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STRATEGIC PERSPECTIVES: Ebola: Legal Implications for the Press, Health Care Workers, Providers, Patients, Employers, and Employees

By Lisa A. Weder

Dr. Kent Brantly; Thomas Eric Duncan; Nina Pham; Amber Vinson; Kaci Hickox; Ashoka Mukpo; Dr. Craig Spencer; and Dr. Martin Salia—these are just some of the names infamously affiliated with the 2014 outbreak of Ebola virus disease (EVD), or Ebola; the worst since [1976](#). How do we know these names? The U.S. media informed us. As there could likely be more Americans' names that will follow this list, questions surrounding patient privacy rights under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) ([P.L. 104-191](#)) and their reconciliation with journalistic reporting arise. Why was the media able to disclose these victims' names; show their residences; report on the manner in which they contracted the virus, or in some cases, report the names of individuals who were only suspected of having the virus; the identity of their personal contacts; and which hospitals treated them? Further, why did hospitals disclose the afflicted individuals' identities through the media? What are health care and labor attorneys' views of these types of situations and of states' and patients' rights in the face of a deadly virus that has an average case [fatality rate](#) of approximately 50 percent?

This strategic perspective explores the rights to privacy for individuals under HIPAA versus the rights of journalists to report about these individuals as well as explores the rights of health workers relating to Ebola, from the perspective of health and labor law experts.

What is Ebola?

The World Health Organization (WHO) describes the [virus](#) as one that:

- is transmitted to people from wild animals and spreads in the human population through human-to-human contact with bodily fluids and has flu-like symptoms that may progress to internal and external bleeding and possible death;
- is not infectious until symptoms are developed (there is a 2- to 21-day incubation period); and
- once contracted, makes humans infectious as long as their blood and bodily fluids, including breast milk, contain the virus.

There is no current cure for Ebola, although two potential vaccine candidates are under evaluation as of November 2014.

HIPAA

HIPAA encompasses several health-related improvement initiatives, such as health care coverage fluidity and the elimination of health insurance and health care fraud and abuse. Health care fraud and abuse violators are subject to the subpoena provisions of the Patient Protection and Affordable Care Act (ACA) ([P.L. 111-148](#)) under section 10606(d)(1), (3)(a), and (3)(c). HIPAA also required HHS to develop national standards for the use and dissemination of health care information, known as the Privacy Rule.

The HIPAA Privacy Rule generally restricts a [covered entity](#), such as health insurance companies, company health plans, health care providers, and their business associates (billing or claims contractors, attorneys, information technology (IT) personnel), from disclosing protected patient health information. Under [45 C.F.R. sec. 164.502\(a\)](#), protected health information (PHI) is any individually identifiable health information held or transmitted by a covered entity regardless of the form of the information. More specifically, according to [45 C.F.R. sec. 160.103](#), individually identifiable health information relates to the health condition of a specific individual or provision of health care services to a specific individual, whose identity can be ascertained through the information; however, as this article will explain, there are certain circumstantial exclusions from protected health information rules.

HIPAA protection under emergency situations. In November 2014, HHS released a [bulletin](#) on HIPAA protections under emergency situations, like the 2014 Ebola crisis. Regarding patient information shared without patient authorization, the following rules apply:

- covered entities may disclose, without a patient’s authorization, PHI about the patient as necessary to treat the patient or to treat a different patient;
- covered entities may share information with public health authorities and others responsible for ensuring public health and safety, such as the Centers for Disease Control and Prevention (CDC), Substance Abuse and Mental Health Services Administration (SAMHSA), or the Food and Drug Administration (FDA), or to a foreign government agency on an ongoing basis; and
- covered entities may share health information to other persons at risk of contracting or spreading a disease or to carry out public investigations. (Persons at risk may include family members, relatives, legal guardians, or friends, and may include the police, the press, or disaster relief organizations.)

As a caveat, HHS stipulates that when possible, covered entities should get verbal permission from affected patients or “otherwise be able to reasonably infer that the patient does not object to the use of his personal health information.” Guidance for disclosures to media was also provided. A hospital or other health care facility may release limited facility directory information to acknowledge that a patient is being cared for at the facility as well as the patient’s condition in general terms, such as “critical,” “stable,” “deceased,” or “treated and released” as long as the patient has not objected to or restricted the release of such information. (For other legal insight on HIPAA and Ebola, see “[Health attorneys tweet on privacy and Ebola](#),” November 6, 2014.)

Ebola and News Coverage

There have been more cases and deaths in the 2014 outbreak than all others combined. It began in the West African nation of Guinea and spread across other West African borders including Sierra Leone, Liberia, Nigeria, and Senegal *via* land and air travel. On August 8, 2014, the World Health Organization (WHO) Director-General declared the 2014 outbreak a “Public Health Emergency of International Concern.”

Recent events and consequences. The first U.S. incidence of Ebola began with a West African patient by the name of Thomas Eric Duncan who visited family in the United States near the end of September 2014. The CDC’s October 2, 2014, [guidelines](#) alert came days after Duncan died from the virus at a hospital in Dallas, Texas. Although many health care workers and his family members who had contact with him were exposed to the virus, only two nurses who had close contact with him contracted Ebola. Once word got out, news outlets exploded with the news that Nina Pham and

Amber Vinson tested positive for Ebola and were quarantined. Their pictures were inescapable as were the details of their condition. Part of the CDC guidelines advised immediate notification to local and state health departments, but nothing in the guidelines advised that the media should be notified. How, then, under HIPAA, was it that the hospital at which the two nurses were quarantined held a news conference to tell the world the nurses' names and detailed circumstances and conditions?

Journalism Code of Ethics. The [Journalism Code of Ethics](#) from the Society of Professional Journalists reads in part, "Recognize that private people have a greater right to control information about themselves than do public officials and others who seek power, influence or attention. Only an overriding public need can justify intrusion into anyone's privacy." How does this statement reconcile itself with the current reporting of U.S. Ebola cases and HIPAA?

As stated previously, one goal of this strategic perspective is to explore individuals' rights to privacy under HIPAA versus the rights of journalists to report about those individuals through the eyes of health and labor law experts. To better understand what the implications HIPAA provisions have on reporting the personal information of the individuals who contracted Ebola, Wolters Kluwer posed several questions to health and labor law experts.

What is your opinion on institutions talking to the media about Ebola cases, in light of HIPAA? Do you think that public safety and the right to know trump such concerns?

[Michael Clark](#), special counsel with the Houston law firm [Duane Morris LLP](#) and chair of the American Bar Association's Section of Health Law, explained that "HIPAA generally requires covered entities and business associates who work with them to respect the privacy of an individual's choices regarding PHI, which would include information about their identity. The public's right to be protected doesn't broadly require identifying individuals who *may* have been exposed or who *may* be infected. Rather, HIPAA includes provisions, as noted, which allow covered entities and business associates to share such information with the CDC. The CDC explains this point on its [website](#):

What about sharing [PHI] with public health authorities?

The Privacy Rule allows for the existing practice of sharing PHI with public health authorities that are authorized by law to collect or receive such information to aid them in their mission of protecting the health of the public.

This practice is described in the preamble to the actual Rule:

'The final rule continues to permit covered entities to disclose protected health information without individual authorization directly to public health authorities, such as the Food and Drug Administration, the Occupational Safety and Health Administration, the Centers for Disease Control and Prevention as well as state and local public health departments, for public health purposes as specified in the NPRM [Notice of Proposed Rulemaking for the Privacy Rule]' ([65 FR 82526](#)).

(See [45 C.F.R. sec. 164.512\(b\)\(1\)\(i\)](#): 'Uses and disclosures for which an authorization or opportunity to agree or object is not required') (noting that HIPAA allows covered entities to disclose PHI to a public health authority authorized by law to collect or receive such information for preventing or controlling disease, injury, or disability, including, the reporting of disease, public health surveillance, public health investigations, and public health interventions)."

[Patricia Wagner](#), member of [Epstein Becker Green](#) in the Health Care and Life Sciences and Litigation practices, in the firm's Washington, D.C., office, stated, "if an Ebola patient provides an authorization for the institution to talk to the media about that patient's case, HIPAA would allow such discussions. So, sometimes discussions with the media can

take place pursuant to those authorizations.” Wagner used the example where a patient was treated in Atlanta, for whom no information was released, other than the fact that the patient was being treated. Wagner added, “in addition, health care institutions can disclose PHI if they have a good faith belief that the disclosure is ‘necessary to prevent or lessen a serious and imminent threat to the health or safety of a person,’ provided that the disclosure is to ‘persons reasonably able to prevent or lessen the threat.’ It is understandable that in some situations, the use of the media may be the most expeditious method for alerting individuals who might have been exposed.”

Additionally, [Donna Fraiche](#), a shareholder at [Baker Donelson](#), noted that “institutions may not divulge the identity of any patient or any personal health information [without express written consent]. Guidance from CDC suggests, however, patient or family members authorized to do so, may divulge whatever they wish subject to other protections at law, such as defamation or libel. A hospital has a statutory duty to protect the privacy rights of its patients despite the nature or type of disease. Only minimally necessary information for health care needs can be accessed and transmitted—and only on a ‘need-to-know’ basis; however, without written consent, certain public health information can be released to *public health* authorities ‘legally authorized to collect and receive this information’ [[42 C.F.R. sec. 164.501](#)]. State or local governmental authorities may also address disclosure exceptions. Those disclosures that are ‘authorized by law’ under the public health exception to public health agencies are broadly interpreted.”

Fraiche added that the balance between legitimate public purpose disclosure and nondisclosure is founded in the public health concern of why and how this information is to be used.

In what ways does the Journalism Code of Ethics require journalists to comply with the HIPAA privacy standards?

According to Michael Clark, “these standards reflect the need to balance the rights of individuals against the right of the public to be informed. In considering the public’s right to be informed about dangerous communicable diseases, such as Ebola, it seems clear that journalists should try to become as informed as possible, under the time constraints presented, about the applicable underlying scientific knowledge. Here, there’s been considerable misinformation carelessly spread about the disease that has not served the public or the journalism profession well.”

Clark explained that with regard to individuals and respecting their privacy rights, “HIPAA is designed to generally limit the flow of PHI unless there are key reasons for not doing so, such as reporting about the spread of infectious diseases to epidemiologists with the [CDC]. Unless an individual freely and intelligently waives his or her rights to keep such private information private, as a general rule that person’s right to privacy should be protected.”

Patricia Wagner maintained that “HIPAA is a framework that addresses, among other things, the ways in which covered entities must keep patient information confidential. While it is possible that the public in general, including the media, might use HIPAA as a benchmark there would be no independent requirement under the HIPAA privacy standards for those individuals to comply with the HIPAA privacy standards.”

Donna Fraiche stressed that “the media is not a ‘covered person’ under HIPAA and is not bound by the same privacy standards. It should [also] be noted that most patients are not ‘public figures’ and, therefore, the verification of information is at a higher standard than that for a so-called ‘public figure.’ Yet, the media may have a great deal of difficulty verifying PHI that cannot be sourced through a covered entity like a hospital or its staff. The staff cannot give the media PHI.”

Fraiche further explained that “when a patient is admitted to a hospital, assuming they are cognizant and capable, they sign a notice of HIPAA policies and can opt out of privacy protections. When the patient elects that ‘no information can be shared about the patient with the general public who may call or ask about the patient ...,’ [the] prohibition extends to the verification that the patient is a patient. The exceptions include information to accomplish a public health objective, authorized public authorities, and certain enforcement agencies. Although journalists are not covered entities

under HIPAA, how they obtain PHI and from whom is an issue. A journalist should not procure or receive PHI on an unauthorized basis from a covered entity.”

Journalists and news agencies may have violated HIPAA standards—how would this most likely be legally handled?

“Certainly, covered entities and business associates who have violated HIPAA by sharing PHI with journalists and news agencies may be subject to regulatory actions by the [OCR] within [HHS], which is tasked with overseeing compliance with HIPAA,” Michael Clark explained. “But the liability of journalists and news agencies isn’t quite so clear when it comes to liability for HIPAA violations in this context because they aren’t expressly named in the rule. (See, *e.g.*, [‘HIPAA & newsgathering.’](#))” Clark added the caveat that private tort actions may be pursued against such individuals and news agencies for privacy invasion; but “the First Amendment considerations certainly weigh in on such theories of liability.”

Patricia Wagner noted that “journalists and new agencies are not subject to the HIPAA privacy standards. The HIPAA privacy standards are a regulatory scheme that is limited to certain portions of the health care industry. Specifically, the HIPAA privacy standards regulate covered entities and vendors that are providing services for those covered entities.”

Health Care Giver Rights in the Face of Public Health Emergencies—When the Health Care Provider Becomes the Patient

It is often said that doctors make the worst patients. The health care givers in the 2014 Ebola cases are certainly no exception. Amber Vinson, one of the Texas nurses in the Duncan case, knew she had a fever before boarding a plane between Cleveland, Ohio, and Dallas, Texas. Because her fever fell below the CDC’s original guideline temperature, she was given permission to fly; however, having first-hand exposure to the Ebola patient and then producing a fever should have provided clues that she may be infected with the virus. The New York case involving Dr. Craig Spencer drew public scorn because the 33-year-old had gone out in public with his friends and fiancée after returning from West Africa. Since then, several states, including New York and Illinois, have mandated that medical staff returning from West Africa must submit to 21-day quarantines and monitoring. With the Ebola outbreak, legal questions concerning health care givers’ rights to refuse care to Ebola patients or refuse to be quarantined abound. The exploration of these questions and the legal experts’ opinions on the topic of health workers’ rights are the second goal of this strategic perspective.

States’ versus health care givers’ rights. One of the most notable legal issues thus far stemmed from the case of Kaci Hickox, a nurse who refused to be quarantined despite detection of a slight fever upon her return to the United States from treating Ebola patients in Sierra Leone in October 2014. After her release from the Newark, New Jersey, airport, Hickox had tested negative for the virus. She was eventually allowed to go to her home in Maine, but Maine officials ordered her to stay confined within it until November 10. She defied the order by going out for a bike ride, noting that she did not have Ebola symptoms and that science showed there was no reason for her to be quarantined.

A Maine District Court Chief [Judge](#) rejected the state’s request to prohibit Hickox from being in public places or using public transportation because the state did not prove its argument that such restrictions were needed to protect the public’s health. Thus, on October 31, 2014, the judge eased the state-imposed restrictions on her with the requirement that she self-monitor for symptoms of the virus on a daily basis. As of November 11, 2014, Hickox’s monitoring period ended without her contracting the disease. She will be forever tied to Ebola, however, because the U.S. media reported on someone who may have had the disease rather than on someone who had contracted the disease.

Other sources have weighed in the Hickox case, including [Michael Clark](#), who said that Maine has the right to impose quarantine for any infected person who poses a threat to the state’s citizens. Clark said, “The Commerce Clause of the U.S. Constitution gives the federal government the power to isolate and quarantine. The state police powers are similar. They have the right to protect the citizens of their state for the benefit of society.”

U.S. Ambassador to the United Nations [Samantha Power](#) in late October 2014 defended federal guidelines for monitoring health care workers returning from Africa's three Ebola-stricken countries.

Sources at [the Hill](#) wrote that as of October 26, 2014, the federal government was trying to get New York and New Jersey to revoke imposed quarantines on returning health workers; however, Governors Chris Christie (New Jersey) and Andrew Cuomo (New York) both [defended the quarantines](#) in their respective states. Christie said, "I don't believe when you're dealing with something as serious as this that you can count on a voluntary system" in which people may or may not comply.

In November 2014, 18,000 Californian nurses working for Kaiser Permanente (Kaiser) held a [two-day strike](#) against underdeveloped health care standards for Ebola. The nurses reported that the hospital refused to address Ebola safety protocols and protective equipment training, and also refused to answer questions by the RNs. The strike against Kaiser reportedly impacted 21 hospitals and 35 clinics.

These actions and the Hickox case bring to light the role of health care workers' rights in the face of a public health emergency and signal that there could be more actions to come.

What are health care givers' rights to refuse care to Ebola patients? What health-related lawsuits have arisen from this refusal?

Michael Clark explained that refusing care to patients "depends on the facts and circumstances presented. For instance, under the Emergency Treatment and Active Labor Act (EMTALA) ([42 U.S. Code § 1395dd](#)), *if* such a patient presents himself or herself to a hospital that has an emergency department, and a request is made to examine or treat that patient's medical condition, then the hospital is mandated to provide an appropriate medical screening examination within its capability to determine if an emergency medical condition exists. If it does, the hospital must stabilize or transfer the patient without regard to his or her ability to pay for the services. Violations of EMTALA by a participating hospital that negligently violates a requirement of this section is subject to a civil money penalty of no more than \$50,000 (or \$25,000 for a hospital with less than 100 beds) for each violation. Individual physicians who are responsible for the examination, treatment, or transfer of an individual in a participating hospital, including a physician on-call for the care of such an individual, and who negligently violate EMTALA are subject to civil money penalties of no more than \$50,000 for each violation, and gross, flagrant, or repeated violations may subject them to being excluded from participation."

There are possible malpractice theories available, but Clark is not aware of any malpractice suits that have been filed by Ebola patients.

[Frank Morris](#), member of Epstein Becker Green in the Litigation and Employee Benefits practices, head of the Labor and Employment practice in the Washington, D.C., office and co-chair of the firm's American with Disabilities Act (ADA) and Public Accommodations Group, stressed that "health care providers should be very careful before refusing to provide care to Ebola patients. Health care providers generally are considered public accommodations under Title III of the [ADA](#). Such public accommodations have the duty to provide the full range of their goods and services to an individual with the disability. As Ebola is likely a disability, a refusal to treat a patient with Ebola is likely a violation of the ADA. Hospitals also generally are covered under [section 504](#) of the Rehabilitation Act of 1973 (Rehab Act) because they receive federal financial assistance by virtue of Medicare and Medicaid. The Rehab Act also prohibits discrimination with the disability and thus refusing treatment of Ebola would be problematic under the Rehab Act. Health care providers who refuse to provide treatment [due to] the lack of necessary equipment or training might have a successful defense [as] of [sic] hospitals, in particular, may be expected to have the necessary personal protected equipment (PPE) and trained staff with regard to protocols from the CDC for handling Ebola."

Patricia Wagner reiterated that “EMTALA was enacted to ensure access to emergency services. Under this statutory requirement, hospitals that participate in the Medicare program (most hospitals) that offer emergency services must provide medical screening for emergency medical conditions. Therefore, the first question will be whether treatment of an Ebola patient constitutes an ‘emergency medical condition.’ Assuming that the answer to that question is yes, the hospital is required to provide stabilizing treatment for those patients. Appendix V of the *Medicare State Operations Manual* describes the responsibilities of Medicare participating hospitals in ‘emergency cases’ and states the following: ‘The enforcement of EMTALA is a complaint driven process. The investigation of a hospital’s policies/procedures and processes and any subsequent sanctions are initiated by a complaint.’ If an investigation determines that the hospital violated the provisions of EMTALA ‘a hospital may be subject to termination of its provider agreement [with the Medicare program] and/or the imposition of civil monetary penalties (CMPs). CMPs may be imposed against hospitals or individual physicians for EMTALA violations.”

On the other hand, [David Gevertz](#), Vice Chair of Baker Donelson's Labor & Employment Group, pointed out that the Occupational Safety and Health Administration (OSHA) “offers limited protections to employees who refuse to perform a job if they believe in good faith that they are exposed to an imminent danger. The level of exposure necessary to qualify as an ‘imminent danger’ has not yet been defined. Similarly, the National Labor Relations Act ([NLRA](#)) allows unionized employees to stop work where they act in good faith to protect their health because of the existence of an ‘abnormally dangerous condition.’ While this phrase also has not been defined, it is likely that the National Labor Relations Board would protect a reasonably grounded refusal to work as a protected activity, thus shielding the employee from disciplinary action.”

What law issues could arise from health care employees or anyone in contact with Ebola-infected individuals refusing to be quarantined?

“This scenario was to some extent raised by the incident involving Kaci Hickox in Maine,” Michael Clark noted. “The federal government has enacted statutes to address its right to protect the public from health threats involving communicable diseases, including hemorrhagic fevers (such as Ebola), which includes the right to quarantine. See generally, CDC ‘[Legal Authorities for Isolation and Quarantine](#)’ (noting, *inter alia*, that ‘[u]nder section 361 of the Public Health Service Act ([42 U.S. Code sec. 264](#)), the U.S. Secretary of Health and Human Services is authorized to take measures to prevent the entry and spread of communicable diseases from foreign countries into the United States and between states,’ and this ‘authority for carrying out these functions on a daily basis has been delegated to the [CDC]’). States have similar measures to take such actions under their police powers as reserved to them by the Tenth Amendment to the U.S. Constitution.”

Gevertz noted that the answer to this question depends on “the state and the circumstances. In response to state directives that could be issued to forcibly quarantine the employee, an employee might be able to successfully argue that she was being discriminated against or harassed on account of a nonexistent but perceived disability under the ADA or similar state statute. Institutions can minimize such liability by paying the employee to remain out on leave and otherwise ensuring that he or she was not subject to inappropriate employment-related inquiries, the unauthorized dissemination of health-related information, inappropriate medical inquiries, and/or hostility both during and after a mandatory leave of absence.”

Potential Lawsuits

Thomas Eric Duncan’s (first U.S. Ebola patient) family members entered a [settlement](#) with Texas Health Presbyterian Hospital Dallas on November 12, 2014, for an undisclosed amount, after Duncan’s nephew initially sought answers into why the hospital discharged Duncan with little more than aspirin and antibiotics. Josephus Weeks claimed racism and

malpractice stating that the hospital prematurely released his uncle because of his color, lack of insurance, and lack of means to pay. If an agreement had not been made, the hospital's parent company, Texas Health Resources, would have faced continuing patient declines and bad press, and the family would have had a challenging legal fight ahead. This settlement begets the question of other legal action to come.

What other Ebola-related law suits do you foresee?

Michael Clark stated that “the difficulty is presented when health care workers who may have been exposed aren't presenting symptoms of an active infection. Judges will likely err on the side of the public's safety, hopefully informed by scientific evidence, when balanced against an individual's liberty interests—but [they] probably will seek a less draconian solution than outright, forced quarantining of the individual so long as there are sufficient protective measures put in place. Theoretically, involuntarily quarantined individuals could sue for civil rights violations under [42]18 [sic] U.S.C. [sec. 1983](#) or perhaps bring a *habeas corpus* action for being illegally detained. There may be some other tort-based causes of action as well, but the likely outcome would be that qualified immunity would protect state actors who were acting in good faith.”

Employee lawsuits. Frank Morris provided details of employers' exposure to a “variety of potential Ebola-related lawsuits involving negligent retention, the ADA, the [Family and Medical Leave Act](#) of 1993 (FMLA), employee compensation, the National Labor Relations Act ([NLRA](#)), and the Occupational Safety and Health Act of 1970 (OSHA) ([P.L. 91-596](#)). If an employer knew or should have known that an employee had Ebola or had been exposed to Ebola or was exhibiting symptoms and did not promptly act to limit contact with that employee by other employees, customers clients or patients, a claim for negligent retention might arise if a customer or co-employee were to become infected through the contact with the employee who was permitted to continue working and interacting with others,” Morris explained.

Morris provided examples of various claims that could arise under the ADA. He explained, “if an employer takes an adverse employment action against an individual who it mistakenly believes has Ebola or has been exposed to Ebola, that employee may have a ‘regarded as’ ADA claim. Another potential ADA claim [arises] if an employer fails to keep an individual's medical information confidential. In addition, while the employer may have the right to exclude from the workplace an employee who has Ebola symptoms or who has been exposed to Ebola under the ADA's direct threat or job related and consistent with business necessary defenses, employers should act only on facts and the best current medical information rather than irrational fears to avoid exposure to suits.”

In addition, Morris noted potential legal issues under the FMLA, using the example that “if employees want to travel to one of the affected West African countries identified by CDC as having substantial Ebola activity, and the purpose for their travel is to care for a sick family member, a refusal to afford such leave could violate the FMLA as long as the employee was eligible for FMLA leave. In addition, a refusal to reinstate an employee returning from caring for a family member in West Africa also might violate FMLA, although it may be defensible to delay reinstatement until the 21-day potential incubation period has run.”

According to Morris, employee compensation also might present various legal issues. For example, Morris wrote, “if an employer believes that an employee was exposed to Ebola and directs the employee not to physically report to work, various potential issues regarding compensation while the employee is not physically at work [arise]. If an employee is teleworking, he or she clearly would be entitled to be paid for his or her services; [however, if] the employee is not performing any services, there would be issues regarding use of any available paid leave time such as sick leave, vacation, and short-term disability. To avoid litigation, employers need to ensure that they provide all available paid leave to any employee held out of work because of Ebola concerns.”

“If employees have a fear of encountering Ebola in the work place and act in a concerted way by refusing to perform their duties, [such as] the New York [airport workers](#) who clean planes and refused to clean a plane used by a person who had Ebola symptoms, an employer could violate the [NLRA](#) if it took disciplinary actions against such employees,” Morris explained. “The employer is allowed to fill its obligations to its customers and clients and thus, could lawfully employ replacements for employees who refuse to work. The key point is that the employer could be exposed to a claim if it disciplines employees who engage in ‘protected concerted’ activity under section 7 of the NLRA.”

Finally, Morris said, “there is a potential for legal claims against employers under [OSHA]. An employer has a duty under OSHA to maintain a safe workplace. Under the OSHA general duty clause, this means an employer, especially a health care employer, that did not properly train its employees in the CDC infection control protocols for Ebola and/or didn’t provide appropriate personal protected equipment (PPE) could be in violation of OSHA. Further, OSHA affords employees who have a reasonable belief as to an imminent threat to their health and safety, a right to refuse to perform assigned duties that pose such a risk. Again, disciplinary actions against employees in such circumstances would be unlawful.”

Conclusion

Detailed media coverage of Kaci Hickox’s refusal to be quarantined, Amber Vinson’s defiance of better judgment, and Dr. Spencer’s New York visits may have helped to generate the public’s ensuing scorn, [paranoia](#), and negative stigma expressed toward them and to many of the aid workers traveling to Liberia, Sierra Leone, and Guinea to combat the Ebola outbreak. Coverage of people thought to pose a threat and the resulting state-imposed quarantines will no doubt impact health care workers’ inclination to provide sorely needed care in Africa. As the contributing attorneys attest, the Ebola crisis does not just center around HIPAA issues, there may be a myriad of employment, compensation, personal liability, character defamation, and civil rights suits brought about by the 2014 Ebola outbreak.

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