Medical Screening and Employment Law: A Note of Caution and Some Observations

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Medical screening of workers, the use of medical criteria in the selection and maintenance of a work force, has become an established practice in many industries. Medical screening is not new. Since the turn of the century large industrial companies have employed “factory surgeons” to determine whether applicants and employees were free of disease and had the necessary strength, stamina, vision, hearing, and other physical attributes to perform the job.

In recent years medical screening has changed both qualitatively and quantitatively. The purpose of screening no longer is simply to decide whether an individual is currently capable of performing the job. Increasingly, “predictive screening” attempts to identify whether currently capable individuals are at risk of developing a medical impairment at some future time. This newer form of medical screening is greatly affected by technological advancements and is likely to become an increasingly important part of the employee selection process.

Each year American companies require their employees to submit to millions of blood tests, urine tests, x-rays, pulmonary function tests, and other medical and laboratory procedures. Why? How essential are these tests? How valuable and accurate is the information they yield? How does the law attempt to regulate medical screening? What policy questions are raised by medical screening?

The burgeoning use of these procedures might suggest that medical screening of workers has been carefully considered, is accurate and effective, and results in net benefits to labor, management, and public health. Unfortunately, this is often not the case. Medical screening is often the inappropriate, simple, “high tech” answer to a wide range of complicated problems. Employers often implement workplace medical screening procedures without a thor-
ough consideration of the consequences. The test results are frequently inaccurate and, even if they were accurate, the use of the tests may still be counterproductive to the interests of labor, management, public health, and public policy.

This Article attempts to discuss the efficacy and social impact of medical screening at a time when its virtues have been widely extolled and when new scientific advances threaten to change fundamentally established tenets of employment relations. The Article necessarily focuses on broad questions involving the future direction of employment law in an age of technological and economic change. Because of the wide array of issues raised in the Article, it is impossible to provide a detailed analysis of each issue. Some of these matters already have been addressed elsewhere by other authors and me.1 The remaining issues may well be worthy subjects for future research. By using a "wide angle lens" approach, this Article seeks to put medical screening in perspective and to make some meaningful observations about the landscape of employment law.

I. THE GROWING PRESSURES TO ENGAGE IN MEDICAL SCREENING

A. The Increase in Medical Screening

The National Institute for Occupational Safety and Health (NIOSH), a part of the Department of Health and Human Services, has conducted the most extensive studies on the frequency of medical screening in industry. A comparison of data from its 1972-1974 study with data from the 1981-1983 follow-up study indicates that medical screening has substantially increased in just a nine-year period.

Table 1 shows increases in both preplacement and periodic

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examinations.²

TABLE 1

Estimated percentage of Workers With Screening Examinations

<table>
<thead>
<tr>
<th>Type of Examination</th>
<th>Estimated % of Workers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preplacement</td>
<td>47.7</td>
</tr>
<tr>
<td>Periodic</td>
<td>33.7</td>
</tr>
</tbody>
</table>


According to Table 2, medical screening continues to be much more common in large plants, but the largest percentage increase has been in preplacement examinations in small plants.³

TABLE 2

Estimated Percentage of Workers With Screening Examinations by Size of Plant

<table>
<thead>
<tr>
<th>Type of Examination</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Small Plants (≤100 Workers)</td>
<td>Medium Plants (100-499 Workers)</td>
<td>Large Plants (&gt;500 Workers)</td>
</tr>
<tr>
<td>Preplacement</td>
<td>19.2      26.6</td>
<td>48.9      56.4</td>
<td>83.3      87.8</td>
</tr>
<tr>
<td>Periodic</td>
<td>12.2      13.4</td>
<td>29.3      38.1</td>
<td>65.4      68.8</td>
</tr>
</tbody>
</table>


Table 3 shows that, by percentage, blood and urine testing increased more than other kinds of tests.⁴

³ Id. at 908.
⁴ Id.
### TABLE 3

Estimated Percentage of Workers With Specific Periodic Examinations

<table>
<thead>
<tr>
<th>Test</th>
<th>Estimated % of Workers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chest radiograph</td>
<td>25.0</td>
</tr>
<tr>
<td>Ophthalmologic</td>
<td>22.3</td>
</tr>
<tr>
<td>Audiometric</td>
<td>21.4</td>
</tr>
<tr>
<td>Blood</td>
<td>14.7</td>
</tr>
<tr>
<td>Urine</td>
<td>14.4</td>
</tr>
<tr>
<td>Pulmonary function</td>
<td>13.5</td>
</tr>
<tr>
<td>Allergies</td>
<td>*</td>
</tr>
<tr>
<td>Immunizations</td>
<td>24.2</td>
</tr>
</tbody>
</table>

*Information not recorded.


Table 4 indicates that the largest increases were in the services and wholesale/retail trade sectors.\(^5\)
TABLE 4
Estimated Percentage of Workers With Screening Examinations by Industry Type

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Preplacement Blood</td>
<td>Blood</td>
<td>Chest Radiograph</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>(Periodic)</td>
<td>(Periodic)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Transportation/public</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>utilities</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>81.6</td>
<td>72.7</td>
<td>12.2</td>
<td>32.6</td>
<td>32.7</td>
</tr>
<tr>
<td>Manufacturing</td>
<td>67.0</td>
<td>61.8</td>
<td>24.1</td>
<td>35.0</td>
<td>35.9</td>
</tr>
<tr>
<td>Services</td>
<td>40.9</td>
<td>69.0</td>
<td>13.7</td>
<td>59.5</td>
<td>30.5</td>
</tr>
<tr>
<td>Wholesale/retail trade</td>
<td>22.0</td>
<td>34.6</td>
<td>5.9</td>
<td>17.3</td>
<td>13.9</td>
</tr>
<tr>
<td>Finance/insurance</td>
<td>33.2</td>
<td>*</td>
<td>1.0</td>
<td>*</td>
<td>7.3</td>
</tr>
<tr>
<td>Contract construction</td>
<td>8.0</td>
<td>12.0</td>
<td>11.0</td>
<td>9.3</td>
<td>4.0</td>
</tr>
</tbody>
</table>

*Not surveyed.


Other forms of medical screening, not specifically covered by the NIOSH studies, also have become much more common. For example, among Fortune 500 corporations, only ten percent performed drug testing in 1982; by 1985 the figure had reached twenty-five percent; and by 1987 nearly fifty percent of the largest corporations performed drug testing.

B. What is Causing the Increase?

The increase in medical screening may be attributable to a number of factors. For employees exposed to toxic substances such as asbestos, lead, and ethylene oxide, Occupational Safety and Health Administration (OSHA) standards require preplacement and periodic medical examinations. This would account for increases in periodic pulmonary function tests, for example. Second, employees working under a collective bargaining agreement also may be subject to periodic medical examinations pursuant to a safety and health provision in the agreement. Approximately one-

* Id.
third of all union contracts contain a provision relating to medical examinations.⁹

These two factors may explain the increased medical screening by large employers (which are more likely to be unionized), in certain industries (e.g., where there is exposure to toxic substances), and in the use of certain procedures (e.g., chest x-rays and pulmonary function tests). Nevertheless, Tables 1 through 4 demonstrate that the largest percentage increases occurred in categories less likely to be affected by OSHA requirements or collective bargaining: Preplacement examinations in small plants, blood and urine tests, and testing in the service sector. The reasons behind these increases offer the best evidence of the future direction of medical screening.

It has become increasingly clear that the newer forms of medical screening are not concerned with workplace hazards so much as employee health in general. Simply stated, medical procedures have been instituted as a cost-containment measure. A healthy work force means lower workers' compensation costs, reduced absenteeism, less turnover, lower disability and health insurance costs, reduced tort liability (such as asbestos products liability suits), and higher productivity. Of course some medical screening is performed because of altruistic concerns with having a safe and healthy work force.

The growing pressures to engage in medical screening also can be traced to four general trends: Medical advances, economic pressures, political pressures, and social pressures.

Medical Advances. Some increases in medical screening can be traced directly to new medical technologies. For example, the development of new immunoassay¹⁰ techniques facilitated widespread drug testing, by providing a method of fast, cheap, and simple urinalysis. The AIDS epidemic and subsequent discovery of a procedure to test for antibodies to the virus created a new form of medical testing. In the long term, however, the medical develop-

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¹⁰ An immunoassay is a test using immunological principles of antigen-antibody reactions to detect the presence and amount of a tested-for substance. This technique is used in, among other things, AIDS and drug testing. In an immunoassay drug test, for example, a known quantity of the tested-for drug is bound to an enzyme or radioactive iodine and is added to a urine specimen. If the urine contains the drug, the added, "labeled" drug competes with the drug in the specimen and cannot bind to the antibodies. As a result, the enzyme or radioactive iodine remains active. By measuring enzyme activity or radioactivity, the presence and amount of the drug can be determined. See Council on Scientific Affairs, American Medical Association, Scientific Issues in Drug Testing, 257 J. A.M.A. 3110, 3112-13 (1987).
ment with the greatest potential for worker screening is genetic screening.

Genetic screening of workers in the United States has been advocated by some individuals since 1963, when research suggested that certain inborn errors of metabolism and biochemical genetic conditions would predispose individuals to illness when working in a particular work environment. These suggestions were not followed by most companies and were ignored by the public until 1980 when a series of articles in the New York Times indicated that DuPont had been performing sickle cell testing and that Dow Chemical and Johnson & Johnson had engaged in cytogenetic monitoring of workers. In rapid succession there were Congressional hearings on genetic testing, a survey of genetic testing in industry, and a report of the Office of Technology Assessment (OTA) which recommended against both genetic screening and genetic monitoring.

The adverse publicity surrounding genetic testing led most observers to conclude that genetic testing, to the extent it was being done in the first place, had essentially stopped by the mid-1980s. It is important to note that this initial phase of genetic testing was concerned with genetic predisposition and genetic changes related to occupational diseases. Although this type of genetic testing raised a host of important issues, it had the potential to affect only the limited part of the work force with specific toxic exposures. The next phase of genetic testing almost certainly will involve diseases that are not occupationally related.

Developments in genetics are occurring at an extremely rapid pace. New genetic markers for disease and new genetic technologies are being discovered seemingly on a daily basis. It is likely that within five to ten years scientists will have refined genetic

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12 Cytogenetic monitoring refers to the periodic testing of workers to assess whether there has been chromosomal damage as a result of exposure to hazardous substances or agents. Genetic changes are believed to be the cellular precursors of diseases such as cancer. See Office of Technology Assessment, Congress of the United States, The Role of Genetic Testing in the Prevention of Occupational Disease 52 (1983).

13 Id. at 9.

14 For example, testing to detect sickle cell trait (the normally benign heterozygous state) has been advocated based on the theory that individuals with sickle cell trait may suffer from a serious illness, such as a hemolytic crisis, by working in environments capable of causing deficient oxygenation of the blood (such as in aircraft or mine rescue work) or where there is exposure to hemolytic agents such as benzene, lead, and carbon monoxide. See Rothstein, Medical Screening of Workers at 54-55 (cited in note 1).
tests for a wide range of genetic conditions and traits, including Huntington's disease, polycystic kidney disease, cystic fibrosis, Duchenne muscular dystrophy, heart disease, and various cancers. Preliminary tests already have been developed for some of these diseases. As discussed in the following section, employers would have substantial economic incentives to use genetic tests.

**Economic Pressures.** One role served by medical screening is keeping costly, high-risk workers out of the work force. It is beyond dispute that unhealthy workers represent a substantial burden to employers. The largest increased cost is health insurance. According to a recent study, ninety-seven percent of medium and large companies offer health insurance as an employee benefit.\(^{15}\) Employee health benefits costs increased from 8.9 percent in 1986 to 9.7 percent of total payroll costs in 1987—about $1985 per employee.\(^{16}\) Both self-insured companies and experience-rated, privately-insured companies will have significantly higher health care expenses with an unhealthy work force.

The effects of economic pressures on employee medical screening practices already can be seen with cigarette smoking. In the last five years a small but growing number of companies have adopted policies of refusing to hire cigarette smokers, even those who do not smoke at work.\(^{17}\) The main reason for these policies is the rising cost of health insurance for smokers. By one estimate, in 1980 health care cost savings per nonsmoking employee ranged from $75-$150 annually.\(^{18}\) Today, total costs of smoking, including productivity losses, have been estimated at $1000 per worker.\(^{19}\)

Another significant economic impetus for screening is the sales pressure of manufacturers, laboratories, and consultants who deal in medical screening products and services. For example, workplace drug testing is more than a $1 billion per year business.\(^{20}\) Aggressive marketing and sales forces often overstate the value of medical screening and paint a bleak picture of the consequences of failing to use the product or service being offered.\(^{21}\)

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\(^{17}\) See Rothstein, 62 Notre Dame L. Rev. at 940 (cited in note 1).


\(^{19}\) Id.


\(^{21}\) For instance, one common sales technique is for a sales representative to approach Company A and say: "I just sold a complete drug testing package to your chief competitor,
**Political Pressures.** Some decisions to implement medical screening programs have little to do with sound medical or business judgments. They are the result of political pressure. For public employers, the testing may be mandated by the government. For private employers, the pressure is indirect, through exhortations by public officials and media attention.

The history of drug testing by employers provides the best example of political pressure causing increases in medical screening. From 1982 to 1987 the percentage of Fortune 500 companies performing drug testing increased from less than ten percent to about fifty percent. During this same time period the rate of drug use in the United States actually declined.\(^2\) The impetus for federal sector drug testing was the report of the President's Commission on Organized Crime, which advocated drug testing by public and private employers in an effort to reduce the demand for illegal drugs.\(^2\) This recommendation led to the issuance of an Executive Order in 1986,\(^4\) mandating drug testing for about 1.1 million federal civilian employees.\(^2\) Although safety, productivity, national security, and other reasons are often used to justify the program, it is clear that the main reason is law enforcement. No testing is performed for alcohol, prescription drugs, or over-the-counter medications which, because of their more widespread abuse, represent a much greater threat to public safety than illicit drugs.\(^2\)

Drug testing in the private sector became more widespread after receiving the imprimatur of the federal government. With a media-conscious "war on drugs," some companies initiated drug testing because the failure to do so might be perceived as condoning drug use. This sentiment was aptly expressed by President Reagan: "I have heard critics say employers have no business looking for drug abuse in the workplace, but when you pin the critics down, too often they seem to be among the handful who still be-

\(^2\) See Annual NIDA Report Says Decline in Use of Cocaine is "Significant," 2 Nat'l Rep. on Substance Abuse 1, 8 (Jan. 20, 1988).


lieve that drug abuse is a victimless crime.”Although this statement reflects more politics than reality, it contains an unmistakable, and, to some, persuasive message advocating drug testing. Moreover, drug testing is an appealing, simple, technological answer to the difficult and significant problem of workplace drug abuse.

Social Pressures. To some extent, the political pressure to engage in employee drug testing is social pressure as well. It is the workplace part of a social problem and a socially-driven response. An even more compelling example of medical screening caused by social pressure is AIDS testing. Management, employees, customers, and the public all have had a part in contributing to the pressure to engage in AIDS testing or, more precisely, testing for antibodies to the human immunodeficiency virus (HIV).

AIDS continues to be a terrifying disease. Its origin, current dimensions, and future spread are uncertain. There is no treatment or cure and it is invariably fatal. The stigma attached to the disease also is caused in large measure by the unpopularity of homosexual men and intravenous drug users, the two most heavily afflicted groups.

AIDS has not only spawned fear in the public, but it also has led to a deep sense of frustration. After over five years of intensive research, no effective vaccine or treatment has been developed and none appears likely in the near term. The only major scientific breakthrough occurred in 1985 when the Food and Drug Administration approved the first tests to detect antibodies to HIV. The test was designed for and has been very effective in screening the nation’s blood supply. With only one tool available, however, and public sentiment to “do something” about AIDS, it was inevitable that there would be calls for widespread testing of individuals, such as in the military, schools, prisons, for insurance, and in employment.

Despite unanimity among experts that AIDS cannot be spread by casual contact, advocates of HIV testing in the workplace assert that it is necessary to test (and exclude those testing HIV positive) in order to: (1) Protect coworkers, customers and the public from

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28 Economic pressures, political pressures, and social pressures may overlap in varying degrees. The key characteristic of social pressure is that it grows from the “bottom up,” on the hopes, fears, and interests of employees, customers, and other members of the public.
29 For further discussion, see Rothstein, AIDS and the Law 126 (cited in note 1).
infection; (2) protect the health of the infected worker; and (3) promote productivity and efficiency by appeasing coworkers and customers, reducing absenteeism, turnover, and sick leave, and limiting health care costs. Only the third reason is based on fact and serves as a legitimate purpose, though coworker or customer preference and increased cost arguments are unlikely to justify discrimination in apparent violation of state and local AIDS laws and state and federal handicap discrimination laws. Nevertheless, the social pressure continues. In a 1987 poll, forty-two percent of the respondents said that all new employees should be tested.

C. Limitations on the Usefulness of Medical Screening

Many diagnostic and predictive medical tests are not nearly as accurate as is popularly believed. Most physicians recognize the limitations of tests and therefore would be extremely reluctant to make a diagnosis on the basis, for example, of a single blood or urine test without a complete history and physical examination. Some medical tests used in the workplace setting, however, despite their low predictive value, may single-handedly disqualify an individual from employment.

It is also important to understand what a test measures and what it does not measure. AIDS tests do not measure AIDS. They...
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detect the nonneutralizing antibodies to HIV infection which develop from four weeks to one year after exposure to the virus.\textsuperscript{34} Drug tests do not measure impairment or intoxication. They measure inert metabolites of the tested-for substance being excreted in the urine. Drug tests cannot determine whether the individual is currently intoxicated, or was ever intoxicated by the substance; how long before testing the individual was exposed to the substance; or the amount of the substance consumed by the individual.\textsuperscript{35}

Finally, in analyzing the desirability and relative merits of any medical screening procedure, managers also need to realize that each new test required of workers carries with it some employee relations cost. This is particularly true if the test procedure is intrusive, invasive, embarrassing, or otherwise unpopular with employees. Once an air of suspicion, distrust, and animosity pervades the labor-management relationship, there may be a number of unpleasant consequences, such as difficulties in recruiting new employees; lower productivity; increases in turnover, absenteeism, theft, sabotage, and disciplinary problems; and, for many companies, the ultimate nightmare—unionization.

II. LAWS AFFECTING MEDICAL SCREENING

A. Laws Regulating Working Conditions

If the primary purpose of medical screening is to safeguard employee health, the first law to consider is the Occupational Safety and Health Act.\textsuperscript{36} The Act covers all private employment in the United States, an estimated five million workplaces and seventy-five million employees.\textsuperscript{37} The purpose of the Act is "to assure so far as possible every working man and woman in the Nation safe and healthful working conditions."\textsuperscript{38} The Occupational Safety and

\textsuperscript{34} See Rothstein, Aids and the Law at 129-31 (cited in note 1).
\textsuperscript{35} See Rothstein, 63 Chi.-Kent L. Rev. at 691-99 (cited in note 1). Perhaps the most misleading "medical" test in use in the workplace is the polygraph or "lie detector" test. Polygraphs do not detect lies. They measure abdominal and thoracic respiration, blood pressure and pulse, galvanic skin response, and muscle contractions. From these measurements the examiner attempts to deduce whether the subject has given truthful answers to specific questions based on the unproven assumption that certain physiological reactions correlate with untruthful answers to questions. See generally Office of Technology Assessment, Congress of the United States, Scientific Validity of Polygraph Testing (1983).
\textsuperscript{36} 29 U.S.C. sec. 651-78 (1982).
\textsuperscript{37} For a discussion of OSHA jurisdiction, see Mark A. Rothstein, Occupational Safety and Health Law 11-21 (2d ed. 1983).
\textsuperscript{38} 29 U.S.C. sec. 651(b).
Health Administration (OSHA), the agency within the Department of Labor charged with enforcing the Act, is responsible for promulgating mandatory safety and health standards and ensuring employer compliance by conducting on-site inspections, issuing citations and abatement orders, and assessing civil penalties.

Medical examination of workers is an important part of occupational health surveillance. OSHA's medical examination requirements, however, are hazard-specific; examinations are only mandated when employees are exposed to substances such as lead, cotton dust, and coke oven emissions. OSHA has not promulgated a generic medical examination regulation with universal applicability. Moreover, even where medical tests are mandated, employers generally must merely perform certain tests. Thus, the standards are notable in what they do not provide: (1) They do not prohibit the use of any additional medical tests; (2) they contain little guidance to medical personnel about how to interpret test results; and (3) with only a few exceptions, they do not indicate what employment actions may be taken as a result of medical tests.

It is unrealistic to expect OSHA to regulate medical screening. To begin with, the employment effects of medical screening may be beyond OSHA's jurisdiction. OSHA's mandate is limited to regulating working conditions by eliminating or reducing hazards. As the Supreme Court has noted, "the Act in no way authorizes OSHA to repair general unfairness that is unrelated to achievement of health and safety goals." In addition, OSHA lacks the necessary resources and political resolve. Between 1971 and December 1984, OSHA promulgated only eleven new permanent health standards, covering twenty-four specific chemical substances. Its remaining health standards, covering approximately 400 substances, are based on 1968 scientific data, and thousands of chemicals commonly used in industry are not regulated at all. It took fifteen years of litigation and a court order before OSHA promulgated a standard requiring drinking water, hand washing facilities, and toilets for the nation's farmworkers. OSHA is unable to deal effectively with traditional workplace hazards and, therefore, at this time, cannot be expected to confront such com-

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91 See Office of Technology Assessment, Congress of the United States, Preventing Illness and Injury in the Workplace 13 (1985).
92 See Farmworker Justice Fund, Inc. v. Brock, 811 F.2d 613 (D.C. Cir. 1987), order vacated 817 F.2d 890 (D.C. Cir. 1987), because the standards had been issued.
plex issues as cigarette smoking, drug testing, genetic testing, and AIDS.\textsuperscript{42}

B. Laws Regulating Benefits

Laws regulating compensation and health benefits for sick and injured workers have had the effect of encouraging employers to engage in increasingly extensive preemployment medical screening. For example, workers' compensation laws, primarily state laws, provide medical and disability benefits to employees who suffer a work-related injury or illness regardless of the fault of any party. Although workers' compensation systems vary, an increase in claims will result in increased expenses for the claimants' employers. Under workers' compensation laws the general rule is that a claimant will not be denied compensation because of a preexisting allergy, weakness, disease, or susceptibility.\textsuperscript{43} Because employers take employees "as is," the fear of increased compensation payments or insurance rates encourages employers to be very selective in hiring.

A similar incentive for medical screening exists under unemployment insurance laws, which provide income replacement to workers who have lost their jobs. Employees who are discharged for misconduct and employees who quit are ineligible for benefits. The majority rule is that employees who quit work because of job-related health problems are entitled to unemployment compensation, even if the employees are particularly sensitive to the workplace environment.\textsuperscript{44} Therefore, an employer that did not administer preemployment allergy tests, for example, and hired an employee who was allergic to a substance in the workplace would be responsible for unemployment insurance benefits when the employee was forced to quit.

The Employee Retirement Income Security Act (ERISA)\textsuperscript{45}

\textsuperscript{42} OSHA has taken some limited action on AIDS. On July 23, 1987, OSHA denied a petition filed by health care unions for an emergency standard to reduce exposure to HIV. OSHA indicated that it was in the process of developing a permanent standard on AIDS and, in the interim, would cite employers under the Act's general duty clause, 29 U.S.C. sec. 654(a)(1) (1982), for failing to comply with infection control measures of the Centers for Disease Control. On October 30, 1987, the departments of Labor and Health and Human Services published joint guidelines for protecting health care workers exposed to AIDS and hepatitis B viruses. 52 Fed. Reg. 41,818 (1987).


\textsuperscript{44} See, for example, Alexander v. Unemployment Ins. Appeals Bd., 104 Cal. App.3d 97, 163 Cal. Rptr. 411 (1980); Ellis v. Iowa Dep't of Job Service, 285 N.W.2d 153 (Iowa 1979).

also may encourage preemployment medical screening. Section 510 of ERISA, applicable to employees but not applicants, prohibits the discharge of an employee in order to deprive the employee of benefits under an employee benefit plan. In addition, according to an amendment in 1986, an employee who is discharged for any reason except gross misconduct must be permitted to continue in the employer's group health plan for up to eighteen months. Although the former employee may be required to pay for coverage, the premiums may not be more than two percent above the premiums paid by current employees and the coverage offered must be the same.

Because of these two provisions of ERISA, employers are, in effect, "stuck" with unhealthy employees once they are hired. Thus, employers have an incentive to identify individuals who are predisposed to illness and to refuse to hire them in the first place.

C. Laws Prohibiting Discrimination

The principal legal protection for applicants and employees against unreasonable medical screening by employers is federal and state handicap discrimination law. At the federal level, the Rehabilitation Act prohibits discrimination in employment against a qualified individual with handicaps by the federal government (Section 501), contractors dealing with the federal government (Section 503), and recipients of federal financial assistance (Section 504). The term "individual with handicaps" is broadly defined in the Rehabilitation Act as "any person who (i) has a physical or mental impairment which substantially limits one or more of such a person's major life activities, (ii) has a record of such an impairment, or (iii) is regarded as having such an impairment." Although a private right of action exists under Sections 501 and 504, the exclusive responsibility for enforcing Section 503 is vested in the Office of Federal Contract Compliance Programs in the De-
State handicap discrimination laws generally apply to all public and private employers in the state (many states exempt small employers) and often provide for a private right of action. Thus, state laws are extremely important in redressing claims of discrimination in employment based on handicap. Mississippi and Alabama have laws applicable only to public employment; the rest of the states and the District of Columbia have laws applicable in both the public and private sectors.

Handicap discrimination laws are relatively easy to apply when the alleged discrimination is based on a person's current physical condition. The issue is whether the person, with reasonable accommodation, is able to perform the essential requirements of the job safely and efficiently. In ruling on these cases, the courts are inclined to give employers greater latitude when co-worker and public safety are involved rather than simply the safety and health of the employee.

The law is much more difficult to apply to medical screening when presently healthy persons are screened out because the employer believes that the persons have an increased risk of future illness. Three of the most important questions to be resolved are the following: (1) Does a person considered to be at increased risk of illness come under the definition of "handicapped"; (2) if so, to what extent may future risk be considered by the employer; and (3) what defenses are available to the employer.

The Supreme Court addressed the first question in School Bd. of Nassau County, Fla. v. Arline, adopting a broad definition of handicap. The Court held that an elementary school teacher afflicted with recurring tuberculosis was a "handicapped individual" and therefore was covered under Section 504 of the Rehabilitation Act. Mere fears of contagion would not justify discrimination by

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54 See generally Laura F. Rothstein, Rights of Physically Handicapped Persons sec. 3.18, 4.04, 4.08 (1984).

55 The range of required reasonable accommodations depends on, among other things, the size of the employer, type of operation, composition of the work force, and cost. Nelson v. Thornburgh, 567 F. Supp. 369, 379 (E.D. Pa. 1983). Reasonable accommodation is not required if doing so would result in undue hardship to the employer. For example, an employer will not be required to rewrite job descriptions to accommodate a single employee. Bento v. I.T.O. Corp of Rhode Island, 599 F. Supp. 731, 745 (D.R.I. 1984).

56 See, for example, National R.R. Passenger Corp. v. Com., etc., 452 A.2d 301 (Pa. Commw. Ct. 1982) (no liability for denying a railroad trackman position to an individual with a glass eye).

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the school board. The case was remanded, however, for a specific determination of whether the plaintiff was "otherwise qualified," including the nature, duration, and severity of the risk she created to third parties. Although Arline is the leading case on the coverage of handicap discrimination laws, it did not directly address the issue of whether an increased risk of future illness is a handicap. Most lower federal court and state court cases, however, have held that future risk of illness is a handicap.

As to the second question, there are a variety of factors that must be considered in deciding whether a future risk will justify the refusal to employ a currently capable individual. The court should consider, among other factors, the severity of the risk, relative and absolute risk, the likelihood of the risk eventuating, the latency period between exposure and illness, and the reversibility of the condition.

Finally, the two defenses to medical screening most likely to be raised by employers are safety and cost. Where the safety of coworkers or the public is involved the courts have given employers greater leeway in fashioning selection criteria. Cost has been rejected in the few cases in which it has been raised, but in those cases the amounts were small and the likelihood of expenditures speculative. It is not clear that the defense will not be given more serious consideration in the case of AIDS or genetic disease where the likelihood and amount of expenditures are substantial.

In addition to handicap discrimination laws, other anti-discrimination statutes may be relevant to medical screening. Specific laws have been enacted dealing with AIDS testing, drug testing, and genetic testing and more state and local legislation is likely. It is not clear, however, that even these new laws will be effective in

58 Id. at 1129-30.
60 Relative risk is "the ratio of the incidence rate for persons exposed to a factor to the incidence rate for those not exposed." J. Mausner and S. Kramer, Mausner and Braun Epidemiology 169 (2d ed. 1985).
61 Absolute risk refers to the incidence rate for an unexposed cohort. See Rothstein, Medical Screening of Workers at 125 (cited in note 1).
62 Id. at 124-27.
III. FORGING PUBLIC POLICY ON WORKPLACE MEDICAL SCREENING

A. Controlling the Flow of Information vs. Controlling the Decisionmaking

Before considering the possible legal regulation of medical screening, it is important to ponder the policy issues at stake. If medical screening is to be controlled, a key question is whether the law should prohibit the employer from obtaining certain medical information or merely prohibit the employer from using the information in making employment decisions related to hiring, firing, promotions, layoffs, job assignment, and other matters.

Employment discrimination laws have used both approaches. For example, Title VII does not specifically prohibit an employer from inquiring into an applicant's race, color, religion, sex, or national origin, although the solicitation of such information may support an adverse inference in a subsequent discrimination suit. Accordingly, virtually no employers ask for this sort of information. By contrast, AIDS discrimination laws prohibit any inquiry into an individual's serological status, not just the use of the information.

The experience under handicap discrimination laws is instructive on the problems of distinguishing between access to medical information and the use of medical information. Handicap discrimination laws generally prohibit an employer from making a preemployment inquiry into whether an individual suffers from any specific medical conditions such as epilepsy, diabetes, and hypertension. The employer, customarily a personnel department employee, is simply permitted to ask if the individual is suffering from any physical or mental impairment which would substantially interfere with the individual's ability to safely and efficiently perform the duties of the job.

The individual's hiring may then be subject to successful completion of a medical examination at which time a doctor or nurse may then lawfully ask much more detailed questions about the same medical conditions that could not be inquired about earlier.

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65 For a discussion of other traditional labor and employment laws and their applicability to medical screening, see Rothstein, Medical Screening of Workers (cited in note 1).
In addition, a complete examination and medical testing may be required. The results of this examination will then determine employability. Any medical disqualification, however, must be job-related or it will run afoul of the handicap discrimination laws. Consequently, the prohibition against inquiring into handicaps by nonmedical personnel only helps to prevent summary disqualification by the nonmedical personnel.

Restrictions on the use of medical information thus appear easier to enforce than restrictions on access to medical information. Bans on access to information would seem more justified when the inquiry is of a sensitive nature (e.g., AIDS) or where stressful (e.g., polygraphs), embarrassing (e.g., observed urination for drug testing), or harmful (e.g., unnecessary x-rays) procedures are used. In other instances, mere “use” bans are likely to be sufficient protection. If an employer is unable to use certain information, it makes no sense for an employer to incur the expense of obtaining and storing the information as well as risk possible employee relations costs and legal liability for the wrongful disclosure of the information.

B. Protecting Privacy and Confidentiality

More medical screening means more medical records and more medical records increases the chances of excess disclosure of sensitive information. In large companies that have their own medical departments, medical records usually are stored in the medical department and access is limited to medical personnel with a need to know. Even with such an arrangement, however, nonmedical personnel sometimes gain access to the records or are informed about specific medical facts in the records. At smaller companies, medical information obtained by contract physicians sometimes is maintained in personnel files where neither ethical canons nor legal strictures assure limited access.

Any attempt to regulate medical screening also should address the issue of medical records. California’s Confidentiality of Medical Information Act is perhaps the most sweeping state law and it requires employers to take specific measures to protect the confidentiality of all employee medical records. Other state laws are more

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69 Id.
70 Cal. Civil Code Annot. sec. 56 to 56.37 (1982):
(a)Each employer who receives medical information shall establish appropriate procedures to ensure the confidentiality and protection from unauthorized use and disclosure of that information. These procedures may include, but are not limited
limited in their applicability. For example, some recently enacted state drug testing laws provide for the confidentiality of drug testing records.\textsuperscript{71} Nebraska's 1988 drug testing law merely prohibits "public" disclosure of test results.\textsuperscript{72}

C. De-coupling Health Insurance from Employment

Employer-provided group health insurance became common during World War II because such fringe benefits were not subject to wartime wage and price controls. Thus, employees (often union members bargaining collectively) were given health insurance coverage when increasing wages was not possible.\textsuperscript{73} During the 1950s and 1960s, the scope of coverage expanded from hospital care to a wide range of medical, dental, and other benefits. Coverage was also extended to retirees and workers' family members.

The driving force behind health insurance as an employer-provided fringe benefit was the tax-favored treatment of benefits. Employer contributions to a group plan are deductible to the employer as a business expense and, more importantly, excluded from the taxable income of the employee. Consequently, health insurance provides a greater after-tax gain to employees than comparable (taxable) wage payments.

During the 1970s and 1980s increasing health insurance costs caused many companies to change from the traditional mode of purchasing coverage from commercial insurance companies or Blue Cross/Blue Shield plans. One of the most significant changes was the growth of self-insurance, whereby large companies would as-
sume direct responsibility for paying claims.\textsuperscript{74} Self-insurance eliminates the risk-spreading function of commercial insurance and increases the pressure to deny employment (and thereby coverage) to bad insurance risks.

With this background, it is easy to see why concerns about health care costs and health insurance rates are likely to be the key factor in increased medical screening. In its traditional role, an employer is concerned about whether applicants and employees are currently capable of performing the job and, therefore, is primarily concerned with what takes place in the workplace. In its role as health insurer, the employer may be concerned about the likelihood or risk of future illness and health care costs\textsuperscript{75} and, therefore, will be concerned about off-work activities such as smoking, drinking, diet, exercise and high-risk hobbies. Moreover, because health insurance frequently covers family members, the employer as health insurer also has an interest in the health and activities of a worker’s family members.

As Professors Epstein\textsuperscript{76} and Liebman\textsuperscript{77} have observed, there is a growing tension between handicap discrimination laws, which require employers to disregard future health risks in deciding employability, and the traditional underwriting function of an insurer. For example, assuming that fifty percent of HIV positive individuals will develop AIDS within five to ten years and that each case of AIDS costs $80,000,\textsuperscript{78} each HIV positive person hired represents an average cost of $40,000. The trend toward mandating health insurance benefits only heightens this tension.\textsuperscript{79} Steps must be taken to relieve the financial burden from individual employers and, simultaneously, to eliminate the employers’ main motivation for discriminating against individuals in high risk groups. It is unrealistic to assume that employers, especially self-insured employers that are unregulated by state insurance laws,\textsuperscript{80} can or will ab-

\textsuperscript{74} Id.
\textsuperscript{75} Id.
\textsuperscript{79} See, for example, Minimum Health Benefits for All Workers Act of 1987, S. 1265, 100th Cong., 1st Sess. (May 21, 1987) (bill of Senator Kennedy, proposing mandatory employer-paid health insurance). In April 1988, Massachusetts became the first state to enact guaranteed health insurance for all residents. See, Robin Toner, Health Insurance and Political Hoopla, N.Y. Times sec. Y, 8 (April 22, 1988).
\textsuperscript{80} ERISA preempts state insurance laws with respect to health insurance benefits pro-
sorb the growing costs of comprehensive health coverage and not attempt to limit who is covered or what medical conditions are covered.

The "simplest" solution would be to de-couple health insurance from employment. Employers would have little incentive to engage in predictive medical screening if future health care costs would not be borne by the employer. The specifics of such an alternative arrangement are beyond the scope of this article. Nevertheless, it is clear that mandating employer-provided health insurance is likely to lead to increased medical screening and employment discrimination.

If health insurance is de-coupled from employment, it must be made available on a universal basis by another source. In the United States, access to quality health care depends on access to adequate health insurance. In 1987 there were thirty-seven million Americans without health insurance, most of whom were not working. If the employment aspects of health insurance are not addressed, the number of uninsured individuals will grow and with dire social consequences.

D. Using the Workplace to Solve Larger Social Problems

Since at least the New Deal, the workplace has been used as a vehicle for social policy. For example, in enacting the Fair Labor Standard Act's minimum wage provision, Congress sought to increase consumer spending and stimulate the economy out of the Great Depression. But employment policies, ranging from the Davis-Bacon Act to wage/price controls generally were limited to economic policy. Even Title VII attempted to promote equal employment opportunity and thereby realign income levels and living standards skewed by race.

In recent years, the workplace has been used increasingly as a way of solving larger, often noneconomic, social problems. There are a number of examples of this phenomenon. The Immigration

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83 OTI Report (cited in note 73).
Reform and Control Act\textsuperscript{88} is premised, at least in part, on the theory that employer sanctions for hiring undocumented workers will decrease the demand for undocumented workers and ultimately stem the flow of illegal immigration. Public sector and private sector drug testing is an attempt to decrease the demand for illegal drugs by making drug users unemployable. The United States is now attempting to end delinquent child support at the plant gate, provide child care at the plant gate, supply health insurance at the plant gate, and encourage wellness at the plant gate. The question is: At what cost?

It may be that, like public schools and the military, the large numbers of people passing through the employment system make it an ideal point to reach large numbers of people. Nevertheless, the long-term economic effects must be considered. For example, a government mandate that each employer provide child care is tantamount to a child care tax placed on every covered employer. It is politically attractive because it is an off-budget expenditure. Yet, it further encourages companies to go abroad for their labor-intensive operations.

Interposing governmental functions in the workplace also may exact noneconomic social costs. Random, house-to-house drug testing would, undoubtedly, be an effective law enforcement technique. It also should be unconstitutional. Regardless of the legality, law enforcement via drug testing in the workplace is a policy with questionable effectiveness for reducing drug abuse but one that is certain to engender labor-management strife.

Medical screening highlights the fact that the proper scope of employer interest would be limited to the workplace. When employers extend their sphere of concerns too far they court trouble for themselves, their employees and society.

\section*{IV. What Medical Screening Indicates About the State of Employment Law}

Medical screening practices are generally not regulated by any specific laws and, to the extent there is some legal control, it is often indirect. Medical screening is also a relatively new phenomenon and one that is likely to be affected by changes in technology. These two factors make the broader study of medical screening particularly revealing because the response to medical screening indicates much about the current state of employment law. The

following are five general observations about employment law suggested by and brought into sharper focus by their application to medical screening.

A. Disparities in the Rights of Public Sector and Private Sector Employees

According to the court in a recent drug testing case, government employees "do not surrender their [Fourth Amendment] rights merely because they go to work for the government." In fact, relative to private employees, public employees gain their constitutional rights by working for the government. Search and seizure, invasion of privacy, due process, equal protection, First Amendment, and other bases for challenging employer action are constitutionally based and therefore are limited to public employees (and private employees whose alleged denial of rights, such as by medical screening, has been governmentally mandated).

The two questions raised by this disparity are whether these constitutional protections should be extended to all private sector employees and, if so, how. To some extent, debate surrounding the first questions parallels the debate over expanding the exceptions to the at-will employment rule. Those in favor of maintaining the at-will rule argue that it is efficient and works well for employers and employees in the vast majority of instances. Those opposed to the at-will rule assert the inequality in bargaining power between employer and employee and the potential for unfairness in arbitrary employer powers. Even assuming the efficacy of extending "constitutional-type" protections to all private sector employees, it is not clear what the extent of these protections should be. Should all unreasonable employer actions be prohibited or only those of a "constitutional" dimension? Who should have the burden of proof? Should the same rights applied to discharge cases also apply to promotions, layoffs, hiring, and conditions of employment?

The second question, regarding the possible legal theories under which greater employee rights are recognized, also raises nu-

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merous issues. In some states, state constitutional protections apply without the need to prove governmental action. These provisions have been invoked, for example, to attack private sector drug testing which is allegedly an unconstitutional invasion of privacy. Specific state statutes regulating drug testing and AIDS testing or prohibiting wrongful discharge are other possibilities. Still another approach is to attempt to extend constitutional protections to private sector employees through the public policy exception to the at-will doctrine.

In *Schultz v. Industrial Coils, Inc.*, an employee wrote a letter to the editor of the local newspaper. In commenting about the local schools, the employee attacked the president of the school board—who happened to be an officer of the company where the employee worked. After being discharged for insubordination, the employee brought a wrongful discharge action under the public policy exception to the at-will doctrine. He claimed that the employer's action denied him freedom of expression as protected by the Wisconsin Constitution and thus was a violation of public policy.

The Wisconsin Court of Appeals held that although free speech may support a wrongful discharge action under the public policy exception, the employer had a legitimate basis for discharging the employee. Relying on *Connick v. Meyers*, the court stated that an employer need not tolerate actions which undermine authority or discipline or are otherwise disruptive of office routine or employee relations. *Schultz* at least raises the possibility of extending constitutional protections to private sector employees via the public policy exception.

In *Schultz*, the constitutional issues involved the First Amendment. With medical screening, the constitutional issues are likely to be related to search and seizure, invasion of privacy, equal protection, and other doctrines. It is not clear whether the courts will be willing to extend these other constitutional principles to the private sector via the public policy exception.

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**125 Wis.2d 520, 373 N.W.2d 74 (Ct. App. 1985).**

**461 U.S. 138 (1983).**
B. The Limited Rights of Applicants

At common law, an employer had virtually unfettered control in selecting its employees. The employer could hire or refuse to hire any person for any reason or no reason at all. This right included the right to refuse to hire an individual because of the employer’s opinion that the prospective employee was physically incapable of performing the job. In determining the medical condition of applicants, employers were free to make submission to medical examinations and tests a valid condition of employment. An applicant could refuse the test, but the employer would then simply not hire the individual.

With few exceptions, this is still the law today. Referring to the drug testing of applicants and employees, one management lawyer recently stated: “In the nonpublic sector, employers have the right to do whatever they damn please—and they are going to do it.”

Even the enactment of an occasional statute has not had much effect on medical screening practices. Maryland enacted a law in 1976 prohibiting employers from requiring applicants to answer any questions about medical conditions which do not bear a direct relationship to the applicant’s fitness to perform the specific job under consideration. Nevertheless, the law “does not prohibit a proper medical evaluation by a physician for the purpose of assessing an applicant’s ability to perform a job.” Thus, company physicians may still require detailed medical examinations as a condition of employment.

Traditional labor and employment laws are unlikely to be of much benefit to applicants, either. The National Labor Relations Act (NLRA), Title VII of the Civil Rights Act of 1964, the Age Discrimination in Employment Act, and the Rehabilitation Act of 1973 all apply to applicants. As a practical matter, however, applicants have fewer rights than employees. For example, appli-

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101 Md. Annot. Code art. 100, sec. 95A(a) (Michie 1985).
102 Id. at sec. 95A(b).
cants are considered "employees" under the NLRA and the terms of their hiring are subject to collective bargaining.\textsuperscript{102} Yet, unions rarely bargain over applicant rights because applicants are not yet members of the bargaining unit and they are often not yet union members. Consequently, unions use their limited economic leverage to secure favorable conditions for current employees.

Applicants are also less likely to sue under any statute or legal theory than are current employees. For one thing, both the applicants and the courts tend to view their loss in not being hired to be less substantial than the denial of benefits or termination of an employee with years of service.\textsuperscript{103} In addition, unlike most employees who are discharged, most applicants who are not hired are never informed of the company's reasons. Without knowing the reason in advance, an applicant is unlikely to initiate a lawsuit and the discovery process during which this information may be obtained.

The limited rights of applicants can be seen in preemployment medical screening. As noted earlier, applicants are often required to complete detailed medical questionnaires and to undergo medical examination and laboratory tests. If the applicant refuses to cooperate he or she is unlikely to be hired. Applicants will be asked to consent to invasive procedures, such as blood tests, but the applicants are rarely told what tests will be run or what the results of the tests are. Applicants usually are not told why they are not hired or given the chance to explain a questionable medical finding. Although, in theory, similar measures may be used with current employees, most employers realize that such insensitivity—at least as to current employees—is counterproductive.

C. The Narrow Scope of the Exceptions to the At-Will Rule

During the last fifteen years almost every jurisdiction has recognized one or more exceptions to the at-will rule. Some highly publicized cases, including some large recoveries, and a flood of law review articles, conferences, and debates have contributed to the impression that the at-will rule has undergone a major transformation.\textsuperscript{104} Although these developments are certainly significant, the

\textsuperscript{102} Phelps Dodge Corp. v. Labor Board, 313 U.S. 177 (1941); NLRB v. Mount Desert Island Hosp., 695 F.2d 634, 638 (1st Cir. 1982).

\textsuperscript{103} See, for example, Pugh v. See's Candies, Inc., 116 Cal. App.3d 311, 329, 171 Cal. Rptr. 917 (1981) (long-term employees may develop contractual rights to retain their jobs absent just cause for their discharge).

\textsuperscript{104} See, for example, William L. Mauk, Wrongful Discharge: The Erosion of 100 Years
changes have been more evolutionary than revolutionary.

Three main exceptions have been recognized. First, provisions in employee handbooks and manuals have been held to create implied contract rights in favor of the employees. Many handbooks and manuals contained statements that employees would not be fired without just cause. After several cases bound employers to these promises, many employers purged their handbooks and manuals of all language that could be construed as a promise of job security.

Second, most jurisdictions have recognized the tort of wrongful discharge in violation of public policy. The availability of large awards for compensatory and punitive damages has focused attention on these tort actions, but public policy is not open-ended. The suit generally must be based on a clearly expressed policy, such as that embodied in a state statute, and is usually restricted to four main categories: Refusing to commit unlawful acts (e.g., perjury, falsification of public records); exercising statutory rights (e.g., filing a workers' compensation claim); performing public functions (e.g., serving on jury duty); and reporting an employer's unlawful conduct (e.g., whistleblowing).

Third, a few jurisdictions have held that every employment contract contains an implied covenant of good faith and fair dealing, breach of which is actionable in contract or even tort. Although this exception represents the application to employment law of a traditional contract doctrine, it has been adopted by only a few courts. Moreover, its use in specific cases is often difficult. Good faith is subjective and therefore the absence of good faith may be difficult to prove except in the most compelling factual situations.

Employee challenges to employer medical screening practices

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brought under common law theories are rare and not often successful. The at-will exceptions only apply to discharges and even in discharge cases the use of medical criteria to determine termination, even if ill-advised, is rarely considered wrongful. For example, in \textit{Bruffett v. Warner Communications, Inc.}, the employer discharged a diabetic employee on the basis of a negative medical report. Although the employer's conduct arguably violated Pennsylvania's Human Relations Act, the court refused to permit a common law action for wrongful discharge.

D. The Limited Economic Power of Unions

Drug testing of applicants and employees is the most controversial of the current medical screening practices. It is interesting to note the response of organized labor to this phenomenon. Most unions have concluded that under some circumstances, such as in certain safety-sensitive jobs, limited drug testing is acceptable. Where drug testing is viewed as unacceptable, however, unions have not responded with strikes and aggressive collective bargaining; they have responded with litigation and lobbying for legislation.

In fairness, some of the unions affected by drug testing represent public employees who are prohibited from striking. Nevertheless, many of the recent gains in working conditions realized by workers have been achieved through the political process rather than by the use of economic power. OSHA, ERISA, and various antidiscrimination laws have been enacted in large measure because of union support. It is an open question, however, whether the legislation will undermine unionization in the long run. With more employment rights, such as pensions and safety, protected by these laws there may be less need for unions. Thus, unions, already declining in members, may be further contributing to their own demise. What would be the effect on union organizing if health insurance benefits were statutorily mandated and discharge without

\textsuperscript{111} 692 F.2d 910 (3d Cir. 1982).
\textsuperscript{113} As a federal court in a diversity case, the Third Circuit was reluctant to expand Pennsylvania law. \textit{Bruffett}, 692 F.2d at 918.
\textsuperscript{114} See James Ellenberger, AFL-CIO Urges Privacy Protection Treatment in Drug Abuse Testing, \textit{Bus. & Health} 58 (Oct. 1987).}
just cause was illegal and redressable through the courts or some administrative body?

E. The Growing Importance of State and Local Laws

The cities and states have replaced the federal government in the forefront of legislative protection of employees. This is certainly true in the area of medical screening. Four states ban genetic testing, ten states restrict AIDS tests, nine states limit drug tests and twenty three states prohibit polygraphs. It is true in other areas as well. While Congress has refused to act, some cities and states have, for example, prohibited marital status and sexual orientation discrimination, regulated smoking in the workplace, and extended collective bargaining rights to farmworkers.

The decentralization of employment law raises various legal issues, foremost of which is preemption. In some instances the state law will be in direct conflict with a federal law or regulation. For example, in French v. Pan American Express Inc., an airline pi-

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lot was fired after he refused to take a drug test following a tip that the pilot was seen smoking marijuana while off duty. The pilot brought an action in state court under Rhode Island’s 1987 drug testing law, which prohibits drug testing unless there is reasonable cause to believe the employee’s performance is impaired. The case was removed to federal court. The district court will have to decide whether Federal Aviation Administration regulations, which mandate drug testing, preempt the Rhode Island statute.

In other instances the federal and state policies will be in agreement, but the preemption issue will center on what is the proper forum. For example, in the last several years, state and local prosecutors have begun to bring criminal prosecutions for criminal negligence, manslaughter, and even murder against various company officials after especially egregious workplace safety and health hazards caused injury or death to workers. Much of this activity is the result of a perceived laxity in federal OSHA enforcement. The courts have reached divergent results on the issue of whether a state criminal prosecution based on conditions in the workplace is preempted by the federal Occupational Safety and Health Act.

With a strong likelihood of new state laws regulating medical screening, preemption is merely one of the potential legal issues. Other problems that may arise include the res judicata or collateral estoppel effect of a prior adjudication in another forum; exhaustion of remedies, and questions of statutory construction, such as whether an employee may be discharged in state A on the basis of a medical test performed in state B that is only illegal in state A.

V. CONCLUSION

Medical screening is more extensive and intensive than at any time in the past. Scientific advances, increased health care costs, and other factors also point to an increase in medical screening. This growth is not an altogether positive development. While medical screening may serve as a mechanism for illness detection, lifestyle modification, and proper job assignment, it has several drawbacks. Many tests commonly used are not as accurate as widely believed; the tests sometimes invade worker privacy and generate records that may be wrongfully disclosed, and numerous currently

healthy workers are rendered unemployable because of future risk of illness.

Employment laws related to medical screening have fostered inconsistent policies. Some laws, including workers' compensation and ERISA, encourage preemployment medical screening. Other specific statutes (e.g., AIDS testing) and handicap discrimination laws prohibit some forms of medical screening. This piecemeal legislative approach, however, dealing with working conditions, benefits, and discrimination separately, is unlikely to be effective in formulating medical screening policy. Such an approach is especially doubtful if it does not deal with the issue of the employer's role in health insurance. The combination of new technology and health care cost containment pressures may give rise to heretofore unimaginable levels of workplace medical screening. The magnitude of the consequences of this widespread screening to employment relations, health insurance, health care, the welfare system, the economy, and civil rights demands that the issues of medical screening be moved to the forefront of public debate.

Medical screening also provides a graphic illustration of the intricacies and shortcomings of modern employment law. From a laissez faire background, legislatures and courts have carved out a series of undecipherable, inconsistent, and compartmentalized limitations on employer prerogatives. Certainly, as applied to medical screening, the various laws are often operating at cross-purposes and seemingly treat like employees quite differently based on dubious criteria. The resulting morass raises fundamental questions about the efficiency and fairness of our system of employment laws.