ings in such areas as nursing care, infection control, patient rights, and life safety will be provided on a comparative basis. Also available for comparison will be facilities' overall summary grid scores, which are the basis for accreditation decisions.

Healthcare organizations will be able to review and comment on the data in the Joint Commission performance reports prior to publication. Official survey reports will remain confidential.

Meanwhile, the Joint Commissions board recently approved plans to begin evaluating delivery networks by January 1994. In addition, the board decided to resume evaluating hospices and to ask hospitals to collect and provide data voluntarily next year for the Joint Commissions indicator monitoring system.

FROM: ***Trustee.*** Chicago, IL: American Hospital Association; July 1993.

## Court Rules That Patient May Sue HIV-Infected Doctor for Emotional Distress

A California state appeals court, in reversing a lower court's decision, ruled that the fear of contracting AIDS (even without proof of contamination) constitutes a compensable injury, at least for the period between learning of the doctor's condition and receiving the patient's negative HIV test results. Setting out the limits for a "reasonable window of anxiety," the court added that the patient's claim became unreasonable and thus uncompensable once the patient had received reports that no exposure had occurred, received the negative HIV test results, and had the opportunity for counseling on the accuracy and reliability of the test methods and the remote possibility of seroconversion more than 18 months after exposure.

The case began in 1986 when a surgeon removed the fibroid uterus of one of his patients. In April 1988, the patient learned of the surgeon's condition after an announcement on a televised news broadcast. The broadcast was connected with an AIDS discrimination suit filed by the surgeon against his medical partners, who had refused to let him return to his surgical practice after recovering from an AIDS-related illness. The patient underwent an HIV test the next day and found out two weeks later that she was not HIV positive. Nonetheless, the patient subsequently sued for damages for emotional distress.

While noting that the majority trend among other state courts holds that emotional distress damages are unrecoverable without proof of actual exposure to the AIDS virus or if it is "substantially likely" the patient was not infected and will not contract AIDS, the court accepted that the patient's fear, at least initially, was a valid cause of action.

In light of this case, concern has been expressed that by taking action to terminate an HIV-infected physician, a medical group may expose itself to potential liability not only to the individual whose employment has been terminated, but also to members of the public who have been treated by that individual.

FROM: Kerins v. Hartley, California Court of Appeals, 2nd Appellate District, Div. 2, no. B 065917. July 30, 1993.

## Physicians Liable for Taxes on Vaccine Inventories

President Clinton's new five-year federal budget includes amendments to the National Childhood Vaccine Injury Compensation Act. Besides creating a new immunization program for low-income children, amendments to the act reinstate the federal vaccine excise tax used to fund a compensation program for victims of adverse reactions from immunization. In effect since 1988 to address escalating liability concerns of drugmakers and providers, the tax lapsed late last year when former President Bush vetoed a bill that contained its renewal. Since January 1, vaccine manufacturers have not collected the tax.

The tax has been reinstated to previous levels: $4.56 per dose of diphtheria, pertussis, and tetanus vaccine; $4.44 for measles, mumps, and rubella vaccine; $0.29 for polio, and $0.06 for diphtheria and pertussis. It does not cover hepatitis B or *Haemophilus influenzae* type b vaccines because they were added to the childhood immunization schedule after the tax went into effect. The budget bill states that providers are liable for tax on vaccines they had in stock on August 10, 1993. The Internal Revenue Service has advised that the tax will be due by February 28, 1994, but has not offered any further details.

Once taxes on existing inventories are collected, the inconvenience for doctors should diminish because vaccine manufacturers will collect the tax on new shipments. But many doctors are unsure of how to handle the inventory problems. It may be easy to determine what was in stock on August 10 for those physicians who keep detailed records. However, this may be difficult for those physicians who do not keep detailed inventories.

Critics say that reinstatement of this tax is ludicrous because it adds to a $600-million fund for claims of adverse reactions from immunizations given after 1988, and the surplus is one of the reasons it was allowed to lapse. Even those who agree that funding should be reinstated say it could have resumed without taxing inventory.

This will create a nightmare for many states that

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have inventories of vaccine intended for public clinics. Some of the vaccines have been purchased with state funds and some with federal grants from the CDC. CDC had set aside the appropriate amount of excise tax from vaccine grants, assuming the tax would be reinstated soon. It has been estimated that a state's tax liability could reach $3 million at a time when states are cash-strapped for basic services. Dr. Walter Orenstein, Director of the CDC's National Immunization Program, said the CDC was not consulted and that "this may create one more impediment to raising immunization rates."

FROM: ***American Medical*** News. September 13, 1993.

## States Get Funding for TB Treatment and Follow-up

Congress has given the states an option for new federal funds for TB treatment and followup. Included in the federal budget bill passed in August 1993 is a five-year, $205-million outlay for Medicaid coverage of TB drugs and related services. The proposal, sponsored by U.S. Representative Henry Waxman (D-Calif), gained widespread support in both houses. In addition to prescription drugs for treatment and preventive therapy, the additional funds will cover services such as chest radiographs, home nurse visits, and outpatient followup. Coverage would begin January 1, 1994.

State health officials say the biggest advantage is coverage of directly observed therapy and case management services. Earlier this year, the CDC recommended that all TB patients be considered for DOT and receive an initial four-drug treatment regime.

Traditionally, the states have been responsible for budgeting TB care with their own funds. This bill would create a process to ensure supplemental funds. This does not mean that states can use federal funds to free state money for other things; rather, this is a supplemental funding based on need. The Health Care Financing Administration, which administers the federal portion of Medicaid, would develop a formula to distribute the funds where they are needed the most. New York will be high on the list: In 1992, it led the nation in TB incidence, with 25 cases per 100,000.

Another bill introduced in the Senate (S 1249) by Edward Kennedy (D-Mass) would allocate $200 million to the CDC for fiscal 1994 for prevention, control, and elimination programs; $26 million to the CDC for research, demonstration projects, and education and training; $46 million to the National Institute of Allergy and Infectious Disease for research; $5 million to the Food and Drug Administration for research, including the development of medication implant devices; and $25 million through the CDC to renovate hospitals and clinics that treat TB patients.

FROM: ***American Medical*** News. September 13, 1993; and ***AIDS Policy and Law***. August 20, 1993.

## Hantavirus-Associated Illness Identified in North Dakota

On August 27, 1993, a previously healthy 14-year-old North Dakota boy died suddenly after a brief, unexplained febrile respiratory illness. Subsequent examination at CDC of specimens from this patient demonstrated the presence of serum immunoglobulin M antibody to the hantavirus antigens, a positive polymerase chain reaction assay for hantavirus genetic sequences in multiple tissue, and a positive immunohistochemical stain for hantavirus antigen in lung tissue, confirming the diagnosis of acute hantavirus infection. The patient had no history of recent travel outside the west north central region. An ongoing investigation of this illness is being conducted.

The recognition of this case in North Dakota, in addition to previously confirmed cases that have occurred outside the four-comers region of the Southwest, reinforces the need for clinicians throughout the United States to maintain a high index of suspicion for this condition and to inform health authorities of suspected cases. As of September 15, 36 cases have been confirmed in the United States.

## Malaria Diagnosed in 130 + U.S. Military Personnel Returning from Somalia

Malaria has been diagnosed in 48 U.S. military personnel who had onset of illness while in Somalia between December 1992 and April 1993, and in 83 additional military personnel following their return from Somalia (through June 1993). Of 53 investigated cases, ***Plasmodium vivax*** was detected in 41 of the cases, ***Plasmodium falciparum*** in nine, a mixed vivax and falciparum infection in two, and ***Plasmodium ovale*** infection in one. This substantial number of cases has reinforced concerns regarding malaria prophylaxis, and it underscores the need for prompt recognition and treatment of malaria in military personnel returning from Somalia and in other persons who have traveled to infested areas.

Mefloquine was used for malaria prophylaxis by 38 persons and doxycycline by 15 persons. Because of the reportedly low frequency of vivax and ovale malaria in Somalia, terminal prophylaxis with primaquine to prevent relapses of vivax or ovale malaria following departure was not recommended for Army personnel. Although terminal prophylaxis had been

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