In 1988, the prevailing wisdom was that by 1991 AIDS would be the number one problem facing the workplace as medical costs and a decimated work force battered businesses and job discrimination and the loss of medical benefits threatened the security of employees.

Thus far, experience has not matched these fears. Drug abuse, not AIDS, remains the primary preventable health problem facing workplaces in the United States. HIV-related medical costs remain manageable. Diligent efforts have forestalled discriminatory legislation and the recently enacted Americans with Disabilities Act accords federal protection to people with HIV disease. However, more subtle issues—such as negotiating reasonable accommodation,* and dealing with the emotional responses of co-workers to seropositive employees—have emerged as businesses have continued to grapple with HIV disease.

In addressing these issues, corporations have developed two critical tools: a clear and comprehensive HIV policy and a well-informed, clinically trained Employee Assistance Program (EAP) staff. The first provides the structure and guidelines through which companies can work when dealing with HIV disease; the second, a mechanism for creatively implementing these guidelines.

Typically, EAPs offer clinical services to employees and their families (sometimes including their unmarried partners), as well as consultation with supervisors and managers when medical and behavioral problems occur in the workplace. They identify trends, recommend policies, conduct trainings, and intervene to resolve conflicts. A trained EAP staff becomes a liaison between HIV antibody positive employees and virtually every aspect of their lives at work.

Any business executive who seeks a reasonable way to handle HIV disease in the workplace asks: How can I maintain employee productivity while ensuring that employees feel well-compensated, adequately covered by medical insurance, valued in their diversity, and supported if they become seriously ill? How can this company address complex issues such as homophobia, employee rights, employer liability, and the supervisor-employee relationship while continuing to function as a profitable and efficient business? The wise executive responds to these questions by adopting what has become the standard approach to HIV disease.

Devising a Corporate Policy

This approach can be summarized in five steps. First, establish a policy that clearly states how the company will and will not react to employees with HIV disease. This might include, for example, details regarding equal treatment and freedom from discrimination, reasonable accommodation, and HIV-related education of the work force.

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To develop a policy, convene representatives from key internal departments such as Law, Benefits, Medical, EAP, Human Resources, and Labor Relations. While policies vary among companies—reflecting the type of business in which a company is engaged, the company's product, and the duties of employees—a review of the policies of other organizations is helpful. Prior to drafting the policy, the group may consult medical, AIDS, and other experts outside the company. Once sufficient research is finished, the group develops the policy.
Most of us work because we have to support ourselves. But the emotional fabric of the workplace is never simply defined by our salaries and job duties. Work carries with it everything from ultimate fears of unemployment and homelessness to ultimate hopes of fame, fortune, security, and fulfillment. For most, it is never more or less than a balancing act between meeting financial and social needs and getting as much satisfaction as we can from our jobs.

The workplace—the setting in which most adults spend most of their time—is an environment heavy with roles and expectations, a central experience yet one that is often dismissed as "just a job." It is also where we most often submit to the constraints of a hierarchy and rules—sometimes arbitrary and sometimes patently unfair—over which we have no control.

In this charged atmosphere, neither employees nor their supervisors can deal with HIV infection free from stress. But, as both articles in this issue of FOCUS suggest, employers can anticipate the complications related to accommodating employees with HIV disease. By implementing fair and consistent policies, and HIV-related employee education, they can reasonably and without great expense meet the obligations of both law and ethics.

**Satisfaction and Productivity**

Employers, wary of the bottom line, must also remind themselves about the central place of employee satisfaction in maintaining productivity. Clear, consistent, and equitable company policies foster a sense of security among employees and go a long way toward guaranteeing productivity. Secretive, arbitrary, and ambiguous policies promise the converse—suspicion, dissatisfaction, fear, and disloyalty—and most importantly, do not forestall conflict. A company that fails to communicate its policies and its implications for the workplace, and about the purpose for the company’s policy. Emphasize the continuing education of managers and supervisors, who play a key role in determining the atmosphere of a workplace.

Fourth, make confidential counseling available through the EAP. The EAP should be a primary resource to respond to questions, expressions of concern, and resistance to the policy. Fifth, keep current about HIV disease, modify the HIV policy accordingly, and notify employees about new information.

**Special Concerns**

Some of the more difficult issues for employers to handle and about which employees have the greatest concerns are: the maintenance of comprehensive health coverage, the effects of HIV disease on job performance, the stigmatization of HIV-infected employees, the threat of HIV transmission in the workplace, and HIV antibody testing as a condition of employment. Fears about health, job security, and stigmatization may lead HIV-infected employees to isolate themselves, and this may further complicate the EAP response to these issues.

**Health Insurance.** For obvious reasons, it is crucial for employees with HIV disease to maintain the insurance coverage they receive as an employment benefit. For their part, employers fear increased insurance costs, and if self-insured, increased medical costs. There is no evidence, however, that companies would save money if they avoided hiring people with HIV disease.

Many large corporations are self-insured for medical coverage. This practice provides considerable flexibility, but also requires that corporate managers pay close attention to medical expenditures. In concert with benefits departments and
An effective Employee Assistance Program provides the mechanism needed to creatively implement the guidelines outlined by a clear and comprehensive company HIV policy.

managed care providers, EAPs often take on the role of case manager, monitoring care to make sure it is medically appropriate and cost effective, and when it is not, recommending alternatives. In this role, EAPs must remain aware of treatment alternatives and how to access them, and in communities where resources are scarce, may advocate for and develop them.

Job Performance. For employers, it is when it affects job performance that HIV disease becomes of greatest concern. How and when should reasonable accommodation be negotiated? How can and should supervisors maintain work goals while they assuage the guilt and frustration of co-workers?

For employees with HIV disease, job performance raises issues in two contexts. First, when HIV-related conditions weaken, but do not disable employees, they may feel discomfort, frustration, and fear about their diminished output. They may also fear that employers will try to pressure them to resign or accept reassignment. Second, HIV-associated dementia may lead to mental incompetence, sometimes so subtle that HIV-infected employees may be unaware of their incapacity. EAPs address performance-related issues by assessing to what extent employees are disabled, what tasks they can perform, and in what ways reasonable accommodation is an appropriate course.

Stigmatization. On hearing that an employee is seropositive, co-workers’ responses may range from sympathetic and supportive to rejecting and fearful. Both responses set infected employees apart. Sympathetic co-workers may display an outpouring of inappropriate sentiment or concern, focusing unwanted attention on seropositive employees and demoralizing them by treating them as terminally ill. Through their reluctance to interact, fearful or judgmental co-workers may evoke anger or sadness among infected employees. Upon disclosure, the work group itself may be emotionally affected. Stigmatization.

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A sound corporate policy should anticipate the possibility that seropositive employees may isolate themselves and that their co-workers may stigmatize them. HIV policies should articulate the consequences for employees who discriminate or, in the absence of a threat of transmission, refuse to work with HIV-infected co-workers. EAPs can work against stigma by providing HIV education—particularly about the difficulty of HIV transmission in the workplace—and counseling, through which EAP clinicians can acknowledge employees’ concerns, help resolve them, and reiterate company policy.

Antibody Testing. Employees fear testing as an unwarranted invasion of their privacy. Some executives believe that mandatory HIV antibody testing of employees and job applicants will enable their companies to avoid HIV-related problems. Most large companies, however, have rejected testing, and in some states, mandatory testing is illegal. Since disabling HIV disease may not emerge for 10 years or more, test results are irrelevant to successful job performance, and since there is virtually no transmission risk in most jobs, test results will not protect co-workers from HIV.

EAP Interventions

A good corporate HIV policy will encourage employees with HIV disease to seek EAP help as soon as possible to develop strategies for dealing with the short- and long-term outcomes of their medical status. When no formal EAP exists, but an HIV policy is in place, a company should consider retaining the services of a mental health professional in the community for guidance and ongoing assistance.

In a typical case, 28-year-old Carl, who does a combination of physical and clerical work calls Susan, an EAP counselor whom he trusts. Two months ago Carl broke up with his lover of almost a year; 10 days ago he learned he was HIV infected. Shocked, frightened, and unable to focus on work, Carl has told nobody this news. Although he is well-liked and competent at work, he has no close co-workers in whom he can confide.

During initial EAP sessions, Carl will need time and encouragement to express sadness, anger, and fear. Susan must allow Carl to ventilate these feelings, but she must also address practical concerns. Has Carl accepted his condition and started to plan appropriate action? Has he have access to medical care from an AIDS-knowledgeable physician? Is his current

References


social and emotional support system adequate? Has he considered joining an HIV support group?

The scenario described above is ideal: Carl seeks help immediately, before illness and impaired job performance complicate the picture. Carl and Susan can eventually develop an action plan based on the flexibility of Carl’s current job duties, whether and when he wishes to inform his supervisor and co-workers about his condition, and the progression of Carl’s illness. Susan might also consider: negotiating with the company benefits department and health plan to expedite Carl’s treatment; beginning to assess reasonable accommodations should they be needed in the future; anticipating and responding to problems within Carl’s work group; and acting as a support and information resource for Carl.

Three years later, Carl has his first HIV-related medical crisis, which requires him to take sick leave and impairs his ability to work. He and Susan agree that it is time to inform his supervisor. They rehearse what Carl should say, anticipate his supervisor’s reaction, define the outcome Carl desires, and decide what role Susan will play in the interaction.

With the cooperation of Carl’s doctor, Susan will also assess whether Carl can continue to perform his regular duties. If he cannot, Susan, Carl, Carl’s supervisor, and other company representatives can explore reasonable accommodation.

Negotiating reasonable accommodation is a complex task that requires the combined efforts of the employee, and the EAP, Human Resources, Labor Relations departments. There is, unfortunately, no cookbook solution for reasonable accommodation, and successful accommodation requires anticipatory planning and ongoing review. Central to the accommodation solution are: the company’s size; the nature of the employee’s work requirements and their flexibility; employee and work group morale; and the openness of communication within the work group. There will be times when accommodation will be impossible to achieve, but employers should not assume this outcome before making good faith efforts to resolve the problem.

When employees are disabled with HIV-related conditions, virtually everyone relies on the EAP for guidance: the ill employee seeking reassurance; the work group seeking support; and the supervisor seeking advice. Avoiding the concerns of any of these parties can lead to absenteeism, lowered productivity, illness, accidents, poor morale, and transfer requests. Supervisors in particular are critical in this process and have a responsibility to balance compassion, fairness, and respect with productivity.

Conclusion

AIDS and work are no longer mutually exclusive conditions. As the two coexist, mental health and medical practitioners will become more involved in negotiating the conditions by which some employees with HIV disease can remain productive just as others become disabled and must leave. In this traditional work setting, where emotional issues are often ignored, AIDS has forced us to confront sexuality, drug use, disability, death, and grief—issues typically denied straightforward discussion at work. While even the most compassionate corporate efforts will lead to painful encounters, a sensitive HIV policy and the intervention of a well-trained EAP staff can shift the odds in favor of constructive results.

Clearinghouse: HIV in the Workplace

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References


Special Publications
The National AIDS Clearinghouse is expanding its “Business Responds to
HIV-Associated Dementia and the Workplace
James W. Dilley, MD

The specter of HIV-associated dementia, a condition of declining cognitive and intellectual capacity, may raise concerns about the competence of employees with HIV disease. This article defines HIV-associated dementia, reviews related issues for employers, and offers recommendations for businesses on how to approach this situation.

Practitioners base a diagnosis of HIV-associated dementia on psychological assessment or on behavioral evidence of cognitive difficulties. This clinical diagnosis is necessary since there is no fail-proof method—no laboratory test or procedure—to detect the condition.

Dementia symptoms may vary over time. In the early stages, motor problems may predominate: patients may have trouble with balance, clumsiness, and leg weakness. They may also demonstrate behavioral changes, including social withdrawal and generalized apathy, a slowing of mental function, and diminished powers of concentration and memory. In people with severe dementia, successfully completing daily tasks of living—for example, cooking, cleaning, and dressing—may become difficult, and eventually patients may become bedridden and require 24-hour care. According to more than a dozen studies from around the world, dementia occurs most often in people already diagnosed with AIDS, particularly in the later stages of disease, and it rarely occurs among asymptomatic seropositive people.

Dementia on the Job

Despite the rarity of HIV-associated dementia in the working population, cases do occur, and the incidence may increase as people with HIV disease continue to live longer. While they may be confident that most HIV-infected employees will remain mentally competent, employers should prepare for the possibility of disabling HIV-associated dementia.

People with HIV-associated dementia most often have two types of employment-related problems. First, mental slowing, impaired concentration and memory, and mental inflexibility can result in difficulties for those employees responsible for making higher-level or quick decisions. Planning and organizational skills...
might also suffer as the ability to attend to a range of complex issues declines. Furthermore, failing memory and inattention to detail can result in an apathetic approach to job-related tasks.

Second, dementia is frequently associated with the diminishment of fine motor skills and, in some studies, with reduced reaction time (the amount of time it takes a person to respond physically to verbal or visual cues). This may compromise the abilities of employees such as word processors, key-punch operators, graphics designers, and artists. It should be stressed that whether deterioration is cognitive or motor-related, new or unfamiliar tasks are likely to be the most difficult for people with HIV-associated dementia.

Because the impairment associated with dementia is difficult to recognize and has potentially serious consequences—for example, legal liability and customer dissatisfaction—employers motivated by fear may react inappropriately. They may interpret HIV disease as equivalent to HIV-associated dementia and take unnecessary and premature action regarding asymptomatic seropositive employees. Conversely, they may deny cognitive disability when it occurs in order to avoid what may seem to be punitive, hostile, or discriminatory responses, or because they overidentify with an employee's struggle with HIV disease.

Recommendations for Management

When dementia-related difficulties are significant enough to impair performance, businesses must find ways of fulfilling legal obligations to reasonably accommodate disabled employees as well as ethical obligations to avoid abandoning them. While cognitive impairment is unlikely to be a common reason for a decline in work performance among people with HIV disease, the following guidelines may help evaluate dementia-associated concerns.

1. Focus on the employee's abilities to perform specific job tasks, not on the fact that he or she is HIV-infected. When workers raise the issue of HIV infection and complain of problems concentrating, they should be referred to HIV-knowledgeable psychiatrists. Neuropsychological testing can help to identify HIV-associated dementia and quantify the degree of impairment, or help identify some other cause for the impairment, such as depression or anxiety. Be aware that some factors—such as stress, prescription drug use, and recreational drug use—may exacerbate dementia. Changes in an employee's habits regarding these factors should also be discussed with the employee's primary care physician.

2. Evaluate the HIV-infected employee's job performance as you would that of any other employee. Focusing on job performance helps to keep unrelated emotional issues from obscuring appropriate responses. The key to any effective job evaluation is the articulation of clear expectations and the maintenance of regular performance documentation. The emphasis must be on successful completion of assigned tasks and not on the potential for problems.

3. If a problem in performance is identified, act immediately. Employee conferences and actions to assess the situation should begin promptly. Obtain professional advice and evaluations in a way consistent with usual and customary company standards. Should HIV-related cognitive impairment be suggested by company consultants, supervisors should move rapidly to secure the employee's cooperation in making appropriate job changes. Since impairment tends to advance, and dementia may affect mood and perception, a timely response ensures that a mutually acceptable resolution can be achieved.

Conclusion

HIV disease generally progresses slowly enough to give employers and employees time to plan for any eventuality. With company assurances that employees will not be abandoned and with safeguards in place to protect health and disability benefits, it is likely that employees will come forward and work with their employers to develop mutually beneficial plans. Companies that implement such employee-centered policies will not only

References


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Comments and Submissions

We invite readers to send letters responding to articles published in FOCUS or dealing with current AIDS research and counseling issues. We also encourage readers to submit article proposals, including a summary of the idea and a detailed outline of the article. Send correspondence to: Editor, FOCUS UCSF AIDS Health Project, Box 0884 San Francisco, CA 94143-0884
Recently, the development of workplace policies has become a priority for many companies. About 10 percent of U.S. corporations have developed AIDS policies for their employees. A review of corporate responses to HIV disease found that these policies address financial issues most prominently, in addition to legal concerns, employee training, and employee rights, such as protection from workplace discrimination and employer-mandated antibody testing.

Companies with AIDS policies acknowledge from the outset that comprehensive educational programs and confidentiality for people with HIV disease are necessary components of an AIDS policy. In addition, most firms with policies have established plans—such as case management for employees with AIDS—that seek to minimize HIV-related costs. These programs mobilize medical, psychological, and social workers who help employees, their families, and physicians determine appropriate care. Case management includes monitoring course of illness, supervising and authorizing necessary medical services, and providing outpatient, home, and hospice care. It saves money in employee and employer health care costs and insurance premiums by keeping workers out of the hospital.

A Model Workplace Policy

The city of Baltimore has developed a comprehensive policy that outlines existing laws that protect workers with HIV infection and then details ways in which its own response goes beyond these laws. The policy covers a work force of 40,000 people, including both employees whose work puts them at risk of HIV transmission as well as those who are unlikely to contract HIV on the job. The article uses Baltimore’s policy as a basis from which to discuss legal issues affecting employees with HIV infection.

Corporate policies also seek to reflect appropriate worker protection laws, such as those that relate to employee dismissal and accommodation. It is only in rare cases that an employee can be dismissed because of HIV infection. An employer may reject a worker or job applicant if there is a “bona fide occupational qualification” that workers be free of infection; the employer would have to prove, however, that there was “a reasonable probability of substantial harm” if workers were infected, a difficult standard to meet.
While supervisors had generally higher HIV knowledge levels than nonsupervisors, only 36 percent of supervisors, compared to 30 percent of nonsupervisors, knew that HIV could not be contracted through the air. After training, both groups—76 percent of supervisors, and 66 percent of nonsupervisors—answered this question correctly, and responded significantly better to other knowledge questions. Researchers attributed group differences largely to the higher educational levels of supervisors, but this was not always the reason.

Supervisors scored no better than nonsupervisors in their ability to respond to the disease. Before training, 67 percent of nonsupervisors, compared to 63 percent of supervisors, expressed confidence in their ability to seek confidential testing and handle an AIDS-related situation at work. After training, 88 percent of both supervisors and nonsupervisors expressed confidence about dealing with such a situation.

Trainings consisted of a brief history of the epidemic, and discussion of methods of transmission, precautions to take when giving first aid, high-risk behaviors, signs and symptoms of disease, and where to go for more information. Researchers said the training’s broad and basic nature was necessary because initially workers displayed low levels of knowledge and came from a variety of skill, educational, and socioeconomic backgrounds.

Dementia
Maj M. Organic mental disorders in HIV-1 infection. AIDS. 1990; 4:831-840. (World Health Organization.)

Basic questions about the cause and progression of HIV-associated dementia remain unanswered and highlight the lack of knowledge surrounding the syndrome, its treatment, and its management, according to a review article of mental disorders associated with HIV infection. The article also summarizes the literature regarding other mental disorders—including mild cognitive impairment, delirium, organic schizophrenia-like disorders, and organic affective disorders—that occur in people with HIV disease.

The causes of HIV-associated dementia are largely unknown. In at least some cases, the syndrome is believed to be the result of direct HIV infection of the brain. Marked immunosuppression also seems to be necessary for dementia to develop. A large prevalence study found dementia in 6.5 percent of adults with AIDS. In 3 percent of the sample, dementia was the only early manifestation of AIDS. Dementia rates appear to increase significantly with age.

The course of dementia is variable, and there is no way to predict the speed of its progression. It may progress rapidly to deterioration and death, but it may also stabilize, or fluctuate and result in reversible deterioration. A study of 132 patients showed that 25 percent progressed from a subclinical stage to a symptomatic stage of dementia within 37 weeks of initial detection, and half of all patients progressed to this stage within 59 weeks.

Studies have found that people with HIV-associated dementia who take zidovudine (ZDV; AZT) show improvement on measures of mental awareness and perception. A preliminary report has suggested that didanosine (ddl; dideoxynosine) is also effective in diminishing symptoms of dementia. However, the long-term impact of these drugs is not known. Patients with dementia who demonstrate retardation of motor skills or apathy may benefit from short-term use of psychostimulants. Antidepressants may provoke or exacerbate delirium and therefore should be used with caution in people with dementia.

Next Month
HIV disease has cut a swath across age, gender, sexual orientation, and class categories within the African American community and left Blacks overrepresented among people with AIDS. In the March issue of FOCUS, Michael T. Myers, Jr., MD, an internal medicine physician at the Massachusetts Institute of Technology and former Chair of the Task Force on AIDS Education of the Massachusetts Medical Society, outlines the epidemiology of HIV disease among African Americans and describes differences in the way HIV infection manifests and is treated in this population.

For another perspective on ethnic differences and HIV disease, Mindy Thompson Fullilove, MD of the HIV Center at Columbia University and formerly of the University of California San Francisco Center for AIDS Prevention Studies, reports on the AIDS in Multi-Ethnic Neighborhoods Study (AMEN), which examines the distribution of HIV infection and risk behaviors in groups defined by race, gender, and sexual orientation.
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