm to the fetus. However, this risk of harm is omnipresent during the term of pregnancy.”¹³ The practice of requiring nurses to treat their patients or be fired was defined by the courts as a neutral practice with an adverse result when applied to the fetus, but not when applied to the employee.

The nurse could not make a *prima facie* case for disparate treatment nor impact because she could not show a differential application nor result. The discriminating action was the employer’s termination for refusing to treat a patient, and every employee is equally subject to that action. The superseding link between the employer policy and her termination was caused by her own act in refusing to do her job. Thus, Nurse Armstrong was not able to establish a statistical disparate impact case. Only two other employees had resigned or been terminated under the particular policy when faced with treating an AIDS patient, and the other was non-pregnant. Thus, the courts found no disproportionate impact on pregnant nurses.

At another level, Nurse Armstrong argued that there had been a *de facto* practice of allowing preferential treatment to pregnant nurses. Yet, she was not able to carry her legal burden of establishing this practice. There was no evidence that the hospital had treated other nurses preferentially by granting an accommodation when there were other risks comparable to the risk she highlighted. The PDA does not require any preferential treatment that an employer is not already providing to other workers disabled by risk. “In fact, the Supreme

¹² *Armstrong*, 33 F.3d at 1315.

¹³ *Armstrong*, 812 F. Supp. at 1191.

Court has noted that the PDA was not intended to provide accommodations to pregnant employees when such accommodations rise to the level of preferential treatment.¹⁴ In summary, the court sided with the employer in rejecting the nurse's plea for special treatment.

Because employer was pitted against employee, mother against her fetus, and health care professional against patient, the *Armstrong* case is as troublesome as *Johnson Controls*. Both *Johnson Controls* and *Armstrong* stand for the proposition that employers cannot unilaterally or preemptively decide for women what is in their future children's best interests. Following *Johnson Controls*, most authorities concluded that it was a correct solution to halting patronizing attitudes towards women in balance with the PDA. A few noted that the apparently insincere motive of Johnson Controls, not to mention the company's historical record of excluding women, may have affected the Court's decision. The *Armstrong's* court interpretation of *Johnson Controls* is convincing and even mesmerizing. However, there are some discrepancies that deserve further investigation.

A. Comparing *JOHNSON CONTROLS* and *ARMSTRONG*

There are interesting comparisons in *Johnson Controls* and *Armstrong*. One obvious distinction is that in *Johnson Controls* the employer determined the policy, whereas in *Armstrong* it was an individual employee who sought fetal protection for herself. Another distinction is the focus on prenatal risks in *Johnson Controls*. In *Armstrong*, a pregnancy risk was the concern. Another difference is the incipency policy used in *Johnson Controls*. Johnson Controls's policy excluded fertile women at its door step; HCS prevented pregnant women from continuing to work once the woman executed her privilege of choice after confronting a risk. In fact, as the court in *Armstrong* pointed out, Nurse Armstrong was encouraged to embrace the work environment risk, unlike the women at the Johnson Controls plant who were encouraged to avoid the work and its risk altogether. In comparison, a factory worker, unlike a licensed professional such as Nurse Armstrong, does not take an oath to uphold the rights of the sick. This distinguishing feature of Nurse Armstrong's occupation justifies an overriding duty to assist her patient, yet it yields her choice as a mother to protect her fetus an empty right.

Another difference is that the toxic hazard in *Johnson Controls* was a danger from gradual buildup, not from a single, irreversible hazard. Also, in *Johnson Controls*, there were potential accommoda-

14. *Id.*

tions offered to the employees such as allowing a transfer out of the unit with appropriate pay reductions, or periodic testing to determine lead levels. *Johnson Controls* was managing its exposure to potential liability. However, for Nurse Armstrong, the choice was only an ultimatum to perform under the perceived fetal risk or to lose employment and benefits.

The *Johnson Controls* decision gave a short-term solution, but even the U. S. Supreme Court observed that courts are not adequately equipped for solving speculative risks of harm. "It is no more appropriate for the courts than it is for individual employers to decide whether a woman's reproductive role is more important to her and her family than her economic role. Congress has left this choice to the woman as hers to make."¹⁵

Another contradiction in *Johnson Controls*, is that even if the women had agreed with Johnson Controls, they would have lost the right to initiate an exercise of choice from the workplace risk because the PDA does not permit employees to dictate the work environment terms. Nurse Armstrong mistakenly read *Johnson Controls* to grant her the prerogative of excluding herself from a work place hazard. "She may choose to continue working, to seek a work situation with less stringent requirements, or to leave the work force."¹⁶ In other words, women who want to work in situations potentially hazardous to a fetus must find other work.

B. DISSECTING THE NURSE'S JUDGEMENT

Aside from her legal proof difficulties, several facts contributing to the action taken by Nurse Armstrong bear review. The court stated that she had not established sufficient evidence about the risks that she apprehended were any greater to a pregnant than to a nonpregnant worker. The court placed more emphasis on the transmission of HIV, rather than on the specific complaint of the transmission of chicken pox and other infectious diseases urged by the nurse. Her employer was convinced that the use of Universal Precautions ("UP")¹⁷ would lower the risk of transmitting HIV and other diseases.

¹⁵*Johnson Controls*, 499 U.S. at 211.

¹⁶*Armstrong*, 33 F.3d at 1315.

¹⁷ Occupational Safety and Health Administration, 29 C.F.R. § 1910.1030 (19—). In 1993, the CDC recommended that the use of the UP would give protection against mucous and air borne pathogens as well. See Gail Allerton Snyder, *Pennsylvania Dental Hygienists' Knowledge, Attitudes, and Infection Control Practices in Relation to AIDS and AIDS Patients*, 67 J. DENTAL HYGIENE 188 (1993).

Nurse Armstrong did not, however, trust that the UP even if properly used would be effective. The situation appears to be an isolated case of insecurity, but her fears were reinforced by the hospital's own inconsistent approaches and conflicting data from other nurses.

While investigating the risks, Nurse Armstrong uncovered confusing and contradictory practices and policies. Although the policies needed for home health care will necessarily be different, Nurse Armstrong perceived that she was being treated unfairly since the hospital made certain allowances for its pregnant nurses. She discovered that pregnant nurses are given special treatment when caring for inpatients with AIDS, and that pregnancy, in general, is regarded.

For example, had Nurse Armstrong's HIV-positive patient been labelled an *isolation* inpatient, then an unwritten hospital policy would not have required a pregnant nurse to treat him. Since Nurse Armstrong could not prove her patient would have been placed into isolation, the court ignored this discrepancy "Even assuming that pregnant nurses in Flowers Hospital are not assigned to work with some or all isolation patients, Armstrong has not established that the patient at issue would have been placed in isolation if he were in Flowers Hospital."¹⁸

Although from a different area hospital, a nurse in infection control told Armstrong that they try to reassign pregnant nurses so as to prevent them from being exposed to very infectious conditions such as chicken pox.¹⁹ Both Flowers and HCS had a written policy excluding health care workers with open skin lesions from direct care of AIDS patients and from handling equipment of AIDS patients. Both also warned that "pregnant healthcare workers should be especially familiar with precautions to minimize the risk of HIV transmission and should strictly adhere to such precautions." This statement contradicts the alleged effectiveness of the UP in lowering risks of infectious diseases. The UP recommend that all patients be treated as though they are infectious, whether or not their HIV status is known, to reduce the risk of transmission of disease, including bloodborne and airborne diseases.²⁰ It is understandable why Nurse Armstrong doubted their protection.

¹⁸ *Armstrong*, 33 F.3d at 1314.

¹⁹ *Armstrong*, 812 F. Supp. at 1186.

²⁰ **The UP provides reciprocal protection to patients from infected HCWs.** Lawrence O. Gostin, *HIV-Infected Physician and the Practice of Seriously Invasive Procedures* HASTINGS CENTER REP., Jan.-Feb. 1989, at 33. See also Petra Wilson, *Colleague or Viral Vector? The Legal Construction of the HIV-Positive Worker*, 16 LAW & POLY 299-322 (1994).

Flowers Hospital also had other written policies, which HCS did not have, that pertained to certain risks faced by pregnant nurses.²¹ Nurse Armstrong had difficulty distinguishing the double standards that were applied by Flowers and HCS to what she perceived to be risks similar to those she was facing when assigned to her first HIV- positive patient. Flowers Hospital was named as her employer, but HCS dictated her work policies. The court defended the differences in the practices and policies between the hospital and the HCS as necessary for different situations. HCS explained that when their administrators create policy, they sometimes turn to hospital staff members for guidance, but ultimately, the suitability of a given policy is adopted for the home health care setting.

In all fairness, the hospital and HCS should have been required to justify the difference in policies for what appeared to be similar risks. For the sake of legal analysis, the court did give Nurse Armstrong the benefit of the doubt, but nevertheless determined that the policies were being applied equally. The court ruled that she failed to prove that nurses were assigned to patients for reasons other than stated in the policies.

Nurse Armstrong never actually specified how the risk of chicken pox was greater than any other risk of harm to her fetus.²² She did not clarify which various methods of contact with infected bodily fluids she feared, though evidence in the health care field indicates that the greatest risk of transmission is from needlesticks.²³ The UP should have resolved this fear, given the protective equipment and methods for handling needles. Likewise, the level of risk to her fetus,

²¹ For example, the policies stated:

1. *Hemodialysis Infection Control*: "Nurses who are pregnant are not allowed to care for HAA+8 patients." (same as Hep B).
2. *Herpes Exposure*: "Women employees who are pregnant should not work in a patient's room who is known to have active herpetic lesions."

Armstrong, 33 F.3d at 1312.

²² Justice Scalia asked some of these questions when he last faced a fetal protection issue.

"How does the Court go about determining what level of protection for fetuses is enough ____ [When] there is a very, very tiny risk -----The workplace is full of risks ----- How are we to determine what the proper balance of risk to fetus and freedom for the women to work in the marketplace is?" Kirp, *supra* note 2, 137—38 n.230 (quoting *Johnson Controls*, 499 U.S. 187 (1991) (No. 89-1215) Transcript of Oral Argument, at 41-42).

²³ Ying C. Huang et al., *Risks of Bloodborne Diseases to Emergency Personnel in Traumatic Wound Management*, 10 *KAOHSIUNG J. MED. Sci.* 63-67 (1994). "Several prospective studies show there is a risk in the range of 0.03 to 0.9 percent that a health care worker will contract HIV following a documented case of percutaneous or mucous membrane exposure to HIV-infected blood. Gostin, *supra* note 20, at 33. "Three large studies have estimated the risk of contracting the virus after accidentally being stuck with a contaminated needle at about 1 in 250. KURT DARR, *ETHICS IN HEALTH SERVICES MANAGEMENT* 239 n.18 (2d ed. 1991).

whether “remote” or “significant,”²⁴ was not specified. Unlike the toxic levels of lead that could be measured at Johnson Controls where there was more active OSHA oversight, the risks in *Armstrong* were not as easily verified. “However, Plaintiff has not presented evidence that these increased risks are comparable to any risk for which HCS or Flowers Hospital made accommodation.”²⁵

Nevertheless, there is a hint that a *de facto* industry practice of accommodation for pregnant nurses had been exposed. There was conflicting evidence that her supervisor had originally offered to reassign her if possible. This alleged accommodation was vehemently denied after the suit was commenced. The differential application between the hospital and HCS policies certainly gave the appearance of preferential treatment between pregnant and nonpregnant nurses.²⁶ It is possible that the hospital’s and HCS’s denials that there were inconsistent applications of pregnant nurses’ assignments were in reaction to defending against an uncertain civil rights violation. *Armstrong* is an instance of discrimination claims because of pregnant and gender status, but it is possible that Nurse Armstrong might have achieved other employee protections by using a different approach to her situation.

C. OTHER LEGAL RIGHTS

When Nurse Armstrong commenced her suit she was not eligible for ADA protection since the earliest effective date would have been July 26, 1992. Even if the ADA had been in effect, pregnancy is not in and of itself a disability. However, complications with pregnancy may qualify an employee for employer accommodation. Arguably, Armstrong had a pregnancy complication or disability that interfered with a major life activity. There was a material factual dispute about whether Nurse Armstrong had timely revealed that she was afflicted with gestational diabetes from which she suffered only when pregnant. Her expert verified that a pregnant woman is more susceptible to contagious diseases, even without gestational diabetes, which weakens the immune system. Whether she suffered from gestational

²⁴ Mark Barnes et al., *The HIV-Infected Health Care Professional: Employment Policies and Public Health*, 18 *Law, Med. & Health Care* 311 (1990).

²⁵ *Armstrong*, 33 F.3d at 1316.

²⁶ Flowers Hospital may have been able to offer a preferential policy for pregnant employees. “The Supreme Court has held that the PDA does not prohibit preferential treatment.” *Armstrong*, 33 F.3d at 1317 (citing *California Fed. S. & L. Ass’n v. Guerra*, 479 U.S. 272, 286-88, 294 n.3 (1987)). “However, permitting preferential treatment and requiring preferential treatment are entirely different matters.” *Id.* at 1317.

diabetes would have been relevant to a just disposition for it would have substantiated her work-related fears and anxiety as a disability, if the fears prevented functioning and interfered with work.

The real culprit was Nurse Armstrong's fear of an increased risk from infections. Nurse Armstrong's fear of transmittable diseases and her distrust of UP are material factors in analyzing her decision. Her workplace stress and the perceived lack of a safe workplace are relevant to show how her determination affected the fate of her fetus. Workplace stress has become a recognized threat to efficiency and productivity. These fears, however, were tacitly deemed unreasonable by her employer and the courts. The district court observed that "[t]he PDA was not intended to extend to such subjective fears. Rather, it was intended to extend to actions of the employer."²⁷ Admittedly, the PDA does not cover fears, but the ADA may provide future protection in an eligible situation. Pursuing this interpretation, a future employer could be responsible for determining whether or not an accommodation without undue hardship would be available for fear and anxiety generated from perceived workplace hazards. One court has recognized that a person has a right to experience emotional distress for a time until it becomes objectively unreasonable, especially after appropriate counseling. Comparing the reasonableness of fear to the reasonableness of one experiencing emotional distress, a California court of appeals adopted a *reasonable window of anxiety* approach in an AIDS phobia case. In the 1993 decision of *Kerins v. Hartley*²⁸ the state court ruled that a surgical patient did not have to prove actual exposure to the AIDS-tainted blood of her HIV infected surgeon in order to recover damages for her fear of contracting AIDS.

The court specifically ruled that her fear of contracting AIDS could be reasonable until she had had an opportunity to verify with medical certainty that she had not been exposed nor was infected and had the opportunity to obtain counseling as to the accuracy and reliability of the testing methods used. The court concluded that the patient's unabated emotional distress became unreasonable and thus not compensable once she received access to the operative report and/or in some other manner received counseling.²⁹ Time to reconcile fears is recognized to be reasonable.

It is appropriate to note that even health care professionals, such as Nurse Armstrong, when faced with treating an HIV-positive person for the first time, require more time to consult and assure them

²⁷ *Armstrong*, 812 F. Supp. at 1192 n.14.

²⁸ No. B 065917 (Cal. App. 2d Dist. Div. 2 July 30, 1993).

²⁹ *Id.* at 28.

selves of the circumstances. When Armstrong's supervisor gave her two days to decide, it was not for allowing Nurse Armstrong to obtain further training or counseling, but rather for her to reconsider her position. An employer in a similar situation should recognize that an inexperienced health care provider would need additional training. In fact, a health care practitioner in Nurse Armstrong's situation should find support under the mandate of the Occupational Safety and Health Administration ("OSHA") that employers provide a safe work environment and specifically offer sufficient HIV training.

Studies indicate that Nurse Armstrong is not alone in her fear of contracting HIV or other infections.³⁰ Others in her profession share her feelings of treating HIV-positive patients. Her reaction should have been anticipated by her supervisor.³¹ The fear of health care professionals in caring for AIDS patients is a result of their perception that the knowledge about AIDS may not be accurate and that precautions may not be adequate. This does not necessarily show a lack of education, since the nurses are aware of studies, but rather a distrust that UP lower the risks.³² Actual practice with the recommended infection control procedures is associated with less fear concerning the treatment of AIDS patients. Thus, experience is a successful management practice and promotes effective health care delivery.

Armstrong's inexperience and lack of training signaled a deficiency in the employer's general responsibilities to provide that training necessary for employees to perform. OSHA requirements derive from a fundamental duty owed by the employer to the employee to protect and to provide a safe work environment. The health care arena recognizes the duty includes education and assistance in preventing harm to patients by providing adequate training.³³ Thus, in the future, inexperienced nurses such as Nurse Armstrong may find support in general duty principles from common law. The employer's acceptance will promote better employer, employee and patient relationships. Nurse Armstrong could have invoked the OSHA general duty clause and asserted that the employer was not providing her with an acceptable safe work environment. Even if Nurse Armstrong's tolerance level exceeded OSHA's minimum require

³⁰ See Allison J. Breault & E. Carol Polifroni, *Caring for People with AIDS: Nurses' Attitudes and Feelings*, 17 J. ADVANCED NURSING 21-27 (1992).

³¹ Breault and Polifroni's study revealed that more than fifty percent of the nurse respondents had fear and anxiety of transmission of HIV despite precautions, and commonly seek a transfer. *Id.* at 21.

³² Matthew E. Turowski, *AIDS in the Workplace: Perceptions, Prejudices and Policy Solutions*, 20 OHIO N.U. L. REV. 139 (1993).

³³ Darr, *supra* note 23, at 236-37.

ments, one general goal of workers compensation is to encourage safe working conditions. This can include eliminating or reducing stress, anxiety, and other emotional damage to workers, if the employer's actions or inactions promote such an environment. The objective is not to burden employers with regulations and expanding adversarial approaches, but rather to encourage employers to assume responsibility for minimal training.

If Nurse Armstrong's fears qualified for disability, accommodation was obviously possible. After Nurse Armstrong's termination, another nurse was assigned to the patient. Whether or not the accommodation presented an undue hardship was not decided by the court. A shortage of nurses can be inferred by the hospital's assumption of Nurse Armstrong's scholarship debt at the time of her hire as an inducement to attracting her. Yet, the fact that HCS found a nurse to take Armstrong's assignment does not mean that HCS should have done so, merely upon one nurse's request. As is intimated in the courts' opinions, it was more cost effective to assign the HIV-positive patient to Nurse Armstrong, given travel times and distances between patients' homes.

One cost effective accommodation could easily have been to provide more training with an experienced nurse. In the long run adequate training and mentoring would reduce the expense of rehiring and training other nurses. If it is beneficial and cost effective, it may be more appropriate to assign nurses based upon their specialized experience with certain patient needs. With the increasing number of AIDS patients who will need care, the employer is in the better position to prepare and train nurses.

Another aspect of an undue hardship and cost-benefit analysis is related to the HCS's responsibility, both legally and ethically, to provide healthcare to the AIDS patient. The ADA prohibits discrimination against disabled patients under its public accommodations title. If the only way to accommodate nurses such as Armstrong is to designate an HIV-positive patient as an isolation patient, a subtle and unwanted segregation of HIV-positive/AIDS patients could result in a perpetuation of discrimination of AIDS patients. This, in turn, could drive up health care costs by extending unnecessary hospital stays.

Certainly, neither the ADA nor the PDA factors the social costs, but those too are ultimately relevant in the overall allocation of the benefits to treating patients equally and of the burdens of adding to health care employee stress, home care patient schedules, and interrupted family lives. "Congress considered at length the considerable cost of providing equal treatment of pregnancy and related conditions, but made the 'decision to forbid special treatment of pregnancy

despite the social costs associated therewith.”³⁴ Nurse Armstrong sacrificed time and money from the work force,³⁵ another social cost for working mothers, in order to prevent her fears from becoming a reality.³⁶

Reliance on the current PDA is ineffective, as Nurse Armstrong discovered. Justice White, with Chief Justice Rehnquist and Justice Kennedy, agreed that the discrimination model provokes the equal versus special treatment dichotomy. Even if the PDA *did* establish a separate BFOQ standard for pregnancy-related discrimination, if a female employee could only perform the duties of her job by imposing substantial safety and liability risks, she would not be “similar in [her] ability or inability to work” as a male employee, under the terms of the PDA.³⁷ The potential absurdity is exaggerated when the situation is viewed as if the nurse had not been pregnant. Then the question about only her fears would arise and still reveal the flaw of ineffective training and development of a care attitude. In this particular health care setting, it underscores the need for better solutions to the dilemma faced by women, fertile or expectant, to have a meaningful choice.

Nurse Armstrong’s employer defended that she is asking for preferential treatment because of her pregnancy. Obviously, the PDA does not promote special treatment. The purpose of the PDA is to avoid perpetuation of women as second class citizens simply because they are pregnant or are capable of becoming pregnant. Fertile women and expectant mothers have difficult choices, but the choice is a protected right. This philosophy is based on privacy rights and on avoiding a paternalistic attitude of employers and patronizing approach by government. Thus, it is not unsound policy that society has dictated that women have the simultaneous right and duty, legally and morally, to determine what is well-being for their children. Studies recognize that humans will rationally decide what is in the best interests of their species and children.³⁸ But the choice is a hollow right when faced with unemployment and a lack of financial support for the children and family.

³⁴ *Armstrong*, 812 F. Supp. at 1192 n.13 (quoting *Johnson Controls*, 111 S.Ct. at 1209).

³⁵ Issacharoff & Rosenblum, *supra* note 4, at 2155-57 (urging reform of maternal leave policies with accommodation to assist women for departures from the workforce).

³⁶ Carol Levine & Ronald Bayer, *The Ethics of Screening for Early Intervention in HIV Disease, Public Health and the Law*, 12 AM. J. PUB. HEALTH 1661,1663 (1989).

³⁷ *Johnson Controls*, 499 U.S. 219 n.7 (White, J., Rehnquist, C.J. and Kennedy, J., concurring).

³⁸ Janet Gallagher, *Prenatal Invasions & Interventions: What’s Wrong With Fetal Rights?*, 10 HARV. WOMEN’S L.J. 9,30 (1987).

The FMLA, another piece of legislation that some have termed *feminist legislation*,³⁹ was not in effect when Nurse Armstrong was terminated. Since she had only worked with HCS for six months, Nurse Armstrong would not have been eligible for FMLA benefits because of its prerequisite one year of employment. In any event, she would have only gained twelve weeks of unpaid leave. The short term solution would not have removed her from the risk of harm throughout her pregnancy had she been assigned to other infectious patients.

By exercising her freedom of choice, Nurse Armstrong became eligible for Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA") benefits that allowed her to continue her medical coverage but at a tripled cost. Without her income, she eventually terminated coverage. Her husband's plan, a family plan, was not comprehensive. Once Nurse Armstrong was terminated, the pregnancy itself constituted a pre-existing disability for medical coverage and created another barrier to her re-entry into the workforce. These events compounded the artificially free choice that a working mother supposedly enjoys.

"Put slightly differently, there is something rather disturbing in having a wealthy society maintain economically-compelled divisions between women who fully join the labor force and women who serve primarily on the reproductive front."⁴⁰ Many advocates for women's rights in the workplace recognize that treating everyone the same is not necessarily treating everyone equally. "Our Equal Protection Clause jurisprudence is based on an Aristotelian theory of equality which posits that like things must be treated alike, while unlike things may be treated differently."⁴¹ A chief argument against the equal treatment approach taken by the PDA is that it is based on the race discrimination model and fails to account for the difference in prejudices faced by women, who are accessing the workplace and those who have gained access.

³⁹ Deborah S. Kleiner, *Family and Medical Leave Act of 1993*, 1 EMPLOY. & LABOR L. SECTION NEWSLETTER 2—3 (Nov. 1993) (published by the Academy of Legal Studies in Business) (on file with author). The FMLA became effective in August of 1993. Pub. L. No. 103-03, 107 Stat. 6 (1993) (codified in scattered sections 2 U.S.C., 5 U.S.C., and 29 U.S.C.).

⁴⁰ Issacharoff & Elyse Rosenblum, *supra* note 4, at 2214-15.

⁴¹ *Id.* at 2196 n.191.

III. PROPOSALS AND SOLUTIONS

Several experts have suggested reasonable solutions to the special treatment versus equal treatment dilemma and the interpretation of the PDA. Recognizing that children and safe workplaces are societal goods, one commentator emphasizes that the solution lies, in part, in the power and duty of OSHA to develop new reproductive policies. OSHA attempted this with the EEOC in 1980.⁴² The intention was to protect the entitlement of all workers to a safe environment while acknowledging the importance of worker autonomy. The proposed guidelines emphasized the vulnerability not the hypersusceptibility of women. In the proposal, an employer could have used a fetal protection plan only for women already pregnant. The women could be removed from the toxic settings, provided that less intrusive strategies had been tried. Because of the opposition, the proposals were withdrawn. “[W]ith them went the last comprehensive attempt to devise a fetal hazards policy that incorporated both a civil rights and public health perspective.”⁴³

The approach by OSHA and EEOC was distasteful to many women rights groups as the policy would not fully reconcile the biological differences, such as pregnancy, and the cultural differences, such as child rearing. Certainly, there are recognized differences between bearing and rearing children. Feminist jurisprudence in the 1980s divided along the equality versus special treatment lines. “The central disagreement among feminists was, and is, whether equality is best achieved when pregnancy is considered to be something that sets women apart from men and should be treated accordingly, or whether equality is better served by disregarding or minimizing any potential differences.”⁴⁴ Other approaches adopted varying terminology including asymmetrical to convey a special treatment model and symmetrical for equal treatment.⁴⁵ Classifying pregnancy as a disability separates the women’s physical capacity from her social capacity and follows the European Union’s model.⁴⁶ The European Union (“EU”) places a high value on childbearing and exempts the pregnancy issue from the overall anti-discrimination model. Their debate is limited to the difference between childbearing and child rearing.

⁴² Kirp, *supra* note 2, at 133.

⁴³ *Id.* at 134.

⁴⁴ Issacharoff & Rosenblum, *supra* note 4, at 2193.

⁴⁵ Brenda E. Knowles, *The Pregnancy Discrimination Act of 1978: A Re-examination* (paper presented at the Southern Academy of Legal Studies in Business meeting, March 1994, Dallas, Texas) (on file with author).

⁴⁶ Issacharoff & Rosenblum, *supra* note 4, at 2201-03.

Special treatment for women during and immediately after pregnancy is now a mandated EU benefit.

IV. CONCLUSION

A better proposal would include a panel with an arbitration feature. Such a process generates less of an adversarial setting and more of a joint decision making situation. The U.S. workplace is already disadvantaged by distrusting environments, underscored by examples shown by the *Armstrong* dispute. Sadly, the Eleventh Circuit noted that “Title VII simply doesn’t require employers to treat their employees with kindness.”⁴⁷

A solution is to use the common law to fashion a public policy exception that allows an expectant mother to request an arbitration for consideration of an employer accommodation. Preferential treatment would be provided only upon the request of an expectant employee, who bears the burden of establishing a good faith showing of a harmful and significant perceived or real risk to the fetus. Then, the burden would shift to employer to establish that the accommodation would not create an undue hardship. A mandatory pre-suit process would support an employer-employee agreement to allocate the benefits and burdens ethically and legally for the special treatment of pregnant workers who face risks of harm to their fetus. A board composed of three arbitrators, one each chosen by the employer and the employee, respectively, with the third selected by the other two arbitrators. Moreover, the employer is protected by a balancing of undue hardship and the efficiency of employees is enjoyed. There would be less acquiescence to an artificial distinction between illnesses and disabilities. Nothing would prevent the arbitrators from taking into account special factors, such as the one that existed in *Armstrong*. She owed a duty to treat her patient and to provide care. In return for the special benefits that society grants to registered nurses, they in turn accept a duty to provide care and to cause no harm. To Nurse Armstrong and the hospital, a panel decision would not have been unlike other processes with which the health care settings are familiar in the form of licensing, competency, and other types of medical ethics committees.

The policy endorses worker autonomy by allowing a choice of opting out, if the employer cannot provide accommodation. A pregnant

⁴⁷ *Armstrong*, 33 F.3d at 1317 (citing *Ulloa v. Am. Express Travel Related Servs. Co.*, 822 F. Supp. 1566, 1571 (S.D. Fla. 1993)).

woman avoids exercising the hollow right between being fired and facing a real or perceived fetal hazard. The suggestion borrows from cases that have created an exception to the employee at will doctrine when employees were forced to either commit an illegal act or lose employment.⁴⁸

A change of expectant employee rights should not be a national approach, but rather an individual state by state adoption to better fit the expected trend of a state's particular approach to employee principles. This would avoid the haggling of amending the PDA. A state created exception would not contravene federal policy because it favors due process and autonomy. There is due process for both the employer and the employee. The expectant employee is exercising a meaningful right of choice and can gain informed consent. The employer can shield against liability. Protracted litigation is avoided, as well as a national call for amending the PDA. The Court in *California Federal Savings and Loan Association v. Guerra*⁴⁹ even recognized a state-adopted preferential policy favoring special treatment of pregnancy.

After time, and given an industry institutionalized experience, both mothers and employers would become better informed about the potential of fetal risks. Had such a process been available in the case of Nurse Armstrong, several problems would have been avoided. For one, the nurse may have acquired the time necessary to educate herself. The employer would have avoided the loss of an employee who had already been trained. Undeniably, more time and expense would be devoted to assembling a panel, but no more time nor less expense would have been gained as compared to the eventual litigation that occurred in the *Armstrong* example.

Any solution must recognize that parents, as the decision makers for their children need adequate time to make the decisions. Studies verify that time for parental decision and response is especially important in matters of health care decisions.⁵⁰ Thus, any model affecting a mother's choice must necessarily provide more than the two days that were given to Nurse Armstrong.

The ultimate benefit is one gained by all involved; public policy favors a pregnant mother's exercise of her choice. One caveat would be the eventual stigmatization of expectant mothers who did not

⁴⁸ Cameron D. Reynolds & Morgan O. Reynolds, *State Court Restrictions on the Employment-at-Will Doctrine*, 1995 *Regulation* 57, 60-61 (Catoe Business Review 1995) (on file with author).

⁴⁹ 479 U.S. 272 (1987).

⁵⁰ Betsy Anderson & Barbara Hall, *Parents' Perceptions of Decision Making for Children*, 23 *J.L. MED. & ETHICS* 15-19 (1995).

accept the usual pattern of avoiding certain risks. If an employee does not avail herself of an opportunity to withdraw, even though optional, social pressure could affect the voluntary choice. Overall, employers gain insight and knowledge as well as obtain the added benefit of educating employees.

For the employer, the employee, the educator, and the ethicist, the *Armstrong* and *Johnson Controls* decisions heighten awareness of the complex social issues confronting families and employers. These situations provoke many to urge this nation to initiate more social discourse and to develop more moral reasoning skills so that society at large may benefit from better decisions with respect to future generations. Women need support for handling workplace hazards, as do fathers and husbands. An entire family, as is a father, is just as affected by a mother's inability to take time from work as is a father. By adopting a state by state approach based upon a known public policy, the right to request a special work assignment would enhance the mother's right of choice, unlike the outcome for Nurse Armstrong.