Coates' Canons Blog: Blood Exposures and Disease Control Law

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UPDATE September 28, 2016: An updated version of this post has been published and is availablehere.

Some of the most interesting questions I get are about exposure to human blood. My work in this area predates the current craze for vampire literature–it's a long-standing public health issue that arises out of fact scenarios that are sometimes pretty gross but always interesting. I've heard tales of a jail inmate who bit off part of another inmate's ear, a school child who found a discarded syringe and then stuck several other children with the (presumably used) needle, and a fast food worker who bled on food that others ingested. More common are the stories of biting or other blood-drawing altercations, or exposures that occur at accident scenes. What all of these stories have in common is that they may result in someone being exposed to a bloodborne pathogen–a disease that is spread by exposure to blood, such as HIV or hepatitis B.

When an employee in a health care facility or certain other work settings is exposed to blood or body fluids, the incident should be managed according to bloodborne pathogen policies that are required by **occupational safety and health regulations**. But when an exposure occurs in the community, or between persons who aren't covered by occupational policies–such as those schoolchildren I mentioned–the procedures for managing the incident come from **North Carolina's communicable disease control rules**.

The route to resolving community-based exposure incidents invariably runs through the local health department. The NC rules put the duty for initiating response to a bloodborne pathogen incident on the exposed person's attending physician or occupational health provider. But when an exposure occurs in the community, health care providers may not be involved. In those cases, notifying the director of the local health department is usually the most efficient way to get the process underway. The rest of this post is a brief primer, in question & answer format, on the NC bloodborne pathogen exposure rules.

What is a bloodborne pathogen exposure incident?

A bloodborne pathogen exposure incident occurs when a person experiences:

- A needlestick, or
- A nonsexual contact in which:
    - The blood or body fluids of one person (the "source person") come into contact with the nonintact skin or mucous membrane of another person (the "exposed person"), *and*
    - The contact is of a nature that would pose a significant risk of transmission of HIV or hepatitis B, if the source person were infected with those viruses.

When do the bloodborne pathogen rules apply?

When there is a contact that constitutes an exposure incident, as described above. They always apply to needlesticks. Otherwise, they apply only if the contact between the source person's blood or body fluids and the exposed person's broken skin or mucous membranes is (1) nonsexual, and (2) is a kind of contact that creates a significant risk of transmission of HIV or hepatitis B.

What constitutes a significant risk of transmission?

This is determined on a case-by-case basis. In deciding whether a particular exposure incident created a significant risk of transmission, public health officials will consider factors such as the type of body fluid involved in the exposure, and will

take into account current scientific knowledge on disease transmission risk.

Do you have to know or suspect that the source person has HIV or hepatitis B for the bloodborne pathogen rules to apply?

No. To the contrary, you essentially need to assume or imagine that the source person *does* have one of those diseases, and then ask: was this a type of contact that creates a significant risk of transmitting disease? In other words, what is important is the nature of the contact, not any knowledge or suspicions anyone may have about the source person's HIV or hepatitis B status.

What happens after an exposure incident occurs?

The procedures vary depending on whether the source person is known or unknown. Known source persons must be tested for HIV and hepatitis B. The test results are provided to the exposed person. Testing and counseling must also be offered to exposed persons, and the exposed person may be offered the hepatitis B vaccine as well, depending on the circumstances. If the source person is unknown, he or she obviously can't be tested but the exposed person still must be offered testing and counseling and possibly vaccination against hepatitis B. The detailed procedures are contained in **10A NCAC 41A.0202(4) (HIV control measures)** and **41A.0203(b)(4) (hepatitis B control measures)**.

Did you just say that a known source person*must* be tested?

Yes. In North Carolina, all persons must comply with communicable disease control measures established by the Commission for Public Health. **GS 130A-144(f).** The control measures for HIV and hepatitis B require testing of known source persons–unless they're already known to be infected. Then they don't have to be tested, but information about their infected status still must be conveyed to the exposed person.

What happens if a known source person refuses to be tested?

There are a couple of legal remedies a local health director may pursue. The director may institute an action for injunctive relief in superior court. **GS 130A-18**. Alternatively, a person who violates communicable disease control measures may be charged with a misdemeanor. **GS 130A-25**.

In a biting incident that breaks the skin, who must be tested—the biter or the bite victim?

It depends on who was exposed to whose body fluids in a manner that created a significant risk of transmission. In a typical incident that breaks the skin, it's likely that the bite victim's broken skin was exposed to the biter's saliva, but the biter's mucous membrane (mouth) was exposed to the victim's blood. Public health officials are likely to conclude that exposure to blood creates a significant risk of transmission, but exposure to saliva does not. This means that, in many cases, the conclusion will be that the bite victim is the source person who must be tested. Of course, it is possible a different conclusion could be reached, depending upon the facts of a particular case.

Are there special rules for testing criminal defendants?

Yes. If there is probable cause to believe that a person under arrest may have exposed someone to HIV or hepatitis B, the magistrate who conducts the initial appearance can order the arrestee detained for up to 24 hours so that public health officials can investigate and decide whether the arrestee should be tested. **GS 15A-534.3**. This applies only to nonsexual exposures, such as when a law enforcement officer gets exposed while arresting a person who has a bloody nose from a fight. The magistrate is not authorized to order the tests in these cases; he or she simply may order the person detained so that public health officials can decide whether testing is indicated. For more information about this provision, see **this post** by my colleague Jeff Welty on the SOG's NC Criminal Law Blog.

Another law, **GS 15A-615**, allows courts to order an alleged sexual offender to be tested for HIV, hepatitis B, chlamydia, gonorrhea, herpes, and syphilis. (This provision isn't part of the bloodborne pathogen rules, but I think it's useful to be aware of it, since the bloodborne pathogen rules address only nonsexual exposures.) A victim of rape or certain other sexual offenses may ask the district attorney to have the defendant tested. Upon receiving the victim's request, the district attorney must petition the court for an order requiring the tests. If the judge finds that there is probable cause to believe

that the alleged sexual conduct would pose a significant risk of transmission of one of the diseases named above, the judge must order the tests. In this case, it is the judge who makes the determination of significant risk of transmission rather than public health officials. The statute goes on to specify who must perform the tests and notify the victim and defendant of the results.

So, bottom line: what should a NC local government official or employee do when this issue comes up?

Call your local health department, and feel free to call me too. I'm always happy to talk through these issues.

Links

- canons.sog.unc.edu/updated-blood-exposures-nc-communicable-disease-law/
- www.ecfr.gov/cgi-bin/text-idx?SID=05cd6b4bf944fcf33ce10dbc856328fc&node=se29.6.1910_11030&rgn=div8
- reports.oah.state.nc.us/ncac/title%2010a%20-%20health%20and%20human%20services/chapter%2041%20-%20epidemiology%20health/subchapter%20a/subchapter%20a%20rules.html
- reports.oah.state.nc.us/ncac/title%2010a%20-%20health%20and%20human%20services/chapter%2041%20-%20epidemiology%20health/subchapter%20a/10a%20ncac%2041a%20.0202.html
- reports.oah.state.nc.us/ncac/title%2010a%20-%20health%20and%20human%20services/chapter%2041%20-%20epidemiology%20health/subchapter%20a/10a%20ncac%2041a%20.0203.html
- www.ncleg.net/EnactedLegislation/Statutes/HTML/BySection/Chapter_130A/GS_130A-144.html
- www.ncleg.net/EnactedLegislation/Statutes/HTML/BySection/Chapter_130A/GS_130A-18.html
- www.ncleg.net/EnactedLegislation/Statutes/HTML/BySection/Chapter_130A/GS_130A-25.html
- www.ncleg.net/EnactedLegislation/Statutes/HTML/BySection/Chapter_15A/GS_15A-534.3.html
- nccriminallaw.sog.unc.edu/?p=1163
- www.ncleg.net/EnactedLegislation/Statutes/HTML/BySection/Chapter_15A/GS_15A-615.html