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HIV and Dentistry

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Notes

HIV AND DENTISTRY*

I. INTRODUCTION

"I blame . . . every single one of you bastards."[1] Twenty-three-year-old Kimberly Bergalis did not hesitate when she blamed her HIV infection not only on the dentist who infected her, but also on the government for failing to prevent it.[2] As her young life dwindled during the summer of 1991, the horror

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* This note is written in honor of my father, the late Dr. Harrison Lawyer, D.D.S., whose concern for the issues facing dentistry today inspired my research, and whose 40 years of leadership and commitment to the field showed me the true meaning of being a professional.

1. 137 CONG. REC. H5204 (daily ed. June 26, 1991) (quoting an article by David Zeman of the *Miami Herald*). The story of Kimberly Bergalis captured the attention of the nation because it realized many people's worst fears: an individual can be monogamous, heterosexual, and not use intravenous drugs, yet still contract and die from HIV. Indeed, an individual can be infected by the very doctor from whom she seeks medical care.

2. Ms. Bergalis contracted the disease while undergoing the extraction of two molars. *See* Barbara Kantrowitz et al., *Doctors and AIDS*, NEWSWEEK, July 1, 1991, at 49. Her dentist, Dr. David Acer, was infected with the HIV virus. Bruce Lambert, *Kimberly Bergalis is Dead at 23; Symbol of Debate over AIDS Tests*, N.Y. TIMES, Dec. 9, 1991, at D9. It has not been determined how Ms. Bergalis became infected during the extraction procedure. *Id.* There is some speculation that the dentist intentionally infected her. *Id.* It has not been determined whether Dr. Acer was conforming with the Centers for Disease Control's (CDC) recommended protective measures of properly disinfecting and not reusing medical equipment such as surgical gloves. *Id.* It is also unclear whether the infection was even transmitted from Dr. Acer or whether Ms. Bergalis contracted the virus from another of Dr. Acer's patients via poorly sterilized dental instruments. Richard Saltus, *Doctors Troubled by AIDS-Test Cry*, BOSTON GLOBE, Aug. 4, 1991, at 1, 19 (reporting that the CDC was investigating the possibility that the virus was spread from an infected patient to other patients via improperly sterilized dental equipment).

Subsequent investigations by the CDC indicate that five other patients of Dr. Acer were also infected during treatment by the dentist. Centers for Disease Control, *Recommendations for Preventing Transmission of HIV and Hepatitis B to Patients During Exposure Prone Invasive Procedures*, 40 MORBIDITY & MORTALITY WKLY. REP. 1, 3 (1991). Investigators have established that none of the patients had any risk factors for AIDS other than dental treatment by Dr. Acer. *Id.* Sophisticated genetic sequencing tests have documented that all of the infected patients share the same viral strain as Dr. Acer. *Id.*

Dr. Harold Jaffe, M.D., has been deluged in the extraordinary controversy over how the patients were infected. As Deputy Director for AIDS Science for the federal CDC, Jaffe stated that he believes the patients contracted the disease from Dr. Acer, but is not sure how the transmission occurred. Dennis L. Breo, *The Dental AIDS Cases—Murder or an Unsolvable Mystery?*, 270 JAMA 2732 (1993). Jaffe further stated:

> Acer was known to have oral Kaposi's sarcoma and he might have used his dental instruments to treat himself and then reused them on patients without proper

of Kimberly Bergalis' tragedy moved the nation and concentrated its attention on the transmission of HIV during medical and dental treatments and the apparent failure of policymakers to minimize the risk of future incidents.[3]

The inability of the American society as a whole to respond promptly and effectively to the HIV crisis stems largely from the struggle to balance the individual privacy rights of HIV carriers with the public health concerns of the state.[4] In one respect, carriers have a strong interest in not disclosing their condition to avoid discrimination and harassment by employers, health care

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sterilization. However, no one in Acer's office ever saw him treat himself in this manner.

Or, he might have injured himself while his fingers were inside the patient's mouth, possibly while palpating the tip of the anesthetic needle, and his blood spilled directly into the patient's mouth. Although there is no documented neuropathy in Acer's medical records, his AIDS might have made his sense of touch less than normal. If so, he might have put his finger and the anesthetic needle into the patient's mouth at the same time, stuck himself, and spilled infectious blood into the patient's mouth.

Or, he might have committed murder through a variety of ways. He might have kept a syringe in his pocket, filled with a mixture of anesthetic and his own blood, and used this to infect the patient. I don't pretend to understand all the possibilities by which he might have intentionally infected patients. However, all six patients were fully awake during their procedures and neither they nor anyone on Acer's staff ever noticed anything unusual . . . .

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It could [happen again] . . . . The fact is that the current CDC guidelines for evaluation of HIV-infected health workers are voluntary and we have no way of enforcing them. And dentists and surgeons do stick themselves with needles and under current technology this risk cannot be reduced to zero. So, another case *could* happen. And, if we do get another documented case of HIV transmission from health worker to patient, there will be a tremendous public demand for mandatory testing of health workers.

Id. at 2732, 2734 (emphasis in original). The CDC spent more than $1 million and dedicated two dozen investigators to try to determine what happened in Acer's dental practice. *Id.* at 2732. However, Jaffe believes that the ambivalence of the dental and medical associations about the case caused them to lose credibility with their patients. *Id.* at 2734. Douglas Feldman, a medical anthropologist in the department of psychiatry at the University of Miami (Fla.) School of Medicine, maintains that contact tracing should be done on Dr. Acer's 1400 patients who have not been tested for HIV because he believes another five or six cases of the transfer of HIV would be discovered. *Id.* at 2733.

3. *See, e.g.*, 137 CONG. REC. H5204-05 (daily ed. June 26, 1991) (statement of Congressman Burton) (proposing legislation requiring mandatory HIV testing of health care providers and disclosure to patients).

4. *See generally* Ugo Colella, *Balancing Confidentiality and Liberal Discovery: A Unified Approach to Discovery Disputes over HIV Information*, J. HEALTH & HOSP. L., Nov. 1993, at 328-35.

providers, friends, and insurance companies.[5] In the other respect, the state has a strong interest in requiring that HIV carriers disclose this information to aid research efforts and to prevent further transmission of the virus.[6] The competition between these conflicting interests has delayed the process of effectively attacking the epidemic through comprehensive legislation, education, science, and medicine.[7]

This Note will analyze the competing privacy and public health interests as they relate to health care, and specifically as they relate to dentistry. Although many studies and legislative efforts have focused on the handling of HIV in the health care industry,[8] few have addressed the concerns and problems that are unique to dentistry.[9] Dentists and patients are without direction as to their legal

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5. Because people are afraid of contracting the disease, they often avoid associating on any level with HIV carriers. Many carriers are fired or denied employment because of this fear. Most carriers are denied health insurance coverage once their conditions are diagnosed and are subsequently left with devastating debts from the medical bills. Insurance companies have employed a number of methods to deny health and life insurance coverage to individuals with HIV. For a detailed discussion, see Mark Scherzer, *Insurance, in* AIDS AND THE LAW: A GUIDE FOR THE PUBLIC 185, 189-200 (Harlon L. Dalton et al. eds., 1987). Some action is being taken by the government to remedy the insurance disaster. For a discussion, see Laura Pincus, *The Americans with Disabilities Act: Employers' New Responsibilities to HIV-Positive Employees*, 21 HOFSTRA L. REV. 561 (1993); Brian McCormick, *HIV Insurance Restrictions Hit in ADA Cases*, AM. MEDICAL NEWS, Jan. 24, 1994, at 6. *See also Company Extends Occupational HIV Coverage to all its Employees*, AIDS WKLY., Jan. 31, 1994, at 15.

6. *See generally* Scott Burris, *Rationality Review and the Politics of Public Health*, 34 VILL. L. REV. 933 (1989).

7. *See supra* text accompanying note 4; *infra* notes 249-91 and accompanying text.

8. *See, e.g.*, Ind. Pub. L. No. 123-1988 (codified in scattered sections of IND. CODE § 16-41 (1993)); Jane H. Barney, *A Health Care Worker's Duty to Undergo Routine Testing for HIV/AIDS and to Disclose Positive Results to Patients*, 52 LA. L. REV. 933 (1992); Gary I. Strausberg & Randal D. Getz, *Health Care Workers with AIDS: Duties, Rights, and Potential Tort Liability*, 21 U. BALT. L. REV. 285 (1992); Troyen A. Brennan, *Transmission of the Human Immunodeficiency Virus in the Health Care Setting—Time For Action*, 324 NEW ENG. J. MED. 1504 (1991); Sev S. Fluss & Dineke Zeegers, *AIDS, HIV and Health Care Workers: Some International Legislative Perspectives*, 48 MD. L. REV. 77 (1989); Larry Gostin, *Hospitals, Health Care Professionals, and AIDS: The "Right to Know" the Health Status of Professionals and Patients*, 48 MD. L. REV. 12 (1989); Michael Kirby, *AIDS and Law*, 118 DAEDALUS 101 (1989); Eugene McCry & the Cooperative Needlestick Surveillance Group, *Occupational Risk of the Acquired Immunodeficiency Syndrome Among Health Care Workers*, 314 NEW ENG. J. MED. 1127 (1986).

9. Dentistry is one area of health care where both the provider and the patient are at particular risk of exposure to the virus because of the presence of blood and tissue during invasive procedures such as extractions, root canal preparations, and periodontal treatments. Hypodermic needles are used for administering local anesthetics, and sharp or abrasive instruments are used during dental procedures. Many opportunities exist for accidental percutaneous injuries to the hands, even with glove use. Patients tend to flinch under pain, causing instruments to slip accidentally. When this happens, both the dentist and patient are at risk because an exchange of blood can result. *See generally* Robert S. Klein et al., *Low Occupational Risk of Human Immunodeficiency Virus Infection Among Dental Professionals*, 318 NEW ENG. J. MED. 86 (1988).

duties and rights, and they are looking to state courts for help in resolving cases of HIV transmission in dental settings.[10] Without proper input from the public, the dental associations, and the legislature, these ill-equipped courts are left to define the emotionally charged and politically sensitive duties of dentists and patients who may have to disclose their conditions to one another.[11] The result is an inconsistent, piece-meal reaction to this serious problem. As more cases of HIV transmission in dental settings are reported and litigated, it will become more clear that there is an urgent need to evaluate the special circumstances and

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In most cases, oral lesions are the first manifestations of AIDS. Charles E. Barr, *Dental Management of HIV-Associated Oral Mucosal Lesions: Current and Experimental Techniques*, *in* PERSPECTIVES ON ORAL MANIFESTATIONS OF AIDS 77-95 (Paul B. Robertson & John S. Greenspan eds., 1988). The time between initial infection with HIV and the appearance of these lesions is unknown. *Id.* Identification, diagnosis, and treatment or oral lesions may be facilitated by consultation with an appropriate specialist. *Id.* Knowledge of the extent of the patient's immunodeficiency is crucial for its proper management. *Id.* Furthermore, there is a significant risk of harmful drug interaction if dentists prescribe medication without knowledge of the other medication patients might be taking. *Id.*

Oral lesions recognized to be associated with HIV infection are: candidiasis, histoplasmosis, geotrichosis, cryptococcoses, herpes simplex, herpes zoster, hairy leukoplakia, warts, kaposi's sarcoma, non-hodgkin's lymphoma, HIV gingivitis, HIV periodontitis, necrotizing stomatitis, mycobacterium avium intracelluare, recurrent aphthous ulcers, xerostomia, salivary gland enlargement, and idiopathic thrombocytopenic purpura. AMERICAN DENTAL ASSOCIATION, FACTS ABOUT AIDS FOR THE DENTAL TEAM 4-5 (3d ed. 1991). Oral candidiasis is perhaps the most common lesion associated with HIV. Aaron Glatt, *Therapy for Oropharyngeal Candidiasis in HIV-Infected Patients*, 46 J. ACQUIRED IMMUNODEFICIENCY SYNDROMES 1317 (1993). Candidiasis is a fungal infection in the mouth characterized by creamy, white lesions with raw, bleeding surfaces underneath. *Id.* The infection can be effectively treated with Fluconazole or Clotrimazole when properly diagnosed. *Id.* Herpes simplex virus (HSV) infection in patients with immune disorders may appear as narrow, linear cracks on the tongue surface. Marc E. Grossman et al., *Brief Report: Herpetic Geometric Glossitis*, 329 NEW ENG. J. MED. 1859 (1993). The cracks have a geometric pattern that runs the length of the tongue and are crossed or branched. *Id.* HSV affects the tongue, the floor of the mouth, the soft palate, and the mucous membranes of the cheek. *Id.*

10. *See generally* Sattler v. New York Commission on Human Rights, 580 N.Y.2d 35 (N.Y. App. Div. 1992); Neuberger v. Olson, No. 12013, 1992 Del. Ch. LEXIS 58 (Del. Ch. Mar. 11, 1992); McBarnette v. Feldman, 582 N.Y.S.2d 900 (N.Y. 1992).

11. For example, a Syracuse doctor was found liable for revealing a patient's HIV status in response to a subpoena for medical records filed by the Pennsylvania Workers Compensation Board. Doe v. Roe, 588 N.Y.S.2d 236 (N.Y. Sup. Ct. 1992). In his holding, Justice Reagan addressed a question that had not been presented squarely to a court before and concluded that an HIV-infected person has a legal duty to disclose that fact to a health care provider before undergoing any bodily intrusive physical examination.

> Such a legal duty arises out of not only moral and ethical considerations, but out of logic, common sense and medical evidence as well, with regard to the general health of society and its physician caretakers. To hold otherwise would be to improvidently elevate policy and the political aspects of this fatal disease over the medically proven health dangers of exposure to HIV infected blood, semen, saliva, etc., and to demonstrated risks of transmission to unknowing and unprepared recipients.

Id. at 239. Justice Reagan stated that this duty comes not only from moral and ethical considerations, but also from medical concerns. *Id.*

risks in the dental community[12] and to develop an aggressive, comprehensive approach to deal with this dilemma through a combination of legislation and dental association policies.[13]

Section II of this Note will survey the medical and scientific epidemiology of HIV to provide a basic understanding of the modes of transmission and the risk this virus poses to our society today.[14] Section III of the Note will examine the current status of laws and dental association policies concerning HIV and dentistry to show what has been done thus far to balance the privacy and public health interests and to curb transmission.[15] This Section will suggest areas where these authorities are deficient in coping effectively with the problem because they are too vague, lack proper enforcement, and work independently of each other. It will conclude that the legislature, the dental association, and the public must be willing to work together for a solution that protects everyone. Section IV will briefly discuss the development of the constitutional right of privacy and how that right plays a significant role in the health care industry and in approaching the HIV crisis.[16] Sections V and VI will examine the competing interests in public health and the development of the power of the state to act for the protection of the public's safety and welfare during an epidemic.[17] In attempting to reach a plausible balance between these competing interests in the context of dentistry, Section VII will suggest a course of action[18] by proposing a statute and potential dental association policies as part of a comprehensive approach to minimize the risk of HIV transmission.[19] These recommendations are meant to serve as a framework to guide dentists, patients, and courts in dealing with HIV.

II. EPIDEMIOLOGY OF HIV AND AIDS

The first American cases of Acquired Immunodeficiency Syndrome (AIDS),[20] a disease caused by HIV, were reported in Los Angeles in 1981.[21]

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12. *See supra* note 9.
13. *See infra* notes 292-96 and accompanying text.
14. *See infra* notes 20-47 and accompanying text.
15. *See infra* notes 48-85 and accompanying text.
16. *See infra* notes 86-198 and accompanying text.
17. *See infra* notes 199-291 and accompanying text.
18. *See infra* notes 292-96 and accompanying text.
19. *See infra* notes 292-96 and accompanying text. *See also* text following note 296.
20. AIDS is caused by the human immunodeficiency virus (HIV) which weakens the body by destroying white blood cells needed to attack and kill bacteria and other infectious material in the body. Alexandra M. Levine, *Technical Article: Acquired Immunodeficiency Syndrome: The Facts*, 65 S. CAL. L. REV. 423 (1991).

HIV infection is a continuum with full-blown AIDS as the final stage of infection. *Id.* at 427. HIV may cause a completely asymptomatic state of infection in which the individual is well in all respects, has no symptom or sign of illness, and yet has the live HIV virus growing in the blood and

Since that time, the academic, medical, scientific, and legal sectors, as well as the community at large, have never been the same. Despite increasing public health and educational efforts,[22] more than thirty million people worldwide[23]

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is capable of transmitting the virus to others. *Id.* at 429. This is perhaps the most dangerous stage for the public health because carriers may not take extra precautions since most do not know they have the virus. The virus is also known to cause AIDS-related complex (ARC) which occurs when an infected person exhibits effects of immunodeficiency, such as fever, weight loss, night sweats, or diarrhea but does not yet have any opportunistic diseases. *Id.* Full-blown AIDS is diagnosed when an individual is found to have one or more of the following illnesses: (1) opportunistic infection (2) Kaposi's sarcoma (3) high-grade, B-cell lymphoma (4) AIDS-dementia/encephalopathy syndrome (5) wasting syndrome (slim disease). *Id.* at 424.

First, an opportunistic infection is a severe or life-threatening infection caused by an organism that normally lives with humans, to the advantage of both, and normally does not cause disease due to the presence of an intact immune, or defense system in normal individuals. *Id.* The second illness by which an individual may be diagnosed with AIDS is a type of cancer of the blood vessel wall, termed Kaposi's sarcoma. *Id.* at 425. The third criterion for diagnosis of AIDS is the development of certain types of malignant lymphoma, termed "high-grade B-cell," "Burkitt's," or "immunoblastic" lymphoma. *Id.* The fourth criterion for a diagnosis of AIDS is the so-called "wasting syndrome" characterized by weight loss, with or without fevers, night sweats, and general debility. Centers for Disease Control, *Revision of the CDC Surveillance Case Definition for Acquired Immunodeficiency Syndrome*, 36 MORBIDITY & MORTALITY WKLY. REP. 1S, 3S-15S (1987). The illness had been previously described in Africa, where it was known as "slim disease," because of the gradual wasting of affected individuals. E. Serwadda et al., *Slim Disease: A New Disease in Uganda and Its Association with HTLV-III Infection*, 2 LANCET 849 (1985). The average duration of the latent period from initial infection to the development of full-blown AIDS is approximately seven to ten years. James J. Goedert et al., *Three-Year Incidence of AIDS in Five Cohorts of HTLV-III-Infected Risk Group Members*, 231 SCIENCE 992 (1986).

21. Centers for Disease Control, *Pneumocystis Pneumonia—Los Angeles*, 30 MORBIDITY & MORTALITY WKLY. REP. 250 (1981).

22. For a discussion on the power of the media over what is socially accepted by society, see Jonathan Alter, *The Power to Change What's "Cool,"* NEWSWEEK, Jan. 17, 1994, at 23.

President Clinton increased funding for AIDS research to $1.3 billion in the 1994 fiscal year, plus a 66% increase in funding for community-based treatment and services. Advocates commend the President's determination to push legislation in treating and preventing AIDS and related diseases. *See Will Attention Bring Action?*, AM. MED. NEWS, Jan. 17, 1994, at 1. However, no cure or vaccine is expected in the near future. *Id.* Clinton backed a plan to increase funding of the Ryan White Comprehensive AIDS Resource Emergency Act by 22% for 1993. *See* Laurie Jones, *More Research, More Treatment—Still More To Be Done*, AM. MED. NEWS, Feb. 7, 1994, at 3. In addition, Clinton authorized a reorganization of the National Institutes of Health Office of AIDS. *Id.* This may signal a move away from clinical research and toward a basic scientific approach to studying the virus. *Id.* Perhaps the main accomplishment of the administration in regard to AIDS has been an advertising campaign aimed at young people developed by the CDC. *See* Laurie Jones, *Prevention Seen as Best AIDS Hope*, AM. MED. NEWS, Jan. 24, 1994, at 3. Overall, the consensus is that effective prevention should center on explicit, community-based programs targeting high-risk populations. *Id.*

23. HIV is rapidly becoming a grave concern for most of the world. For example, HIV infection in the continent of Africa rose by 1.5 million in 1993, according to Dr. Michael Merson of the World Health Organization's Global Program on AIDS. *Infections Climb to Two-Thirds of World Total, Conferees Told*, AIDS WKLY., Dec. 20, 1993, at 8. The number raises the estimated total of African HIV infections to around 10 million, two-thirds of the world total of 15 million.

could be infected with HIV by the year 2000.[24] To date, the pharmaceutical industry is not close to refining and marketing a cure or vaccine for this virus.[25] In fact, some smaller researchers have begun to curb research and development efforts because the enormous financial investments necessary to support the research seem to be yielding few results.[26]

HIV is transmitted primarily by direct blood-to-blood contact or by exchange of other bodily fluids with an infected individual.[27] Except through

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Id. Most experts agree that traditions such as men inheriting widows of deceased male relatives are spreading the disease. *Kenya Custom Boosts AIDS Epidemic, Officials Say*, JET, Jan. 10, 1994, at 40; R.M. Anderson et al., *The Spread of HIV-1 in Africa: Sexual Contact Patterns and the Predicted Demographic Impact of AIDS*, 352 NATURE 581-89 (1991). In Canada, the death toll from AIDS reached 1078 in 1992. *AIDS Deaths Reached 1078 in 1992*, FACTS ON FILE, Nov. 18, 1993, at 868. In Haiti, sixty percent of urban hospital beds are occupied by HIV patients. J. Pape & W.D. Johnson, *AIDS in Haiti*, AIDS WKLY., Dec. 20, 1993, at 23.

24. Christine Gorman, *Invincible AIDS*, TIME, Aug. 3, 1992, at 30. A new study found that AIDS is now the leading killer of American men between the ages of 25 and 44. *AIDS News Brief*, FACTS ON FILE, Dec. 9, 1993, at 918. Sadly, only two percent of men believe that they have a medium or high chance of contracting AIDS. Linda Wasmer Smith, *The Numbers Racket: What are the Odds You Should Let Health Statistics Rule Your Life?*, JOE WEIDER'S MEN'S FITNESS, Feb. 1994, at 74. Because many more people have contracted HIV in recent years, the number of deaths resulting from AIDS is expected to increase dramatically. *See Will Attention Bring Action?*, *supra* note 22, at 1. Analysis of figures on the AIDS epidemic indicates that deaths will exceed 320,000 by September of 1994, compared to 204,390 in 1993, and 25,000 in 1990. J. Michael McGinnis & William H. Foege, *Actual Causes of Death in the United States*, 270 JAMA 2207 (1993).

25. The AIDS drugs Maitec and ABLC are entering latter-stage testing by Liposome Company, Inc., but problems are expected. *AIDS Drugs to Enter Latter-Stage Testing*, AIDS WKLY., Jan. 24, 1994, at 8. Most of the efforts are directed toward relieving the painful symptoms of AIDS instead of developing a cure. Marinol (dronabinol), a prescription drug containing a synthetic form of one of marijuana's active ingredients (delta- 9- tetrahydrocannabinol), was approved in 1992 to prevent weight loss in AIDS patients. *See "Pot," "Crack," Increases Pneumonia in AIDS Patients*, FDA CONSUMER, Dec. 1993, at 3; Wayne Hearn, *Burning Issue: Should Patients Go to Pot?*, AM. MED. NEWS, Feb. 7, 1994, at 14.

26. Eli Lilly & Co. recently reduced AIDS research by a significant margin. *Eli Lilly & Co. Cutting AIDS Research*, L.A. TIMES, Jan. 17, 1994, at D2. Furthermore, the Pentagon recently canceled a plan to test a vaccine called VaxSyn. John Schwartz, *Pentagon Drops Plan to Test an AIDS Vaccine*, WASH. POST, Jan. 23, 1994, at A3.

27. Joseph A. Kovacs & Henry Masur, *Opportunistic Infections, in* AIDS: ETIOLOGY, DIAGNOSIS, TREATMENT AND PREVENTION 199-225 (Vincent T. DeVita, Jr., et al. eds., 2d ed. 1988). Some concentration of the virus is found in every bodily fluid of those who are infected, including saliva, tears, sweat, and semen. However, only semen, vaginal secretions, blood, and breast milk are implicated in the transmission of HIV because the concentration of the virus in saliva, sweat, and tears is too low to make transmission probable. Centers for Disease Control, *Recommendations for Prevention of HIV Transmission in Health-Care Settings*, 36 MORBIDITY & MORTALITY WKLY. REP. 35 (Supp. No. 2S 1987); *HIV Antibody Detection in Oral Fluids*, 71 BULLETIN OF THE WORLD HEALTH ORGANIZATION 641 (1993). While there is no conclusive scientific determination, "[s]aliva does not seem to be an effective route of transmission, probably because of the low titers found and the co-existence of anti-body." Nancy Mueller, *The Epidemiology of the Human Immunodeficiency Virus Infection*, 14 LAW, MED. & HEALTH CARE

sexual contact or use of an infected intravenous needle, the most probable means of transmission is through the exchange of bodily fluids between a patient and a health care worker when one of them is HIV-positive.[28] While the risk of contracting HIV in a health care setting is very low,[29] infections allegedly related to occupational risk have surfaced in the last few years.[30] Treatment procedures where blood and mucous membranes are frequently present create a higher risk of exposure to the virus for health care providers and patients than do procedures where bodily fluids are not present.[31] The risk of exposure is also significantly higher where sharp objects and instruments are used during treatment because of the increased likelihood of accidental injuries drawing

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250, 256 (1986). Generally, for transmission to occur, a concentrated amount of the virus must be transmitted from an infected person into the blood stream of another. If infected bodily fluid comes into contact with skin, transmission is still unlikely because "[i]ntact skin . . . is an absolute barrier" to the virus. Krim, *The AIDS Virus and its Public Health Implications*, *in* LEGAL, MEDICAL AND GOVERNMENTAL PERSPECTIVES ON AIDS AS A DISABILITY 3 (A.B.A. Commission of the Mentally Disabled 1987). For the virus to be transmitted, infected fluid must come into contact with an opening in the skin. *Id.* By all accounts it is improbable, but not impossible, for the virus to be transmitted through purely casual contact. *Id.* However, a case study of two children revealed the transmission of HIV from one child to the other by undocumented contact with blood or bodily fluids. R.J. Simonds & Martha F. Rogers, *HIV Prevention—Bringing the Message Home*, 329 NEW ENG. J. MED. 1883 (1993).

28. *See generally* Mueller, *supra* note 27. While statistically the odds are low, the risk is substantial due to the frequent exposure to blood and other bodily fluids. *Id.*

29. It is now apparent that it is rather difficult to transmit HIV by a direct needle-stick injury from an HIV-infected patient to health care worker. *See* David K. Henderson et al., *Risk of Nosocomial Infection with Human T-Cell Lymphotropic Virus Type III/Lymphadenopathy-Associated Virus in a Large Cohort of Intensively Exposed Health Care Workers*, 104 ANNALS INTERNAL MED. 644 (1986); McCray, *supra* note 8, at 1127; David K. Henderson, *HIV-1 in the Health Care Setting*, *in* PRINCIPLES AND PRACTICE OF INFECTIOUS DISEASES 2221 (G.F. Mandell ed., 1989).

The risk of HIV infection by a needle stick is approximately 0.4%, indicating that it is highly unusual to actually become infected, even by needle-stick exposure. Levine, *supra* note 20, at 442. HIV is primarily intracellular, requiring that the health care worker actually be exposed to T4 lymphocytes that may be trapped on the end of the offending needle. *Id.* at 443. Further, only approximately one in 1000, or one in 10,000 T4 cells, are actually infected at any one time in an HIV-infected individual. *See* Mario Clerici et al., *HIV-Specific T-Helper Activity in Seronegative Health Care Workers Exposed to Contaminated Blood*, 271 JAMA 42 (1994); David D. Ho et al., *Quantitation of Human Immunodeficiency Virus Type 1 in the Blood of Infected Persons*, 321 NEW ENG. J. MED. 1621 (1989). It is thus apparent that the risk of HIV infection to a health care worker is extremely small, even when accidentally stuck with an infected needle; the risk of acquiring hepatitis B infection is far greater, for example, than is the risk of acquiring HIV from a needle-stick injury. Levine, *supra* note 20, at 443.

30. Centers for Disease Control, *supra* note 27, at 4S-5S. While fewer than forty occupational infections have been documented, the actual number may be higher. *AIDS in Health Care Workers*, JONA, Mar. 1992, at 5.

31. *See supra* notes 27-28 and accompanying text.

blood from health care workers.[32]

As a preliminary matter, health care workers who use universal precautions[33] and who do not perform invasive procedures[34] present little risk of HIV transmission to patients and are at minimal risk of being exposed to the virus by a patient.[35] More specifically, the Centers for Disease Control (CDC) issued a document that quantifies the risk of HIV transmission from dentist to patient.[36] The CDC estimates that during dental procedures performed by a dentist or an oral surgeon which result in patient bleeding,[37] the risk that a

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32. *Id.* "[T]hese [incidents of transmission] were among health workers who pricked themselves with needles containing blood from an infected person or who were exposed to contaminated blood through an open wound or on mucous membranes." *Forum Interview with Walter Dowdle: AIDS (Acquired Immunodeficiency Syndrome)*, 11 WORLD HEALTH F. 388, 389 (1990).

33. "Universal precautions" is an approach to infection control where all human blood and certain human body fluids are treated as if known to be infectious for HIV and other bloodborne pathogens. Centers for Disease Control, *supra* note 2, at 2.

Office sterilization procedures involve the proper use of steam, dry heat, chemical vapor, and gas sterilizers. *See* Chris H. Miller, *Cleaning, Sterilization, and Disinfection: Basics of Microbial Killing for Infection Control*, 124 JADA 48, 48-56 (1993). The effectiveness of the procedures can be routinely verified during office use by spore testing. *Id.* Disinfection is a less lethal process than sterilization and is intended to kill disease-producing micro-organisms, but not bacterial spores. *Id.* Office disinfection procedures involve using a liquid chemical at room temperature to kill microorganisms on submerged instruments or operatory surfaces. *Id.* If the chemical used is not sporicidal, it is called a disinfectant and can be expected to achieve only disinfection. *Id.*

Processing contaminated instruments for reuse on subsequent patients is a key part in patient-protection aspects of the office infection control program. The CDC and the ADA recommend that surgical and other instruments that normally penetrate soft tissue or bone must be sterilized after each use and that other instruments, burs, and handpieces that come into contact with oral tissue should be sterilized after each use. Center for Disease Control, *Recommended Infection-Control Practices for Dentistry*, 35 MORBIDITY & MORTALITY WKLY. REP. 237-42 (1986); ADA Councils on Dental Materials, Instruments and Equipment; *Dental Practice* and *Dental Therapeutics, Infection Control Recommendations for the Dental Office and Dental Laboratory*, 116 JADA 241-48 (1988).

The approach to sterilize all reusable instruments contaminated with blood or saliva (Universal Sterilization), rather than to sterilize some and disinfect others, is the safest approach to preventing disease spread to patients from instruments. Chris H. Miller, *Sterilization: Disciplined Microbial Control*, 35 DENT. CLIN. N. AM. 339-55 (1991). This is being recognized more and more, as evidenced by laws in Ohio and Indiana requiring sterilization, rather than just disinfection of all reusable dental instruments. OHIO STATE DENTAL BOARD OF EXAMINERS, INFECTION CONTROL RULES (Nov. 1, 1987); Ind. Pub. L. 123-1988 (codified in various sections of IND. CODE § 16-41 (1993)).

34. Invasive procedures involve "surgical entry into tissues, cavities, or organs or repair of major traumatic injuries." Centers for Disease Control, *supra* note 27, at 6.

35. CENTERS FOR DISEASE CONTROL, DRAFT: ESTIMATES OF THE RISK OF ENDEMIC TRANSMISSION OF HEPATITIS B VIRUS AND HUMAN IMMUNODEFICIENCY VIRUS TO PATIENTS BY THE PERCUTANEOUS ROUTE DURING INVASIVE SURGICAL AND DENTAL PROCEDURES (Jan 30, 1991) [hereinafter DRAFT].

36. *Id.*

37. *Id.* at 1.

patient will be infected by an HIV-positive dentist in general practice ranges from 1 in 263,158 to 1 in 2,631,579.[38] The risk that a patient will be infected by an HIV-positive oral surgeon ranges from 1 in 41,667 to 1 in 416,667.[39] Based on these figures, the CDC estimates that during the years 1981 through 1990, only between ten and one hundred patients were infected with HIV by dentists.[40] However, the CDC noted that its ability to estimate risk in the dental-care setting was hampered by the lack of prospective studies on the frequency of percutaneous injuries[41] in dental workers and the percentage of such injuries which result in possible exposure of a patient to the workers' blood.[42] Additionally, many have criticized the CDC study and its underlying assumptions,[43] suggesting that the actual instances of transmission are much lower.[44] By all reports, the probability that any patient will contract HIV from an infected dentist is very low.[45] Furthermore, the transmission of the disease in the dental setting can largely be halted if proper precautions are taken.[46] Because the virus is communicable, incurable, capable of mutation,[47] and fatal,

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38. *Id.* at 8.

39. *Id.* at 7.

40. *Id.* at tbl. 2.

41. Percutaneous injuries are puncture wounds caused by a sharp instrument or object during treatment.

42. DRAFT, *supra* note 35, at 8.

43. Testifying through one of its members at the CDC Conference on Health Care Worker Guidelines on February 21, 1991, the AIDS Action Council (AAC) argued that the CDC's study relies on unfounded assumptions. The AAC contended that the CDC had no basis for its assumption that sharp instruments or needles that cause percutaneous injury to the dentist recontact the patient at a 32% rate. Ruth Finkelsteinm, *AIDS Action Council Testimony Presented to the Centers for Disease Control* (Feb. 21, 1991). This figure was derived by CDC observers who conducted a prospective investigation of surgical procedures at four hospitals. Because of the vast range of recontact rates noted in CDC's small sample (range among medical specialties, 8%-57%; range among hospitals, 24%-42%), the 32% figure is problematic even for surgery. The AAC also criticized the CDC modelling assumptions that relied on studies spanning a ten-year period and ignored changes in the use of universal precautions. *Id.* at 3-5.

44. Dr. Henry Finger, President of the Academy of General Dentistry, criticized an estimate of patient risk presented in the CDC's draft document in a March 11, 1991, letter to the CDC, which is discussed in Zev Remba, *HIV*, AGD IMPACT, June 1991, at 16, 20.

45. It is important to note that the CDC report did not estimate the risk posed to a dentist by an infected patient. Reports state that the risk to a surgeon from operating on an HIV-infected patient ranges from 1 in 4500 to 1 in 130,000. *See* Michael D. Hagen et al., *Routine Preoperative Screening for HIV: Does the Risk to the Surgeon Outweigh the Risk to the Patient?*, 259 JAMA 1357, 1358 (1988) (stating that, surprisingly, there would be far fewer instances of health care worker-to-patient transmission than of transmission from patient to health care worker).

46. *See supra* note 33.

47. *See Aidspeak: From New Tests to New Viruses*, TIME, Feb. 8, 1988, at 56-57 (reporting that researchers in the United States have identified a new strain of the virus that is sometimes not detected by the current tests for HIV-1). Mutation poses a significant threat because new strains of the HIV virus may go undetected by current HIV virus tests such as the enzyme-linked immunosorbent assay (ELISA). *Id.* Moreover, such mutations jeopardize the potential effectiveness of any cure or vaccine developed for a specific strain of the HIV virus. *Id.*

immediate action by legislatures and dental associations is warranted to encourage or require these precautions designed to protect the public's health and safety.

III. CURRENT STATUS OF THE LAW AND AMERICAN DENTAL ASSOCIATION POLICIES

As the HIV crisis grows, so do the problems it poses to our legal system. An effective vaccine or cure for the virus is unlikely to reach the market for several more years. Indeed such a medical solution to the HIV crisis may elude researchers for decades.[48] Therefore, for the next several years, public health officials must rely upon measures such as easing the public's fear through education and prevention to stem the rising number of deaths from HIV.[49] With that end in mind, health departments and legislators have proposed a variety of means to control the spread of this fatal disease.[50]

In the wake of the Kimberly Bergalis tragedy,[51] legislators searched for ways to restore public confidence in the health care system and to ease the outcry for government regulation of HIV-positive health care workers.[52] Before her death, Ms. Bergalis testified before the House Subcommittee on Health and the Environment of the Committee on Energy and Commerce in support of a bill that would require virtually all doctors and other health care workers to be tested for HIV.[53] However, the proposed Kimberly Bergalis

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48. *See supra* notes 25-26 and accompanying text.

49. *See infra* notes 256-60 and accompanying text.

50. The measures have included various regulations governing education. *See* Ind. Pub. L. No. 123-1988 (codified as IND. CODE § 20-8.1-11 (1988)). Other measures concern disclosure of HIV-positive conditions to health departments, health care providers, and others. *See, e.g.*, CAL. HEALTH & SAFETY CODE §§ 199.215, 199.25 (West Supp. 1989) (permitting physicians to disclose the identity of HIV carriers to their spouses and people who the physicians reasonably believe share needles or have sexual relations with the carriers).

51. *See supra* notes 1-2 and accompanying text.

52. *See, e.g.*, 137 CONG. REC. E2377 (daily ed. June 26, 1991) (proposed Kimberly Bergalis Patient and Health Provider Protection Act of 1991).

53. *See* H.R. 2788, 102d Cong., 1st Sess. (1991) (proposing the establishment of protections against transmission of certain communicable diseases for both health care workers and patients); *see also Prevention of HIV Transmission: Hearings on H.R. 2788 Before the SubComm. on Health and the Environment of the Comm. on Energy and Commerce*, 102d Cong., 1st Sess. 128 (1991) (statement of Kimberly Bergalis); 137 CONG. REC. E2377 (daily ed. June 26, 1991) (proposed Kimberly Bergalis Patient and Health Provider Protection Act of 1991). According to the Bergalis Act, health care workers testing positive for one of the enumerated diseases would be prohibited from performing the medical and dental procedures listed by the Health and Human Services Department for the duration of the infection. H.R. 2788, 102d Cong., 1st Sess. § 101 (1991) (proposed § 2648A(b)(2)(A)). The proposal required notification to past patients of their possible exposure to HIV and other listed diseases when a health care worker tested positive for any such disease. *Id.* (proposed § 2648A(c)(1)). The proposal also authorized health care workers involved

Patient and Health Provider Protection Act of 1991[54] was not enacted. In fact, Congress has yet to enact any law mandating large-scale testing of health care workers.[55] This inaction may be because most of the proposed legislation ignores the enormous financial and administrative burdens imposed by mandatory screening programs in light of the small risk of transmission from infected health care workers to patients.[56] However, Congress has passed a law[57] requiring state legislatures to enact practice guidelines for HIV-positive

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in procedures encompassing a risk of viral transmission to perform nonconsensual testing on patients under certain conditions. *Id.* (proposed § 2648B(b)).

However, the cost of testing alone would be enormous, approximately $65 per person who tests negative and $250 per person who tests positive. *See* Larry Gostin, *Symposium on AIDS and the Rights and Obligations of Health Care Workers: Hospitals, Health Care Professionals, and AIDS: The "Right to Know" the Health Status of Professionals and Patients*, 48 MD. L. REV. 12, 50 (1989). Because of the high level of false positive and negative results, the expensive and time-consuming tests would have to be administered twice, making the utility of mass screening highly questionable. *Id.*

While the Bergalis Act sought to minimize HIV transmission in the health care setting, the means adopted to achieve this end were highly invasive of individual privacy interests. The proposal called for the systematic collection and disclosure of extremely personal information from both patients and health care workers, information that forecasted serious consequences for patients' future health. H.R. 2788, 102d Cong., 1st Sess. § 102 (1991) (proposed §§ 2648A & 2648B). This invasiveness was further exploited by the complete absence of strict confidentiality protections. Thus, in calling for testing and disclosure provisions without corresponding confidentiality protections, the proposed act lacked a key means of safeguarding individual privacy interests. For a more detailed discussion of the Bergalis Act, see Jeffery W. Cavender, Note, *AIDS in the Health Care Setting: The Congressional Response to the Kimberly Bergalis Case*, 26 GA. L. REV. 539 (1992).

54. 137 CONG. REC. E2377 (daily ed. June 26, 1991).

55. *See* H.R. 2788, 102d Cong., 1st Sess. (1991) (bill sponsored by Rep. William E. Dannemeyer).

56. There are 4.5 million health care workers in the United States. Of these, the CDC estimates that approximately 360 surgeons, 1200 dentists, 5000 physicians, and 35,000 other health care workers are HIV positive. Betsy A. Lehman, *AIDS Tests for Health Caregivers?*, BOSTON GLOBE, Aug, 10, 1992, at 27.

57. *See* Treasury, Postal Service and General Government Appropriation Act of 1992, Pub. L. No. 102-141, § 633, 105 Stat. 834, 876 (codified at 42 U.S.C. § 300ee-2) (detailing the steps that states must take regarding prevention of HIV and hepatitis-B virus transmission to avoid becoming ineligible for assistance under the Public Health Service Act). Senator Jesse Helms, a North Carolina Republican, originally succeeded in persuading the Senate to pass an amendment to this Appropriations Act that would have made it a federal crime for health care workers who know they are HIV-positive to perform invasive medical procedures without informing patients. *See* 137 CONG. REC. S10, 363 (daily ed. July, 18, 1991) (listing results of the vote on the Helms amendment). The pertinent section reads:

> (a) Whoever, being a registered physician, dentist, nurse, or other health care provider, knowing that he is infected with the Human Immunodeficiency Virus, intentionally provides medical or dental treatment to another person, without prior notification to such person of such infection, shall be fined not more than $10,000, or imprisoned not less than ten years, or both.

137 CONG. REC. S9778 (daily ed. July 11, 1991). Although Helms' initiative passed in the Senate,

health care workers based on the guidelines promulgated by the CDC.[58] The

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a conference committee subsequently rejected the amendment. 137 CONG. REC. H7385 (daily ed. Oct. 3, 1991).

According to one source, the Helms amendment was killed "because it was recognized up front that the House would never accept it with that language in it." *See* Joyce Price, *AIDS Testing Likely to Pass*, WASH. TIMES, Sept. 29, 1991, at A3 (quoting Bob Maynes, spokesperson for Senator Dennis DeConcini, ranking Democrat on conference committee). As commonly pointed out during the debates on the proposal, requiring actual knowledge may discourage health care workers in high risk groups from voluntarily submitting to testing. 137 CONG. REC. S10, 332 (daily ed. July 18, 1991) (quoting Senator Edward M. Kennedy from Massachusetts as arguing that the Helms amendment "[c]ould seriously undermine the willingness of health care workers to seek HIV testing when they know they have been placed at risk"). By avoiding the requisite knowledge for punishment under the proposal, high-risk health care workers could continue their practice without fear of possible criminal sanction. *Id.* Opponents thus argued that by discouraging voluntary testing, such a proposal would actually increase the likelihood of viral transmission. *Id.* Senator Kennedy stated: "[M]any more Americans are more likely to be unknowingly exposed to AIDS if their doctor faces a 10-year jail sentence, than if careful, considered review were available to guide that doctor into safe practices under the CDC guidelines." *Id.*

Furthermore, seropositive health care professionals know that any mention of their health status to patients would mean almost certain death for their practices. *See* 137 CONG. REC. S10, 341 (daily ed. July 18, 1991) (quoting statement of Senator Durenberger saying that "because of the fear and ignorance [surrounding the AIDs epidemic,] disclosure of HIV status is tantamount to forcing [a health care worker] to withdraw from practice all together"). The health care industry would face large expense increases in retraining and replacing valuable health care professionals unnecessarily excluded from practicing because of forced disclosure provisions. 137 CONG. REC. S10, 344 (daily ed. July 18, 1991) (reprinting letter to Senator Kennedy). The American Hospital Association also stressed that penalties and practice restrictions for HIV-infected health care workers who pose no risk to their patients could result in a shortage of personnel available to care not only for HIV-infected patients, but for all patients living in areas with a high prevalence of the virus. *Id.* As a result of such a provision, non-infected health care professionals would possibly become even more reluctant to treat AIDS-infected patients for fear of contracting the virus and consequently losing their practices. 137 CONG. REC. S9784 (daily ed. July 11, 1991) (reprinting *Doctors with AIDS*, NEWSWEEK, July 1, 1991, which reported a study of medical residents finding that two-thirds of the residents said they did not plan to treat people with AIDS and that 74% of the residents would not give lifesaving treatment to seropositive patients if the risk of infection to the residents was one in 100). Finally, the proposal sought no promotion of public awareness or education regarding possible transmission in the health care setting. *Id.*

Instead of accepting the Helms proposal, the conference committee adopted an amendment introduced by Senator Robert Dole (R-Kan.) that had previously passed by unanimous consent in the Senate. 137 CONG. REC. S10, 348-50 (daily ed. July 18, 1991) (providing language of Senator Dole's amendment and listing the results of the vote on the amendment). Section 633 of the Treasury, Postal Service and General Government Appropriations Act of 1992 subsequently incorporated the substance of Senator Dole's amendment and was enacted into law. Pub. L. No. 102-141 § 633, 105 Stat. 834, 876 (codified at 42 U.S.C. § 300ee-2). For a detailed discussion and analysis of the Helms and Dole amendments, see Cavender, *supra* note 53, at 539.

58. *See* Centers for Disease Control, *supra* note 2, at 5 (1991) (reprinting the CDC guidelines). Specifically, the CDC guidelines call for strict adherence to universal precautions in all surgical procedures with specific guidelines for exposure-prone procedures. *Id.* at 4. The guidelines do not require mandatory testing of health care workers, but instead urge them to undergo voluntary testing for HIV infection. *Id.* According to the guidelines, health care workers who test positive for the virus should generally refrain from practicing "exposure-prone" procedures. *Id.* at 5. Interestingly,

states may adopt either the CDC guidelines as presented or other guidelines equivalent to those of the CDC.[59] Additionally, federal law requires each state's public health official to certify that guidelines have been instituted in the state.[60] Failure to issue such guidelines will render the state ineligible for

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the CDC leaves to each hospital and institution the responsibility of defining for itself what procedures should be classified as "exposure-prone." *Id.* Thus, the guidelines would not prevent seropositive health care workers from practicing invasive procedures not likely to expose patients to the virus if such professionals practice proper surgical techniques, follow universal precautions, and obey proper sterilization techniques. *Id.* Furthermore, an infected health care worker may perform exposure-prone procedures only after seeking the counsel of an expert review panel that had advised the health care worker as to the circumstances, if any, under which continuation of such procedures would be appropriate. *Id.* Such circumstances would include notifying prospective patients of the health care worker's seropositivity before they undergo exposure-prone procedures. *Id.* In instances where an HIV-positive health care worker performs an exposure-prone procedure without the patient's consent, postoperative notification of the patient should be decided on a case-by-case basis. *Id.* at 6.

These guidelines are geared toward preventing HIV transmission both from patient to health care provider and from provider to patient. Through forced adoption of infection control techniques, the Dole Amendment seeks to apply the most effective methods of preventing HIV transmission to patient or health care worker in all medical procedures. At the heart of the amendment is the belief that the low risk of viral transmission during invasive procedures and the high cost of testing do not support the diversion of funds necessary for a mandatory periodic testing program. Instead, the CDC believes that full implementation of universal precautions and proper safety training can substantially reduce the already low risk of viral transmission during invasive procedures. However, critics have pointed out that certain aspects of the CDC guidelines, such as those dealing with exposure-prone procedures, are quite general in scope and will be hard to implement with any uniformity on a national basis. *See, e.g.*, 137 CONG. REC. S10, 358 (daily ed. July 18, 1991) (debate discussion of Senator Durenberger). The Dole Amendment may be further criticized for its lack of specific guidelines regarding financing, implementing, and enforcing nationwide adoption of the CDC guidelines. It fails to specify whether states will receive additional financial assistance for enforcing compliance with all CDC infection control guidelines. The cost of following all of the CDC recommendations for infection control is extremely high. One dentist estimated his cost of full implementation at between $15,000 to $25,000 per year. Gideon Gil, *Kentucky Dentists Attend AIDS-Education Program and Hear Comforting News*, LOUISVILLE COURIER J., Apr. 6, 1991, at A5. Such prohibitive costs may dissuade some health care workers from full implementation unless strict enforcement measures are adopted.

59. The statute reads in pertinent part:

> [E]ach State Public Health Official shall, not later than one year after the date of enactment of this Act, certify to the Secretary of Health and Human Services that guidelines issued by the Centers for Disease Control, or guidelines which are equivalent to those promulgated by the Centers for Disease Control, concerning recommendations for preventing the transmission of the human immunodeficiency virus and the hepatitis B virus during exposure prone invasive procedures . . . have been instituted in the State.

Pub. L. No. 102-141, § 633, 105 Stat. 834, 876 (codified at 42 U.S.C. §300ee-2).

60. Pub. L. No. 102-141, §633, 105 Stat. 834, 876 (codified at 42 U.S.C. §300ee-2) (stipulating that guidelines apply to all health officials practicing within states and that compliance with the guidelines is the responsibility of state public health officials).

federal monies under the Public Health Service Act.[61]

In response to the transmission of HIV from Dr. Acer to Ms. Bergalis and five of his other patients in Florida, the ADA's Board of Trustees adopted the "ADA Interim Policy on HIV-Infected Dentists" in 1991.[62] The policy generally stated that because no scientific evidence existed to indicate that HIV-positive health care providers posed an identifiable risk of HIV transmission to their patients, the recommended infection control procedures were effective in preventing transmission of the virus.[63] The policy did, however, recommend that seropositive[64] dentists either refrain from performing invasive procedures or disclose their condition to patients until more evidence is gathered as to the risk of transmission in a dental setting.[65] It further stated that the ADA would "assist and support infected dentists in sustaining meaningful professional careers."[66]

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61. *Id.* (providing an ineligibility requirement that allows for the extension of the time period where a state shows that additional time is required to institute guidelines); *see also* Public Health Service Act, 42 U.S.C. §§ 210 to 300aaa-13 (1988) (detailing organization, function, and powers of Public Health Service).

62. The Interim Policy reads as follows:

> The dental profession has long adhered to a moral commitment of service to the public and an ethical obligation to protect the health of the patient. An advisory opinion to the American Dental Association's Code of Professional Conduct urges dentists who become ill or impaired to limit the activities of practice to those areas that do not endanger either patients or dental staff.
>
> Currently, there is no scientific evidence to indicate that HIV-positive health care providers pose an identifiable risk of HIV transmission to their patients. There has been only one documented case of transmission from an HIV-infected health care provider to patients during the past 10 years of experience with AIDS, an indication that the risk is infinitesimal. The ADA continues to believe that the recommended infection control procedures are effective in preventing transmission of infection.
>
> However, the recent case of possible HIV transmission from dentist to patient has raised some uncertainty about the risk of transmission from health care provider to patient. While there is evidence that this dental practice did not consistently adhere to all recommended guidelines for prevention of disease transmission, the precise mechanism of transmission in this case remains unknown. This uncertainty leads to the conclusion that the foremost concern of the dental profession must continue to be protection of the patient. Thus, until the uncertainty about transmission is resolved, the ADA believes that HIV-infected dentist[s] should refrain from performing invasive procedures or should disclose their seropositive status.
>
> The American Dental Association will assist and support infected dentists in sustaining meaningful professional careers.

AMERICAN DENTAL ASSOCIATION, INTERIM POLICY ON HIV-INFECTED DENTISTS, *reprinted in A Letter of Importance*, JADA, Feb. 1991, at 8.

63. *Id.* This is generally accepted among experts. Unfortunately, many dentists are not strictly following the recommended infection control procedures. *See supra* note 33.

64. This term refers to persons carrying HIV.

65. *See supra* text accompanying notes 35-42.

66. *See supra* note 62.

Although directly responding to the Bergalis tragedy was a positive step, the Interim Policy proved to be little comfort to patients and dentists. It failed to provide concrete guidelines for what actions should be taken by seropositive dentists until more research became available. The policy told seropositive dentists that the ADA would support them, but that they should refrain from practicing until further study is completed. No support networks or procedures were created. Thus, the policy provided little incentive for seropositive dentists to disclose their conditions to either their patients or the ADA. Additionally, the policy did not mandate compliance with strict sterilization procedures and did not impose disciplinary action upon those not following accepted infection control techniques. Further, it mentioned nothing about improving and requiring other preventive measures and education for dentists and patients. Perhaps most importantly, the policy did not address seropositive patients at all and did not outline the duty of care owed to them by dentists. Therefore, the Interim Policy was the first step in acknowledging the problem, but it did not provide a solution or plan for lowering incidents of transmission in dental settings.

The ADA later adopted a series of resolutions aimed at satisfying some of the vacancies left by the Interim Policy.[67] These resolutions are more specific

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67. The resolutions state:

Resolved, that the American Dental Association take the necessary action to encourage disability insurance coverage and benefits for dentists who test HIV seropositive and no longer practice dentistry because of their HIV status.

AMERICAN DENTAL ASSOCIATION, RESOLUTIONS ADOPTED BY THE ADA GENERAL HOUSE OF DELEGATES RELATING TO ASSOCIATION'S AIDS POLICY, 1992:55H (1992).

Resolved, that the American Dental Association direct the appropriate councils to investigate the risk of opportunistic infection of HIV-positive/AIDS patients at various stages of the disease and develop a protocol which would act as a guide to the dental practitioner in the following areas:

. . . .

2. Evaluation of individual procedures which would best be avoided based on the results of those tests and for patients who exhibit various signs and symptoms of progressive stages of the disease.

3. Determination of which patients would best be treated in a more controlled environment than is possible in the normal dental office and would therefore make referral of these patients an ethical obligation.

Id. at 1992:92H.

Resolved, that if the government mandates HIV testing and disclosure for health care workers, the ADA Council on Governmental Affairs and Federal Dental Services investigate and pursue national legislative possibilities, that would guarantee reasonable financial compensation to health care workers who may be discriminated against upon disclosure of being tested HIV positive.

Id. at 1992:134H.

Resolved, that the ADA is opposed to any laws or regulations that require mandatory HIV testing of dentists and other health care workers.

Id. at 1991:595.

Resolved, that the American Dental Association Policy on HIV-Infected Dentists read

as follows:

> The dental profession has long adhered to a moral commitment of service to the public and an ethical obligation to protect the health of the patient. An advisory opinion to the American Dental Association's *Code of Professional Conduct* urges dentists who become ill or impaired to limit the activities of practice to those areas that do not endanger either patients or dental staff.
>
> Currently, there is no scientific evidence to indicate that HIV-infected health care providers pose an identifiable risk of HIV transmission to their patients. There has been only one alleged case of transmission from an HIV-infected health care provider to patients during the past ten years of experience with HIV disease, an indication that the risk is infinitesimal. The ADA strongly affirms that universal precautions are an effective and adequate means of preventing the transmission of HIV from dental health care worker to patient and patient to dental health care worker.
>
> However, since the foremost concern of the dental profession must continue to be protection of the patient, the Association strongly encourages all dental health care workers to undergo personal assessments to determine the need for HIV testing. Dental health care workers who believe they are at risk of HIV infection should monitor their HIV serostatus. All HIV-seropositive dental health care workers who perform procedures viewed to have identifiable risk should practice only under the evaluation and monitoring of their personal physician and/or under recommendations of public health officials, expert review panels, or in compliance with institutional policies. HIV infection alone does not justify the limiting of professional duties, or automatically mandate disclosure, unless the dental health care worker poses a risk of transmitting infection through non-compliance with universal precautions, a lack of infection control competence, or presents signs of functional impairment. If the HIV-infected dentist discontinues the practice of dentistry, the Association believes the dentist to be totally disabled with respect to the practice of dentistry.
>
> The American Dental Association will assist and support infected dentists in sustaining meaningful professional careers.
>
> and be it further,

Resolved, that appropriate agencies of the Association continue their efforts to educate the public about the efficacy of universal precautions and the infinitesimal risk of contracting HIV infection during the course of dental treatment, and be it further

Resolved, that the appropriate agencies of the Association continue to monitor studies and the policies, reports and guidelines developed by major health care organizations, CDC and other groups, with a report back to the 1992 House of Delegates.

Id. at 1991:592.

The Association believes that all HIV-infected patients should disclose their HIV status and medical history: dentists, like physicians, need to know every patient's medical history in order to make appropriate treatment decisions that are in the best interests of the patient. For the same reason, the Association also strongly supports state and federal legislation that gives an HIV-infected patient's health care providers the right to share knowledge of the patient's HIV status and current medical condition without risking a violation of state or federal anti-discrimination laws and HIV confidentiality laws. The Association further strongly supports state and federal legislation that protects a dentist from charges of discrimination if a dentist, in a sincere effort to protect a patient's health, elects to refrain from treating a patient who fails to disclose his/her HIV status and medical history or allow an HIV test to be performed.

The Association urges dentists to maintain strict confidentiality of the patient's

and provide a better prediction of the ADA's future stance on some of the difficult issues developing from HIV transmission in dental settings. The resolutions clearly state that the ADA believes all seropositive patients should disclose their conditions and medical histories before any kind of dental treatment is rendered.[68] Dentists, like physicians, need to know every patient's complete medical history to make appropriate treatment decisions that are in the patient's best interest.[69] In addition, the ADA supports legislation that permits seropositive patients' health care providers to share knowledge of the patients' conditions with each other and that protects dentists from charges of discrimination for refusing to treat patients who fail to disclose their HIV positive conditions and medical histories.[70] The resolutions address the separate issues surrounding seropositive dentists, as well as seropositive patients. The resolutions discuss the need for proper diagnoses and critical evaluations of seropositive patients' conditions to determine proper treatment.[71] The resolutions acknowledge that seropositive patients must receive special consideration when determining treatment because their immune systems do not function normally,[72] causing them to be at risk of developing infection from bacteria and germs exposed during dental treatment that healthy patients naturally resist.[73] What is a simple infection or a minor cold to a healthy patient can be a serious, if not fatal, illness to an HIV carrier.[74] The resolutions make the referral of these high risk patients an ethical obligation.[75]

The resolutions also state that the ADA is strongly opposed to any laws or regulations that would require mandatory testing of dentists and other health care

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> HIV status and medical condition, except as noted above with respect to sharing of information among the patient's health care providers when allowed by state or federal law. . . .
>
> The Association believes that individuals with HIV infection should have access to dental treatment. Treatment considerations should provide for a judicious balance between the well-being of these patients and the protection of the health of the public as well as the dental care providers.

Id. at 1991:591.

68. *See* AMERICAN DENTAL ASSOCIATION, supra note 67, at Resolution 1991:591.

69. *Id.*

70. *Id.*

71. *Id.* at Resolution 1992:92H.

72. *See generally* Levine, *supra* note 20.

73. *Id.* Many kinds of bacteria and germs may be present in the mouth during dental treatment because the dentist may clean decay and puss from abscesses on teeth and gums. These organisms are released into the mouth during treatment.

74. *Id.*

75. *See* AMERICAN DENTAL ASSOCIATION, *supra* note 67, at Resolution 1992:92H.

workers.[76] Rather, the ADA encourages all dental health workers to undergo personal assessments to determine the need for HIV testing.[77] Workers who believe they are at risk of HIV infection should monitor their serostatus individually.[78] All seropositive workers performing procedures viewed to have an identifiable risk of transmission should practice only under the evaluation and

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76. *Id.* at Resolution 1991:595. This opposition largely stems from the concern that testing would impose an unacceptable financial and practical burden on dentists. Screening would need to be administered periodically, perhaps annually or semi-annually. There could be no assurance that a dentist, having once tested negative, had not subsequently become infected or seroconverted. *See generally* Martha A. Field, *Testing for AIDS: Uses and Abuses*, 16 AM. J.L. & MED., 33, 41 (1990). It is also possible that the dentist could be infected at the time of the test but had not yet formed antibodies to the virus. *Id.* Thus, the dentist would test negative but would still be infected and infectious. *Id. See generally* Lawrence O. Gostin et al., *The Case Against Compulsory Casefinding in Controlling AIDS—Testing, Screening, and Reporting*, 12 AM. J.L. & MED. 7 (1986). The rationale for mandatory screening is that public health officials would be able to identify those dentist who are unaware of their own infection, as well as those who are aware of but refuse to disclose their infection. *See* Steven Eisenstat, *An Analysis of the Rationality of Mandatory Testing for the HIV Antibody: Balancing the Governmental Public Health Interests with the Individual's Privacy Interest*, 52 U. PITT. L. REV. 327, 347-48 (1991); Larry Gostin, *The HIV-Infected Health Care Professional: Public Policy, Discrimination, and Patient Safety*, 18 LAW, MED. & HEALTH CARE 303 (1990). Once identified, these dentists could be prohibited from performing invasive procedures without disclosing their condition to their patients. For further discussion of mandatory screening, see Frank S. Rhame & Dennis G. Maki, *The Case for Wider Use of Testing for HIV Infection*, 320 NEW ENG. J. MED. 1248, 1250 (1989); Ronald Bayer et al., *HIV Antibody Screening: An Ethical Framework for Evaluating Proposed Programs*, 256 JAMA 1768 (1986); Harvey V. Fineberg, *Screening for HIV Infection and Public Health Policy*, 18 LAW, MED & HEALTH CARE 29 (1990); Barney, *supra* note 8, at 933.

77. *See* AMERICAN DENTAL ASSOCIATION, *supra* note 67, at Resolution 1991:592.

78. *Id.* The United Kingdom took a similar approach in coping with seropositive dentists even before the incident with Dr. Acer. On January 13, 1988, the General Dental Council in the United Kingdom stated its position in the following terms:

> 1. There has been considerable public concern about the risk of contracting AIDS and, more recently, about the possibility that patients might be infected by doctors or dentists who are themselves suffering from AIDS or are HIV positive. There is no known instance of transmission of the AIDS virus from dentist to patient in the course of treatment. The risk of cross-infection in dental surgery has always existed. Dentists have a duty to understand the risk and the precautions which must be taken to avoid it.
> 2. It is the ethical responsibility of dentists who believe that they have been infected with HIV to obtain medical advice and, if found to be infected, to submit to regular medical supervision. Their medical supervision will include counselling, in particular, in respect of any changes in their practice which might be considered appropriate in the best interests of protecting their patients. It is the duty of such dentists to act upon the medical advice they have been given, which may include the necessity to cease the practice of dentistry altogether or to modify their practice in some way.
> 3. Dentists who know that they are, or believe that they may be, HIV positive and who might jeopardize the well being of their patients by failing to obtain appropriate medical advice or to act upon the advice that has been given to them are behaving unethically and contrary to their obligations to patients. Behavior of this kind may raise a question of serious professional misconduct.

UNITED KINGDOM GENERAL DENTAL COUNCIL (Jan. 13, 1988).

supervision "of their personal physician and/or under recommendations of public health officials, expert review panels, or in compliance with institutional policies."[79] The resolutions further state that HIV infection alone does not justify limiting professional duties or automatically mandating disclosure unless the dental health care worker poses a risk of transmitting infection to patients or other workers as a result of non-compliance with universal precautions, a lack of infection control competence,[80] or signs of functional impairment.[81]

In an advisory opinion issued by the Council on Ethics, Bylaws, and Judicial Affairs, the ADA stated that dentists have an ethical duty to treat seropositive patients unless "the patient's health status would be significantly compromised by the provision of dental treatment."[82] In such cases, referrals

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79. *See* AMERICAN DENTAL ASSOCIATION, *supra* note 67, at Resolution 1991:592. In reality, this recommendation is too vague to be helpful. For example, the resolution mentions expert review panels, but does not elaborate on or create such panels. *Id.*

80. Universal precautions and infection control guidelines are mandated through the OSHA Industry Standards, 29 C.F.R. § 1910.1030 (1992). These Industry Standards outline sterilization procedures for the office and equipment, appropriate attire for all personnel in the office, vaccination requirements for Hepatitis B, training requirements for all personnel, and record keeping procedures for incidents of exposure. *Id.* The sterilization requirements are stringent, including regulations for decontamination, disposal of infectious waste, and barrier protectors. *Id.* However, some dentists find the regulations difficult to follow. *See infra* note 85.

81. *See* AMERICAN DENTAL ASSOCIATION, *supra* note 67, at Resolution 199:592. A recent case of alleged HIV transmission from a health care professional to his patients has renewed interest in disclosure of the HIV status of physicians. *See* Centers for Disease Control, *Possible Transmission of Human Immunodeficiency Virus to a Patient During an Invasive Dental Procedure*, 39 MORBIDITY & MORTALITY WKLY. REP. 489 (1990); Centers for Disease Control, *Update: Transmission of HIV Infection During Invasive Dental Procedures—Florida*, 40 MORBIDITY & MORTALITY WKLY. REP. 377 (1991). As a result of this single case, health departments, hospitals, and other medical institutions have implemented "lookback" policies, whereby they notify the former patients of physicians who die from HIV-related conditions. For some examples of lookbacks performed by medical institutions, see Jean Latz Griffin, *Dental Student Has HIV, Patients Told*, CHI. TRIB., July 24, 1991, at C1 (reporting that a dental school notified patients that they had been treated by an HIV-positive dental student); *Doctor Died of AIDS, Hospital Tells Parents*, N.Y. TIMES, Apr. 11, 1991, at A16 (reporting that a hospital notified the parents of 59 patients that a medical resident had died of AIDS). An institution's decision to perform a "lookback" may reduce the number of people exposed to HIV as a result of medical workplace exposures and may also reduce the cost of subsequent lawsuits.

82. The provision states:

> A dentist has the general obligation to provide care to those in need. A decision not to provide treatment to an individual because the individual has AIDS or is HIV seropositive, based solely on that fact, is unethical. Decisions with regard to the type of dental treatment provided or referrals made or suggested, in such instances, should be made on the same basis as they are made with other patients, that is, whether the individual dentist believes he or she has need of another's skills, knowledge, equipment or experience and whether the dentist believes, after consultation with the patient's physician if appropriate, the patient's health status would be significantly compromised by the provision of dental treatment.

should be made to those dental specialists who are equipped to safely treat special-needs patients.[83]

All of these policies contain important information and are a good beginning to manage HIV in dentistry. However, the policies are vague and provide little help in implementing the conclusions drawn by the ADA. For instance, the policies have little authority to force dentists to accept their professional responsibility to treat HIV patients and to monitor their own serostatus. Furthermore, the policies have no authority to enforce the stringent sterilization and training procedures outlined in the OSHA Industry Standards.[84] Also, the policies do not include an outline of disciplinary proceedings that could result from failure to follow the infection control regulations. Finally, the policies insufficiently emphasize the dire need for better education for both the patients and the dentists. Therefore, the current legislation and dental association policies are incomplete and incongruent. For example, while one pushes for mandatory testing, the other resists such efforts. These groups must work together toward minimizing the risk of transmission in the dental setting by establishing the duties and responsibilities of seropositive dentists and patients. Dentists and patients must be willing to sacrifice some degree of privacy and

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COUNCIL ON ETHICS, BYLAWS, AND JUDICIAL AFFAIRS, AMERICAN DENTAL ASSOCIATION, ADVISORY OPINION (1988) [hereinafter ADVISORY OPINION].

The American Medical Association (AMA) has adopted a similar policy concerning the treatment of seropositive patients. The AMA's Council on Ethical and Judicial Affairs determined that "when an epidemic prevails, the physician must continue his labors without regard to the risk to his own health . . . . [A] physician may not ethically refuse to treat a patient whose condition is within the physician's realm of competence" because the patient is HIV-infected. Centers for Disease Control, *Council Says Doctors Have Obligation to Treat AIDS Patients*, AIDS WKLY., Jan. 11, 1988, at 10. The AMA also recently developed physician guidelines for the treatment of HIV patients. Laurie Jones & Deborah Shelton Pikney, *Help on the Way for Treating Growing HIV Epidemic*, AM. MED. NEWS, Feb. 7, 1994, at 7.

83. ADVISORY OPINION, *supra* note 82.

84. David Lewis, an environmental microbiologist at the University of Georgia in Athens, maintains that dental handpieces attached to a leaky piece of dental equipment known as a "prophy (lactic) angle" can transfer at least 50 times more blood than a needle stick in just five minutes of operation during routine treatments to clean and polish teeth. *See* Breo, *supra* note 2, at 2732-33. The prophy angle, which is connected to the head used to clean teeth, is a metal joint that gives a dentist the proper angle to maneuver within the mouth. *Id.* at 2733. Lewis theorizes that Dr. Acer treated himself or one of his infected partners with this device, failed to properly sterilize it, and oral detritus, including blood and saliva with HIV, passed from patient to patient through the leaky prophy angle. *Id.* at 2733. Heat sterilization kills HIV and other infectious agents, but Lewis fears that 10% of all dentists do not adequately sterilize their devices. *Id.* With this assumption, he theorizes that AIDS and Hepatitis B cases that are not attributed to traditional risk factors may, in fact, be due to infection in a dental office. *Id.* "It is terribly difficult to track these unidentified AIDS . . . cases back to the dentist's office and that is why dentists must be made to comply with heat sterilization procedures." *Id.* *See 20/20* (ABC television broadcast, Oct. 1, 1993).

comfort to reduce the risk of transmission for all those involved.[85]

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85. Many dentists resist efforts to implement testing programs and to enforce strict sterilization procedures because of the cost. J. Randoph Mullins & Paul B. Harrison, *The Questionable Utility of Mandatory Screening for the Human Immunodeficiency Virus*, 166 AM. J. SURGERY 676 (1993). Many dentists with small practices, especially dentists practicing in areas where the presence of HIV is virtually non-existent, feel that the cost in updating equipment and training staff to meet the standards is not justified by the minute risk of HIV. These dentists fear that raising their fees as a result of updating equipment will cause many patients to cease seeking dental treatment except when seriously needed.

The use of gloves, masks, and gowns by dentists has increased throughout the practice of dentistry over time. Kent D. Nash, *How Infection Control Procedures are Affecting Dental Practice Today*, JADA, Mar. 1992, at 67. Eyewear, both protective and corrective, has been used by about 80% of dentists since 1986 and has remained relatively steady since then. *Id.* at 68. In 1986, slightly more than 20% of dentists reported using gloves on all patients, and about the same percentage indicated using a mask. *Id.* Only about 12% said they wore gowns for all patients. *Id.* Five years later, the picture had changed dramatically. *Id.* at 69. By 1991, more than 60% of dentists indicated using gloves, masks, gowns, or eyewear for all patients. *Id.* Use of gloves has risen to more than 90% among dentists, hygienists, and dental assistants. *Id.* Mask utilization has climbed to more than 60% of dentists and assistants, and more than 75% of hygienists. *Id.* Use of gowns took a significant jump in 1991, when 64% of dentists, more than 75% of hygienists, and about 60% of assistants reported using them. *Id.*

Guidelines for using barrier techniques are intended to boost the overall safety of patients, dentists, and dental team members. *Id.* at 70. Their adoption affects treatment procedures rendered in the dental office, practice costs, and fees charged to patients. *Id.* Early on, practitioners probably absorbed the costs of barrier techniques by adjusting the rate at which the techniques were adopted, lowering net earnings, or offsetting adjustments in other expenses. *Id.* at 71. More recently, there have been signs that dentists are beginning to pass on these added costs to patients in the form of higher fees. *Id.*

The use of gloves, gowns, masks, and eyewear all directly affect the dental office supplies budget regardless of whether the dentist uses the procedures with some or all the patients. *Id.* Costs for dental supplies account for 10% to 12% of a practice's total average expense. *Id.* Over the past few years, the supplies expense per patient visit has increased from six dollars per visit to about $12.50 per visit, an increase of about 108%. *Id.* To compensate, gross billings have increased 10.5% each year since 1986. *Id.* Dentists adopting recommended barrier techniques incur higher supply expenses per patient visit than dentists who have not complied with the procedures or who use them only with some patients. *Id.* The use of barrier techniques has also boosted the time dentists devote to each patient—donning gloves, masks, gowns, and protective eyewear, and properly disposing of the items after use takes time. *Id.* As a result, heavy users of these techniques see roughly 410 fewer patients each year. *Id.* This also increases the operating costs for the office. *Id.* It is important to note that these figures do not include the cost and time factors for updating sterilization equipment such as autoclaves, stocking sterilization materials such as plastic film and alcohol, training costs for personnel, or renovating office space to accommodate the changes.

However, Dr. Trusten Lee, D.D.S., states that total compliance with the sterilization regulations can be achieved with a cost of approximately $10 per patient visit. Interview with Dr. Trusten Lee, D.D.S., Lakeland Dental Center, in Merrillville, Indiana (Nov. 23, 1993). These figures suggest that the overall cost of compliance is not as cumbersome as some dentists believe. Furthermore, Dr. Lee estimates that dentists who treat approximately 20 patients per day will average one seropositive patient every seven days. *Id.* The striking point here is that the overwhelming majority of these seropositive patients will not disclose their condition to the dentist. *Id.* Thus, the dentists must rely on their sterilization procedures, which Dr. Lee states are far from adequate in some cases. *Id.*

These authorities need to work together to outline and implement the best possible disease management plan. To do this, each body needs to understand the role and position of the other. Each must realize its dependence upon the other to achieve their mutual goals. The legislature has the authority to transform disease control guidelines into law, thus increasing the weight and implementation power of the requirements. The legislature has the authority and support of the entire federal system behind it. However, Congress frequently does not have the thorough knowledge needed to create medically sound and logistically feasible laws. Congress needs the national and state dental associations to assist in drafting the laws and to help in policing and enforcing them once they are enacted. The dental associations govern ethical standards for the industry and conduct disciplinary proceedings for inappropriate behavior by dentists. Furthermore, the associations have the primary responsibility of organizing and overseeing education for both dentists and patients. Finally, many standards of care used in civil malpractice cases are derived from the guidelines provided by the dental associations. However, before the dental associations will cooperate, they must be assured the legislature is listening to their concerns and acting in their interests. Dentists want legislation tailored to and specifically addressing the special needs and risks present in the dental setting.

IV. THE RIGHT OF PRIVACY

A concern that has plagued attempts to curtail the general spread of HIV is the outcry by carriers that proposed measures do little to protect their personal and medical privacy rights and, in fact, cause unjustifiable breaches of these rights.[86] More specifically, the most important issue to most carriers in effective policymaking is the urgent need to protect confidential information shared with their health care providers. Thus, before any legislation can be proposed specifically to handle HIV and dentistry, the general issues of how to protect these privacy rights of carriers and of how the judiciary should approach any legislation infringing upon these rights must be addressed. This Section will briefly trace the development of the right of privacy and the standards courts have used to review infringements upon various aspects of the privacy right. This Section will then analyze the level of scrutiny a court would use to review a piece of legislation created to control the spread of HIV in dental settings.

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86. An invasion of privacy is an injury to one's personality. 3 ROSCOE POUND, JURISPRUDENCE 58 (1959). It impairs the mental peace and comfort of the individual and may produce suffering much greater than that produced by a bodily injury. *Id.*; *see* John W. Wade, *The Communicative Torts and the First Amendment*, 48 MISS. L.J. 671 (1977).

A right of privacy has been heralded in the American political tradition,[87] even though the Constitution itself does not mention such a right. Without a specific constitutional reference, the privacy right's very nature and scope are unclear.[88] The United States Supreme Court has recognized that a right of personal privacy, or a guarantee of certain zones of privacy,[89] does exist under the protections offered by the Constitution.[90] The Court has recognized that the Constitution enables a certain private sphere of individual liberty to be kept largely beyond the reach of government.[91] In varying contexts, the Court or individual justices have found at least the roots of that right in the First Amendment,[92] the Fourth and Fifth Amendments,[93] the penumbras of the Bill

87. Privacy is commonly understood as a value asserted by individuals against the demands of a curious and intrusive society. *See generally* THOMAS I. EMERSON, THE SYSTEM OF FREEDOM OF EXPRESSION 549 (1970); RICHARD F. HIXSON, PRIVACY IN A PUBLIC SOCIETY: HUMAN RIGHTS IN CONFLICT (1987); JOHN STUART MILL, ON LIBERTY (M. Warnock ed., 1962) (1859); ALAN F. WESTIN, PRIVACY AND FREEDOM (1967); Steven J. Andre, *Privacy As an Aspect of the First Amendment: The Place of Privacy in a Society Dedicated to Individual Liberty*, 20 U. WEST. L.A. L. REV. 87 (1988-89); Edward J. Bloustein, *Privacy as an Aspect of Human Dignity: An Answer to Dean Prosser*, 39 N.Y.U. L. REV. 962 (1964); J. Braxton Craven, Jr., *Personhood: The Right to Be Let Alone*, 1976 DUKE L.J. 699, 701-02; Louis Henkin, *Privacy and Autonomy*, 74 COLUM. L. REV. 1410, 1428-29 (1974); Samuel D. Warren & Louis D. Brandeis, *The Right To Privacy*, 4 HARV. L. REV. 193 (1890).

88. The concept of privacy has, of course, psychological, social, and political dimensions that reach far beyond its analysis in a legal context. *See generally* HANNAH ARENDT, THE HUMAN CONDITION, (1958); ERIC HOFFER, THE TRUE BELIEVER: THOUGHTS ON THE NATURE OF MASS MOVEMENTS (1951); GEORGE ORWELL, NINETEEN EIGHTY-FOUR: A NOVEL (1949); George J. Stigler, *An Introduction to Privacy in Economics and Politics*, 9 J. LEGAL STUD. 623 (1980). However, these dimensions will only be dealt with incidentally in this note. Furthermore, this note will not present a detailed exposition on the case law and statutes developing the right of privacy. Rather, the aim is more limited to briefly surveying the right of privacy and its development so that the reader may better understand how privacy profoundly affects the management of HIV.

89. *See* Griswold v. Connecticut, 381 U.S. 479 (1965) (articulating various "zones of privacy").

90. For discussions concerning the early development of the right of privacy, see Wilfred Feinberg, *Recent Developments in the Law of Privacy*, 48 COLUM. L. REV. 713 (1948); Leon Green, *The Right of Privacy*, 27 ILL. L. REV. 237 (1932); Rufus Lisle, *The Right of Privacy (A Contra View)*, 19 KY. L.J. 137 (1931); Louis Nizer, *The Right of Privacy: A Half Century's Developments*, 39 MICH. L. REV. 526 (1941); Denis O'Brien, *The Right of Privacy*, 2 COLUM. L. REV. 437 (1902); Leon R. Yankwich, *The Right of Privacy: Its Development, Scope, and Limitations*, 27 NOTRE DAME L. REV. 499 (1952); R.T. Kimbrough, Annotation, *Right of Privacy*, 138 A.L.R. 22 (1942); R.T. Kimbrough, Annotation, *Right of Privacy*, 168 A.L.R. 446 (1947); W.E. Shipley, Annotation, *Right of Privacy*, 14 A.L.R.2d 750 (1950).

91. *See, e.g.*, Thornburgh v. American College of Obstetricians & Gynecologists, 476 U.S. 747 (1986) (holding that a state's law subordinating women's privacy right to abortion was unconstitutional).

92. Stanley v. Georgia, 394 U.S. 557 (1969). In *Stanley*, the Supreme Court held that, despite the government's valid interest in eliminating obscenity, criminal prosecution for private possession of obscene material in the home constituted too drastic an invasion of the "right to be free from state inquiry into the contents of [one's] library." *Id.* at 565. After discussing the fundamental First Amendment right to receive information and ideas, the Court said: "For also fundamental is the

of Rights,[94] the Ninth Amendment,[95] and the first sections of the Fourteenth Amendment.[96] These justices make it clear that only personal rights that can be deemed fundamental or "implicit in the concept of ordered liberty" are included in this guarantee of personal privacy.[97] They also make it clear that the right extends to some degree to activities relating to individual autonomy regarding child rearing,[98] education,[99] familial relations,[100] pro-creation,[101]

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right to be free, except in very limited circumstances, from unwanted governmental intrusions into one's privacy." *Id.* at 564. *Stanley* protected nondisclosure of use, not use itself. *Id.* at 564; *see Project, Government Information and the Rights of Citizens*, 73 MICH. L. REV. 971, 1291 (1975) (analyzing *Stanley* as a nondisclosural privacy case).

93. *See generally* Terry v. Ohio, 392 U.S. 1 (1968); Katz v. United States, 389 U.S. 347, 361 (1967).

94. *See* Griswold v. Connecticut, 381 U.S. 479 (1965) (invalidating a statute making use of contraceptives by married couples illegal because it deprived couples of the liberty protected by the fundamental right of privacy). *See generally* Paul G. Kauper, *Penumbras, Peripheries, Emanations, Things Fundamental and Things Forgotten: The* Griswold *Case*, 64 MICH. L. REV. 235, 253 (1965).

95. *Griswold*, 381 U.S. at 487 (Goldberg, J., concurring).

96. *See* Meyer v. Nebraska, 262 U.S. 390 (1923) (rejecting the prohibition of teaching in languages other than English and teaching of languages other than English below the eighth grade as unconstitutional because it deprived teachers and parents of their liberty interest without due process of law); Roe v. Wade, 410 U.S. 113 (1973) (holding that a prohibition on abortion violated the Due Process Clause as an unjustified deprivation of liberty because it unnecessarily infringed on women's right of privacy).

97. The Court's use of the term "privacy" often differs substantially from the common definition of the term. In many instances, a more descriptive term might be the right to "personal autonomy." *See, e.g.*, Planned Parenthood v. Casey, 112 S. Ct. 2791 (1992); Carey v. Population Servs. Int'l, 431 U.S. 678 (1977) (recognizing the right of persons under the age of 16 to choose whether to use contraceptives); Planned Parenthood v. Danforth, 428 U.S. 52 (1976) (invalidating the requirement of spousal or parental consent to obtain abortions); Roe v. Wade, 410 U.S. 113 (1973) (holding that a prohibition on abortion violated the Due Process Clause of the Fourteenth Amendment as an unjustified deprivation of liberty because it unnecessarily infringed upon women's fundamental right of privacy); Eisenstadt v. Baird, 405 U.S. 438 (1972) (expanding the right to access of contraceptives to single people because the fundamental right of privacy exists in the individual and not in the marital relationship); Stanley v. Georgia, 394 U.S. 557 (1969); Griswold v. Connecticut, 381 U.S. 479 (1965) (invalidating a statute making the use of contraceptives by married couples illegal because it deprived couples of the liberty protected by the fundamental right of privacy); Skinner v. Oklahoma, 316 U.S. 535 (1942) (striking down a statute allowing the sterilization of people convicted of two or more felonies and establishing that marriage and procreation are liberties with special constitutional significance).

98. *See* Quilloin v. Walcott, 434 U.S. 246 (1978) (holding that a state cannot force the breakup of a natural family over the objection of the parents and their children, for the sole reason that to do so was thought to be in the children's best interests, without some showing of unfitness, because the Due Process Clause would clearly be violated); Wisconsin v. Yoder, 406 U.S. 205 (1972) (holding that only those interests of the highest order, and those not otherwise served, can overbalance the legitimate claims to the free exercise of religion and to the power of parents to make such decisions for their children); Pierce v. Society of Sisters, 268 U.S. 510 (1925) (holding that an act requiring attendance at public schools for all normal children between the ages of eight and 16 violated the Fourteenth Amendment because it deprived the parental liberty interest in the upbringing and education of their children). *See generally* JOHN E. NOWAK ET AL.,

marriage,[102] contraception,[103] and abortion.[104]

CONSTITUTIONAL LAW 635 (3d ed. 1986); Dennis J. Hutchinson, *Unanimity and Desegregation: Decisionmaking in the Supreme Court, 1948-1958*, 68 GEO. L.J. 1 (1979); Richard A. Posner, *The Uncertain Protection of Privacy by the Supreme Court*, 1979 SUP. CT. REV. 173, 195-96.

99. *See* Meyer v. Nebraska, 262 U.S. 390 (1923). *See also supra* note 96.

100. *See* Michael H. v. Gerald D., 491 U.S. 110 (1989) (holding that a father does not have a constitutionally protected fundamental liberty interest in his relationship with a child conceived by him with another man's wife); Califano v. Jobst, 434 U.S. 47 (1977) (holding that reasonable regulations that do not significantly interfere with the decision to enter into the marital relationship may legitimately be imposed); Belle Terre v. Boraas, 416 U.S. 1 (1974) (holding that unrelated people have no fundamental right to live together); Stanley v. Illinois, 405 U.S. 645 (1972) (striking a state's irrebuttable statutory presumption that all unmarried fathers are unqualified to raise their children); Prince v. Massachusetts, 321 U.S. 158 (1944) (stating that the custody, care, and nurturing of the child resides first in the parents, whose primary function and freedom include the preparation for obligations that the state can neither supply nor hinder); Moore v. East Cleveland, 431 U.S. 494 (1977) (striking a zoning ordinance that interfered with families' liberty and privacy interests, including the right to live with whom they chose). *See generally* John H. Garvey, *Children and the Idea of Liberty: A Comment on the Civil Commitment Cases*, 68 KY. L.J. 809, 832-833 (1979-1980).

101. *See* Skinner v. Oklahoma, 316 U.S. 535 (1942) (striking down a statute allowing for the sterilization of some persons convicted of two felonies and establishing the right to marriage and procreation as those of special constitutional significance).

102. *See* Loving v. Virginia, 388 U.S. 1 (1967) (holding that miscegenation statutes, adopted to prevent marriages between persons on the basis of racial classification, violate the Equal Protection and Due Process Clauses of the Fourteenth Amendment).

103. *See* Eisenstadt v. Baird, 405 U.S. 438 (1972); Griswold v. Connecticut, 381 U.S. 479 (1965).

104. *See* Planned Parenthood v. Casey, 112 S. Ct. 2791 (1992); Webster v. Reproductive Health Servs., 492 U.S. 490 (1989) (holding that a state may prohibit the use of public resources to promote or perform abortions and may require physicians to test for viability); Thornburgh v. American College of Obstetricians, 476 U.S. 747 (1986) (holding that states may not enact statutes discouraging women from choosing abortions under the pretext of maternal health); Akron v. Akron Ctr. for Reproductive Health, 462 U.S. 416 (1983) (striking five provisions of an ordinance regulating abortions); Planned Parenthood v. Ashcroft, 462 U.S. 476 (1983) (invalidating a second-trimester hospitalization requirement but upholding a requirement that a second physician be present during abortions performed after viability); H.L. v. Matheson, 450 U.S. 398 (1981) (upholding a statute requiring physicians to notify parents if their minor seeks an abortion); Harris v. McRae, 448 U.S. 297 (1980) (determining that Title X does not obligate a state to pay for medically necessary abortions for which Congress has withheld federal funding); Bellotti v. Baird, 443 U.S. 622 (1979) (striking down a statute requiring that either parental or judicial consent be obtained for abortions by women under age 18); Maher v. Roe, 432 U.S. 464 (1977) (upholding a state's reimbursement of childbirth and medically necessary abortion expenses through Medicare even though the state did not provide such funds for abortions); Planned Parenthood v. Danforth, 428 U.S. 52 (1976); Roe v. Wade, 410 U.S. 113 (1973).

See generally LAURENCE H. TRIBE, ABORTION: THE CLASH OF ABSOLUTES 5 (1990); FRED W. FRIENDLY & MARTHA J.H. ELLIOTT, THE CONSTITUTION: THAT DELICATE BALANCE 202-04 (1984); David A.J. Richards, *Constitutional Privacy, Religious Disestablishment, and the Abortion Decisions, in* ABORTION: MORAL AND LEGAL PERSPECTIVES 148, 171-73 (Jay L. Garfield & Patricia Hennessey eds., 1984); ARCHIBALD COX, THE ROLE OF THE SUPREME COURT IN AMERICAN GOVERNMENT 113-14 (1976); Susan Estrich & Kathleen Sullivan, *Abortion Politics: Writing for an Audience of One*, 138 U. PA. L. REV. 119, 125-127 (1989) (commenting that privacy

When a fundamental right is at stake, the Court has applied a strict scrutiny standard and has held that regulation limiting or infringing upon these rights may be justified only by a compelling state interest and that the legislation must be narrowly tailored to protect that compelling state interest.[105] When a non-fundamental right is at stake, the Court has applied the far less stringent standards of a balancing test[106] or a mere rationality test, under which a law will be upheld if it is rationally related to any conceivable legitimate end of government.[107]

The Supreme Court has mentioned another aspect of the constitutional right of privacy: the right of informational privacy or, alternatively stated, the right of nondisclosure of personal matter.[108] In several instances, the Court has

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cases rest centrally on the moral fact that a person belongs to oneself, not to others or to society as a whole); Ruth Bader Ginsburg, *Some Thoughts on Autonomy and Equality in Relation to* Roe v. Wade, 63 N.C. L. REV. 375 (1985); John T. Noonan, Jr., *The Root and Branch of* Roe v. Wade, 63 NEB. L. REV. 668 (1984); Thomas I. Emerson, *The Power of Congress to Change Constitutional Decisions of the Supreme Court; The Human Life Bill*, 77 NW. U. L. REV. 129, 131 (1982); Donald H. Regan, *Rewriting* Roe v. Wade, 77 MICH. L. REV. 1569, 1639 (1979); Michael J. Perry, *Abortion, the Public Morals, and the Police Power: The Ethical Function of Substantive Due Process*, 23 UCLA L. REV. 689, 705-06 (1976); R.A. Epstein, *Substantive Due Process by any Other Name: The Abortion Cases*, 1973 SUP. CT. REV. 159, 170-72; Philip B. Heymann & Douglas E. Barzelay, *The Forest and the Trees:* Roe v. Wade *and Its Critics*, 53 B.U. L. REV. 765, 773-74 (1973).

105. Roe v. Wade, 410 U.S. 113 (1973).

106. *See infra* notes 172-190 and accompanying text.

107. The significance of the Court's decision to classify a particular right as fundamental or non-fundamental is even greater than might at first be supposed. Where the right is not found to be fundamental and that a legitimate state objective and a rational relation between the means chosen and that objective are all that is required, the Court's deference to the legislative judgment is so extreme that there is virtually no scrutiny at all. *See generally* J. Braxon Craven, Jr., *Personhood: The Right to Be Let Alone*, 1976 DUKE L.J. 699, 700-01. For instance, no statute in the area of economic legislation has been invalidated on substantive due process grounds for over 40 years. By contrast, if the right is found to be fundamental, the scrutiny is so strict that few statutes impairing the right can meet the test of showing that the state's objective is "compelling" and that it cannot be achieved in a less burdensome way. *Id.* Thus, the Court's decision on "fundamentalness" tends to be virtually dispositive of whether the statute is upheld or invalidated.

108. *See, e.g.*, Detroit Edison Co. v. NLRB, 440 U.S. 301 (1979) (upholding the right to privacy for psychological testing results); Whalen v. Roe, 429 U.S. 589, 599 (1977) (upholding a statute requiring that official drug prescription forms identifying a patient's name be filed with the state health department). Nondisclosure of personal information is an essential element of individual privacy. *See* ARTHUR R. MILLER, THE ASSAULT ON PRIVACY 25 (1971) (discussing privacy as an "individual's ability to control the circulation of information relating to him"); Hyman Gross, *The Concept of Privacy*, 42 N.Y.U. L. REV. 34, 37 (1967) (discussing the ability to mandate the nondisclosure of personal information about oneself as privacy in its "primary or strong sense"). "Information preserves, like spatial territories, provide a normative framework for the development of individual personality." Robert C. Post, *The Social Foundations of Privacy: Community and Self in the Common Law Tort*, 77 CAL. L. REV. 957 (1989). Just as we feel violated when our bedrooms are invaded, so too we experience the inappropriate disclosure of private information "as

used the right of privacy to protect the release of private information.[109] Prior

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pollutions or defilements." Ferdinand Schoeman, *Privacy and Intimate Information, in* PHILOSOPHICAL DIMENSIONS OF PRIVACY: AN ANTHOLOGY 403, 406 (Ferdinand D. Schoeman ed., 1984).

Professor Westin, author of *Privacy and Freedom*, defines privacy as the right of individuals, groups, or institutions to determine for themselves when, how, and to what extent, information about them is communicated to others. *See* WESTIN, *supra* note 87, at 7. Professor Westin identifies four reasons why the right to privacy is essential. *Id.* at 32. First, it preserves the personal autonomy that is essential to the development of the individual's "sacred individuality." *Id.* at 33-34. In addition, privacy facilitates emotional release from the pressures of daily life, especially during periods of loss, shock, or sorrow. *Id.* at 34-36. Moreover, it makes possible self-evaluation, including the exercise of conscience. *Id.* at 36-37. Finally, privacy enables individuals to engage in limited, reserved, and protected communications. *Id.* at 37-39. This in turn gives the individual the ability to share confidences and yet maintain a necessary mental distance in interpersonal relationships. *Id.*

Professor Krattenmaker, who also defines privacy as the individual's control over communication about himself, explains:

> Privacy permits people to share intimacies and ideas upon their own terms, and thus to establish those mutual reciprocal relinquishments of the self that underlie the relations of love, friendship, and trust. Without a reserve of privacy, we would have nothing to share and, hence, nothing to build upon in our human relationships save fear, mistrust, and combativeness. The ability to shield ourselves from public view permits the exchange of intimate confidences necessary to establish a secure love or trust. The right to privacy thus is an inseparable aspect of our humanity.

Thomas G. Krattenmaker, *Interpersonal Testimonial Privileges Under the Federal Rules of Evidence: A Suggested Approach*, 64 GEO. L.J. 613, 651 (1976).

Ruth Gavison has defined privacy as a gradient that varies in three dimensions: secrecy, anonymity, and solitude. Ruth Gavison, *Privacy and the Limits of Law*, 89 YALE L.J. 421, 425-40 (1980). She believes that an individual's loss of privacy can be objectively measured "as others obtain information" about him, "pay attention to him, or gain access to him." *Id.* at 428. Robert Merton rests his claim that privacy "is an important functional requirement for the effective operation of social structure" on the neutral definition of privacy as "insulation from observability." ROBERT K. MERTON, SOCIAL THEORY AND SOCIAL STRUCTURE 429 (1968). Privacy is necessary because without it "the pressure to live up to the details of all (and often conflicting) social norms would become literally unbearable; in a complex society, schizophrenic behavior would become the rule rather than the formidable exception it already is." *Id.*

109. For an analysis of several cases, see Bruce E. Falby, *A Constitutional Right to Avoid Disclosure of Personal Matter: Perfecting the Privacy Analysis in* J.P. v. DeSanti, 653 F.2d 1080 (6th Cir. 1981), 71 GEO. L.J. 219 (1982). The common law also provides protection against the unauthorized release of private and personal information. For a general discussion, see WILLIAM L. PROSSER & W. PAGE KEETON, PROSSER & KEETON ON THE LAW OF TORTS 784 (5th ed. 1984); Jack Hirshleifer, *Privacy: Its Origin, Function, and Future*, 9 J. LEGAL STUD. 649 (1980); Richard A. Posner, *The Right of Privacy*, 12 GA. L. REV. 393 (1978); Post, *supra* note 108. As commentators on tort law have pointed out, "the law protects emotional tranquility and personal dignity . . . ." RICHARD A. EPSTEIN ET AL., CASES AND MATERIALS ON TORTS 1034 (4th ed. 1984). *See also* William L. Prosser, *Privacy*, 48 CAL. L. REV. 383 (1960). One way tort law protects these interests is by imposing liability for the disclosure of private facts. To satisfy a prima facie case, the plaintiff must prove that the defendant released the private information, that the defendant intended to release the information, and that the private facts released were highly offensive to him and would be highly offensive to an average reasonable person. RESTATEMENT (SECOND) OF TORTS § 652D (1976). Additionally, the plaintiff must prove both actual and

to *Whalen v. Roe*[110] in 1977, however, the Court did not explicitly distinguish between autonomy[111] and nondisclosure,[112] but referred only to a general right to privacy.[113] In *Whalen*, the Court attempted to clarify its privacy analysis.

Whalen addressed the constitutionality of a New York statute, provisions of which required the New York Public Health Commissioner to obtain from physicians the names and addresses of all persons who had received certain "Schedule II" medications[114] for which there were both legal and illegal markets.[115] In addition, the provisions required the Commissioner to record this information on a centralized computer file.[116] The appellees, users of the medications, alleged that the statutory provisions violated their constitutional right of privacy.[117] The district court agreed, concluding that doctor-patient privacy is constitutionally protected and can be regulated only if there is a compelling state interest and a statute narrowly tailored to promote that interest.[118] The district court conceded that the statute promoted a compelling state interest,[119] but found that the patient identification requirements were not

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proximate cause. *Id.* The plaintiff is not required to plead and prove special damages. *Id.*

110. 429 U.S. 589 (1977).

111. This branch of the right of is concerned with freedom from government interference in decisionmaking. *See supra* note 100. Traditionally, courts have recognized only rights falling within the autonomy branch as fundamental. *See generally* Roe v. Wade, 410 U.S. 113 (1973).

112. This branch protects private information from unwarranted disclosure. *See generally* Griswold v. Connecticut, 381 U.S. 479 (1965); Falby, *supra* note 109.

113. *See, e.g.*, Roe v. Wade, 410 U.S. 113, 152 (1973) (discussing the right of privacy); Eisenstadt v. Baird, 405 U.S. 438, 453 (1972) (discussing the right of privacy); Stanley v. Georgia, 394 U.S. 557, 564 (1969) (discussing the right to be free from unwanted governmental intrusions); Griswold v. Connecticut, 381 U.S. 479, 485 (1965) (discussing the right of privacy). *See also* Note, Roe *and* Paris: *Does Privacy Have a Principle?*, 26 STAN. L. REV. 1161 (1974). The note contends that the Court in *Griswold* actually protected the disclosure of contraceptive use by married couples, not the use itself, inasmuch as it approved state regulation of contraceptives by less intrusive means. *Id. at 1163*. The note also states that in *Roe v. Wade*, however, the Court clearly protected the right of a woman to decide privately whether to bear a child. *Id.*

114. Schedule II medications included opium and opium derivatives, cocaine, methadone, amphetamines, and methaqualone. *Whalen*, 429 U.S. at 593.

115. Whalen v. Roe, 429 U.S. 589, 591-92 (1977). The statute's purpose was to allow authorities to monitor the use of drugs and prevent their abuse. *Id.*

116. *Id.* at 591.

117. *Id.* at 600.

118. Roe v. Ingraham, 403 F. Supp. 931, 936-37 (S.D.N.Y. 1975), *rev'd sub nom.* Whalen v. Roe, 429 U.S. 589 (1977).

119. *Ingraham*, 403 F. Supp. at 937. Although the court stated that the statute promoted a "legitimate" state interest, the court's formulation of its standard of review indicates that it meant "compelling." *Id.*

narrowly tailored because they were not necessary to promote that interest.[120] The court therefore held that the law was unconstitutional and enjoined enforcement of the patient identification requirements.[121]

On direct appeal,[122] the Supreme Court rejected the district court's holding.[123] The Court held that there was nothing unreasonable in the legislature's assumption that the patient-identification requirement might aid in the enforcement of laws designed to minimize the misuse of dangerous drugs.[124] The district court's failure to find a necessity for the patient identification-requirement was not a sufficient reason to hold the requirement unconstitutional.[125]

The Court then addressed the appellees' claim that the statute violated their right to privacy.[126] In doing so, the Court apparently recognized a right to nondisclosure of personal matters.[127] The Court cited its opinions in *Griswold*

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120. *Id.* at 937. The district court based this conclusion on the following facts. An existing state prescription form program provided for the issuance of serially numbered prescription forms to physicians. In addition, doctors prescribing and pharmacists dispensing Schedule II drugs were given a Drug Enforcement Administration number. Consequently, the state could promptly determine the quantity of drugs prescribed and dispensed by particular physicians and pharmacists. Thus, over-prescription and over-dispensation, thefts, and forgeries could be detected. Given this scheme, the district court concluded that the patient identification requirement added nothing to the state's effort to control the abuse of Schedule II drugs. *Id.*

121. *Id.* at 938. The district court's decision is an illustration of strict scrutiny, the heightened scrutiny courts give statutes that impinge on some liberties protected by the Due Process Clause. *See supra* note 105 and accompanying text.

122. Jurisdiction was conferred on the Supreme Court by 28 U.S.C. §§ 1253, 2101(b) (1970). Whalen v. Roe, 429 U.S. 589, 591 (1977). Section 1253 provided that any party may appeal directly to the Supreme Court from an order granting or denying injunctive relief in a suit required to be heard and determined by a district court of three judges. 28 U.S.C. § 1253 (1970). Section 2101 set forth the procedural requirements for a direct appeal. 28 U.S.C. § 2101 (1970).

123. *Whalen*, 429 U.S. at 603-04.

124. *Id.* at 597-98. In effect, the Supreme Court applied the rational relation test, the deferential standard of review applied to regulations that do not infringe upon specially protected aspects of liberty. *See supra* note 107 and accompanying text. The Court never discussed the applicability of a higher standard of review because, as the rest of the opinion indicates, the Court failed to find a constitutional violation of a liberty interest specially protected by the Due Process Clause. *See Whalen*, 429 U.S. at 598-606 (reasoning that the statute did not constitutionally violate the privacy interest in the nondisclosure of personal matters or autonomous decisionmaking).

125. *Whalen*, 429 U.S. at 598.

126. *Id.* at 598-606.

127. The Court stated:

> The cases sometimes characterized as protecting "privacy" have in fact involved at least two different kinds of interests. One is the individual interest in avoiding disclosure of personal matters, and another is the interest in independence in making certain kinds of important decisions. Appellees argue that both of these interests are impaired by this statute. The mere existence in a readily available form of the information about patients' use of Schedule II drugs creates a genuine concern that the information will

v. Connecticut[128] and *Stanley v. Georgia*[129] in support of the proposition that the right to privacy includes the right of nondisclosure of personal matters.[130] The Court also cited with approval[131] an article by Professor Philip Kurland which identifies one facet of constitutional privacy as the right of an individual not to have private affairs made public by the government.[132]

The *Whalen* Court held, however, that the New York program did not on its face pose a sufficiently grievous threat to the privacy interest to establish a constitutional violation.[133] The Court reasoned that the statutory safeguards to prevent dissemination of the potentially damaging information to the public adequately protected the individual's interest in nondisclosure.[134] The Court further concluded that disclosure by the patients to the state was an essential part of modern medical practice and thus not an impermissible invasion of privacy.[135]

> become publicly known and that it will adversely affect their reputations. This concern makes some patients reluctant to use, and some doctors reluctant to prescribe, such drugs . . . . Thus, the statute threatens to impair both their interest in the nondisclosure of private information and also their interest in making important decisions independently.

Whalen v. Roe, 429 U.S. 589, 598-600 (1977).

128. 381 U.S. 479, 485 (1965) (upholding the constitutional right to marital privacy).

129. 394 U.S. 557, 565 (1969) (upholding the constitutional right "to be free from state inquiry into the contents of [one's] library").

130. *Whalen*, 429 U.S. at 599.

131. *Id.* at 600 n.24.

132. Philip B. Kurland, *The Private I*, U. CHI. MAG., Autumn 1976, at 8. The Court quoted the following passage from the article:

> There are at least three facets [of a constitutional right of privacy] that have been partially revealed, but their form and shape remain to be fully ascertained. The first is the right of the individual to be free in his private affairs from governmental surveillance and intrusion. The second is the right of an individual not to have his private affairs made public by the government. The third is the right of an individual to be free in action, thought, experience, and belief from governmental compulsion.

Whalen v. Roe, 429 U.S. 589, 600 n.24 (1977) (quoting Kurland, *supra*, at 8). The Court stated that the first facet Kurland describes is directly protected by the Fourth Amendment, while the second and third correspond to the liberty interest in the nondisclosure of personal matters and the liberty interest in making autonomous decisions. *Id.*

133. *Whalen*, 429 U.S. at 600.

134. *Id.* at 600-02. The Court also reasoned that because the state did not entirely prohibit the use of Schedule II drugs nor condition access to them on the consent of a third party, the individual was not deprived of the right to decide, with the advice of a physician, to use the medication. *Id.* at 603.

135. *Id.* at 594-600. The Court also noted that the disclosure to the New York Department of Health was neither significantly different from the disclosure required under prior New York law, nor was it "meaningfully distinguishable from a host of other unpleasant invasions of privacy that are associated with many facets of health care." *Id.* at 602. The Court cited examples of statutory reporting requirements related to venereal disease and child abuse. *Id.* at 602 n.29. In addition, the Court cited *Planned Parenthood v. Danforth*, a case that upheld a section of a statute that

Anomalously, the Court concluded its opinion[136] by appearing to eviscerate its prior recognition of a right to nondisclosure.[137] The Court noted that the government's duty to keep information private was only arguably constitutional[138] and that the Court did not decide any constitutional questions which might be presented by unwarranted disclosure of information in government computer banks.[139] The Court thus took away with one hand what it had given with the other.[140]

In fact, it is difficult to determine if *Whalen* recognized a constitutional right of nondisclosure of personal matter.[141] Although the Court initially determined that the right to privacy includes a right to nondisclosure of personal matter, it disclaimed any such determination in the concluding portion of its opinion.[142] Thus, the split in the federal courts over the proper interpretation of *Whalen* is not surprising. The majority of federal courts, including the Fifth

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imposed reporting requirements on health facilities and physicians that perform abortions. *Id.*

136. *Whalen*, 429 U.S. at 605.

137. A strict scrutiny standard of review did not need to be applied because the Court refused to explicitly recognize informational privacy as a fundamental right. Instead, the Court applied a lesser standard and balanced the state's interest in the information against the risk of harm caused by disclosure. Whalen v. Roe, 429 U.S. 589, 598-604 (1977).

138. *Id.*

139. *Id.* at 605-06.

140. Justice Brennan wrote separately to clarify the Court's meaning. *Whalen*, 429 U.S. at 606-07 (Brennan, J., concurring). He explained:

> The Court recognize[s] that an individual's "interest in avoiding disclosure of personal matters" is an aspect of the right of privacy . . . but holds that in this case, any such interest has not been seriously enough invaded by the State to require a showing that its program was indispensable to the State's effort to control drug abuse.

Id. at 606 (citing to majority opinion).

141. The thrust of the *Whalen* opinion as a whole, and the Supreme Court's previous and subsequent nondisclosural privacy decisions, support the interpretation that *Whalen* recognized a right to nondisclosure of personal matters. Even if *Whalen* only assumed for the purpose of analysis that the right to nondisclosure exists, but then considered it unnecessary to decide whether the right had not been violated, *Whalen* at the very least demonstrated the Court's willingness to recognize the right if presented with facts that show that the right was violated. The *Whalen* Court, evincing sensitivity to the need for nondisclosural privacy protection, revealed this willingness when it stated:

> We are not unaware of the threat to privacy implicit in the accumulation of vast amounts of personal information in computerized data banks or other massive government files. The collection of taxes, the distribution of welfare and social security benefits, the supervision of public health, the direction of our Armed Forces, and the enforcement of the criminal laws all require the orderly preservation of great quantities of information, much of which is personal in character and potentially embarrassing or harmful if disclosed.

Id. at 605. In addition, *Whalen* indicated that the right to nondisclosure is a limited right. The Court's concern about the possible dissemination of information "personal in character and potentially embarrassing or harmful if disclosed" suggests that only personal matters meeting this definition, rather than all matters arguably personal, are protected by nondisclosural privacy. *Id.*

142. *Id.* at 605-06.

and Third Circuits, interpret *Whalen* as recognizing a constitutional right to nondisclosure.[143] These courts, however, merely recite the *Whalen* Court's language about an interest in avoiding nondisclosure of personal matters and make no attempt to reconcile this language with the opinion's concluding disclaimer.[144] In contrast, the few courts that hold that the *Whalen* Court did not recognize a constitutional right to nondisclosure of personal matter rely on the disclaimer.[145]

The next major Supreme Court case addressing the issue of informational privacy was *Nixon v. Administrator of General Services.*[146] In *Nixon*, the Court rejected the former President's claim that an act of Congress directing the General Services Administrator to take custody of Nixon's tapes and papers violated Nixon's constitutional privacy rights.[147] In the course of its discussion of Nixon's claim, the Court repeated the nondisclosure language from *Whalen*, stating that one element of privacy has been characterized as "the

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143. *See* Plante v. Gonzalez, 575 F.2d 1119, 1127-28, 1132 (5th Cir. 1978) (holding that *Whalen* recognized the right to avoid the disclosure of personal matters); McKenna v. Peekskill Housing Auth., 497 F. Supp. 1217, 1224 (S.D.N.Y. 1980) (stating that *Whalen* identified nondisclosure as major element of constitutionally protected privacy), *modified on other grounds*, 647 F.2d 332 (2d Cir. 1981); Doe v. United States Civil Serv. Comm'n, 483 F. Supp. 539, 566 (S.D.N.Y. 1980) (stating that the declared zone of privacy declared in *Whalen* and safeguarded by the Constitution embraces the individual interest in avoiding the disclosure of personal matters); Hawaii Psychiatric Soc'y, Dist. Branch v. Ariyoshi, 481 F. Supp. 1028, 1043 (D. Haw. 1979) (stating that *Whalen* identified the right to nondisclosure but not the applicable standard of review); Service Mach. & Shipbuilding Corp. v. Edwards, 466 F. Supp. 1200, 1203 (W.D. La. 1979) (stating that *Whalen* recognized that plaintiffs had valid privacy interests at stake); McKenna v. Fargo, 451 F. Supp. 1355, 1379 (D.N.J. 1978) (stating that *Whalen* recognized the constitutional right to informational privacy), *aff'd without opinion*, 601 F.2d 575 (3d Cir. 1979).

144. United States v. Westinghouse Elec. Corp., 638 F.2d 570 (3d Cir. 1980); Plante v. Gonzalez, 575 F.2d 1119, 1127-28, 1132 (5th Cir. 1978); McKenna v. Peekskill Hous. Auth., 497 F. Supp. 1217, 1224 (S.D.N.Y. 1980), *modified on other grounds*, 647 F.2d 332 (2d Cir. 1981); Doe v. United States Civil Serv. Comm'n, 483 F. Supp. 539, 566 (S.D.N.Y. 1980); Hawaii Psychiatric Soc'y, Dist. Branch v. Ariyoshi, 481 F. Supp. 1028, 1043 (D. Haw. 1979); Service Mach. & Shipbuilding Corp. v. Edwards, 466 F. Supp. 1200, 1203 (W.D. La. 1979), *rev'd on other grounds*, 617 F.2d 70 (5th Cir. 1980), *aff'd without opinion*, 449 U.S. 913 (1980); McKenna v. Fargo, 451 F. Supp. 1355, 1380 (D.N.J. 1978), *aff'd without opinion*, 601 F.2d 575 (3d Cir. 1979).

145. J.P. v. DeSanti, 653 F.2d 1080 (6th Cir. 1981); Crain v. Krehbiel, 443 F. Supp. 202, 209 (N.D. Cal. 1977).

146. 433 U.S. 425 (1977).

147. *Id.* at 457. The Presidential Recording and Materials Preservation Act directed the General Services Administrator to take custody of Nixon's papers and tapes, separate private from public portions, and return the private portions. Note following 44 U.S.C. § 2107 (Supp. V 1975). The most sensitive materials were those relating to "his wife, his daughters, his physician, lawyer, and clergyman, and his close friends, as well as personal diary dictablets and his wife's personal files." *Nixon*, 433 U.S. at 459.

individual interest in avoiding disclosure of personal matters."[148] The *Nixon* Court concluded that, although the former President had a legitimate expectation of privacy in the documents, protective provisions of the Act and an overriding public interest in the documents militated against holding the Act unconstitutional.[149] The Court used a balancing standard to weigh Nixon's privacy interests against the public's interest in the documents, instead of the strict scrutiny standard that is used when recognized fundamental rights are implicated.[150]

Although the protection of personal privacy[151] has largely evolved in the last hundred years,[152] privacy of medical information has always been recognized as essential to the practice of medicine.[153] In the landmark case *United States v. Westinghouse Electric Corporation*,[154] the Third Circuit held that constitutional protection of privacy extends in part to medical records and medical information even though the court refrained from terming it a fundamental right.[155] The court stated that medical records, which may

148. *Nixon*, 433 U.S. at 457 (quoting Whalen v. Roe, 429 U.S. 589 (1977)). The *Nixon* Court cited *Whalen* apparently to establish that the former President had a legitimate expectation of privacy in the tapes and records and that he was entitled to fourth amendment protection. *Id.*

149. *Id.* at 458. The Court upheld the Act as reasonable, citing cases, including Camara v. Municipal Court, 387 U.S. 523 (1967) and Terry v. Ohio, 392 U.S. 1 (1968), that discuss the fourth amendment balancing test. *Nixon*, 433 U.S. at 458.

150. *See supra* text accompanying note 105.

151. Areas possibly falling within the right to privacy have grown dramatically in recent years, along with the ability of technology to store, disseminate, and use personal data. *See, e.g.*, COMMISSION ON FEDERAL PAPERWORK, CONFIDENTIALITY AND PRIVACY (1977); U.S. DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE, SECRETARY'S ADVISORY COMMITTEE ON AUTOMATED PERSONAL DATA SYSTEMS, RECORDS, COMPUTERS, AND THE RIGHTS OF CITIZENS (1973); A. WESTIN, COMPUTERS, HEALTH RECORDS AND CITIZEN RIGHTS (National Bureau of Standards, Monograph No. 157, 1976); MYRON BRENTON, THE PRIVACY INVADERS (1964); SAMUEL DASH ET AL., THE EAVESDROPPERS (1959); MARTIN L. GROSS, THE BRAIN WATCHERS (1962).

152. *See* Warren & Brandeis, *supra* note 87. Prosser mentioned the Warren and Brandeis article in his discussion of the right of privacy, noting that "[t]he recognition and development of the so-called 'right of privacy,' is perhaps the outstanding illustration of the influence of legal periodicals upon the courts." WILLIAM L. PROSSER, HANDBOOK OF THE LAW OF TORTS § 117, at 802 (4th ed. 1971).

153. For an overview of privacy of medical records and the physician-patient privilege, see Robert M. Gellman, *Prescribing Privacy: The Uncertain Role of the Physician in the Protection of Patient Privacy*, 62 N.C. L. REV. 255 (1984).

154. 638 F.2d 570 (3d Cir. 1980).

155. *Id.* at 577 (holding that employee medical records clearly fall within the zone of privacy protection). *See also In re* Search Warrant (Sealed), 810 F.2d 67, 71 (3d Cir.) (stating that medical records clearly are within the constitutional sphere of the right to privacy), *cert. denied*, 483 U.S. 1007 (1987); Carter v. Broadlawns Medical Ctr., 667 F. Supp. 1269, 1282 (S.D. Iowa 1987), *modified on other grounds*, 857 F.2d 448 (8th Cir. 1988) (extending the right to privacy to patient records held by a county hospital), *cert. denied*, 489 U.S. 1096 (1989); Shoemaker v. Handel, 608

contain intimate facts of a personal nature, are well within the ambit of material entitled to privacy protection.[156] "Information about one's body and state of health is a matter which the individual is ordinarily entitled to retain within the 'private enclave where the individual may lead a private life.'"[157] The court

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F. Supp. 1151, 1159 (D.N.J. 1985) (holding that the right to privacy does extend to avoiding disclosure of "personal medical information," but must be weighed against competing state interest), *aff'd*, 795 F.2d 1136 (3d Cir. 1986); Trade Waste Management Ass'n v. Hughey, 780 F.2d 221, 234 (3d Cir. 1985) (stating that personal medical history is protected from random governmental intrusion).

156. *Westinghouse*, 638 F.2d at 577.

157. *Id.* (quoting United States v. Grunewald, 233 F.2d 556, 581-82 (2d Cir. 1956) (Frank, J., dissenting), *rev'd* 353 U.S. 391 (1957)). "The amount of medical information about patients that is routinely recorded [has] increased tremendously in recent decades." Gellman, *supra* note 153, at 257. "[A] hospital record may contain considerable amounts of non-medical data, including information about a patient's relatives, financial status, education, employment history, lifestyle, and any other aspect of a patient's life that is deemed to be relevant to treatment or research." *Id.* at 258. "Patients have become used to the routine disclosure of medical information" because of the surge of insurance and government requirements for reimbursement of medical expenses. *Id.* at 261. Although these disclosures are considered to be with the consent of the patients, the patients must provide the information to receive the aid. *Id.* Therefore, the patients have no real alternative.

"Third party payors [primarily consisting of insurance carriers] require an extensive amount of information to support payment of a claim." *Id.* at 260; *see also Privacy of Medical Records: Hearings on H.R. 2979 and 3444 Before a Subcomm. on the Comm. on Government Operations House of Representatives*, 96th Cong., 1st Sess. 553-76 (1979) (statement of Marshall R. Crawford, Senior Director, Blue Cross and Blue Shield Association) [hereinafter *Privacy Hearing*]. According to the Blue Cross and Blue Shield Association, the information disclosed must be sufficient to establish that services billed were included under the benefit agreements, necessary and warranted, and actually delivered. Information needed includes identity of the patient, identity of the physician, identity of the facility, diagnosis, treatment description, length of stay, and billed charges. In addition, when Blue Cross serves as an intermediary for government programs, other items of personal information may be necessary to satisfy the program requirements. Gellman, *supra* note 153, at 260.

"Increased government spending for health care has further increased the required number of disclosures." *Id.* "With the implementation of Medicare and Medicaid in 1966, the share of the nation's health bill paid by government increased significantly." *Id.* "A major consequence of increased government spending for health care is the growth of government programs to control the cost and improve the delivery and quality of health care." *Id.* "These programs, which include routine audits, medical peer review, and fraud, abuse, and waste investigations, frequently require access to identifiable patient information to carry out their functions." *Id.* at 260-61. *See, e.g.*, 42 U.S.C. § 1395(f) (1976) (prohibiting payments to Medicare providers unless they provide the information necessary to determine the amounts due); 42 U.S.C. § 1320(c) (1976) (establishing Professional Standards Review Organizations); Tax Equity and Fiscal Responsibility Act of 1982, Pub. L. No. 97-248, §§ 141-50, 96 Stat. 381-95 (1982) (codified at 42 U.S.C. §§ 1320, 1395, 1396) (replacing Professional Standards Review Organizations with "utilization and quality control peer review organizations"); 42 U.S.C. § 3525 (1976) (granting the Inspector General of the Department of Health and Human Services subpoena power to prevent fraud and abuse in Department programs). "Thus, in addition to [the] disclosures necessary to justify payment of claims, government involvement in health care may require additional levels of disclosures to support oversight and control mechanisms." Gellman, *supra* note 153, at 261. "One consequence

applied the balancing test, noting that governmental intrusion into medical records is permitted only after a finding that the societal interest in disclosure outweighs the individual's privacy interest on the specific facts of the case.[158]

Modern circumstances such as the HIV crisis have caused some courts to revaluate the issue of disclosing medical information. Many courts agree that the sensitive nature of medical information about HIV makes a compelling argument for keeping this information confidential.[159] Society's moral judgments about the high-risk activities associated with the disease, including sexual relations and drug use, make the information extremely personal.[160] Thus, the privacy interest surrounding one's serostatus is even greater than one's privacy interest in ordinary medical records because of the social stigma attached to the disease.[161]

Because the potential for harm resulting from nonconsensual disclosure is substantial,[162] some courts have expanded traditional notions of the fundamental right of privacy and have applied strict scrutiny to the infringement of informational privacy.[163] For example, in *Faison v. Parker*,[164] a district

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is that both physicians and patients have become used to the routine disclosure of medical information that was previously disclosed, if at all, only on rare occasions." *Id.*

Disease control measures resulting from the onset of communicable diseases were another major step in allowing greater disclosure of patient information. These measures permitted information concerning communicable diseases to be released to governmental public health boards and sometimes to other people without the patients' consent. These measures were driven by the developing concept of a general duty to society that is of a higher order than the duty to protect a patient's privacy. Thus, in addition to breaching confidentiality for the sake of third party payors, breaching it for the sake of society became acceptable.

158. United States v. Westinghouse Elec. Corp., 638 F.2d 570, 578 (3d Cir. 1980). The court stated that the factors in deciding whether to intrude into an individual's privacy include: (1) the type of record requested; (2) the information it does or might contain; (3) the potential for harm in any subsequent nonconsensual disclosure; (4) the injury from disclosure to the relationship in which the record was generated; (5) the adequacy of safeguards to prevent unauthorized disclosures; (6) the degree of need for access; and (7) whether there is an express statutory mandate, articulated public policy, or other recognizable public interest militating toward access. *Id.* *See also* Fraternal Order of Police, Lodge No. 5 v. Philadelphia, 812 F.2d 105, 110-11 (3d Cir. 1987).

159. *See infra* note 230.

160. *See infra* note 231.

161. *See infra* notes 230-31. *But see* Plowman v. U. S. Dep't of Army, 698 F. Supp. 627 (E.D. Va. 1988) (holding that the privacy interest in the nondisclosure of one's HIV status is no greater than the privacy interest in the nondisclosure of other medical information).

162. *See infra* note 230.

163. The government must demonstrate a compelling interest in the information, to disclose matters that are defined as highly personal and sensitive. Generally, the compelling state interest must be accompanied by adequate safeguards to protect against widespread dissemination of the information. *See, e.g., supra* note 105 and accompanying text. *See also* McKenna v. Fargo, 451 F. Supp. 1355, 1381 (D.N.J. 1978).

164. 823 F. Supp. 1198 (E.D. Pa. 1993).

court applied a strict scrutiny analysis to an action claiming that a presentence report revealed the plaintiff's HIV results and other medical information in violation of her constitutional right of privacy.[165] The court found that the state had demonstrated a compelling interest in including private medical and mental health information of the plaintiff in the presentence report.[166] Further, the court found that state statutes and rules concerning the confidentiality of presentence reports adequately safeguarded against disclosure to the general public.[167]

Another case applying strict scrutiny to the disclosure of medical information is *Doe v. Barrington*,[168] which held that disclosure of a person's exposure to or infection with HIV is a disclosure of a personal matter that falls within the ambit of a protected privacy interest.[169] The court in *Barrington*, however, also emphasized that "[a]n individual's privacy interest in medical information and records is not absolute." In analyzing a governmentally imposed deprivation of those privacy interests, "[a] court must determine whether the societal interest in disclosure and mandatory testing outweighs the privacy interest involved."[170] Under this rationale, for a legislative proposal that infringes upon these privacy interests to pass constitutional muster, the government must show a compelling state interest in breaching a health care worker's or patient's right to privacy.[171]

Other courts analyzing HIV disclosure provisions have not gone so far as to extend fundamental right protection to the release of HIV information and thus do not apply the strict scrutiny standard. Rather, the courts use a lesser standard that balances the interests of the state against the privacy interests of the individual.[172] One such case is *Woods v. White*,[173] where a district court

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165. *Id.* at 1201-02.

166. *Id.* at 1202.

167. *Id.* at 1203-04.

168. 729 F. Supp. 376 (D.N.J. 1990).

169. *Id.* at 385.

170. *Id.* (holding that the governmental interest in a police officer's disclosure of a person's HIV infection to his neighbors did not outweigh the substantial privacy interest of the individual). In *Barrington*, a police officer warned a person of her neighbor's infection with HIV. Because her children attended the same school as the four children of the infected neighbor, she contacted the media and school officials. Nineteen children were removed from the school by parents fearful of AIDS transmission among students. The story received local news coverage with at least one report revealing the family name of the HIV-infected person.

171. *Id.* at 385.

172. Under this standard, the state would not be forced to present a compelling interest and would not have to demonstrate that the provision was tailored. This standard is significantly easier for the state to satisfy, thus significantly greater intrusions into the privacy interests of carriers are allowed.

173. 689 F. Supp 874 (W.D. Wis. 1988).

held that prison officials who discussed with nonmedical prison personnel and with other inmates the fact that the plaintiff had tested positive for HIV violated the inmate's constitutional rights.[174] The court recognized the inmate's privacy interest in the information and stated that it must balance his right to confidentiality against the governmental interest in disclosure to define the scope of the right to privacy in personal information.[175] The court noted that information about one's body and state of health is particularly sensitive and that such information has traditionally been treated differently from other types of personal information.[176] Recognizing that HIV is related more closely than other diseases to sexual activity and intravenous drug use, the court stated that it was difficult to argue that information about this disease was not information of the most personal kind, or that an individual would not have an interest in protecting against the dissemination of such information.[177] Acknowledging that there might be circumstances that would limit plaintiff's right to privacy of his condition, the court noted that this case did not present such circumstances.[178]

Another case that used a balancing standard to review the disclosure of medical information concerning a person's serostatus is *Leckelt v. Board of Commissioners*.[179] In *Leckelt*, a hospital fired a nurse suspected of being infected with HIV after he failed to comply with hospital policies requiring health care workers to inform the hospital of any infectious diseases they might be carrying. The lower court sustained the firing, holding that the hospital's infection control policy of requiring all nurses who had been voluntarily tested to divulge their serostatus was rationally related to the legitimate state interests of protecting patients and health care workers from the spread of infectious diseases.[180] "[The hospital's] interest in knowing [Leckelt's] health status far outweighed the limited intrusion of requiring him to produce the results of a test he had already taken voluntarily."[181]

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174. *Id.* at 876.

175. *Id.*

176. *Id.* (citing United States v. Westinghouse Elec. Corp., 638 F.2d 570, 577 (3d Cir. 1980)).

177. *Woods*, 689 F. Supp. at 876.

178. Woods v. White, 689 F. Supp. 874, 876 (W.D. Wis. 1988).

179. 714 F. Supp. 1377 (E.D. La. 1989), *aff'd*, 909 F.2d 820 (5th Cir. 1990). Leckelt, a male nurse, refused to submit to the hospital the results of an AIDS test that he voluntarily undertook following the admission of his infected roommate to the hospital. Administrators requested results from the test in accordance with hospital infection control policies. After termination for failure to comply with this request, Leckelt brought an action against the hospital for violation of § 504 of the Rehabilitation Act. The claim of interest to this discussion, however, is his additional assertion of violations of his Fourth Amendment right to privacy.

180. *Leckelt*, 714 F. Supp. at 1390-91.

181. *Id.* at 1392.

In affirming the lower court's analysis in *Leckelt*, the Fifth Circuit emphasized that health care workers have a diminished expectation of privacy.[182] Participation in an occupation pervasively regulated to ensure safety reduces health care workers' privacy rights.[183] Hospitals have a strong interest in protecting the health of employees and patients by preventing the spread of infectious diseases, and the effectiveness of any infection-control policies depends upon the health and fitness of the health care workers practicing in the hospital.[184] The court thus concluded that the hospital's strong interest in maintaining a safe workplace through infection-control policies outweighed the limited intrusion on Leckelt's privacy interest in the results of his HIV test.[185].

In re Milton S. Hershey Medical Center[186] is another analysis of a disclosure provision which used a balancing approach. In *Hershey*, a Pennsylvania court addressed whether a hospital may disclose a surgeon's HIV-positive status to a surgical patient who had undergone invasive procedures. The health care worker sustained a cut through a surgical glove while performing an invasive procedure, thus exposing the patient to infected blood. In affirming disclosure, the court emphasized the duty of both the hospital and the health care worker to provide safe and adequate medical care despite the slim, but deadly, possibility of HIV transmission.[187] The *Hershey* court recognized health care workers' right to privacy, but also noted that health care workers' medical problems are not just their own.[188] Health care providers' health conditions "became a public concern the moment [they] picked up a surgical instrument and became a part of . . . invasive procedures."[189] The public's compelling right to be informed about this type of health threat far outweighed a practicing surgeon's right to keep his HIV status confidential.[190]

To summarize, courts have continued to subject regulations that interfere with fundamental rights to strict scrutiny.[191] A few courts have afforded this

182. Leckelt v. Board of Comm'rs, 909 F.2d 820, 833 (5th Cir. 1990).
183. *Id.*
184. *Id.*
185. *Id.*
186. 595 A.2d 1290 (Pa. Super. Ct. 1991).
187. *Id.* at 1295-97.
188. *Id.* at 1298.
189. *Id.*
190. *In re* Milton S. Hershey Medical Ctr., 595 A.2d 1290, 1302 (Pa. Super. Ct. 1991).
191. *See* Zablocki v. Redhail, 434 U.S. 374 (1978) (using a strict scrutiny analysis to reject a statute requiring court approval for marriage in cases where one of the parties has a child that it is supporting under court order); Carey v. Population Servs. Int'l, 431 U.S. 678 (1977) (applying a strict scrutiny analysis in striking down the prohibition of distributing contraceptives to individuals under the age of 16).

protection to informational privacy over medical records containing serostatus information.[192] Under this analysis, the courts demand a compelling state interest in the information and proof that the regulation infringing upon the privacy right is narrowly tailored to promote that interest.[193] In most cases, states cannot meet this rigorous standard and the regulation fails.

Despite the increased recognition of the right of privacy, however, most courts have rejected the notion that informational privacy is a fundamental right and have applied the less stringent balancing test in reviewing legislation infringing upon an HIV carrier's privacy.[194] In these cases, courts have weighed the utility of the medical information against the possibility and magnitude of harm to the carrier resulting from its disclosure.[195] These courts have developed the theory that the release of a person's serostatus is sometimes justified to protect the public health and therefore, will not be completely protected by the right of privacy. However, because the harms[196] caused by releasing a person's serostatus tend to reflect unfavorably on the character of the patient, the cases suggest that the balancing test must be carefully applied to ensure that each right is given proper consideration and is not discounted prematurely simply because the state has an interest in the information.[197] Even under such analysis, statutes allowing limited dissemination of the identity of HIV carriers and including safeguards against broad and unnecessary release of such information will likely be affirmed.[198]

V. GOVERNMENT'S INTEREST IN PROTECTING PUBLIC HEALTH AND WELFARE

It is a well-recognized principle that one of the first duties of a state is to take necessary steps to protect and promote the health of its inhabitants.[199]

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192. *See supra* notes 164-71 and accompanying text.

193. *See supra* note 105 and accompanying text.

194. *See supra* notes 172-90 and accompanying text.

195. *See supra* notes 172-90 and accompanying text.

196. These harms may include discrimination in the workplace and in insurance, rejection from co-workers and friends, and being stereotyped as having a certain lifestyle.

197. The court will not simply decide that disclosure is appropriate just because the state can show an interest in the information. If the harm caused to the carrier by the disclosure is greater than the benefit to the state, disclosure will not be allowed. A court will weigh the damage to the victim heavily in this analysis to ensure that disclosure will not be frivolously permitted. *See supra* notes 172-90 and accompanying text.

198. *See supra* notes 172-90 and accompanying text.

199. *See, e.g., In re* Halko, 54 Cal. Rptr. 661, 662-64 (Cal. Ct. App. 1966) (holding that the quarantine and isolation for periods of six months each, "without means of questioning and judicially determining" the conclusion of the health officer is not an unconstitutional act; also noting that the legislature has significant authority in protecting the public's health and that a statute granting authority to quarantine is not unconstitutional so long as there are "reasonable grounds" for its

Even when extremely protective measures have been taken by a state, courts have held the health and safety of citizens to be of the utmost importance.[200] States have passed legislation to combat serious health threats such as tuberculosis, venereal disease, smallpox, bubonic plague, scarlet fever, and leprosy.[201] According to the case law arising from such legislation, the harm of quarantine, forced vaccinations, or other measures taken to curb the spread of these diseases was often outweighed by the lifesaving benefits.[202] These early decisions firmly established public health as a legitimate and important state interest. However, courts today must use these dated precedents carefully to review protective measures taken to curb the spread of HIV because of medical advances and progress in the way courts evaluate civil rights infringements.[203]

Early twentieth-century courts used the minimum scrutiny standard when considering public health regulation, the same standard applied to economic regulation and civil rights infringement alike.[204] This standard presumes legislation to be valid unless it bears no reasonable relationship to the achievement of a proper governmental objective.[205] Using this test, courts allowed popularly held beliefs about the spread of disease to support the medical

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existence); Jacobson v. Massachusetts, 197 U.S. 11 (1905) (upholding the compulsory vaccination of adults against smallpox even though the statute infringed on personal liberty); Benton v. Reid, 231 F.2d 780 (D.C. Cir. 1956); State v. Snow, 324 S.W.2d 532 (Ark. 1959); Moore v. Armstrong, 149 So. 2d 36 (Fla. 1963); Greene v. Edwards, 263 S.E.2d 661 (W. Va. 1980). *But see* Wendy E. Parmet, *AIDS and Quarantine: The Revival of an Archaic Doctrine*, 14 HOFSTRA L. REV. 53 (1985) (arguing against the quarantine of AIDS patients mainly because AIDS is not contagious and because people can be carriers for their entire lives without actually contracting the disease, and noting the changing legal climate and the substantially increased role of procedural review since early quarantine cases).

200. *See* Crayton v. Larabee, 116 N.E. 355 (N.Y. 1917) (upholding a statute that prohibited all contact with a house when the occupants contracted smallpox or scarlet fever).

201. Larry Gostin, *Traditional Public Health Strategies, in* AIDS LAW TODAY 47 (Scott Burris et al. eds., 2d ed. 1983).

202. *See Ex parte* Martin, 188 P.2d 287 (Cal. 1948) (holding the state had full power of quarantine).

203. Because the prevention and treatment capabilities were drastically limited in large part by the elementary scientific and medical understanding of disease transmission, early states often took overly drastic measures to cope with the epidemics. These means were evaluated in the context of the contemporary disease control capabilities. Using these judicial standards today would be inappropriate given the current disease control capabilities. *See infra* note 222 and accompanying text.

204. *See supra* note 107 and accompanying text.

205. *See* Miller v. Wilson, 236 U.S. 373, 380 (1915). *See also* People *ex rel.* Baker v. Strautz, 54 N.E.2d 441, 443 (Ill. 1944) ("It has almost universally been held in this country that constitutional guarantees must yield to the enforcement of the statutes and ordinances designed to promote the public health as a part of the police powers of the State.").

soundness of a regulation[206] and rarely found regulations enacted to protect public health to be "unreasonable," "arbitrary," or "oppressive."[207] These limiting principles were articulated in 1905 by the Supreme Court in the landmark case *Jacobson v. Massachusetts* and quickly became the universal standard for reviewing public health legislation.[208]

Judicial treatment of public health regulation has changed very little since the turn of the century. Although courts in the 1920s began to require some showing of medical foundation for protective measures as the science of public health advanced,[209] they continued to allow class membership alone to justify public health restrictions when a disfavored class, such as prostitutes, was the subject of the regulation.[210] These judicial opinions assumed that victims were to blame for their illnesses.[211] The attitude that the diseased were a menace

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206. *See* Jacobson v. Massachusetts, 197 U.S. 11, 35 (1905) (stating that "the legislature has the right to pass laws which, according to the common belief of the people, are adapted to prevent the spread of contagious diseases" and that "'[a] common belief, like common knowledge, does not require evidence to establish its existence, but may be acted upon without proof by the legislature and the courts . . . .'") (quoting Viemeister v. White, 72 N.E. 97 (N.Y. 1904)).

207. *See, e.g.*, *Jacobson*, 197 U.S. at 27, 38 (upholding the compulsory vaccination of adults); People *ex rel.* Barmore v. Robertson, 134 N.E. 815, 820 (Ill. 1922) (upholding a quarantine order). *But see* Jew Ho v. Williamson, 103 F. 10, 26 (N.D. Cal. 1900) (invalidating the quarantine of 15,000 Asians after nine deaths from the bubonic plague had been reported in the community).

208. *Jacobson*, 197 U.S. at 25, 38.

> Although this court has refrained from any attempt to define the limits of that [police] power, yet it had distinctly recognized the authority of a state to enact quarantine laws and "health laws of every description" . . . . According to settled principles, the police power of a state must be held to embrace, at least, such reasonable regulations established directly by legislative enactment as will protect the public health and the public safety.

Id. at 25.

The Court also noted the necessity of restrictions on liberty in order to "secure the general comfort, health, and prosperity of the state." *Id.* at 26. The Court upheld the statute and did not even require medical proof of the effectiveness of such precautions. *Id.* at 27, 30. The Court reasoned that the vaccine met the rationality test because the "mass of the people" believe that the vaccine "has a decided tendency to prevent the spread of [a] fearful disease." *Id.* at 34. The predilection of the Court to uphold such legislation may signal that courts will treat AIDS legislation with similar deference.

209. *See, e.g.*, *Robertson*, 134 N.E. at 819 (stating that quarantine regulations are "sustained on the law of necessity, and when the necessity ceases, the right to enforce the regulation ceases").

210. *See, e.g.*, *Ex parte* Clemente, 215 P. 698 (Cal. Ct. App. 1923) (holding that a quarantine was justified because information about a woman's acts of prostitution furnished a reasonable ground to believe she carried disease); *accord* Huffman v. District of Columbia, 39 A.2d 558, 562 (D.C. 1944).

211. *See, e.g.*, *Ex parte* Company, 139 N.E. 204, 206 (Ohio 1922) (stating that "those who by conduct and association contract such disease as makes them a menace to the health and morals of the community must submit to such regulation as will protect the public"); *Ex parte* Dayton, 199 P. 548, 549 (1921) (justifying the jailing of a woman until she submitted to a physical examination for disease "upon the ground that she is a lewd and dissolute person, and, in fact, a prostitute").

to both public health and community morals survived through the 1950s and 1960s, when incarcerated tuberculosis patients challenged state authority to quarantine.[212] Thus, although medical necessity for protective measures was needed in some cases, society's morality still played a major role in efforts to prevent the spread of disease.

Examination of public health legislation changed significantly in the 1960s with the onset of equal protection decisions. These decisions established that laws infringing upon the fundamental rights of certain classes would be held to the more demanding review standard of strict scrutiny, a standard once reserved for classifications based on race, national origin, and alienage.[213] These classifications were termed "suspect" classifications.[214] The Supreme Court also introduced a middle tier of intermediate scrutiny to the equal protection analysis, which requires that legislation burdening certain "quasi-suspect" classes or impairing important, but not fundamental, rights be substantially related to an important state interest.[215] In determining whether a classification merits heightened scrutiny, a court may consider the way the class is treated by others, the relationship of class members to one another, and the relevance of the class' defining characteristics to the class members' abilities to participate in society.[216] Although no one characteristic is determinative, political powerlessness, stigmatization, a history of unequal treatment, and the inability of individuals to control their membership may identify the class as a "discrete

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212. *See, e.g.*, Moore v. Draper, 57 So. 2d 648, 649 (Fla. 1952).

213. *See* Dunn v. Blumstein, 405 U.S. 330, 342-43 (1972). Strict scrutiny requires the state to prove that the chosen action was the least restrictive alternative: the state must show that the legislation is drawn with precision, that it is closely tailored to serve the objective, and that there is no other reasonable way to achieve the goal with a lesser burden on constitutionally protected activity. *See id.*

214. According to the Supreme Court, "unless a classification trammels fundamental personal rights or is drawn upon inherently suspect distinctions such as race, religion, or alienage," it need only be "rationally related to a legitimate state interest" to pass muster under the Equal Protection Clause. City of New Orleans v. Dukes, 427 U.S. 297, 303 (1976). Thus, HIV carriers will not be considered a "suspect" class worthy of heightened protection because no established fundamental personal right is infringed upon by HIV legislation, and no distinction is made by race, religion, or alienage.

215. *See, e.g.*, Craig v. Boren, 429 U.S. 190, 197 (1976) (treating gender classification as quasi-suspect); Bell v. Burson, 402 U.S. 535 (1971) (subjecting a law depriving individuals of their driver's licenses to intermediate scrutiny). State discrimination against HIV-infected health care workers need only meet the rational review standard because the deferential treatment does not rest upon any suspect or quasi-suspect classification scheme. *See generally* LAURENCE H. TRIBE, AMERICAN CONSTITUTIONAL LAW § 16-2 (2d ed. 1988).

216. *See* Cleburne v. Cleburne Living Ctr., Inc., 473 U.S. 432 (1985) (holding that mental retardation is not a quasi-suspect classification); Mathews v. Lucas, 427 U.S. 495, 506 (1976) (denying illegitimate children status as a suspect class); Frontiero v. Richardson, 411 U.S. 677 (1973) (giving heightened scrutiny to gender-based classifications).

and insular minorit[y]" deserving of special treatment.[217] Under this analysis, public health legislation controlling the behavior of HIV carriers would have to be substantially related to an important state interest if HIV carriers are considered a "quasi-suspect" class of people.[218] Thus, they will be entitled to more constitutional protection by virtue of the heightened burden of proof. If carriers are not considered part of a "quasi-suspect" class, HIV legislation will only have to satisfy the mere rationality test developed throughout traditional public health law.[219]

Furthermore, most public health precedent predates the developments during this century in both judicial construction of the Constitution and evolution of medical science. In the last two decades, the Supreme Court has expanded and redefined the scope of constitutionally protected individual rights. More specifically, the unenumerated substantive due process right of privacy has undergone significant development in the last decades.[220] The Supreme Court has held that the privacy right encompasses both a general interest of autonomy in making "certain kinds of important decisions" and an individual interest in the nondisclosure of "personal matters."[221] This change in the construction of the right to privacy changes the analysis of public health laws because the disclosure of people's medical conditions could be considered a violation of their newly protected privacy rights, and the states' interest in the laws would have to be stronger.

Revolutionary innovations in methods of disease control since the early years of this century have paralleled the development of constitutionally protected individual rights. Important medical developments now allow more closely targeted efforts to control communicable disease.[222] Fifty years ago,

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217. United States v. Carolene Prods., 304 U.S. 144, 152 n.4 (1938).

218. Commentators have addressed the issue of whether homosexuals should be considered a recognized classification. Although the Supreme Court has neither granted nor refused homosexuals quasi-suspect or suspect status, commentators have made a strong case for heightened scrutiny of classifications based on sexual preference. *See, e.g.*, Note, *The Constitutional Status of Sexual Orientation: Homosexuality as a Suspect Classification*, 98 HARV. L. REV. 1285 (1985); Harvis M. Miller II, Note, *An Argument for the Application of Equal Protection Heightened Scrutiny to Classifications Based on Homosexuality*, 57 S. CAL. L. REV. 797 (1984).

219. *See supra* note 107 and accompanying text.

220. The Court in the 1960s and 1970s expanded the traditional sphere of marital privacy. *See, e.g.*, Roe v. Wade, 410 U.S. 113, 153 (1973); Eisenstadt v. Baird, 405 U.S. 438, 453 (1972).

221. Whalen v. Roe, 429 U.S. 589, 599-600 (1977).

222. Researchers have begun to show medical and scientific causes of transmission of communicable diseases. This progress has enabled public health officials to target high risk groups and to encourage prevention techniques that are closely linked to the means of transmission. For example, prostitutes were formerly quarantined because their immorality caused the spread of sexually transmitted diseases. *See supra* note 210 and accompanying text. Today, researchers have established that the sexual behavior, not the immorality, causes the spread of the diseases. Because

quarantine may have been the least restrictive means of controlling some communicable diseases, but large-scale quarantine is now rarely justified.[223] Research, education, and individual treatment characterize the modern approach to public health policy, and courts now commonly rely on medical, rather than popular, assessments of the appropriate public health actions.[224] For example, the current state of scientific knowledge has made it possible to develop a basic biological understanding of HIV in a fraction of the time it would have taken twenty years ago.[225] Such advances in scientists' understandings of viral etiology[226] now allow closely targeted efforts to stop the spread of the disease. Thus, drastic measures, such as quarantine, would have little chance of being judicially upheld because of the enormous intrusion on the rights of the carriers compared to the minimal risk the carriers pose to society in everyday activities.

Society's concern that HIV will continue to spread is legitimate. However, apprehension that efforts to slow its transmission may violate the civil rights of carriers and members of high-risk groups is also legitimate. HIV regulation affects many rights of these individuals, including the rights to liberty, privacy, property, free association, and free expression. When constitutionally challenged, such regulation should be evaluated under the proper level of scrutiny to determine if the state interest at stake is compelling, important, or legitimate.[227] If the regulation meets the purpose test, then the relationship between the state's objective and the means employed to achieve it must be considered.[228]

Society has placed a stigma on those infected with HIV, and thus a program

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of frequent sexual contact, prostitutes are in a high risk group for both contacting and transmitting diseases. Therefore, they should be targeted for education on preventive measures, such as condoms. This example demonstrates the progression of society's understanding of the social and scientific aspects of the transmission of communicable diseases.

223. *See* Scott Burris, Note, *Fear Itself: AIDS, Herpes and Public Health Decisions*, 3 YALE L. & POL'Y REV. 479 (1985) (chronicling twentieth-century developments in medicine and public health case law); *see also* Michael S. Morgenstern, *The Role of the Federal Government in Protecting Citizens from Communicable Diseases*, 47 U. CIN. L. REV. 537, 543-44 (1978) (outlining the history of federal public health programs).

224. *See, e.g.*, New York State Ass'n for Retarded Children, Inc. v. Carey, 612 F.2d 644, 650-51 (2d Cir. 1979) (granting the state leave to return to court with a plan executed "in light of the most current medical information"); LaRocca v. Dalsheim, 467 N.Y.S.2d 302, 311 (Sup. Ct. 1983) (declining, after consideration of a medical opinion, to require that a prison protect healthy prisoners from HIV, but granting leave to renew claims as the state of scientific knowledge and hygienic procedures evolved).

225. *See* HARV. MED. SCH. LETTER, Dec. 1985, at 5, col.2.

226. Viral etiology is the study of the causes and origins of viruses. THE AMERICAN HERITAGE DICTIONARY 467 (2d college ed. 1985).

227. *See infra* note 237 and accompanying text.

228. *See* Kramer v. Union Free School Dist., 395 U.S. 621, 633 (1969).

for the control of this disease is difficult to facilitate.[229] In short, HIV has been socially defined as a disease of marginal groups.[230] Because of the stigma attached to HIV carriers,[231] improper state purpose for legislation infringing upon carriers' liberty should be a concern of courts reviewing such legislation, especially when important civil rights are at issue. Although courts have not often been willing to inquire into the motives of legislators,[232] the Supreme Court has held that courts, especially in equal protection cases, should not accept assertions of legislative purpose at face value, when an examination of the legislative scheme and its history demonstrates that the asserted purpose could not have been a goal of the legislation.[233] The failure of a state to

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229. Dr. Michael Merson, director of the WHO's Global Program on AIDS, recounted the AIDS epidemic in its worldwide social framework during the Eighth International Conference on AIDS in 1992. He explained that HIV feeds on society's weakness because it thrives on our reluctance to discuss sexuality. Dr. Michael Merson, Director of WHO's Global Program on AIDS, Address at the Eight Int'l Conference on AIDS, Morocco (Dec. 12-16, 1993), *cited in* Amy Lou Raney, *Legislative Instruments Dealing with AIDS and the Importance of Education*, 27 INT'L LAW. 495 n.30 (1993). He went on to remark that HIV exploits the desperate inadequacies of our health and social systems, such as poverty, gender, inequality, and racial discrimination. *Id.*; *see generally Infections Climb to Two-Thirds of World Total, Conferees Told*, *supra* note 23, at 8.

Problems associated with HIV are not confined to the United States. Australia and Great Britain have taken stringent measures to prevent the spread of HIV. In both of these countries, the public's health is a top priority. A 1984 amendment to the Australian Queensland Health Act allows a government official to "give information [regarding an individual's HIV status] to any department or official of the government of the Commonwealth having . . . a legitimate interest in possessing the information." Marlene C. McGuirl & Robert N. Gee, *AIDS: An Overview of the British, Australian, and American Responses*, 14 HOFSTRA L. REV. 107, 116 (1985). Also, anyone who suspects that they may have HIV must report to a physician within three days or be subject to a fine. *Id.* Great Britain health laws provide for compulsory hospital detention and examination for those suspected of having HIV. *Id.* at 113. These two countries seek to promote the public health, even at the expense of informational privacy interests. As commentators have stated: "Where AIDS is concerned, the British apparently feel that the need to protect the public easily outweighs the individual's interest in freedom from government intervention." *Id.* at 113.

230. The Florida Supreme Court neatly phrased the problem: "AIDS is the modern day equivalent of leprosy. AIDS, or a suspicion of AIDS, can lead to discrimination in employment, education, housing, and even medical treatment." Rasmussen v. South Florida Blood Servs., Inc., 500 So. 2d 533, 537 (Fla. 1987) (citation omitted). As a result, public perceptions of AIDS have unveiled thinly disguised prejudices about race, religion, social class, sex, and nationality.

231. The stigma is primarily due to the disease's close association with homosexuality and intravenous drug use. *Id.*

232. *See Developments in the Law—Equal Protection*, 82 HARV. L. REV. 1065, 1092-1101 (1969).

233. The law "reflects and expresses certain attitudes and preferences." Michael H. Shapiro, *On Not Watering All the Flowers: Regulatory Theory and the Funding of Heart Transplantation*, 28 JURIMETRICS J. 21, 23 (1987). This notion is quite logical and intuitive. *Id.* The values of a society are necessarily inculcated into its laws. *Id.* For instance, the criminal law prohibits drug abuse at least in part because it poses a significant risk to one's health. The criminal law is based upon the moral principle that life is sacred and should be preserved. *See* Patrick Devlin, *The Enforcement of Morals, reprinted in part in* CRIMINAL LAW AND ITS PROCESSES 238 (Sanford H. Kadish et al. eds., 4th ed. 1983). However, the values of the majority must not be allowed to

characterize a regulation accurately and limit its scope undermines the claim that the compelling purpose of controlling HIV is the rule's true objective.[234] Even under minimum scrutiny, the Court has looked closely at state-articulated justifications and evaluated them for their credibility, factual foundation, and logical consistency, striking down a rule that rested on irrational prejudice.[235]

With this in mind, regulation designed to preserve public health[236] by controlling HIV will almost certainly meet the proper purpose requirement, whether at the strict, intermediate, or minimum level of scrutiny.[237] HIV's potential to spread at an exponential rate supports the proposition that strong preventive measures could be appropriate.[238] Quieting the unsubstantiated

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manifest themselves in discriminatory laws. Thus, the true intent behind legislation must be uncovered. *See, e.g.*, Weinberger v. Wiesenfeld, 420 U.S. 636, 648 (1975); Hunter v. Erickson, 393 U.S. 385, 392 (1969) (rejecting a city's articulated justification for a racially discriminatory rule).

234. *See* New York State Ass'n for Retarded Children, Inc. v. Carey, 612 F.2d 644, 650 (2d Cir. 1979) (finding that the identification and quarantine of some, but not all, children carrying hepatitis B suggested that "the Board did not regard its own evidence of risk as particularly convincing"). This type of inquiry should be useful in determining the true purpose of HIV-control regulations; the classes of people who pose the greatest health threat to the population rarely have been singled out for specific action. For example, intravenous drug users pose the most direct threat to the heterosexual majority and make up a growing percentage of the HIV patients. *See* Centers for Disease Control, *Heterosexual Transmission of Human T-Lymphotropic Virus Type III/Lymphadenopathy-Associated Virus*, 34 MORBIDITY & MORTALITY WKLY. REP. 561 (1985). Nevertheless, gays are more often singled out as culpable and dangerous. *See* Ronald Bayer, *AIDS and the Gay Community: Between the Specter and the Promise of Medicine*, 52 SOC. RESEARCH 581, 589 (1985). American jurisdictions have all but ignored eliminating a significant means of transmitting HIV—shared intravenous needles. In the United States, where needles can be purchased only by prescription, 26% of AIDS patients have been intravenous drug users; in Canada, where needles are sold over the counter and are thus in such ready supply that few persons are likely to be tempted to share needles, the figure is 0.5%. *See* HARV. MED. SCH. LETTER, *supra* note 225 at 5, col. 2.

235. *See* Cleburne v. Cleburne Living Ctr., Inc., 473 U.S. 432 (1985).

236. *See, e.g.*, Brown v. Stone, 378 So. 2d 218 (Miss. 1979) (finding the state's interest in compulsory vaccination of school children sufficiently compelling to override parents' religious interests), *cert. denied*, 449 U.S. 887 (1980).

237. Under strict scrutiny, the state carries the burden of advancing a compelling justification for its action. Intermediate scrutiny requires the state to show that the legislation serves an "important" state objective. Under minimum scrutiny, legislation is presumed valid and will be upheld if it advances any legitimate state interest. *See The Supreme Court, 1984 Term*, 99 HARV. L. REV. 120, 161-62 (1985).

238. *See* Stephen Collier, *Preventing the Spread of AIDS by Restricting Sexual Conduct in Gay Bathhouses: A Constitutional Analysis*, 15 GOLDEN GATE U.L. REV. 301 (1985). *See also* Steven Lee Myers, *Adult Movie Theatre is Shut as a Health Hazard*, N.Y. TIMES, Jan. 23, 1994, at C23; Mireya Navarro, *Regulations for Sex Clubs are Strengthened in Effort to Curb AIDS Risk*, N.Y. TIMES, Jan. 22, 1994, at C25. *See* Thomas C. Quinn et al., *AIDS in the Americas: An Emerging Public Health Crisis*, 320 NEW ENG. J. MED. 1005, 1007 (1989) (reporting that Cuba implemented screening of the entire population for HIV and isolation of seropositive persons).

fears of the voting public, however, is neither a compelling, important, nor legitimate state interest.[239] Furthermore, the state does not have an appropriate interest in discriminatory laws, disguised as public health regulation, that are actually designed to attack or harass members of high risk groups.[240]

Further, the concern as to the appropriate governmental purpose for HIV legislation causes courts to examine the medical reality behind the policymakers' assertions to expose what motivated their choice of means. For example, since it has been established that seropositive dentists pose virtually no risk to patients except during invasive procedures, courts would likely find that restrictions on seropositive dentists limiting the scope of their duties beyond such procedures do not in fact decrease the risk of HIV transmission.[241] Courts would then conclude that if seropositive dentists pose no risk to patients by the nature of their duties, or if they follow the CDC's universal precautions, then a policy significantly limiting the scope of their duties is probably based on an impermissible motive or on misinformation. Discrimination on the basis of prejudice, misinformation, or ignorance cannot be countenanced under the Equal Protection Clause. Thus, courts would find the policy unconstitutional. However, forcing dentists and patients to release their serostatus to each other prevents the further spread of HIV, decreases society's anxiety about the virus because of the increase in discussion and education, expedites efforts to find a cure for the virus by allowing medical researchers to chart the course of the disease, and reinforces the important value of protecting and cherishing human life.[242] Thus, a guideline for disclosure would be found to be medically grounded.

However, a law requiring patients to disclose their seropositive conditions to their dentists before treatment would have to be closely examined to ensure that legislators had a legitimate purpose or motivation. For example, if disclosure is sought to enable dentists to refuse treatment to seropositive patients, the government's purpose would not be considered proper and the law would fail. However, if the purpose of disclosure is to promote accurate diagnoses and effective treatments, the law would be appropriate and upheld.

In sum, states have traditionally had the responsibility and authority to

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239. *See* Cleburne v. Cleburne Living Ctr., Inc., 473 U.S. 432 (1985) (holding that negative attitudes or unsubstantiated fears are not permissible justifications for treating a home for the mentally retarded differently from other multiple dwellings).

240. *See* O'Connor v. Donaldson, 422 U.S. 563, 575 (1975) ("Mere public intolerance or animosity cannot constitutionally justify the deprivation of a person's physical liberty.").

241. *See supra* notes 36-46 and accompanying text.

242. As Laurence H. Tribe noted, "[o]bviously, the compilation of accurate information about the incidence and transmission of this fatal condition is essential for the development of an effective public health response." *See* TRIBE, *supra* note 215, at 1394.

promote and protect public health, even at the expense of some rights of disease victims.[243] Public health laws generally are reviewed under a minimum scrutiny analysis, whereby legislation is presumed to be valid unless it bears no reasonable relationship to the achievement of a proper governmental objective.[244] Under this analysis, most legislation aimed at protecting public health has been upheld.[245] However, the development of equal protection case law introduced a new angle to the review of public health statutes.[246] Legislation infringing upon fundamental rights of certain groups is held to the more demanding review standard of strict scrutiny, a standard once reserved for suspect classifications based on race, national origin, and alienage.[247] Further, legislation burdening certain "quasi-suspect" classes or impairing important, but not fundamental, rights must be substantially related to an important state interest.[248] Thus, if HIV carriers are deemed a "quasi-suspect" class, legislation impairing their rights will have to satisfy a higher standard of scrutiny than the rational basis test. Regardless of the level of scrutiny applied to a piece of legislation, however, the state will have to demonstrate a legitimate purpose and a medical foundation for the law. The examination of various proposed laws suggests that this basic requirement has been and will continue to be a stumbling block for legislative progress in controlling HIV until all facets of the health care industry work together with the policymakers to design legislation grounded in a legitimate state interest and a sound medical foundation.

VI. BALANCING PRIVACY AND PUBLIC HEALTH IN THE CONTEXT OF DENTISTRY

A. Balancing the Interests Generally

The HIV crisis has presented an irreconcilable conflict of interest, whereby HIV carriers are reluctant to disclose their conditions because they fear invasions of their privacy and subsequent discrimination,[249] while the public demands information to curb the spread of the virus. Carriers are caught in a dilemma in which they have a profound desire for information that may contribute to prevention or treatment of HIV, but also a particularly acute need for privacy. However, the very information that may be useful in protecting the public health may directly infringe upon the privacy so desperately needed.[250] The solution

243. *See supra* notes 199-202 and accompanying text.
244. *See supra* notes 204-08 and accompanying text.
245. *See supra* notes 205-08 and accompanying text.
246. *See supra* text accompanying notes 213-21.
247. *See supra* note 213 and accompanying text.
248. *See supra* note 215 and accompanying text.
249. *See supra* note 230-31.
250. *See supra* notes 159-90 and accompanying text.

to this seemingly hopeless conflict in the context of dentistry emerges upon a closer examination of the reasons why the problem has not yet been addressed effectively. By examining the conflict of interests surrounding a few of the most important issues, a consistent way to manage HIV in dental offices will emerge.

Three basic practices will create the cornerstone of a solution to curbing transmission. First, strict sterilization procedures must be followed in all dental facilities and with all patients.[251] No infection control system will be effective without uniform enforcement of these procedures.[252] Practicing such procedures minimizes the risk of transmission of HIV, as well as many other communicable diseases.[253] Furthermore, reliable sterilization techniques make disclosure between patients and dentists less important since the procedures alone should virtually eliminate any risk of transmission.[254]

Second, maintaining confidentiality of medical information about the virus is crucial. Rather than posing an obstacle for proponents of HIV reporting and testing laws, the individual interest in confidentiality is in fact an important weapon in the disease control effort. Protection of the confidentiality of potential HIV carriers should help to create an atmosphere conducive to voluntary participation in reporting, testing, and educational programs.[255] Full participation in these programs will in turn promote the success of efforts to isolate, treat, and cure the deadly disease.

Finally, patients and dentists must be educated about the disease, its symptoms, and its modes of transmission.[256] They must understand that the virus cannot be transmitted through casual contact and that the risk of transmission in a dental office is extremely low.[257] Increasing awareness of the disease will minimize the irrational fears and negative stereotyping that frequently surround it.[258] Patients will be less afraid of contracting the virus

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251. Currently, the CDC guidelines are the governing authority on sterilization. *See supra* note 58.

252. *See supra* note 58.

253. *See supra* note 58.

254. *See supra* note 58.

255. People will be more willing to share medical information and be voluntarily tested if they think the information will be kept confidential.

256. *See supra* notes 20-47 and accompanying text.

257. *See supra* notes 20-47 and accompanying text.

258. The highly publicized case of Ryan White dramatically illustrates the need for AIDS education. Frederic C. Kass, *Schoolchildren with AIDS, in* AIDS AND THE LAW 66, 76 (Harlon L. Dalton & Scott Burris eds., 1987). Ryan, a thirteen-year-old hemophiliac with AIDS, was denied admittance to Western Middle School in Kokomo, Indiana. The state guidelines allowed children with AIDS to be admitted to public school provided they behave acceptably (e.g., do not bite, are toilet-trained) and have no uncoverable sores or skin eruptions. INDIANA STATE BOARD OF HEALTH, GUIDELINES FOR CHILDREN FOR CHILDREN WITH AIDS/ARC ATTENDING SCHOOL (July 1985).

from their dentists, and dentists will be more willing to treat seropositive patients.[259] Furthermore, dentists must receive special training in diagnosing and treating oral manifestations of HIV.[260]

There are several additional steps which need to be taken to effectively curb HIV transmission in dental offices. These steps tend to be more intrusive into privacy and other liberty interests. Therefore, they require further analysis as to balancing the privacy interests with the public health concerns to determine what kind of legislation would be constitutional given the standards of review used by courts.[261] Because informational privacy has not yet been deemed a fundamental right by the Supreme Court, a balancing of the harm and benefit from legislation infringing upon this interest, rather than strict scrutiny, would be appropriate.[262] Moreover, legislation designed to protect public health will only be held to a mere rationality standard unless the law infringes upon a suspect classification or a substantial, but not fundamental, interest.[263] Thus, each of these additional and necessary steps should be examined with these standards in mind to determine where the balance between the competing interests rests.

B. Seropositive Patients

The issue of whether seropositive patients may be forced to disclose their conditions to their dentists is important to the general public, but particularly important to those patients who are carrying the virus or who are in a high-risk group. These patients argue that disclosing their serostatus to their dentists

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Although Ryan met all of the state's criteria and presented a very minimal threat to his classmates and teachers, he was still denied enrollment. Ryan's family was forced to seek an injunction to prevent the school from denying Ryan admittance. White v. Western Sch. Corp., IP 85-1192-C (S.D. Ind. 1985); *see also* District 27 Community Sch. Bd. v. Board of Educ. of New York, 502 N.Y.S.2d 325 (Sup. Ct. 1986) (concluding that the denial of public school admission to children with AIDS violated their rights). For a more detailed discussion of the benefits of AIDS education, see Jane Harris Aiken, *Education as Prevention, in* AIDS AND THE LAW 90 (Harlon L. Dalton et al. eds., 1987). It is argued that AIDS education will prevent the spread of the disease because knowledge of how HIV is spread will result in proper precautions and a decreased amount of discrimination. *Id.* at 91-95.

259. One dentist noted a decline in patients who seek dental care, which was presumably attributable to the fear of contracting HIV. *See* Jeffrey M. Gold, *Fear of AIDS Keeps Dentist Chairs Empty*, N.Y. TIMES, Nov. 3, 1991, at D14. *See also* Mireya Navarro, *Patients Grilling Health Workers on AIDS*, N.Y. TIMES, Aug. 2, 1991, at B1 (reporting some doctors and dentists believe that patients delay procedure and treatment because of fear of HIV infection, and dentists in the New York Metropolitan area reported cancellations after the newspapers reported the death of an HIV-infected dentist).

260. *See supra* note 9.

261. *See supra* note 237.

262. *See supra* notes 108-61 and accompanying text.

263. *See supra* note 107 and accompanying text.

would violate their privacy and could lead to discrimination and other forms of harassment.[264] Since the right to informational privacy has not been deemed a fundamental right by the Supreme Court,[265] courts reviewing a law requiring disclosure on the part of seropositive patients would balance the privacy interests of these patients against the public health interest in obtaining such information.[266]

Carriers argue that disclosure of their conditions to friends, insurance companies, or employers could be disastrous.[267] These carriers anticipate discrimination in the workplace and rejection from their insurance companies. Furthermore, they fear that many seropositive patients will be refused dental treatment or may not be treated with the same level of courtesy and professionalism that seronegative patients enjoy. Moreover, many patients see no need for dentists to know their serostatus because they do not believe it relates to their receipt of dental treatment. Thus, they argue that the intrusion into their privacy is not justified by the minimal benefit which could be derived from disclosure.

However, this perspective is unfounded. There are several reasons why it is imperative that dentists know the serostatus of the patients they are treating.[268] Perhaps the most obvious is that dentists could take extra precautions and care in treating these patients to minimize the possibility of transmission to themselves, to other dental staff, and to other patients.[269] This in and of itself is a strong interest in which the government has a legitimate purpose in protecting. However, the public health concern goes much deeper than giving the dentists a chance to "double-glove" or to clean the operatories with special care.

Making dentists aware of patients' seropositive conditions is crucial to ensure that patients receive proper dental care. As with other kinds of doctors, dentists must have a complete medical history on each patient to ensure that maladies are characterized and treated properly.[270] Because oral manifestations of HIV are common in most carriers, proper diagnosis of the lesions is critical to the treatment received by these patients.[271] Furthermore, dentists need to know medications and other forms of treatment seropositive

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264. *See supra* notes 230-31.

265. *See supra* notes 108-45 and accompanying text.

266. *See generally* Leckelt v. Board of Comm'rs, 909 F.2d 820, 833 (5th Cir. 1990); *In re* Milton S. Hershey Medical Ctr., 595 A.2d 1290 (Pa. Super. Ct. 1991).

267. *See supra* note 230-31.

268. *See supra* note 9.

269. *See supra* note 33.

270. *See supra* note 9.

271. *See supra* note 9.

patients are receiving from physicians to prevent dangerous interactions with medications prescribed for oral conditions.[272] Dentists are part of the overall medical team for the patients, thus they must have accurate medical histories of patients and must work in concert with physicians to prevent dangerous conflicts in treatments.[273] Disclosure is in the best interests of seropositive patients to ensure safe and effective treatment.[274] Furthermore, this information protects dentists from potential malpractice suits for failing to properly diagnose or treat seropositive patients if the dentists did not know of the presence of the virus and of prescriptions.

Therefore, the interests in minimizing the risk of transmission, in preserving the health of the patients through promoting proper diagnoses and treatments, and in preventing dentists from facing malpractice charges outweigh the seropositive patients' privacy interests and warrant an infringement on the privacy interests to the extent of mandating disclosure. However, any law requiring such disclosure must also afford strong measures to protect the confidentiality of the information and must not require disclosure to any parties other than the treating dentists. Once the information is released, these conditions on the law must make sure that the privacy interests will be preserved and respected to the greatest extent possible.

C. Seropositive Dentists

Determining how to deal with seropositive dentists raises sensitive ethical questions.[275] Do dentists have a duty to be tested and to monitor their serostatus? Furthermore, do dentists have a duty to disclose positive results to their patients before treatment begins? Most people believe that dentists do indeed have an ethical duty to be tested and to disclose positive test results to their patients.[276] There is more controversy, however, as to whether a legal duty to be tested and to disclose can constitutionally be imposed on dentists. To determine the answer, the privacy interests of the dentists should be weighed against the public's interest in obtaining the information.

Given that one of the possible routes of transmission is through blood-to-blood contact, dentists can transmit the virus when performing invasive procedures by cutting themselves and thereby commingling their infected blood with the blood of their patients.[277] Since the virus can be transmitted in this

272. *See generally* AMERICAN DENTAL ASSOCIATION, *supra* note 9.
273. *Id.*
274. *Id.*
275. *See supra* note 62.
276. *See supra* note 8.
277. *See supra* note 9.

manner, proposals which would require testing the dentists or which would restrict the procedures practiced by seropositive dentists must be evaluated. Like seropositive patients, dentists who have the virus are concerned about breaches in their right of privacy caused by testing and disclosure schemes. Dentists worry that disclosure of their serostatus will cause them to lose their professional insurance coverage and will force them out of practice. Even if this does not happen, they could lose their practices anyway if their patients are made aware of their condition.[278] Few, if any, patients are willing to risk being treated by a seropositive dentist even though the actual chance of transmission is extremely small.[279]

The competing public health interest in obtaining the serostatus reports of dentists is significant. Patients argue that they have a right under the doctrine of informed consent to know if their dentists are infected so that they can make informed decisions about pursuing treatment.[280] Patients point to the Kimberly Bergalis case and argue that they should at least be entitled to know which dentists are seropositive since they have no way knowing whether proper sterilization techniques are being strictly followed.[281] Patients want dentists to be reviewed and supervised to make sure that the risk of transmission is extinguished in all dental offices. In fact, many patients feel that all dentists should be tested, and those who are infected should cease practicing completely because jeopardizing the life of even one patient is too great a risk to bear.[282] While very few individuals might contract HIV from their dentists, the good of

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278. *See* Beverly Beyette, *The Plight of a Gay Pediatrician*, L.A. TIMES, Nov. 30, 1987, at E1. A successful pediatrician in Texas was discovered to be a homosexual with AIDS. *Id.* When this information became public, the physician's practice immediately evaporated. *Id.* When parents discovered the doctor had AIDS, they were furious and wanted to "crucify him," notwithstanding the fact that medical evidence indicated that it was highly unlikely to transmit HIV in such a situation. *Id.*

The AIDS hysteria has provoked numerous examples of this irrationality. *See, e.g.*, Chalk v. United States Dist. Court Cent. Dist., 840 F.2d 701, 703 (9th Cir. 1988) (concerning the termination of a teacher with HIV); Cronan v. New England Telephone & Telegraph Co., No. 86-0242 (Mass. Super. Ct. 1986) (resulting from coworkers of an AIDS victim who refused to use a truck previously driven by him and who threatened to kill the victim if he ever returned to work from a leave of absence); Poff v. Caro, 549 A.2d 900, 903 (N.J. Super. Ct. Law. Div. 1987) (concerning a landlord who refused to rent an apartment to three gay men for fear of AIDS); David M. Freedman, *Wrong Without Remedy*, 72 A.B.A. J. 34, 40 (1986) (reporting that a judge in Florida required AIDS victims to wear masks in his courtroom); John Parry, *AIDS as a Handicapping Condition*, 9 MENTAL & PHYSICAL DISABILITY L. REP. 402 (1985) (reporting that Los Angeles paramedics denied prompt assistance to a heart attack victim because they feared he had AIDS).

279. *See supra* note 278.

280. *See supra* note 8.

281. *See supra* notes 52-53 and accompanying text. *See also* notes 1-2.

282. *See supra* note 8.

the many must take precedence over the good of the few.[283]

Many schemes requiring testing and disclosure for all dentists are problematic because they pose too great a burden on privacy rights or fail to sufficiently protect public health to be constitutionally valid. Although the legitimate state interest in preventing transmission from dentists to patients is being promoted, such legislation extends beyond the scope of the medical realities about transmission, and the privacy rights of the dentists are not protected at all. More specifically, the intrusion into the privacy of dentists caused by universal mandatory testing and disclosure is not warranted by the benefit to public health.[284] The risk of transmission of the virus is so minute in a dental setting that it does not support the personal, financial, and administrative burdens imposed by compulsory screening of all dentists.[285] Furthermore, disclosing dentists' seropositive conditions to their patients is also not warranted by the risk of transmission. The harm caused by disclosure is extensive, including the doubtless termination of their practices and the end of their clinical careers. Thus, mandatory testing and disclosure provisions for all dentists are too drastic and cause too great a deprivation of privacy rights given the actual medical risk of transmission of the virus from dentist to patient.

Testing and disclosure provisions should be drafted to provide the greatest amount of protection to both the privacy of the dentists and the safety of the public health. Because a minute risk of transmission from a dentist to a patient does exist,[286] measures calling for the testing of those dentists posing the greatest risk could be acceptable. However, for the invasion of privacy to be warranted, these measures must apply only to those dentists who perform invasive procedures or who otherwise pose greater risks to their patients than do those in general practice. Furthermore, having dentists share their seropositive conditions could also be appropriate to protect the public health as long as certain steps are taken to protect the confidential nature of the information.

Perhaps the ideal way to protect the privacy of the dentist, while also preserving the public's safety, is to have seropositive dentists report to a third

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283. This philosophy is ingrained in American jurisprudence. Individuals are often forced to accept tragedy and injustice so that other important values and rights that impact upon society as a whole are safeguarded. For example, the doctrine of public necessity in tort law allows the state to destroy a citizen's personal property without compensation to protect a greater number of citizens' property. *See* PROSSER & KEETON, *supra* note 109, at 146-47. So too, when Holocaust survivors who live in Skokie are told that they must endure Nazis parading in their home town, or when individuals convicted of serious crimes are permitted to go free because of illegally obtained evidence, the good of the many is placed above the needs of the few.

284. *See supra* note 53.

285. *See supra* note 53.

286. *See supra* note 9.

party, such as an expert review panel.[287] This panel would be responsible for limiting the scope of seropositive dentists' practices to only those procedures posing virtually no risk to patients and would be charged with supervising their activities and sterilization procedures.[288] The panel would protect the welfare of the public by providing a means of supervising and limiting the activities of seropositive dentists.[289] At the same time, dentists would not be required to release their status to their patients because the panel would assess the risk posed to patients and would take the appropriate measures to minimize this risk.[290] This would mean that liability for any transmission from a seropositive dentist to patient while under the supervision of an expert review panel would be shared between the infected dentist and the panel supervising the dentist. Thus, more people would have a stake in preventing transmission and would be held accountable for any negligent mishaps. In the end, this will benefit public health because seropositive dentists and their expert review panels will be forced to use the utmost care in deciding what the scope of the dentists' activities should be.

D. Conclusion

If society is to survive the HIV epidemic with both public health and civil liberties intact, it is essential to determine where the Constitution draws the line between the protection of public health and the defense of individual liberty.[291] In light of the significance of both privacy and health interests, no decision will be reached without anguish and cost. It is time for the ADA and the legislature to work together to find an acceptable balance and to develop an aggressive, comprehensive plan to attack the problem.

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287. *See supra* text accompanying note 79. *See also infra* section VII.

288. *See supra* text accompanying note 79. *See also infra* section VII.

289. *See supra* text accompanying note 80. *See also infra* section VII.

290. *See supra* text accompanying note 80. *See also infra* section VII.

291. A variety of public health measures might generate constitutional issues. For example, litigants have challenged the constitutionality of orders closing bathhouses, City of New York v. New Saint Mark's Baths, 497 N.Y.S.2d 979 (N.Y. Sup. Ct. 1986), and segregating prisoners with AIDS from other inmates, Cordero v. Coughlin, 607 F. Supp. 9 (S.D.N.Y. 1984). Although the analysis developed in this note may be useful in evaluating the constitutionality of some of these measures, a detailed consideration of these measures outside the dental setting is beyond the scope of this note. For further discussions about the constitutionality of these and other restraints, see Leonard Orland & Sue L. Wise, *The AIDS Epidemic: A Constitutional Conundrum*, 14 HOFSTRA L. REV. 137 (1985); Judith A. Rabin, *The AIDS Epidemic and Gay Bathhouses: A Constitutional Analysis*, 10 J. HEALTH POL., POL'Y & L. 729 (1986); Note, *The Constitutional Rights of AIDS Carriers*, 99 HARV. L. REV. 1274 (1986). For an eloquent argument that all coercive restraints to control AIDS are immoral, see Richard D. Mohr, *AIDS, Gay Life, State Coercion*, 6 RARITAN 38 (1986).

VII. PROPOSED FEDERAL STATUTE

No piece of legislation or dental association policy to date has addressed all of the issues involved in curbing transmission of HIV in dental offices.[292] Instead, each has taken only a narrow approach to the problem.[293] This piecemeal approach is insufficient and fails to create uniform standards among dentists. Effective standards must address all of the issues together in a comprehensive proposal supported by both legislators and dentists. The legislature and the dental associations must cooperate and support the same goals and the means by which to achieve those goals for any legislation to have enough respect and enforcement power to make progress in minimizing the risk of transmission.

Carefully drafted legislation and dental association policies balancing the competing interests of HIV carriers and the public health will begin to make the issue of HIV in dentistry more manageable. The guidelines suggested here take a strong stand both on disclosure and on confidentiality. They are generated from the notion that everyone will be safer if information is available to the appropriate parties and if seropositive people believe their medical information will be held in the strictest confidence. The guidelines mandate stiff sanctions against those who breach this confidentiality and those who fail to closely follow the provisions. Civil and criminal penalties create a strong incentive to comply with the statute and are extremely important to its overall success and implementation.

The statute proposed here is limited in application to patients and dentists. A statute actually implemented would have to address the rights and responsibilities of the other dental workers, namely hygienists, in coping with the potential presence of HIV. Extending the scope of the statute would be critical in trying to attack the problem comprehensively. Additionally, this proposed statute does not directly address the quandary of enforcing strict sterilization and infection control procedures, which is truly at the heart of minimizing the risk of transmission.[294] This is primarily due to the enactment of the Dole amendment to the Postal Service and General Government Appropriation Act of 1992, requiring state legislatures to adopt practice guidelines for HIV-positive health care workers based on the guidelines promulgated by the CDC.[295] This Act should force states to implement

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292. *See supra* notes 51-85 and accompanying text.

293. *See supra* notes 51-85 and accompanying text.

294. *See supra* note 33.

295. Pub. L. No. 102-141, § 633, 105 Stat. 834, 876 (codified at 42 U.S.C. § 300ee-2 (1988 & Supp. IV 1992)) (detailing the steps that states must take regarding the prevention of HIV and hepatitis-B virus transmission in order to avoid becoming ineligible for assistance under Public

rigorous infection control standards.[296] Thus, it would be counterproductive to create competing legislation. Before any legislation similar to what is proposed here could be enacted, legislators should carefully scrutinize the reaction to the Act to evaluate the potential degree of cooperation and compliance with the infection control procedures. If the reaction is negative, then further measures would be appropriate to address the problem.

FEDERAL STATUTE GOVERNING HIV CONTROL IN DENTISTRY

Chapter 1: Definitions

§1 (1) *AIDS*: Acquired Immune Deficiency Syndrome caused by the Human Immunodeficiency Virus. Full-blown AIDS is diagnosed when an individual is found to have one or more of the following illnesses: (1) opportunistic infection, (2) Kaposi's sarcoma, (3) high-grade, B-cell lymphoma, (4) AIDS-dementia/encephalopathy syndrome, or (5) wasting syndrome (slim disease).

(2) *HIV*: Human Immunodeficiency Virus causing AIDS and other opportunistic diseases.

(3) *Oral Invasive Procedures*: exposure-prone procedures performed within the mouth which expose significant amounts of blood and/or mucous membranes and which call for the simultaneous presence of dentists' fingers and needles or other sharp instruments in the mouth; procedures with higher risk of dentists cutting themselves due to poor visualization or to a highly confined anatomic site.

(4) *Oral Surgery*: the branch of dentistry dealing with diseases and injuries in the oral cavity or on the lower half of the face requiring operative procedures which include, but are not limited to: extractions, skin grafts, bone treatments, and mass biopsies and removal.

(5) *Periodontics*: the branch of dentistry concerned with the prevention and treatment of the supportive tissues surrounding the teeth.

(6) *Seropositive*: when a person tests positive for having the HIV antibodies.

Health Service Act). *See supra* note 57.

296. *See supra* note 57.

Chapter 2: Seropositive Patients

§ 1 (1) All dental patients who know they have HIV, have tested positive for the virus, or have AIDS or any related illness have a legal duty to:

(a) truthfully and accurately disclose this information to their dentists before any kind of treatment is rendered;

(b) truthfully and accurately disclose to the dentists the names and doses of all medications being taken at the time of dental treatment before such treatment is rendered; and

(c) truthfully and accurately disclose to the dentists the names, addresses, and phone numbers of all physicians who are treating or have treated the patients for HIV related conditions before any dental treatment is rendered.

(2) Any patient who fails to act according to Section 1(1) of this Chapter may be refused treatment by a dentist for intentionally supplying false or inaccurate medical information.

(3) Any patient who fails to act according to Section 1(1) of this Chapter commits a Class A misdemeanor punishable by up to one year in prison and/or a fine of up to $5000. Furthermore, any patient who fails to act according to Section 1(1) of this Chapter may be held civilly and/or criminally liable for any injuries caused by this failure. Such injuries include, but are not limited to, transmission of the virus to the dentist, to other dental staff, or to other patients.

(4) Dental personnel shall not disclose information provided pursuant to Section 1(1) of this Chapter without the explicit permission of the patient. Any violation of this confidentiality shall be governed by Section 3(2) of this Chapter.

§ 2 (1) No dentist may refuse treatment to a patient solely on the basis of the patient's seropositive status.

(2) In instances where a patient is seropositive, decisions with regard to the type of dental treatment provided or referrals suggested should be made on the same basis as they are made with other patients. Referrals are appropriate when dentists believe they are in need of another's skills, knowledge, equipment, or experience or when dentists believe, after consultation with patients' physicians, that the patients' health would be significantly compromised by the provision of dental

treatment.

§ 3 (1) Dentists shall have a right to share medical knowledge with any and all physicians who have treated or are currently treating the dentists' seropositive patients if this information is relevant to the patients' dental treatment without risking a violation of state or federal anti-discrimination laws and confidentiality laws. However, dentists shall not disclose this information to persons other than treating physicians and the respective patients without explicit permission from those patients. Any violation of this confidentiality shall be governed by Section 3(2) of this Chapter.

(2) A person responsible for recording, reporting, or maintaining information required to be reported under this Chapter who recklessly, knowingly, or intentionally discloses or fails to protect medical information classified as confidential under this Section commits a Class A misdemeanor punishable by up to one year in prison and/or a fine of up to $5000.

Chapter 3: Seropositive Dentists

§ 1 (1) All dentists performing periodontics and/or oral surgery of any kind shall undergo HIV testing at their own expense every six months beginning January 1995 and shall have an official report sent by the agency performing the test to a named state representative of the American Dental Association. This information shall be kept strictly confidential and shall under no circumstances be released to the public or the media.

(2) All dentists testing seropositive during an initial screening shall undergo a confirmation test at the expense of the American Dental Association and shall have an official report sent by the agency performing the test to a named state representative of the American Dental Association. This information shall be kept strictly confidential and shall under no circumstances be released to the public or the media.

(3) A person responsible for recording, reporting, or maintaining information required to be provided under this chapter who recklessly, knowingly, or intentionally discloses or fails to protect medical information classified as confidential under this Section commits a Class A misdemeanor punishable by up to one year in prison and/or a fine of up to $5000.

(4) All dentists testing seropositive after a confirmation test (including those dentists who discover their seropositive status on their own instead of through mandatory testing) who wish to continue practicing without disclosing their seropositive condition to their patients shall be referred to an expert review panel from their respective states.

(a) Each state shall have at least one expert review panel.

(b) The expert review panels shall be selected and supervised by the respective state dental associations.

(c) The expert review panel shall:

(i) consist of six dentists per state who have successfully completed forty hours of intensive training by the Centers for Disease Control on HIV as it relates to dentistry and on sterilization procedures;

(ii) work with each seropositive dentist to examine treatment and sterilization procedures performed in that dental office to evaluate the potential risk of transmitting the virus to patients and assistants;

(iii) make an official recommendation to each dentist reviewed as to which treatment procedures, if any, may continue to be safely performed and as to changes that must be made in the office's sterilization procedures. Dentists are bound by the recommendations of the acting expert review panel unless they choose to disclose their conditions to their patients. Dentists who are not satisfied with the recommendations may appeal to the disease control committee of the respective state dental association for review within sixty days of the report;

(iv) initiate disciplinary proceedings against those dentists who fail to comply with the official recommendations of the panel within sixty days of the presentation of the report and who fail to appeal through the proper procedure. Disciplinary action may include, but is not limited to, monetary fines, probation, license suspension or revocation;

(v) keep all actions, contact, investigations, findings, recommendations and disciplinary proceedings strictly confidential. A person responsible for recording, reporting,

or maintaining information required to be provided under this Chapter who recklessly, knowingly, or intentionally discloses or fails to protect medical information classified as confidential under this Section commits a Class A misdemeanor punishable by up to one year in prison and/or a fine of up to $5000.

(5) All seropositive dentists who choose to terminate their practices shall qualify for disability insurance with their professional insurance carriers.

AMERICAN DENTAL ASSOCIATION POLICIES
CONCERNING HIV EDUCATION

Resolved, that each dentist licensed to practice in the United States shall complete twenty hours of certified continuing education per annum focussing on these areas: facts about HIV and transmission as they relate to dentistry, HIV-related oral lesions, medications for HIV patients, the most effective and cost-efficient sterilization techniques available, professional responsibility in the HIV crisis, and education for patients on HIV and sterilization procedures for the dental office.

Resolved, that the American Dental Association shall encourage and assist all dentists in educating each and every patient before treatment begins, to build trust among patients and dentists and to minimize unjustified fears about HIV. The American Dental Association shall encourage and assist dentists in developing educational packets, brochures and videos for their patients concerning HIV, other communicable diseases, and sterilization practices in the dental office.

VIII. CONCLUSION

The HIV crisis demands that both public health and individual liberties be zealously guarded. In doing so, HIV raises perplexing questions for legislators and public health officials who must attempt to stop the spread of a deadly disease without unduly restricting the civil liberties of citizens infected by it. Nowhere is achieving the proper balance between individual and collective rights more difficult. In short, protecting the human rights and dignity of HIV carriers is a necessity, not a choice. The issue is not the "rights of many" versus the "rights of few"; the protection of the uninfected majority depends upon and is inextricably bound with the protection of the rights and dignities of the infected minority.

Kimberly Bergalis was right when she blamed more than just her dentist for

her infection. The legislature, the dental professionals, as well as the patients, are charged with the burden of working together to minimize the risk of transmission of this deadly disease in dental offices. All of us are responsible for preventing another Kimberly Bergalis tragedy.

Marjorie H. Lawyer