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**NONCONSENSUAL HIV TESTING IN THE HEALTH
CARE SETTING: THE CASE FOR EXTENDING
THE OCCUPATIONAL PROTECTIONS
OF CALIFORNIA PROPOSITION 96
TO HEALTH CARE WORKERS**

I. INTRODUCTION

In 1981 the fatal progression of symptoms that later came to be known as Acquired Immune Deficiency Syndrome (AIDS) was first described in medical literature.¹ More than a decade later, the causative agent has been isolated—a virus now called the Human Immunodeficiency Virus (HIV).² Scientists have learned that AIDS is transmitted by commingling blood or body fluids with those of an infected person,³ and there are now serological tests⁴ that can detect exposure to the virus.⁵ However, in spite of a worldwide outpouring of scientific research, neither a reliable vaccine nor a cure is on the horizon.⁶

AIDS is not spread by casual contact. Nevertheless, convincing the public to treat victims with compassion and understanding has proven to be a daunting task.⁷ Recognizing the need to protect HIV-positive persons from unwarranted discrimination in housing, education and em-

1. STEPHEN A. FLANDERS & CARL N. FLANDERS, AIDS 58 (1991). The Centers for Disease Control (CDC) reported on the unusual cases of *Pneumocystis carinii* pneumonia that had been observed in the preceding months. *Id.*; see also RANDY SHILTS, AND THE BAND PLAYED ON: POLITICS, PEOPLE, AND THE AIDS EPIDEMIC (1988) (relating history of early days of AIDS epidemic).

2. FLANDERS & FLANDERS, *supra* note 1, at 7-8; Susan W. Barnett & Jay A. Levy, *Human Immunodeficiency Viruses*, in MANUAL OF CLINICAL MICROBIOLOGY 1011, 1011 (Albert Balows et al. eds., 5th ed. 1991).

3. FLANDERS & FLANDERS, *supra* note 1, at 18-20; Barnett & Levy, *supra* note 2, at 1013.

4. Serological tests are those that test the body's immune response to infection by measuring serum antibody levels. DORLAND'S ILLUSTRATED MEDICAL DICTIONARY 1511 (27th ed. 1988). See *infra* note 29 for a description of the serological tests most commonly used to detect the HIV antibody.

5. Barnett & Levy, *supra* note 2, at 1014-17; Judith C. Wilber, *HIV Antibody Testing: Methodology*, in THE AIDS KNOWLEDGE BASE 2.1.2-1, 2.1.2-1 to 2.1.2-5 (P.T. Cohen et al. eds., 1990).

6. FLANDERS & FLANDERS, *supra* note 1, at 27-29; see also Christine Gorman, *Invincible AIDS*, TIME, Aug. 3, 1992, at 30, 34 (describing current status of worldwide AIDS epidemic and difficulties in finding effective treatment or vaccine).

7. Citizens Comm'n on AIDS for N.Y. City and Northern N.J., *AIDS Prevention and Education: Reframing the Message*, 3 AIDS EDUC. & PREVENTION 147, 147-48 (1991).

ployment, both Congress⁸ and many states⁹ have passed laws specifically forbidding such practices.

Antidiscrimination laws have been only part of the legislative response. States also have recognized the need for testing and early treatment, especially in high-risk population groups.¹⁰ Yet many persons resist being tested, fearing that the results of a positive test will become publicly known.¹¹ To protect the privacy of tested individuals, many states, including California, have enacted special statutes to safeguard the confidentiality of HIV-related information.¹²

At one time, a major component of AIDS law in California was that *no one* could be tested without first giving written consent.¹³ However, it soon became obvious that such all-encompassing rules went too far. Convinced that in some instances there was a compelling need for non-consensual testing in order to slow the spread of AIDS, the California Legislature passed several exceptions to the consent requirement in 1988. These exceptions permitted nonconsensual testing of prisoners, convicted prostitutes and sex offenders.¹⁴

In 1988, voters also passed Proposition 96, a ballot initiative allowing law enforcement, fire and rescue personnel, custodial personnel and victims of sexual crimes to petition the court to order HIV testing of the person who may have exposed them to the virus.¹⁵ This option, however, was restricted to the criminal context and was not extended to health care workers who also run the risk of exposure on a daily basis.¹⁶

8. See *infra* notes 63-85, 172-74 and accompanying text.

9. Larry O. Gostin, *Public Health Strategies for Confronting AIDS: Legislative and Regulatory Policy in the United States*, 261 JAMA 1621, 1628 (1989).

10. See *infra* note 44 and accompanying text for a discussion of high-risk groups.

11. Barry R. Furrow, *AIDS and the Health Care Provider: The Argument for Voluntary HIV Testing*, 34 VILL. L. REV. 823, 828-31 (1989).

12. See, e.g., CAL. HEALTH & SAFETY CODE § 199.21 (West Supp. 1993); ILL. ANN. STAT. ch. 111½, para. 7309 (Smith-Hurd 1992); N.Y. PUB. HEALTH LAW § 2782 (McKinney Supp. 1993); see also Gostin, *supra* note 9, at 1622-23 (listing states that have HIV confidentiality statutes).

13. CAL. HEALTH & SAFETY CODE § 199.22 (West 1990).

14. See CAL. PENAL CODE § 1202.1 (West Supp. 1993) (permitting HIV testing of convicted sex offenders); *id.* § 1202.6 (West Supp. 1993) (permitting HIV testing of repeat prostitution offenders); *id.* § 7501 (West Supp. 1993) (permitting HIV testing of prisoners).

15. Proposition 96, 1988 Cal. Stat. A-271 to -274 (codified at CAL. HEALTH & SAFETY CODE §§ 199.95-99 (West 1990)).

16. Health care workers are usually exposed by contaminated needlesticks. Linda S. Billet et al., *Needlestick Injury Rate Reduction During Phlebotomy: A Comparative Study of Two Safety Devices*, 22 LABORATORY MED. 120, 120 (1991). Current studies estimate that the risk of becoming HIV positive from a single contaminated needlestick is less than one percent. J. Louise Gerberding & Merle A. Sande, *Accidental Parenteral or Mucous Membrane Exposure to HIV*, in THE AIDS KNOWLEDGE BASE 10.2.9-1, 10.2.9-1 (P.T. Cohen et al. eds., 1990).

As the law now stands, a physician, nurse, laboratory technician or any other health care worker who suffers an exposure from a patient whose HIV status is unknown cannot compel that patient to be tested without written consent.¹⁷ Without knowing whether they are potentially infected, these workers must wait and worry. The exposed health care worker faces the dilemma of whether to obtain early prophylactic treatment, whether to change sexual practices so as not to endanger sexual partners, and if the exposed worker is a female of childbearing age, whether to refrain from attempts to become pregnant or to continue a pregnancy.¹⁸ These questions cannot be answered without knowing as many facts as possible, the most important being the HIV status of the patient in question. The psychological stress in such a situation can be overwhelming.¹⁹ This was the rationale behind the voter initiative that placed Proposition 96 on the California ballot in 1988.²⁰

This Comment addresses patient rights under current California consent and confidentiality laws, particularly those that relate to AIDS and HIV,²¹ as well as the prohibitions against unreasonable searches and seizures under the Fourth Amendment.²² It also addresses the inequitable distribution of burdens under current law in the context of the legal and ethical duty of physicians and other health care providers to treat AIDS and HIV-infected patients.²³ This Comment concludes that any health care worker who can document an exposure to blood or body fluids should have the option to have a nonconsenting patient tested for HIV.²⁴

Other means of exposure include mucocutaneous inoculation (such as splashing blood into the eye or other mucous membrane) and prolonged cutaneous contact when the area of contact is chapped, abraded or afflicted with dermatitis. *Id.*

17. CAL. HEALTH & SAFETY CODE § 199.22 (West 1990).

18. HIV can cross the placenta during pregnancy via the circulatory system, thereby infecting the developing fetus. FLANDERS & FLANDERS, *supra* note 1, at 20; Barnett & Levy, *supra* note 2, at 1013.

19. *See* Johnetta J. v. Municipal Court, 218 Cal. App. 3d 1255, 1266-67, 267 Cal. Rptr. 666, 671-73 (1990) (testimony of expert witnesses); *infra* notes 224-25, 228-29 and accompanying text.

20. CAL. HEALTH & SAFETY CODE § 199.95 (West 1990). The stated purpose of Proposition 96 is to protect the health and safety of the public, peace officers, firefighters, victims of sexual crimes and custodial personnel by requiring that when such persons are exposed they may "be relieved from groundless fear of infection." *Id.*

21. *See infra* part II.C.2.

22. *See infra* part IV.

23. *See infra* part III.A.

24. *See infra* parts III-V. On March 2, 1993, Senator Newton Russell introduced a bill into the California Senate which would permit nonconsensual testing of patients for HIV under certain conditions. S. 627, 1993-94 Reg. Sess. (Cal. 1993). This bill allows a health care worker who has suffered a "significant exposure" to a patient's blood or body fluids to have a

II. BACKGROUND

A. *The AIDS Epidemic: A Gloomy Forecast*

AIDS is a slowly progressive fatal illness characterized by suppression of the immune system, which leaves the host open to a variety of opportunistic infections.²⁵ Once infected, a person might not develop the symptoms of full-blown AIDS for years.²⁶ These individuals carry the virus in their blood and body fluids and are capable of transmitting it to others, even though they appear to be perfectly healthy. After the virus invades the body and begins to replicate, an antibody response is stimulated in the host.²⁷

Serological tests now have been developed that can detect antibodies specific to HIV.²⁸ Generally, these tests are reliable and accurate when

previously legally obtained specimen tested for HIV without consent provided that: (1) a physician certifies in writing that there has been a significant exposure; (2) the health care employee first submits to a baseline HIV test which is negative; (3) a good faith effort to obtain voluntary informed consent is made (by someone other than the exposed employee) after notifying the patient of the exposure; (4) the patient who refused consent is notified that the test will be performed, and that the results of the test will be made available to the patient, if desired, along with appropriate counseling; and (5) the exposed employee is advised that all information, including information relating to the identity or HIV status of the source patient, is subject to statutory confidentiality protection and may not be further disclosed. *Id.*

The legislation now under consideration has one major advantage over the proposal advanced in this Comment—it treats both patient and employee fairly without incurring additional expenses in legal fees or involving the court's time. Senate bill 627 does *not*, however, cover those cases in which there is no blood sample available to be tested. *See id.* An appropriate compromise would incorporate the best of both—the provisions of Senate bill 627 would apply to those situations in which a blood sample is available for testing; if no specimen is available, the exposed employee may petition the court to compel the patient to submit to testing.

25. Barnett & Levy, *supra* note 2, at 1011-12. Some of the opportunistic diseases suffered by AIDS patients include Kaposi's sarcoma, *Pneumocystis carinii* pneumonia, cryptosporidial diarrhea, cryptococcal meningitis, toxoplasmosis and dementia. *Id.* at 1011.

26. *Id.* Recently, the federal government has expanded the definition of exactly what is required for a diagnosis of "AIDS." CENTERS FOR DISEASE CONTROL, *1993 Revised Classification System for HIV Infection and Expanded Surveillance Case Definition for AIDS Among Adolescents and Adults*, MORBIDITY & MORTALITY WKLY. REP., Dec. 18, 1992, at 1, 1, 4. Previously a person was diagnosed with AIDS when he or she contracted any one of a list of 23 conditions after becoming HIV positive. *Id.* Under the new criteria, two more conditions commonly seen in intravenous drug abuse—pulmonary tuberculosis and recurrent pneumonia—are diagnostic. *Id.* Additionally, AIDS is diagnosed when the number of a special type of white blood cell that HIV seems to particularly affect drops below a specified standard (CD4 lymphocytes less than 200 per cubic millimeter). *Id.* The definition now includes some diseases unique to women, such as invasive cervical cancer, which is a reflection of the rising toll of AIDS among heterosexuals. *Id.* at 7-8; *see also* Keith Stone, *U.S. Expands Definition of AIDS Patient*, L.A. DAILY NEWS, Jan. 2, 1993, at 1, 9 (describing new CDC standards for AIDS diagnosis).

27. FLANDERS & FLANDERS, *supra* note 1, at 13.

28. *Id.* at 8; Wilber, *supra* note 5, at 2.1.2-1.

performed by qualified technologists in licensed laboratories.²⁹ They have been approved since 1985 to screen the nation's blood supply³⁰ and to test individuals for HIV infection.

HIV antibody tests, however, are not an infallible indicator of a person's infective status.³¹ They are not designed to test for the presence of the virus itself, but only for the presence of antibodies to the virus.³² It may be weeks or months before an infected individual seroconverts.³³ Therefore, a negative test does not necessarily mean that a person is free of the virus—subsequent testing at regular intervals is recommended to monitor an individual's HIV status.³⁴ At the present time, however, a positive HIV antibody test is the best indicator that a person is infected and capable of transmitting the virus to someone else.³⁵

Currently, zidovudine (AZT) is widely recognized as having limited efficacy in slowing the progress of the disease.³⁶ AZT is not a cure, nor is a cure on the immediate horizon.³⁷ The length of time a victim can survive after infection varies from months to years, but once the active disease manifests itself it has proven to be ultimately fatal.³⁸

29. The most commonly used test methodology is the enzyme-linked immunosorbent assay (ELISA), supplemented by a Western Blot test. FLANDERS & FLANDERS, *supra* note 1, at 8; see Wilber, *supra* note 5, at 2.1.2-1. ELISA has a sensitivity and specificity of 98% or more, but it has a low predictive value in populations with a very low rate of infection. *Id.* at 2.1.2-1 to 2.1.2-2. Because of the potential harm that results from reporting a false positive result, positive tests must be verified by a confirmatory test, such as a Western Blot test, before reporting the result to the patient. *Id.* at 2.1.2-1.

30. 21 C.F.R. § 610.45 (1992); AMERICAN ASS'N OF BLOOD BANKS, STANDARDS FOR BLOOD BANKS AND TRANSFUSION SERVICES § B5.500 (14th ed. 1991).

31. Wilber, *supra* note 5, at 2.1.2-1.

32. *Id.*

33. "Seroconversion" is a term used to describe the transformation of an infected individual's blood from negative to positive for the particular antibody being tested. DORLAND'S ILLUSTRATED MEDICAL DICTIONARY, *supra* note 4, at 1510.

34. Gerberding & Sande, *supra* note 16, at 10.2.9-1.

35. Wilber, *supra* note 5, at 2.1.2-1.

36. FLANDERS & FLANDERS, *supra* note 1, at 24-25. AZT therapy is not without its drawbacks. Aside from the extremely high cost, it produces side effects in some patients that are severe enough to contraindicate continued therapy. PHYSICIAN'S DESK REFERENCE 802-05 (1992). The most common of these side effects is anemia, but they may also include gastrointestinal disorders, anxiety or depression, respiratory symptoms and other effects. *Id.* A further complication is that over a period of time the virus appears to be able to develop some resistance to AZT by a mechanism that is not yet entirely understood. FLANDERS & FLANDERS, *supra* note 1, at 24; Gorman, *supra* note 6, at 33.

37. Although there are some promising new drugs under development, none of these is anywhere near ready for clinical trials. FLANDERS & FLANDERS, *supra* note 1, at 24-27; Gorman, *supra* note 6, at 31-32.

38. Gorman, *supra* note 6, at 31. The situation has been grimly summarized: "It's clear we're losing the battle. We have one class of drugs that slows AIDS down by two or three

The World Health Organization (WHO) estimates cumulative adult HIV infection worldwide at ten to twelve million cases in 1992, which may grow to at least thirty million by the year 2000.³⁹ The number of full-blown AIDS cases in 1992 was nearly two million worldwide, with over a quarter million of those in the United States.⁴⁰ Figures released in September 1992 show that AIDS is now the number one cause of death in young adult males in several major U.S. cities, including Los Angeles and San Francisco.⁴¹ The AIDS mortality rate in this age group now surpasses that for cancer, heart disease and homicide.⁴² Given these grim statistics, it is reasonable to assume that hospitals and other health care institutions will see increasing numbers of HIV-infected and AIDS patients,⁴³ especially in areas with large concentrations of high-risk groups.⁴⁴

B. Implementation of Universal Precautions

Faced with increasing numbers of AIDS patients, in 1987 the Centers for Disease Control (CDC) recommended that all hospitals adopt "universal precautions"⁴⁵ as an infection control practice. Under such procedures, blood and body fluids of all patients are *presumed* to be infectious and are handled with appropriate care, using barrier precautions if there is any chance of contact.⁴⁶ Studies have shown that when univer-

years, and then people go on and die.'" *Id.* (quoting Mark Harrington, member of Treatment Action Group of New York City).

39. *Id.* at 31, 33 (reporting World Health Organization (WHO) statistics in graph and chart).

40. *Id.* at 33.

41. CENTERS FOR DISEASE CONTROL, *Increased HIV/AIDS Mortality Among Residents Aged 25-44 Years—Baltimore, Maryland, 1987-1989*, 41 MORBIDITY & MORTALITY WKLY. REP. 708, 709 (1992).

42. *Id.*

43. For example, in 1988 five percent of the hospital beds in New York City were already being used by AIDS patients. D.S. Weinberg & H.W. Murray, *Coping with AIDS: The Special Problems of New York City*, 317 NEW ENG. J. MED. 1469, 1471 (1987). One commentator has speculated that 25% or more of the hospital beds in some urban areas will be occupied by AIDS patients in the near future. Deborah J. Cotton, *The Impact of AIDS on the Medical Care System*, 260 JAMA 519, 522-23 (1988).

44. The first cases of AIDS were confined almost exclusively to gay and bisexual men, but soon spread among intravenous drug abusers. FLANDERS & FLANDERS, *supra* note 1, at 21-22; Gorman, *supra* note 6, at 33. In 1992, these two groups comprised 81% of AIDS cases. But the disease is spreading rapidly into the heterosexual population and is in fact increasing at a faster rate among heterosexuals than homosexuals. *Id.* at 33-34.

45. CENTERS FOR DISEASE CONTROL, *Recommendations for Prevention of HIV Transmission in Health-Care Settings*, MORBIDITY & MORTALITY WKLY. REP., Aug. 21, 1987, at 3S-17S (Supp. 2S).

46. *Id.* at 3S, 5S. These include wearing gloves, masks and face shields, as well as handwashing between patient contacts. *Id.* at 9S.

sal precautions are properly instituted as hospital policy and followed by health care workers, they significantly reduce blood and body fluid exposures.⁴⁷

Accidental needlesticks, however, remain the single biggest threat to health care worker safety.⁴⁸ Although universal precautions have substantially reduced needlestick incidents, they have not eliminated all such events.⁴⁹ The fact remains that most exposures *cannot* be avoided.⁵⁰

The CDC's policies have served only as guidelines for hospitals to follow, but the Occupational Safety and Health Administration (OSHA) has recently promulgated a rigid set of *mandatory* standards designed to reduce the transmission of bloodborne pathogens, such as the HIV and hepatitis B viruses.⁵¹ These standards describe specific barrier precautions and work practice controls⁵² that all employers whose employees perform exposure-prone tasks must follow.⁵³ Employers are required to design and implement an "exposure control plan" that is accessible to all employees.⁵⁴ They also must implement annual training programs for employees.⁵⁵ Because these federal rules only became effective on March 6, 1992, it is too soon to tell what, if any, additional impact they will have

47. See Ruthanne Marcus et al., *Surveillance of Health Care Workers Exposed to Blood from Patients Infected with the Human Immunodeficiency Virus*, 319 NEW ENG. J. MED. 1118, 1119 (1988) (37% of reported occupational exposures reviewed were deemed preventable by use of universal precautions); Edward S. Wong et al., *Are Universal Precautions Effective in Reducing the Number of Occupational Exposures Among Health Care Workers?*, 265 JAMA 1123, 1123 (1991) (stating that exposures decreased nearly 50% among physicians who used universal precautions when caring for patients).

48. One survey found that 10% of hospital personnel are involved annually in injuries from sharp instruments, accounting for one-third of all work accidents. Billiet et al., *supra* note 16, at 120. Safety shielded needles are now available for routine phlebotomy (blood drawing) procedures; however, they are extremely expensive and not yet widely used. *Id.* at 123. Measured against the costs of following up on exposure incidents, the cost can be justified. *Id.*

49. Kristin White, "Why Weren't You Just More Careful?": *What Does It Take to Avoid Occupational Exposure to HIV?*, AIDS PATIENT CARE, June 1990, at 13, (citing estimates that universal precautions would have prevented 40% of 1500 needlesticks reported to CDC since 1983).

50. If 40% of needlesticks would have been prevented by universal precautions, simple arithmetic leads to the conclusion that 60% were *not* preventable. *See id.*

51. 29 C.F.R. § 1910.1030 (1992).

52. "Work practice controls" are procedures that reduce the chance of exposure by altering the manner in which a task is performed. For example, recapping needles by a two-handed technique is now prohibited. *Id.* § 1910.1030(b).

53. *Id.* § 1910.1030(c). *See infra* note 208 for a description of what constitutes an "exposure-prone" task.

54. 29 C.F.R. § 1910.1030(c) (1992).

55. *Id.* § 1910.1030(g)(2).

on the current level of exposures in health facilities that already observe universal precautions.⁵⁶

C. Social and Political Complications

1. Discrimination

A unique feature of the HIV epidemic is that it has affected stigmatized groups such as homosexuals, intravenous drug abusers and minorities in disproportionate numbers.⁵⁷ Prevalence of the disease in these traditionally disfavored groups is cited as a major cause of the federal government's slow response to the crisis and the low level of funding for research in the crucial early stages of the epidemic.⁵⁸ As the public became aware of the disease, HIV-infected persons found themselves suffering not only from the ravages of the disease itself, but also from unwarranted public fear and revulsion.⁵⁹

A study released in 1988 by the AIDS Institute of the Harvard School of Public Health⁶⁰ found that: (1) Most Americans believe the AIDS epidemic has led to increased discrimination against HIV-positive persons and those with active AIDS; (2) most Americans think that controlling the spread of AIDS will necessarily require some loss of privacy and civil rights; (3) a substantial minority of Americans perceive AIDS as "deserved punishment for offensive or immoral behavior;"⁶¹ (4) a smaller minority would refuse to work with an AIDS-infected person and believe that employers have the right to fire such persons; (5) many parents would not permit their children to attend school if a classmate had AIDS; and (6) a substantial minority does not want individuals with AIDS living nearby and would support landlords having the right to

56. Because they are mandatory, however, these rules should significantly lower the number of exposure incidents in facilities that have a record of poor compliance with recommended universal precautions. Some studies have concluded that "[h]ealthcare workers in low-prevalence areas are less likely to follow universal precautions and are selectively motivated to be more careful when caring for known HIV-positive patients. Adherence to universal precautions requires continuous educational efforts because compliance diminishes over time." R.J. Zabransky, *National AIDS Forum*, 14 *CLINICAL MICROBIOLOGY NEWSL.* 129, 135-36 (1992) (reporting findings released at Fifth National Forum on AIDS, Hepatitis and Other Blood-Borne Diseases, held in Atlanta, Georgia, March 29 through April 1, 1992).

57. Mary C. Dunlap, *AIDS and Discrimination in the United States: Reflections on the Nature of Prejudice in a Virus*, 34 *VILL. L. REV.* 909, 912 (1989).

58. See generally SHILTS, *supra* note 1 (relating early history of AIDS epidemic in United States).

59. Dunlap, *supra* note 57, at 912-20.

60. Robert J. Blendon & Karen Donelan, *Discrimination Against People with AIDS: The Public's Perspective*, 319 *NEW ENG. J. MED.* 1022 (1988).

61. *Id.* at 1023.

evict them.⁶² Although recent public education programs may have made inroads toward changing some of these attitudes, these findings show indisputably that persons suffering from HIV are in dire need of legal protection against unwarranted discrimination.

Victims of such practices usually have been successful in using both federal and state antidiscrimination laws to assert their rights.⁶³ For example, in *School Board v. Arline*,⁶⁴ the U.S. Supreme Court decided that section 504 of the Rehabilitation Act of 1973⁶⁵ applies to persons with contagious diseases.⁶⁶ Section 504 provides that "[n]o otherwise qualified individual with handicaps . . . shall, solely by reason of her or his handicap, be excluded from the participation in . . . or be subjected to discrimination under any program or activity receiving Federal financial assistance."⁶⁷ *Arline* addressed the issue of what constitutes "otherwise qualified."⁶⁸ Justice Brennan, writing for the majority, stated that "[a]n otherwise qualified person is one who is able to meet all of a program's requirements in spite of his handicap,"⁶⁹ defined as being able to perform the "essential functions of the job."⁷⁰ If a person can no longer perform those "essential functions," a court will consider whether the employer could make "reasonable accommodations" to enable the handicapped person to perform those functions.⁷¹

The Supreme Court further stated that "[a] person who poses a significant risk of communicating an infectious disease to others in the workplace will not be otherwise qualified for his or her job if reasonable accommodation will not eliminate that risk."⁷² Trial courts must consider four factors when determining whether there are health and safety risks: (1) the nature of the risk (how the disease is transmitted); (2) the duration of the risk (how long the carrier is contagious); (3) the severity of the risk (potential harm to third parties); and (4) the probability of

62. *Id.* at 1023-25.

63. *See infra* notes 64-102 and accompanying text.

64. 480 U.S. 273 (1987).

65. 29 U.S.C. § 794 (1988).

66. *Arline*, 480 U.S. at 289.

67. 29 U.S.C. § 794.

68. *Arline*, 480 U.S. at 287-88.

69. *Id.* at 287 n.17 (quoting *Southeastern Community College v. Davis*, 442 U.S. 397, 406 (1979)).

70. *Id.* (quoting 45 C.F.R. § 84.3(k) (1985)) (codified without amendment at 45 C.F.R. § 84.3(k) (1991)).

71. *Id.*

72. *Id.* at 287 n.16. In *Arline*, the plaintiff was a school teacher with tuberculosis. *Id.* at 276. The Court remanded the case for findings of fact as to whether the plaintiff's presence in the classroom posed no risk to students. *Id.* at 289.

transmitting the disease and ensuing harm.⁷³ Courts must base findings related to these factors on "reasonable medical judgments given the state of medical knowledge"⁷⁴ and should defer to the opinions of public health officials.⁷⁵

Using the *Arline* criteria, courts have specifically applied section 504 to persons infected with AIDS.⁷⁶ For example, in *Chalk v. United States District Court*,⁷⁷ the Ninth Circuit decided that an HIV-infected teacher could return to the classroom under section 504 because, as interpreted in *Arline*, there was no " 'significant risk of [transmitting the] disease to others.' "⁷⁸ Under current medical knowledge, this simply is not the case with AIDS.⁷⁹

Notably, section 504 of the Rehabilitation Act expressly applies only to employers or agencies that receive federal funds.⁸⁰ This limitation has been corrected with the passage of the Americans with Disabilities Act of 1990 (ADA),⁸¹ which reaches private employers as well as state and local governments.⁸² Under the ADA, persons are considered disabled if they are substantially limited in one or more "major life activities."⁸³ The appendix to the ADA notes that HIV is one of several impairments which are *inherently* substantially limiting.⁸⁴ An employee may not be removed from a position unless there is a "direct threat . . . to the health

73. *Id.* at 288 (citing Brief of American Medical Association as amicus curiae at 19).

74. *Id.* (citing Brief of American Medical Association as amicus curiae at 19).

75. *Id.*

76. *See Doe v. Centinela Hosp.*, 57 U.S.L.W. 2034 (C.D. Cal. 1988) (holding plaintiff wrongfully discharged from drug rehabilitation program because of HIV-positive status); *Thomas v. Atascadero Unified Sch. Dist.*, 662 F. Supp. 376 (C.D. Cal. 1987) (holding child with AIDS "otherwise qualified" to attend school).

77. 840 F.2d 701 (9th Cir. 1988).

78. *Id.* at 708 (quoting *School Bd. v. Arline*, 480 U.S. 273, 287 n.16 (1987)).

79. *Id.* at 708-09 (describing previous cases concerning transmissibility of AIDS). The court noted that in the future, the deterioration of Chalk's immune system may lead to his being infected with an opportunistic disease, which itself could be communicable in a classroom situation. *Id.* at 711. The Ninth Circuit instructed the district court to review the medical situation, should this occur, and to make a determination as to what reasonable procedures school officials could take to ensure that no significant risk of harm would result from Chalk's presence in the classroom. *Id.*

80. 29 U.S.C. § 794(a) (1988).

81. Americans with Disabilities Act of 1990, Pub. L. No. 101-336, 104 Stat. 327 (codified in scattered sections of 42 U.S.C.). For a general discussion of the Americans with Disabilities Act of 1990, see S. TROWERS-CROWLEY, *ADA PRIMER: A CONCISE GUIDE TO THE AMERICANS WITH DISABILITIES ACT OF 1990* (1990).

82. 42 U.S.C. § 12111(5)(A) (Supp. III 1991); *see id.* § 12111(5)(B) (Supp. III 1991).

83. *Id.* § 12102(2)(A) (Supp. III 1991).

84. 29 C.F.R. § 1630 app. (1992).

and safety of others that cannot be eliminated or reduced by reasonable accommodation."⁸⁵

State statutes may fill the gap if federal statutes have failed or have been interpreted unfavorably for HIV-infected plaintiffs. Such has been the case in California. For example, in *Raytheon Co. v. Fair Employment & Housing Commission*,⁸⁶ an employee with AIDS, John Chadbourne, was discharged from his position at Raytheon because of his HIV status.⁸⁷ Raytheon was concerned that he could transmit the disease to his co-workers,⁸⁸ although his position involved primarily clerical duties.⁸⁹ Chadbourne filed complaints with both the Office of Federal Contract Compliance Program (OFCCP) of the U.S. Department of Labor and the California Department of Fair Employment and Housing (the Commission).⁹⁰ The OFCCP found that Raytheon was subject to the Rehabilitation Act of 1973 because Raytheon was a government contractor,⁹¹ but the OFCCP failed to find evidence of discrimination.⁹² Chadbourne was thus denied relief under the Federal Rehabilitation Act;⁹³ however, the outcome was more favorable to him in California.⁹⁴ The Commission found that "Raytheon had deprived Chadbourne of his fundamental civil right to be free of employment discrimination based upon a physical handicap."⁹⁵ The California Court of Appeal upheld the Commission's findings and award of relief.⁹⁶

The *Raytheon* decision was based on a prior California Supreme Court case, *American National Insurance Co. v. Fair Employment & Housing Commission*,⁹⁷ which interpreted the California Fair Employ-

85. *Id.* § 1630.2(r) (1992) (emphasis added). The section of the ADA that directly addresses communicable diseases applies only to individuals employed in food-handling positions. *Id.* § 1630.16(e). Employers may not act against food-handling employees with an infectious or communicable disease unless the Secretary of Health and Human Services has recognized an actual danger. *Id.* On May 16, 1991, the Public Health Service issued a list of the diseases and symptoms for which an employee may be removed from a food-handling position. 56 Fed. Reg. 22,726 (1991). Notably, HIV was not on the list. *See id.*

86. 212 Cal. App. 3d 1242, 261 Cal. Rptr. 197 (1989).

87. *Id.* at 1247, 261 Cal. Rptr. at 200.

88. *Id.*

89. *Id.* at 1245, 261 Cal. Rptr. at 198-99.

90. *Id.* at 1247, 261 Cal. Rptr. at 200.

91. *Id.*

92. *Id.* at 1247-48, 261 Cal. Rptr. at 200.

93. *Id.* at 1248, 261 Cal. Rptr. at 200.

94. *Id.*

95. *Id.*

96. *Id.* at 1252-53, 261 Cal. Rptr. at 203. Unfortunately, Chadbourne had died by the time the Commission ruled on his claim. The relief was awarded to Chadbourne's estate, which became a party to the litigation after his death. *Id.* at 1248, 261 Cal. Rptr. at 200.

97. 32 Cal. 3d 603, 651 P.2d 1151, 186 Cal. Rptr. 345 (1982).

ment and Housing Act's provisions prohibiting employment discrimination against persons with physical handicaps.⁹⁸ The *American National* court held that "[t]he law clearly was designed to prevent employers from acting arbitrarily against physical condition[s] that, whether *actually or potentially* handicapping, may present no current job disability or job-related health risk."⁹⁹

A 1989 survey of state antidiscrimination laws as applied specifically to AIDS revealed that all fifty states and the District of Columbia have statutes similar to the Rehabilitation Act that prohibit discrimination against individuals with handicaps.¹⁰⁰ Most state laws also reach private as well as public employers.¹⁰¹ Some, including California, have also passed AIDS-specific statutes directly targeting areas such as housing, insurance and employment.¹⁰²

2. Consent and confidentiality

While antidiscrimination laws are helpful to protect the rights of HIV-infected persons, the cornerstone of public health policy regarding AIDS testing has been consent and confidentiality requirements.¹⁰³ The discriminatory practices and social stigmatization that often result from the disclosure of positive test results make confidentiality an essential factor in encouraging voluntary testing.¹⁰⁴ Health authorities have long recognized that people who should be tested, such as those in high-risk groups, are much more likely to come forward voluntarily if they know the results of the tests will be completely confidential.¹⁰⁵ The individual states have been responsible for legislation in this area under their police power over health and safety concerns.¹⁰⁶

California has some of the most protective laws in the nation.¹⁰⁷ Section 199.22(a) of California's Health and Safety Code provides that all persons to be tested for HIV must give written consent;¹⁰⁸ the statute

98. CAL. GOV'T CODE § 12940 (West Supp. 1993).

99. *American Nat'l*, 32 Cal. 3d at 610, 651 P.2d at 1155, 186 Cal. Rptr. at 349 (emphasis added).

100. Gostin, *supra* note 9, at 1628.

101. *Id.*

102. *Id.* at 1628, 1630 nn.147-49.

103. See *infra* notes 104-27 and accompanying text.

104. Richard C. Turkington, *Confidentiality Policy for HIV-Related Information: An Analytical Framework for Sorting Out Hard and Easy Cases*, 34 VILL. L. REV. 871, 883-86 (1989).

105. *Id.*

106. See 8 BERNARD E. WITKIN, *SUMMARY OF CALIFORNIA LAW, Constitutional Law* §§ 784-786 (9th ed. 1988) (discussing nature of state's police power).

107. See *infra* notes 108-27 and accompanying text.

108. CAL. HEALTH & SAFETY CODE § 199.22(a) (West 1990).

mandates severe penalties for unauthorized disclosure of the results.¹⁰⁹ Physicians are *permitted*, but not *required* to warn persons believed to be the sexual partners or needle-sharing partners of a patient who tests positive for HIV,¹¹⁰ but the test results must first be discussed with the patient and "appropriate educational and psychological counseling" offered.¹¹¹ If a physician discloses positive results to a third party, the physician may not provide any information that identifies the person who has been tested.¹¹² Neither a patient nor a physician can be compelled to disclose an HIV test result.¹¹³ Even blood donors who test positive are shielded from identification if litigation results from the transfusion of HIV-contaminated blood.¹¹⁴

The California Constitution is an additional source of privacy rights.¹¹⁵ Unlike the United States Constitution,¹¹⁶ the California Con-

109. *Id.* § 199.21. Subsection (a) provides that *negligent* disclosure to:

any third party, in a manner which identifies or provides identifying characteristics of the person to whom the test results apply, except pursuant to a written authorization . . . shall be assessed a civil penalty in an amount not to exceed . . . [\$1000] plus court costs . . . paid to the subject of the test.

Id. § 199.21(a). Subsection (b) states that *willful* disclosure shall result in a \$5000 penalty. *Id.* § 199.21(b). Subsection (c) establishes criminal penalties for negligent or willful disclosure if "economic, bodily, or psychological harm" is inflicted on the person tested. *Id.* § 199.21(c). Such disclosure constitutes a misdemeanor, punishable by up to one year in prison or a \$10,000 fine, or both. *Id.*

110. *Id.* § 199.25(c). This section may effectively remove the physician's affirmative duty to warn, which was established in the landmark case of *Tarasoff v. Regents of the Univ. of Cal.*, 17 Cal. 3d 425, 551 P.2d 334, 131 Cal. Rptr. 14 (1976), at least as applied to HIV. In *Tarasoff*, the California Supreme Court held a psychiatrist liable in tort for failing to warn a murder victim of his patient's homicidal delusions. *Id.* at 433-44, 551 P.2d at 342-49, 131 Cal. Rptr. at 22-29. The court held that when a medical practitioner learns that his or her patient poses a danger to a third party, the practitioner has an obligation to use reasonable care to protect that third party, even though doing so may breach the traditional doctor-patient trust relationship. *Id.* at 431, 551 P.2d at 340, 131 Cal. Rptr. at 20.

111. CAL. HEALTH & SAFETY CODE § 199.25(b) (West 1990).

112. *Id.* § 199.25(a).

113. *Id.* § 199.20.

114. All donated blood is to be screened for HIV. Those yielding a positive result are placed on a confidential state donor register. *Id.* §§ 1603.1-.2. In *Irwin Memorial Blood Bank v. Superior Court*, the plaintiffs filed a negligence lawsuit against a blood bank for supplying AIDS-infected blood to a heart transplant patient. 229 Cal. App. 3d 151, 153, 279 Cal. Rptr. 911, 912 (1991). The plaintiffs unsuccessfully attempted to obtain the names and addresses of implicated donors during discovery. *Id.* The trial court was willing to allow deposition of the suspect donors behind a privacy screen. *Id.* at 155, 279 Cal. Rptr. at 913. The California Court of Appeal, however, found this to violate § 199.20 of the Health and Safety Code because it was inevitable that the donor would be seen and heard by at least the reporter and the court-appointed referee. *Id.* at 157, 279 Cal. Rptr. at 914. The court stated that even "[t]he appearance and the voice of a person are obviously identifying characteristics." *Id.*

115. See *infra* notes 116-27 and accompanying text.

116. The issue of whether the U.S. Constitution guarantees a right of privacy is still open to interpretation because there is no explicit clause enumerating such a right. See *generally*

stitution *explicitly* guarantees citizens the right to privacy.¹¹⁷ Courts have interpreted this right as protecting against invasions of privacy by private citizens as well as by the state.¹¹⁸ For example, in *Urbaniak v. Newton*,¹¹⁹ the plaintiff brought a suit for damages¹²⁰ after undergoing a neurological examination pursuant to a worker's compensation claim against his former employer.¹²¹ In the course of the test, electrodes with sharp protrusions were placed on his head, which drew a small amount of blood (as is common with this procedure).¹²² The patient cautioned the nurse in attendance to take extra care to sterilize the equipment before using it on another patient because he was HIV positive and did not wish that anyone else be inadvertently exposed.¹²³ The nurse, in turn, notified the doctor who informed the insurance company handling the worker's compensation claim.¹²⁴ The court found no violation of the AIDS-specific confidentiality statute¹²⁵ because the disclosure was not

LAURENCE H. TRIBE, *AMERICAN CONSTITUTIONAL LAW* § 15-3 (2d ed. 1988) (describing line of U.S. Supreme Court cases dealing with privacy issue). The holdings in early cases such as *Griswold v. Connecticut*, 381 U.S. 479 (1965) (invalidating law that banned use of contraceptives by married couples as violative of "penumbra" or zone of privacy) and *Roe v. Wade*, 410 U.S. 113 (1973) (holding that choice to terminate pregnancy is right of privacy under "liberty" guarantee of Fourteenth Amendment) seem to validate an implied constitutional right to privacy.

In *Whalen v. Roe*, 429 U.S. 589 (1977), the U.S. Supreme Court recognized two distinct privacy interests: (1) an interest in avoiding disclosure of personal information, and (2) an interest in the freedom to make personal decisions without government interference. *Id.* at 598-99. This dispute involved a New York statute that required doctors to submit reports, containing the names and addresses of all patients who were receiving certain prescription drugs, to a centralized computer network. *Id.* at 591. A unanimous Court found that the government interest in obtaining the information outweighed the individuals' privacy interest in preventing the state from gathering medical information about their drug usage. *Id.* at 600. The Court did not reach the issue of whether there was any "unwarranted disclosure of accumulated private data—whether intentional or unintentional—by a system that did not contain [adequate] security provisions." *Id.* at 605-06.

117. CAL. CONST. art. I, § 1. "All people are by nature free and independent and have inalienable rights. Among these are . . . pursuing and obtaining safety, happiness, and *privacy*." *Id.* (emphasis added).

118. *See, e.g., Chico Feminist Women's Health Ctr. v. Scully*, 208 Cal. App. 3d 230, 242, 256 Cal. Rptr. 194, 200 (1989).

119. 226 Cal. App. 3d 1128, 277 Cal. Rptr. 354 (1991).

120. The trial court granted the defendant's motion for summary judgment. *Id.* at 1133, 277 Cal. Rptr. at 356. The plaintiff appealed, but died before the case was decided; his estate was substituted as the appellant. *Id.*

121. *Id.* at 1133-34, 277 Cal. Rptr. at 356.

122. *Id.* at 1134, 277 Cal. Rptr. at 356.

123. *Id.*

124. *Id.*

125. *Id.* at 1142-43, 277 Cal. Rptr. at 362 (citing CAL. HEALTH & SAFETY CODE § 199.21 (West 1990) (codified as amended at CAL. HEALTH & SAFETY CODE § 199.21 (West Supp. 1993))).

made pursuant to the performance of an HIV test.¹²⁶ However, the court held that the plaintiff had a cause of action under the privacy provisions of the California Constitution.¹²⁷

The California Legislature has adopted exceptions to the consent provisions in the Health and Safety Code since the original legislation went into effect. In response to concerns about the possible spread of AIDS within prison populations, prisoners may be screened for HIV without their consent.¹²⁸ Courts may require convicted prostitutes to undergo HIV testing,¹²⁹ and victims of sexual crimes may request a court to order HIV testing of the alleged offender.¹³⁰

3. Occupational exposure

The only California law to directly address *occupational* exposure to potentially infective blood or body fluids is Proposition 96.¹³¹ Under the California Constitution, citizens may introduce statutes or proposed amendments to the Constitution by submitting a petition to the Secretary of State that sets forth the proposed text of the law and that is signed by the requisite number of registered voters.¹³² Before introducing Proposition 96, Los Angeles County Sheriff Sherman Block, along with State Senator Ed Davis, promoted passage of Senate bill 1158, which would have permitted testing of persons formally charged with sexual assault for sexually transmitted diseases, including AIDS.¹³³ Under this bill, the victim of the assault would have been informed of the results of the test.¹³⁴ The bill died in committee in 1987 because opponents could not agree to the provision for AIDS testing.¹³⁵ Sheriff Block introduced Proposition 96 in response to the defeat of Senate bill 1158.¹³⁶ California voters passed it in November 1988.¹³⁷

126. *Id.*

127. *Id.* at 1140-41, 277 Cal. Rptr. at 360-61.

128. CAL. PENAL CODE § 7501 (West Supp. 1993).

129. *Id.* § 1202.6.

130. *Id.* § 1202.1. Test results may not be used as evidence against the defendant to obtain a conviction because of the high degree of prejudice that may result. *Id.*

131. Proposition 96, 1988 Cal. Stat. A-271 to -274 (codified at CAL. HEALTH & SAFETY CODE §§ 199.95-.99 (West 1990)).

132. CAL. CONST. art. II, § 8. The signatures "must [be] equal in number to 5 percent in the case of a statute . . . of the votes for all candidates for Governor at the last gubernatorial election." *Id.* § 8(b).

133. Kelly A. Bennett, Note, *Mandatory AIDS Testing: The Slow Death of Fourth Amendment Protection?*, 20 PAC. L.J. 1413, 1419 n.53 (1989).

134. *Id.*

135. *Id.*

136. *Id.*

137. *Id.* at 1413.

The stated purpose of Proposition 96 is to: require that information that may be vital to the health and safety of the public . . . be obtained and disclosed in an appropriate manner in order that precautions can be taken to preserve their health and the health of others or that such persons can be relieved from groundless fear of infection.¹³⁸

In addition to the provisions allowing testing of sexual offenders,¹³⁹ which would have been included in Senate bill 1158, Proposition 96 also addressed law enforcement's concerns with occupational exposure to AIDS. Proposition 96 allows peace officers, firefighters and emergency rescue personnel¹⁴⁰ to petition the court to require HIV testing if the defendant is charged with interfering with official duties by "biting, scratching, spitting, or transferring blood or other bodily fluids on, upon, or through the skin or membranes."¹⁴¹ Personnel employed in any state facility in which adults or minors are incarcerated who learn of an inmate's HIV-positive status (or potential infectivity to others because of an exposure) are required to report this knowledge to supervisory personnel.¹⁴² Supervisors can then take appropriate steps to protect both employees and other inmates from contact with blood and body fluids.¹⁴³

Proposition 96 also contains provisions to protect the tested individual's privacy rights. These protective measures mandate that "the court shall order all persons, other than the test subject, who receive test results . . . to maintain the confidentiality of personal identifying data relating to the test results except for disclosure which may be necessary to obtain medical or psychological care or advice."¹⁴⁴ In addition, the test results are for health and safety purposes only and cannot be used as evidence in any criminal or juvenile proceeding.¹⁴⁵

138. CAL. HEALTH & SAFETY CODE § 199.95 (West 1990).

139. *Id.* § 199.96. Section 199.96 allows HIV testing of defendants charged with violations of California Penal Code §§ 261 (rape), 261.5 (statutory rape), 262 (rape of a spouse), 266b (abduction to live in illicit relationship), 266c (rape with foreign object), 286 (sodomy), 288 (lewd and lascivious acts with minor under age 14), and 288a (oral copulation). CAL. PENAL CODE §§ 261, 261.5, 262, 266b, 266c, 286, 288, 288a (West 1988 & Supp. 1993).

140. CAL. HEALTH & SAFETY CODE § 199.97 (West 1990).

141. *Id.*

142. *Id.* § 199.99(a).

143. *Id.* § 199.99(c).

144. *Id.* § 199.98(e).

145. *Id.* § 199.98(f).

III. ANALYSIS: WHY OCCUPATIONAL PROTECTIONS AVAILABLE TO PUBLIC SAFETY OFFICERS SHOULD BE EXTENDED TO HEALTH CARE WORKERS

A. *The Health Care Professional and the Duty to Provide Care*

The AIDS crisis has reached epidemic proportions worldwide.¹⁴⁶ As a result, contemporary health care providers find themselves caught between the ethical and legal obligation to provide care to the victims of this modern plague and an understandable concern for personal safety.¹⁴⁷

Surprisingly, the early history of physician care during times of epidemic is one of economics, not virtue.¹⁴⁸ During the plague outbreaks in Europe between the fifteenth and seventeenth centuries, doctors often fled the infested urban areas along with their healthiest patients.¹⁴⁹ As a public policy matter, cities were forced to negotiate contractual arrangements with physicians who were willing to stay behind to care for plague victims.¹⁵⁰

Although a variety of ethical canons and treatises existed on the subject,

ethical consciousness was less effective a motive for action than economic interest or, more broadly, fear of loss of status. Thus the author of a sixteenth century treatise on professional ethics said that "to avoid infamy [I] dared not absent myself but with continual fear preserved myself as best I could."¹⁵¹

The concept of designating "plague doctors" endures today, although they are generally not referred to in such terms.¹⁵² During the twentieth century, the medical problems of the sick and impoverished became institutionalized through vestiture in government agencies, with public and private hospitals staffed by medical school faculty and interns.¹⁵³ Although it is possible to censure physicians when they balk at providing care to AIDS patients,¹⁵⁴ the primary incentive to treat AIDS patients is an economic one. Those doctors who treat AIDS patients are

146. See *supra* notes 39-44 and accompanying text.

147. See *supra* notes 48-50; *infra* note 321 and accompanying text.

148. Daniel M. Fox, *The Politics of Physicians' Responsibility in Epidemics: A Note on History*, HASTINGS CENTER REP., Apr.-May 1988, at 5.

149. *Id.*

150. *Id.* at 6-7.

151. *Id.* at 7 (quoting Darrel W. Amundsen, *Medical Deontology and Pestilential Disease in the Late Middle Ages*, 32 J. HIST. MED. & ALLIED SCI. 403, 411 (1977) (alteration in original)).

152. *Id.* at 8-9.

153. *Id.* at 8.

154. *Id.* at 9.

more likely to be offered rewards such as funding for research and increased academic standing.¹⁵⁵

The prevalence of this voluntary contract theory of medical ethics among bioethicists has "reinforced the notion that physicians, as free moral agents, have a perfect right to choose whomever they wish to serve. This claim to contractual freedom . . . fails to address the question of whether physicians have a special duty to enter into contracts with hazardous patients."¹⁵⁶ Modern physicians had not been forced to deal with this issue until the advent of AIDS. Thirty years ago, one entered the profession with the knowledge that there were inherent risks; these were accepted as part of the definition of being a physician.¹⁵⁷ However, sterilization techniques and the development of modern antibiotics eventually reduced contemporary health care providers' concerns about personal safety.¹⁵⁸ AIDS has broken the spell.¹⁵⁹ When most of today's practitioners entered the profession, the possibility of contracting a fatal illness from a patient was not part of the bargain.¹⁶⁰ The modern health care worker is now forced to consider the moral conflict between personal risk and duty.¹⁶¹

No matter where an individual physician might voluntarily draw the line,¹⁶² the American Medical Association (AMA) has directly addressed

155. *Id.*

156. John D. Arras, *The Fragile Web of Responsibility: AIDS and the Duty to Treat*, HASTINGS CENTER REP., Apr.-May 1988, at 10, 11.

157. *Id.* at 10.

158. *Id.*

159. *Id.*

160. *Id.*

161. *Id.*

162. A disturbing poll in the medical journal *Cardiovascular News* regarding a cardiovascular surgeon's public announcement that he would no longer treat HIV-infected patients illustrates that the line may not always be drawn in favor of a duty to provide care. *Id.* at 18 (citing *Surgeon Won't Operate on Victims of AIDS*, N.Y. TIMES, Mar. 13, 1987, at A21). Ninety-one percent of the physicians who responded to the survey agreed with the surgeon's decision. *Id.* (citing *Surgeon Won't Operate on Victims of AIDS*, N.Y. TIMES, Mar. 13, 1987, at A21). Notwithstanding the low response rate of 1.5%, this may indicate a lack of willingness by most physicians to subject themselves to the risks of caring for AIDS patients. *Id.* (citing *Surgeon Won't Operate on Victims of AIDS*, N.Y. TIMES, Mar. 13, 1987, at A21).

Physicians also harbor basic societal prejudices that affect their voluntary behavior. One Illinois family practitioner stated: "I would not knowingly treat a homosexual patient with AIDS, but I would treat patients who got the disease by blood transfusion, and I would treat children with AIDS." *Id.* at 20 n.35 (quoting *What Doctors Think About AIDS*, MD, Jan. 1987, at 95).

However, these attitudes may be slowly changing in favor of providing care to AIDS patients. A more recent survey found that 72% of surgeons polled would operate if an HIV-infected patient were referred for needed surgery that the surgeon was capable of performing. Gene A. Shelley & Richard J. Howard, *A National Survey of Surgeons' Attitudes About Pa-*

this conflict. The Council on Ethical and Judicial Affairs of the AMA (CEJA) has mandated that:

A physician may not ethically refuse to treat a patient whose condition is within the physician's realm of competence solely because the patient is [HIV] seropositive. The tradition of the American Medical Association, since its organization in 1847, is that: "when an epidemic prevails, a physician must continue his labors without regard to the risk of his own health."¹⁶³

Likewise, the American Nurses' Association (ANA) has published a position paper dealing with the issue of responsibility to provide care in the face of personal risk.¹⁶⁴ The ANA paper delineates four criteria for nurses to consider when deciding whether there is a moral *duty* or a moral *option* to care for patients with communicable or infectious diseases.¹⁶⁵ These are:

1. The patient is at significant risk of harm, loss or damage if the nurse does not assist.
2. The nurse's intervention or care is directly relevant to preventing harm.

tients with Human Immunodeficiency Virus Infections and Acquired Immunodeficiency Syndrome, 127 ARCHIVES OF SURGERY 206, 208 (1992).

163. D. Anthony Forrester, *Aids: The Responsibility to Care*, 34 VILL. L. REV. 799, 808-09 (1989) (quoting COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS, AMERICAN MEDICAL ASS'N, ETHICAL ISSUES INVOLVED IN THE GROWING AIDS CRISIS (1988)). This mandate seems to conflict with the AMA's *Principles of Medical Ethics*, which provides that "except in emergencies, [physicians are] free to choose whom to serve, with whom to associate, and the environment in which to provide medical services." *Id.* at 809 (quoting COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS, AMERICAN MEDICAL ASS'N, CURRENT OPINIONS OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS OF THE AMERICAN MEDICAL ASSOCIATION at ix (1986)). This freedom to decide how to conduct a practice, however, must not be used as a smokescreen to disguise "illegal or invidious discrimination." *Id.*; see also Benjamin Freedman, *Health Professions, Codes, and the Right to Refuse to Treat HIV-Infected Patients*, HASTINGS CENTER REP., Apr.-May 1988, at 20, 24 (describing how medical codes of ethics are interpreted with regard to treating AIDS patients).

Medical authorities have construed the foregoing principles to mean that physicians must provide care to AIDS patients if they feel competent to do so. *Id.* If they do not, they may refer, but may not abandon these patients. *Id.* (citing COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS, AMERICAN MEDICAL ASS'N, ETHICAL ISSUES INVOLVED IN THE GROWING AIDS CRISIS (1987)).

164. Forrester, *supra* note 163, at 806 (citing AMERICAN NURSES' ASS'N COMM. ON ETHICS, AMERICAN NURSES' ASSOCIATION STATEMENT REGARDING RISK VERSUS RESPONSIBILITY IN PROVIDING NURSING CARE, *in* ETHICS IN NURSING: POSITION STATEMENTS AND GUIDELINES 6, 6-7 (1988)).

165. *Id.* at 806-07 (citing AMERICAN NURSES' ASS'N COMM. ON ETHICS, AMERICAN NURSES' ASSOCIATION STATEMENT REGARDING RISK VERSUS RESPONSIBILITY IN PROVIDING NURSING CARE, *in* ETHICS IN NURSING: POSITION STATEMENTS AND GUIDELINES 6, 6-7 (1988)).

3. The nurse's care will probably prevent harm, loss, or damage to the patient.

4. The benefit the patient will receive outweighs any personal harm the nurse might incur and does not present more than minimal risk to the health care provider.¹⁶⁶

If all these criteria are met, the nurse is obligated to provide care; if only one is not met the nurse may exercise a moral option to do so.¹⁶⁷ In most situations, caring for AIDS patients meets all four criteria because of the low risk of harm to the nurse;¹⁶⁸ thus nurses have an obligation to provide care.¹⁶⁹

Regardless of whether health care providers have an ethical duty to treat AIDS patients, they definitely have a *legal* duty to do so.¹⁷⁰ Both the common law¹⁷¹ and recent statutory enactments¹⁷² require health care providers to respond to the needs of *any* patient in an emergency. Under the ADA, places of "public accommodation" may not discriminate against persons with AIDS.¹⁷³ The ADA lists a variety of establishments that are considered to be public accommodations, including but

166. *Id.* at 807 (citing AMERICAN NURSES' ASS'N COMM. ON ETHICS, AMERICAN NURSES' ASSOCIATION STATEMENT REGARDING RISK VERSUS RESPONSIBILITY IN PROVIDING NURSING CARE, in ETHICS IN NURSING: POSITION STATEMENTS AND GUIDELINES 6, 6-7 (1988)).

167. *Id.* (citing AMERICAN NURSES' ASS'N COMM. ON ETHICS, AMERICAN NURSES' ASSOCIATION STATEMENT REGARDING RISK VERSUS RESPONSIBILITY IN PROVIDING NURSING CARE, in ETHICS IN NURSING: POSITION STATEMENTS AND GUIDELINES 6, 6-7 (1988)).

168. *See id.*

169. *Id.*

170. An employee can refuse to work for safety reasons under the Occupational Safety and Health Act. 29 U.S.C. §§ 651-678 (1988); *see* 29 C.F.R. § 1977.12 (1992). One of the purposes of this statute is to "provid[e] medical criteria which will assure insofar as practicable that no employee will suffer diminished health, functional capacity, or life expectancy as a result of his work experience." 29 U.S.C. § 651(b)(7). For a discussion of the Occupational Safety and Health Administration (OSHA) guidelines specific to AIDS in the health care environment, *see supra* notes 51-56 and accompanying text. *See also* 29 C.F.R. § 1910.1030 (detailing OSHA policy on preventing occupational exposure to bloodborne pathogens). However, an employee may *only* refuse to work if there is no reasonable alternative because the employer has not corrected the dangerous condition after receiving notification. 29 C.F.R. § 1977.12(b). The dangerous condition must also be so threatening that a reasonable person would conclude that there was no time to compel corrective action through normal enforcement procedures. *Id.*

171. George J. Annas, *Legal Risks and Responsibilities of Physicians in the AIDS Epidemic*, HASTINGS CENTER REP., Apr.-May 1988, at 26, 26-27.

172. *See* 42 U.S.C. § 1395dd (Supp. III 1991). Commonly known as COBRA, this statute particularly addresses the evil of "patient dumping"—the practice of denying care to less desirable patients, such as the uninsured or those with AIDS—when these patients come to a medical facility with an emergency medical condition. *Id.* A similar provision has been enacted by the state of California. *See* CAL. HEALTH & SAFETY CODE § 1317.2 (West 1990).

173. 42 U.S.C. § 12182(a) (Supp. III 1991); *see also* TROWERS-CROWLEY, *supra* note 81, at 12 (describing ADA regulations for places of public accommodation).

not limited to "professional offices [] of . . . health care providers and others[] and hospitals."¹⁷⁴

B. Balancing the Burdens: Do Patients Have Duties?

An established obligation to provide care on the part of health care workers raises the question of whether the patient owes a reciprocal duty, especially if there is a health and safety issue at stake. When a health care worker in California is occupationally exposed to the blood or body fluids of a patient of unknown HIV status, there is no legal way to compel that patient to undergo testing.¹⁷⁵ The risk of potential infection with a lethal disease is a heavy burden for health care providers to carry.

Precedent, however, supports the notion that persons with contagious diseases have duties to those whom they might infect. California courts have previously established, on strong public policy grounds, that a person who has a sexually transmissible disease has a duty to disclose the condition to sex partners.¹⁷⁶ Thus, a person who, through either negligence or deceit, transmits the disease to another may be liable in tort for damages.¹⁷⁷ Furthermore, an infected person is not relieved of this duty even if he or she believes that the disease cannot be transmitted.¹⁷⁸ The courts also have held that the constitutional right of privacy does not absolve an individual from this duty.¹⁷⁹ "The right of privacy is not ab-

174. TROWERS-CROWLEY, *supra* note 81, at 12.

175. See BIOETHICS COMM. OF THE L.A. COUNTY BAR ASS'N, RECOMMENDATION FOR STUDY REGARDING EXPOSURES OF HEALTH CARE PROFESSIONALS TO THE HUMAN IMMUNODEFICIENCY VIRUS (1991) [hereinafter BIOETHICS COMMITTEE RECOMMENDATIONS] (on file with *Loyola of Los Angeles Law Review*). Several other states have allowed for this contingency. See, e.g., DEL. CODE ANN. tit. 16, § 1202(c)(4) (Supp. 1992); ME. REV. STAT. ANN. tit. 5, § 19203-C (West 1989 & Supp. 1992); TEX. HEALTH & SAFETY CODE ANN. § 81.107 (West 1992). For example, Illinois has dispensed with the written informed consent requirement for HIV testing when either a public safety officer or health care provider has been exposed. ILL. ANN. STAT. ch. 111½, para. 7307 (Smith-Hurd Supp. 1992). Florida requires an effort to obtain consent; if consent is not obtained, the test may be performed on a previously voluntarily obtained specimen, and the patient is to be notified that the test will be performed. FLA. STAT. ANN. § 381.004 (West Supp. 1993).

176. *Kathleen K. v. Robert B.*, 150 Cal. App. 3d 992, 996-97, 198 Cal. Rptr. 273, 276-77 (1984) (holding that plaintiff had cause of action for negligence and fraud because defendant had lied about having herpes).

177. *Id.*

178. *Doe v. Roe*, 218 Cal. App. 3d 1538, 1543-44, 267 Cal. Rptr. 564, 566-67 (1990). In this case, the defendant, who knew he had genital herpes but was asymptomatic, engaged in a sexual relationship with the plaintiff, who eventually contracted the disease from him. *Id.* at 1541-42, 267 Cal. Rptr. at 564-65. The court found the man negligent because he had made no effort to obtain information from his doctor as to whether asymptomatic herpes was transmissible. *Id.* at 1544-45, 267 Cal. Rptr. at 567.

179. *Kathleen K.*, 150 Cal. App. 3d at 996, 198 Cal. Rptr. at 276.

solute, and in some cases is subordinate to the state's fundamental right to enact laws which promote public health, welfare, and safety, even though such laws may invade the offender's right of privacy."¹⁸⁰

Because a person with a sexually transmitted *nonfatal* disease, such as herpes, has a duty to disclose this information to sex partners,¹⁸¹ it is reasonable to impose a similar obligation on a patient to disclose his or her HIV status (or, if unknown, to consent to testing) when a potentially *fatal* exposure is at issue. Imposing such a duty would have the effect of more equitably distributing the legal burdens between patient and health care worker.

In 1993, a jury in the Los Angeles Superior Court decided a case that specifically raised the issue of patient duties in the context of AIDS, at least in cases in which the patient already knows his or her HIV status. In *Boulais v. Lustig*,¹⁸² a surgical technician sued a patient for fraudulently concealing the fact that she was HIV-positive from the surgical team that performed cosmetic surgery on her.¹⁸³ The patient gave false information on a medical history form—stating that she was not currently under treatment for any illnesses, when in fact she had been diagnosed with AIDS in 1987 and was under a physician's care for the disease.¹⁸⁴ During the course of the operation, the technician's hand was lacerated with a scalpel, thereby exposing the technician to the patient's infected blood.¹⁸⁵ The jury found that the patient had a duty to inform the surgical team of her HIV-positive status.¹⁸⁶ According to one juror, "[t]here was a message we wanted to send to people that you can't do what this defendant did: misrepresenting her health status so that somebody else's life was endangered. That just cannot be tolerated."¹⁸⁷

Similarly, a New York court recently took the position that HIV-positive patients have a legal duty to inform health care workers of their infection,¹⁸⁸ even though New York, like California, has protective

180. *Id.* (citing *Barbara A. v. John G.*, 145 Cal. App. 3d 369, 380, 193 Cal. Rptr. 422, 430 (1983)).

181. *See supra* notes 176-80 and accompanying text.

182. No. BC 038105 (L.A. Super. Ct. filed Sept. 23, 1991).

183. Penelope McMillan, *Jury Rules Against AIDS Patient*, L.A. TIMES, Feb. 10, 1993, at B1, B8. The defendant plans to appeal the verdict. *Id.* at B1; *see also* Lauren Blau, *Medical Worker Wins Suit Against Patient with AIDS*, L.A. DAILY J., Feb. 10, 1993, at 1, 9 (describing outcome and legal implications of case).

184. Blau, *supra* note 183, at 1.

185. *Id.*

186. *See id.* at 9; McMillan, *supra* note 183, at B8.

187. McMillan, *supra* note 183, at B8.

188. *Doe v. Roe*, 588 N.Y.S.2d 236 (Sup. Ct. 1992).

AIDS statutes.¹⁸⁹ In *Doe v. Roe*,¹⁹⁰ the plaintiff brought an action against his doctor for the doctor's release of confidential HIV information.¹⁹¹ Although the court found that the doctor breached the duty of confidentiality,¹⁹² it also concluded that New York law did not negate the plaintiff's legal duty to disclose his HIV-positive status to the doctor.¹⁹³ The court stated that whether such a duty exists depends on whether the doctor's interests are also entitled to protection.¹⁹⁴ While the New York confidentiality statute in question is undoubtedly intended to provide protection to those afflicted with HIV, it does not insulate such persons from responsibility for transmission of the disease through negligence or fraud.¹⁹⁵ The court reasoned that:

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 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.¹⁹⁶

Health care professionals clearly have an ethical and legal obligation to provide care to AIDS and HIV-infected patients. This duty makes it impossible to completely avoid the risk of contact with infected blood or body fluids, even if universal precautions are rigorously followed.¹⁹⁷ To balance this legal burden, some courts have recently determined that patients also have a duty to inform health care providers of their HIV status, if known. A logical extension of this duty is to require that a patient be tested when his or her HIV status is unknown *and* a health care worker has suffered an exposure.

189. See N.Y. PUB. HEALTH LAW § 2781 (McKinney Supp. 1993) (describing consent requirements for HIV testing); *id.* § 2782 (relating to confidentiality and disclosure of HIV-related information); *id.* § 2785 (describing circumstances under which court may order disclosure of HIV-related information).

190. 588 N.Y.S.2d 236 (Sup. Ct. 1992).

191. *Id.* at 239.

192. *Id.* at 246-47.

193. *Id.* at 241-42; see also John Horty, *Court Rules Patient Has Legal Duty to Reveal HIV Status*, PATIENT CARE L., reprinted in OR MANAGER, Nov. 1992, at 18 (describing outcome and legal implications of case).

194. *Doe*, 588 N.Y.S.2d at 241-42.

195. *Id.* at 242.

196. *Id.*

197. See *supra* notes 48-50 and accompanying text; *infra* note 321.

C. Repercussions from the Florida Dentist Case

Medical professionals have long regarded the potential for exposure to HIV as a serious occupational safety issue.¹⁹⁸ The general public, however, was not as concerned with the reality of HIV transmission in the health care setting until it was discovered that *patients* may also be at risk.

In July 1990, the CDC reported that a patient of a dentist known to have died of AIDS had become infected.¹⁹⁹ The patient, later identified as Kimberly Bergalis, became an active voice in the movement to require HIV testing of health care workers.²⁰⁰ Ms. Bergalis was presumably infected when she underwent an invasive dental procedure,²⁰¹ although this has not been conclusively proven.²⁰² Before her death from AIDS in 1991, Ms. Bergalis, who was twenty-three, testified before Congress, pleading for passage of legislation requiring mandatory testing of patients and health care workers.²⁰³ Her testimony produced a flurry of media attention, which in turn has generated a great deal of public discussion about mass HIV testing.²⁰⁴ The focus of the debate, however, has been on the need to screen health care workers, not patients.²⁰⁵

Because it now seems at least possible that the virus can be transmitted to patients by infected caregivers, the CDC has promulgated a new set of guidelines designed to prevent transmission of HIV to patients in the health care setting.²⁰⁶ The CDC recommends: (1) adherence to uni-

198. See *supra* notes 45-56 and accompanying text.

199. CENTERS FOR DISEASE CONTROL, *Possible Transmission of Human Immunodeficiency Virus to a Patient During an Invasive Dental Procedure*, 39 MORBIDITY & MORTALITY WKLY. REP. 489, 489 (1990) [hereinafter CENTERS FOR DISEASE CONTROL, *Invasive Dental Procedure*]. Four other patients of this dentist also became HIV positive, but other risk factors were identified for at least two of these patients. CENTERS FOR DISEASE CONTROL, *Update: Transmission of HIV During an Invasive Dental Procedure—Florida*, 40 MORBIDITY & MORTALITY WKLY. REP. 21, 21-22 (1991).

200. See Mike Clary, *AIDS Victim Infected by Dentist Dies*, L.A. TIMES, Dec. 9, 1991, at A4.

201. See CENTERS FOR DISEASE CONTROL, *Invasive Dental Procedure*, *supra* note 199, at 489-91. CDC investigators concluded that the dental procedure was responsible for infecting Ms. Bergalis because it could identify no other risk factors for this patient. *Id.* at 489-90.

202. CENTERS FOR DISEASE CONTROL, *Update: Investigations of Patients Who Have Been Treated by HIV-Infected Health-Care Workers*, 41 MORBIDITY & MORTALITY WKLY. REP. 344, 344-45 (1992).

203. See Clary, *supra* note 200, at A4.

204. *E.g.*, Barbara Ehrenreich, *Cauldron of Anger*, LIFE, Jan. 1992, at 61, 63.

205. See *id.*; see also *A Death Not in Vain*, L.A. TIMES, Dec. 10, 1991, at B6 (editorial) (describing aftermath of Kimberly Bergalis' testimony before Congress).

206. CENTERS FOR DISEASE CONTROL, *Recommendations for Preventing Transmission of Human Immunodeficiency Virus and Hepatitis B Virus to Patients During Exposure-Prone Invasive Procedures*, MORBIDITY & MORTALITY WKLY. REP., July 12, 1991, at 1, 1-6. *But see*

versal precautions; (2) identification of exposure-prone procedures; (3) health care workers who perform these procedures should know their HIV and HBV (hepatitis B virus) status; (4) health care workers who are infected with either HIV or HBV should seek assistance from an expert review panel to determine under what, if any, circumstances they may continue to perform exposure-prone procedures; and (5) patients should be notified before undergoing these procedures when performed by infected health care workers.²⁰⁷ However, these guidelines also state that there is no basis for restricting the practice of HIV- or HBV-infected health care workers who perform noninvasive procedures or procedures that are invasive but not exposure prone.²⁰⁸

Shortly after the CDC published these guidelines, Congress passed a compromise bill that required states to adopt these guidelines (or a state equivalent) or risk losing federal Public Health Service funds.²⁰⁹ This legislation stops short of mandating testing of health care workers, but it may create liability for those who do not comply.²¹⁰ Thus, it has the effect of requiring health care workers who perform invasive procedures to be tested for HIV and, if positive, to disclose this fact to the patient.²¹¹ The lopsided allocation of legal burdens is further imbalanced because

Study Finds No HIV Transmitted from Doctors to Patients, L.A. DAILY NEWS, Apr. 14, 1993, at 8 (reporting study which found no HIV seroconversion among approximately 2500 patients who had undergone invasive medical procedures performed by HIV-infected physicians).

207. CENTERS FOR DISEASE CONTROL, *supra* note 206, at 5.

208. *Id.* Exposure-prone procedures:

include digital palpation of a needle tip in a body cavity or the simultaneous presence of the [health care worker's] fingers and a needle or other sharp instrument or object in a poorly visualized or highly confined anatomic site. Performance of exposure-prone procedures presents a recognized risk of percutaneous injury to the [health care worker], and—if such an injury occurs—the [worker's] blood is likely to contact the patient's body cavity, subcutaneous tissues, and/or mucous membranes.

Id. at 4.

209. Act of Oct. 28, 1991, Pub. L. No. 102-141, § 633, 105 Stat. 834, 876-77 (codified at 42 U.S.C. § 300ee-2 (Supp. III 1991)).

210. *See id.*

211. The Office of Technology Assessment, in a background paper, endorsed the creation of safe harbors against liability for infected health care workers who do not perform invasive procedures; it also favors safe harbors for those who perform invasive procedures that are not exposure-prone, provided the standard of proof allows for the possibility of recovery of damages for infection resulting from gross negligence. U.S. OFFICE OF TECHNOLOGY ASSESSMENT, HIV IN THE HEALTH CARE WORKPLACE: A BACKGROUND PAPER (1991), reprinted in 6 AIDS PATIENT CARE 169, 182 (1992).

Notably, several jurisdictions had approved measures similar to the requirements of the new federal law before it was enacted. *See* Estate of Behringer v. Medical Ctr., 592 A.2d 1251 (N.J. Super. Ct. 1991) (holding that HIV-infected physician was required to obtain informed consent from patients before performing surgeries); *In re* Milton S. Hershey Medical Ctr., 595 A.2d 1290 (Pa. Super. Ct. 1991), appeal granted, 611 A.2d 712 (Pa. 1992) (holding that HIV-infected resident physician required to disclose HIV status to certain patients before perform-

under this bill, as well as under California statutes, patients are not reciprocally required to reveal HIV-related information to the health care provider.²¹²

D. Other Considerations

The perception by health care workers that the legal system forces them to carry an inequitable share of the burden may undesirably encourage surreptitious HIV testing. Hospital patients are frequently subjected to having blood drawn for a variety of testing purposes; it is a simple matter to divert some of the legitimately obtained specimen for an HIV test.²¹³ This practice of "civil disobedience" is rationalized as a matter of fairness and necessity.²¹⁴

However, if the result of the surreptitious testing is positive, it leaves the health care worker who engineered it in a difficult ethical situation. First, if the patient has not consented and is informed of the positive result, the trust relationship between the patient and caregiver is destroyed.²¹⁵ Second, because of the emotional trauma that such news is likely to cause, adequate counseling is absolutely essential but may not be provided if the testing was conducted outside procedural channels.²¹⁶ Finally, if the health care provider keeps the results from the patient to avoid civil or criminal penalties that may ensue, the health care provider must decide whether to warn others who may come in contact with the HIV-infected patient, if that contact may result in transmission of the disease.²¹⁷ Further, the patient will be denied the opportunity to obtain early treatment, which could prolong life.²¹⁸

ing surgery or obstetrical care). See *infra* notes 301-13 and accompanying text for a discussion of *Leckelt v. Board of Commissioners*, 714 F. Supp. 1377 (E.D. La. 1989).

212. Depending on the outcome of the anticipated appeal in *Boulais v. Lustig*, No. BC 038105 (L.A. Super. Ct. filed Sept. 23, 1991), this may no longer be true in California, at least if the patient already knows his or her HIV status. *Boulais* did *not* deal with the issue of whether the patient must submit to testing if there has been an exposure and his or her HIV status is unknown. See *supra* notes 182-87 and accompanying text. This was also the situation in the New York case of *Doe v. Roe*, 588 N.Y.S.2d 236 (Sup. Ct. 1992). See *supra* notes 188-96 and accompanying text.

213. This can be unofficially accomplished through interdepartmental cooperation (the laboratory performing the test is willing to overlook the written consent requirement if a health care worker is involved). Because the results are never charted, they do not officially exist, thus circumventing the consent requirement.

214. Furrow, *supra* note 11, at 826-27.

215. *Id.* at 853.

216. See FLANDERS & FLANDERS, *supra* note 1, at 33; Furrow, *supra* note 11, at 830.

217. Furrow, *supra* note 11, at 853.

218. FLANDERS & FLANDERS, *supra* note 1, at 24; see *infra* note 224.

Another difficult situation emerges when an exposed health care worker wishes to obtain proper consent to test from the patient, but that patient is incompetent to give consent and is without a conservator. Under the California Probate Code, the court may order medical testing, but only for the benefit of the *patient*, not a third party.²¹⁹ This significant gap in the law reinforces the belief among health care workers that they bear the burdens of California AIDS legislation.

It is ironic that shortly after Kimberly Bergalis testified before Congress amidst a barrage of media attention, Joann Ruiz, a Sacramento nurse, became the first occupationally infected health care worker to die from AIDS.²²⁰ Ms. Ruiz dedicated her last months to providing home care for AIDS patients, including the one who had infected her,²²¹ yet her sacrifice received little attention.

Occupational exposure to HIV is a constant risk in the course of caring for patients; although universal precautions have helped reduce exposures, they cannot totally eliminate them. Proposition 96 took the first step by recognizing that for public safety employees, occupational exposure is a reality and it fairly treats both interests involved.²²² The person to be tested has the security of knowing that strict confidentiality must be maintained or severe penalties will result,²²³ the exposed employee will, one way or the other, be able to make informed decisions about future activities, such as whether to obtain prophylactic AZT treatment²²⁴ or change sexual practices.²²⁵

The California Legislature should extend the occupational protections of Proposition 96 beyond the criminal context to health care work-

219. See CAL. PROB. CODE §§ 3200, 3201, 3208 (West 1991).

220. *First Healthcare Worker Occupationally Infected With HIV Dies*, 12 CLINICAL LAB LETTER 105, 108 (1991); Robert J. Fitzgibbon, *AIDS: Medical Groups Balk at Naming High-Risk Procedures*, MED. LABORATORY OBSERVER, Oct. 1991, at 9; Arlene Jech, *A Case for AIDS Testing*, S.F. CHRON., July 19, 1991, at A25.

221. Fitzgibbon, *supra* note 220, at 9.

222. See *supra* part II.C.3.

223. *Johnetta J. v. Municipal Court*, 218 Cal. App. 3d 1255, 1284, 267 Cal. Rptr. 666, 684 (1990).

224. According to Dr. Julie Gerberding's testimony in *Johnetta J.*, early AZT therapy might prevent infection, but it is costly and has "severe side effects." *Id.* at 1267, 267 Cal. Rptr. at 672 (quoting Dr. Gerberding). Knowing the HIV status of the person to whom the employee is exposed is an "important factor . . . to consider in deciding whether to subject his or her body to this prophylactic treatment." *Id.* (quoting Dr. Gerberding). *But see* Lawrence K. Altman, *Study Says AZT May Not Stem Onset of AIDS*, L.A. DAILY NEWS, Apr. 2, 1993, at 1 (reporting results of Concorde study on ineffectiveness of early AZT treatment of HIV-positive individuals).

225. *Johnetta J.*, 218 Cal. App. 3d at 1266, 267 Cal. Rptr. at 672 (testimony of Dr. William Drew).

ers.²²⁶ This will equalize the current imbalance in the law that forces health care professionals to carry a disproportionate share of the legal burdens. Recognizing this inequity, the Bioethics Committee of the Los Angeles County Bar Association has taken the position that the legislature should "consider whether California needs additional legislation to address [the] problem of the exposed health care professional who cannot obtain information about the HIV status of the patient who is the source of that exposure."²²⁷

Health care workers are in the front lines of the AIDS crisis on a daily basis. They endure the same anxieties and fears as anyone else confronted with the possibility of contracting a fatal disease. Consider the opinion of one of the medical experts expressed in *Johnetta J. v. Municipal Court*.²²⁸

Patients who fear an HIV infection "suffer extreme anxiety because AIDS is fatal. . . . [B]eing informed the risk [of infection] is remote provides little comfort in the face of a lethal disease. Patients are anxious to know the HIV status of the person with whom they have come into contact. *This information is useful for both the treating physician and the patient.* A positive test of the person who may have infected the patient would inform the physician that additional and more extensive monitoring of the patient's medical condition is warranted than would be the case were the results of the test negative. If the results of the HIV test of the source is negative, this information may be useful in helping to allay the concerns of the patient."²²⁹

IV. CHALLENGES TO NONCONSENSUAL HIV TESTING

AIDS is a political and social issue in modern society, but it is also a contagious fatal disease. Under current California AIDS confidentiality statutes, health care workers may not divulge HIV-related information.²³⁰ Because of these disclosure restrictions, it is fair to require a

226. Under the California Constitution, the legislature may not amend or repeal voter initiatives. CAL. CONST. art. II, § 10(c). An amendment to an initiative statute requires approval by the voters unless the initiative statute contains provisions that permit legislative amendment or repeal without voter approval. *Id.* However, the legislature is free to enact separate statutes to deal with this issue which would not amend the original provisions of Proposition 96.

227. BIOETHICS COMMITTEE RECOMMENDATIONS, *supra* note 175.

228. 218 Cal. App. 3d 1255, 267 Cal. Rptr. 666 (1990).

229. *Id.* at 1266, 267 Cal. Rptr. at 671-72 (alterations in original) (quoting testimony of Dr. William Drew).

230. CAL. HEALTH & SAFETY CODE §§ 199.21-215 (West 1990 & Supp. 1993).

patient to submit to an HIV test when a health care worker has been exposed to the patient's blood or body fluids. However, any law that permits a nonconsensual intrusion into the body will be subjected to close scrutiny by the courts. If the legislature chooses to redistribute the legal burdens between patients and health care providers, it is necessary to examine whether such statutes can withstand federal and state constitutional challenges.

A. Fourth Amendment and "Special Need"

Under the Fourth Amendment to the United States Constitution, people have the right "to be secure in their persons, houses, papers, and effects, against unreasonable searches and seizures."²³¹ Courts have allowed governmental intrusions into the body to obtain evidence in criminal cases if there is probable cause to believe such a search will discover evidence and if it is deemed reasonable.²³² This was specifically applied to the involuntary taking of a criminal defendant's blood for testing in *Schmerber v. California*.²³³ The U.S. Supreme Court first concluded a compulsory blood test was a search under the Fourth Amendment²³⁴ subject to probable cause restrictions. Probable cause was subsequently found to exist, and the Court concluded that the search was reasonable because the intrusion was minimal and did not subject the defendant to excessive "risk, trauma, or pain."²³⁵

231. U.S. CONST. amend. IV; see also CAL. CONST. art. I, § 13 (incorporating Fourth Amendment into California Constitution).

232. *Schmerber v. California*, 384 U.S. 757 (1966).

233. 384 U.S. 757 (1966). *Schmerber* involved a motorist suspected of drunk driving. Authorities collected a blood sample without first obtaining a search warrant. *Id.* at 758-59.

234. *Id.* at 767.

235. *Id.* at 771. The Court also expressed the belief that the warrantless search was reasonable because there was no time to obtain a proper warrant. The evidence would have disappeared by the time a warrant could be lawfully obtained. *Id.* at 770-71.

In *People v. Scott*, 21 Cal. 3d 284, 578 P.2d 123, 145 Cal. Rptr. 876 (1978), however, the California Supreme Court found that a court-ordered acquisition of a semen sample by prostatic massage from a criminal defendant suspected of child molestation did constitute an unreasonable search. *Id.* at 294, 578 P.2d at 128, 145 Cal. Rptr. at 881. This was because the nature of the intrusion was found to be "very substantial," constituting a "very significant invasion of both dignity and privacy," which the Fourth Amendment was designed to protect. *Id.* There also must be a clear indication that the evidence desired is likely to be found as a result of the search. *Id.* at 295, 578 P.2d at 128, 145 Cal. Rptr. at 881.

Likewise, in *Winston v. Lee*, 470 U.S. 753 (1985), the United States Supreme Court held that a state could not force an armed robbery suspect to undergo surgery to remove a possibly incriminating bullet. *Id.* at 766. The Court held that this search was unreasonable because: (1) The surgery could be dangerous for the defendant; (2) the intrusion by surgery was much more severe than the mere taking of a blood sample as in *Schmerber*; and (3) the state had other evidence that would be sufficient to convict the defendant. *Id.* at 765-67.

The U.S. Supreme Court has defined an unreasonable search to be one that violates a person's subjective expectation of privacy;²³⁶ the expectation must also be one that society would recognize as "reasonable."²³⁷ Taking blood for testing can be either for criminal or administrative purposes.²³⁸ Unlike criminal searches, in administrative searches the probable cause requirement is relaxed.²³⁹ This is because such regulatory programs are widely accepted by the public and the courts; also this type of search is usually neither "personal in nature nor . . . aimed at the discovery of evidence of crime."²⁴⁰ Because the court-ordered HIV testing under Proposition 96 is for health and safety reasons and specifically is not to be used as criminal evidence, it is classified as an administrative search.²⁴¹

An administrative search, as defined in *Camara v. Municipal Court*,²⁴² is conducted for the purpose of obtaining information used in regulatory schemes involving public health and safety,²⁴³ monitoring government employees²⁴⁴ or the business practices of "closely regulated"²⁴⁵ entities. In *Camara*, which involved the search of a home for health code violations, the U.S. Supreme Court established a balancing test to determine whether an administrative search was valid.²⁴⁶ The need for the search is determined by ascertaining whether the search fulfills a valid public interest, which is weighed against the competing private interest to be free from such intrusions.²⁴⁷ If a valid public interest exists to justify the intrusion, then a suitably restricted search warrant may be issued.²⁴⁸

Recently, the U.S. Supreme Court has expanded the scope of the "reasonableness" doctrine. In *Skinner v. Railway Labor Executives*

236. *Katz v. United States*, 389 U.S. 347, 361 (1967).

237. *Id.*

238. Bennett, *supra* note 133, at 1423.

239. *Camara v. Municipal Court*, 387 U.S. 523, 538-39 (1967).

240. *Id.* at 537.

241. Bennett, *supra* note 133, at 1438.

242. 387 U.S. 523 (1967).

243. *Id.*; see also *In re Clemente*, 61 Cal. App. 666, 666-67, 215 P. 698, 698-99 (1923) (upholding quarantine and testing of owner of house of prostitution for venereal disease).

244. *National Treasury Employees Union v. Von Raab*, 489 U.S. 656 (1989) (allowing drug testing of customs employees); *O'Connor v. Ortega*, 480 U.S. 709 (1987) (permitting search of office and desk of physician employed by state psychiatric hospital).

245. *New York v. Burger*, 482 U.S. 691 (1987) (upholding constitutionality of statute authorizing warrantless search of closely regulated businesses as applied to vehicle dismantling operation).

246. 387 U.S. at 536-37.

247. *Id.*

248. *Id.* at 539.

Ass'n,²⁴⁹ the Court held that the usual warrant and probable cause requirements may be suspended in the face of a "special need,"²⁵⁰ in which "the burden of obtaining a warrant is likely to frustrate the governmental purpose behind the search."²⁵¹ Most importantly for purposes of analyzing Proposition 96, the Court also determined that in certain circumstances, "where an important governmental interest furthered by the intrusion would be placed in jeopardy by a requirement of individualized suspicion, a search may be reasonable despite the absence of such suspicion."²⁵² Therefore, even though Proposition 96 does not require a determination that the person to be tested is likely to have the virus, it passes the requirements established by the Court in *Skinner*.

Extending the protections of Proposition 96 to health care workers fulfills an important governmental interest by enhancing occupational safety when an exposure has occurred. Under these circumstances, a requirement of individualized suspicion is unreasonable because it is impossible for the exposed health care worker to know a patient's HIV status from the information in the medical history. Therefore, a statute allowing nonconsensual testing of a patient for HIV when a health care worker has been exposed is "reasonable" under the *Skinner* test.

B. Proposition 96 Survives Constitutional Scrutiny

Before the adoption of Proposition 96, there were few exceptions to the strict consent requirements of the California AIDS statutes.²⁵³ For example, in *Barlow v. Superior Court*,²⁵⁴ the plaintiff's blood was taken for an HIV test without his consent after he bit a police officer during an altercation at a gay rights parade.²⁵⁵ Although the plaintiff had alluded to the distinct possibility of AIDS transmission,²⁵⁶ the court ordered the test canceled and his blood sample returned to him.²⁵⁷ The court recog-

249. 489 U.S. 602 (1989).

250. *Id.* at 620 (quoting *Griffin v. Wisconsin*, 483 U.S. 868, 873 (1987)).

251. *Id.* at 623 (quoting *Camara v. Municipal Court*, 387 U.S. 523, 533 (1967)).

252. *Id.* at 624. This case involved drug testing of railroad employees to prevent impaired workers from operating trains as an urgent matter of public safety. *Id.* at 620. The Court found that dispensing with probable cause and warrant requirements was justified because of the "special need" to detect impaired workers. *Id.* The balance was tipped in favor of the government because the procedures involved in obtaining a warrant would result in the loss of evidence: Drugs and alcohol would dissipate from the blood and urine over time. *Id.* at 623.

253. *See supra* notes 128-30 and accompanying text.

254. 190 Cal. App. 3d 1652, 236 Cal. Rptr. 134 (1987) (depublished opinion).

255. *Id.* at 135.

256. The plaintiff allegedly told someone at the hospital, "You better take it that I do have AIDS for the officers' sake." *Id.* at 135-36.

257. *Id.* at 140.

nized that blood may be taken under a properly obtained warrant,²⁵⁸ but even if probable cause existed in this case,²⁵⁹ the court could not order the test because of the California law prohibiting nonconsensual testing.²⁶⁰

The outcome of *Barlow* would likely have been different after Proposition 96. Though the results of the HIV test would be inadmissible as evidence against Barlow in the criminal trial, the court still could have ordered the test for the officer's protection.²⁶¹ Indeed, a case with similar facts, which arose after Proposition 96 went into effect, did result in a decision favoring a nonconsensual test.²⁶²

The plaintiff in *Johnetta J. v. Municipal Court*²⁶³ specifically challenged Proposition 96. *Johnetta J.* involved a defendant who was charged with assault on an officer after she became disruptive in court during a child dependency hearing.²⁶⁴ In the altercation that ensued when a deputy attempted to subdue her, she inflicted a deep bite on the deputy's arm, which drew blood.²⁶⁵ The deputy filed a request in civil court to order the plaintiff tested for HIV.²⁶⁶ Pursuant to Proposition 96, the lower court ordered the HIV test, following extensive medical expert testimony.²⁶⁷ The plaintiff challenged the order based on Fourth Amendment and California right-to-privacy grounds.²⁶⁸

Johnetta J. claimed that the mandatory HIV testing scheme of Proposition 96 is a violation of the Fourth Amendment because: (1) The law does not require probable cause that evidence of the virus will be found as a result of the testing; and (2) the law does not allow for a balancing test to ascertain "whether the character of the intrusion is appropriate to

258. *Id.* at 137 (citing *Schmerber v. California*, 384 U.S. 757, 769-71 (1966)).

259. The court decided that the warrant was issued without probable cause because Barlow was charged with an intent crime (assault with intent to commit great bodily harm); whether or not Barlow had HIV would not be useful in demonstrating the requisite intent. *Id.* at 138.

260. *Id.* at 138-39. The court concluded that California law prohibited nonconsensual HIV testing under such circumstances, as well as the disclosure of the results. *Id.* (citing CAL. HEALTH & SAFETY CODE §§ 199.20, 199.22 (West Supp. 1986)); *see also* Department of Social Servs. v. Janice T., 524 N.Y.S.2d 267 (App. Div. 1988) (reversing court order to require AIDS testing of defendant who bit bailiff, because no statute expressly authorized such order).

261. *See* CAL. HEALTH & SAFETY CODE § 199.97 (West 1990) (allowing mandatory testing of persons charged with assault on officer); *id.* § 199.97(f) (specimens and results of tests are not admissible evidence in any criminal proceeding).

262. *Johnetta J. v. Municipal Court*, 218 Cal. App. 3d 1255, 267 Cal. Rptr. 666 (1990).

263. 218 Cal. App. 3d 1255, 267 Cal. Rptr. 666 (1990).

264. *Id.* at 1261, 267 Cal. Rptr. at 668.

265. *Id.*

266. *Id.*

267. *Id.* at 1263-64, 267 Cal. Rptr. at 669-70.

268. *Id.*

the circumstances.”²⁶⁹ The appeals court acknowledged that such testing qualified as an administrative search under the Fourth Amendment, noting that “‘it is surely anomalous to say that the individual and his private property are fully protected by the Fourth Amendment only when the individual is suspected of criminal behavior.’”²⁷⁰ However, based on a *Skinner* “special needs” analysis, the court found that in this case the balance was not in favor of the warrant and probable cause requirements of the Fourth Amendment.²⁷¹ Establishing probable cause that the person with whom contact was made is likely to be HIV-positive is not practical in this situation because “in the vast majority of cases the officers will have no way of knowing the infection status of the person who has bitten them.”²⁷²

The plaintiff argued that in this case, taking blood for an AIDS test was *not* a “minimal intrusion” because of the adverse psychological impact a positive test would cause and because of the stigma associated with it should the results become generally known.²⁷³ On this basis, she claimed that *Skinner* did not apply and relied on a line of cases that forbade searches of the body if the intrusion was more than minimal.²⁷⁴ The court, however, found that the strict confidentiality provisions and the very limited disclosure allowed under Proposition 96 are adequate to satisfy the “minimal intrusion” requirement.²⁷⁵ Additionally, the court held that the governmental need, which included consideration of the officer’s apprehension about potential infection, outweighs any negative psychological effects the plaintiff might suffer if the test were positive.²⁷⁶ The court also felt that the intrusion was justified because the medical experts could not establish with certainty that HIV could *not* be transmitted through saliva from a bite.²⁷⁷

269. *Id.* at 1270, 267 Cal. Rptr. at 675.

270. *Id.* at 1271-72, 267 Cal. Rptr. at 675 (quoting *Camara v. Municipal Court*, 387 U.S. 523, 530 (1967)).

271. *Id.* at 1284, 267 Cal. Rptr. at 684.

272. *Id.* at 1280, 267 Cal. Rptr. at 681.

273. *Id.* at 1277-78, 267 Cal. Rptr. at 679-80.

274. *Id.* at 1274-75, 267 Cal. Rptr. at 677-78. One of the cases petitioner relied on was *People v. Scott*, 21 Cal. 3d 284, 578 P.2d 123, 145 Cal. Rptr. 876 (1978), discussed *supra* note 235. *Johanna J.*, 218 Cal. App. 3d at 1274-75, 267 Cal. Rptr. at 677-78.

275. *Johanna J.*, 218 Cal. App. 3d at 1277-79, 267 Cal. Rptr. at 679-80.

276. *Id.* at 1278, 267 Cal. Rptr. at 679-80.

277. *Id.* at 1265-70, 267 Cal. Rptr. at 671-74. Although the risk of transmission was thought by all expert witnesses to be “‘remote,’” they felt it was best to “‘err on the side of caution’” because the disease is fatal. *Id.* at 1266, 267 Cal. Rptr. at 671 (quoting testimony of Dr. William Drew).

Johnetta J. was also unsuccessful in claiming a violation of her privacy rights under the California Constitution.²⁷⁸ While acknowledging her claim that this right is fundamental,²⁷⁹ the court noted that "the California right of privacy is 'not absolute' and may be subordinated to a compelling state interest."²⁸⁰ The court concluded that given the risks to public safety officers, the unique nature of AIDS, and the fact that medical experts could not rule out the possibility of transmission, the state's interest was sufficiently compelling to overcome the right of privacy against a minimal intrusion.²⁸¹

In other cases, plaintiffs have challenged the nonconsensual HIV testing permitted under the California Penal Code. Section 1202.6 of the Penal Code allows testing after repeat offenses by convicted prostitutes.²⁸² For example, in *Love v. Superior Court*,²⁸³ the petitioner contested the testing requirement of the statute on Fourth Amendment grounds.²⁸⁴ Relying heavily on the reasoning in *Johnetta J.*, the court found: "With the minimal intrusion of a blood test and the disclosure restrictions, . . . the Fourth Amendment balancing must be struck in favor of the testing requirement."²⁸⁵

Federal courts have also found that some circumstances may warrant mandatory testing. In *Local 1812, American Federation of Government Employees v. United States Department of State*,²⁸⁶ the D.C. District Court rejected the plaintiff's request for an injunction prohibiting AIDS testing as part of an overall physical health exam required of any person to be posted in a foreign nation.²⁸⁷ The court stated that such a policy was reasonably related to an individual's fitness for duty, consid-

278. *Id.* at 1283, 267 Cal. Rptr. at 683.

279. *Id.* at 1282-83, 267 Cal. Rptr. at 683.

280. *Id.* at 1283, 267 Cal. Rptr. at 683 (citing *Boler v. Superior Court*, 201 Cal. App. 3d 467, 473, 247 Cal. Rptr. 185, 188 (1987)).

281. *Id.*

282. CAL. PENAL CODE § 1202.6.

283. 226 Cal. App. 3d 736, 276 Cal. Rptr. 660 (1990).

284. *Id.* at 740, 276 Cal. Rptr. at 662. The statute was also challenged on due process and equal protection grounds, both of which were rejected by the California Court of Appeal. *Id.* at 746-47, 276 Cal. Rptr. at 666-67. The court found no due process violation because the statute provided for mandatory AIDS education, making possible the avoidance of an enhanced penalty for repeat offenses. *Id.* at 747, 276 Cal. Rptr. at 667. The equal protection claim was based on the fact that a similar statute requiring testing of violent sexual offenders contained provisions limiting disclosure of test results, but the statute under which *Love* was charged had no comparable restrictions. *Id.* The court dispensed with this contention by stating that the disclosure limitation applies with equal force to both statutes. *Id.*

285. *Id.* at 746, 276 Cal. Rptr. at 666.

286. 662 F. Supp. 50 (D.D.C. 1987).

287. *Id.* at 51-52, 55.

ering that many employees were to be sent to countries in which modern facilities would not be available to treat the inevitable medical complications of HIV infection.²⁸⁸ Although this case can be distinguished from *Johnetta J.* in that the HIV test in question did not require an intrusion into the body,²⁸⁹ the court found that it was not likely that the plaintiff's constitutional claims would succeed.²⁹⁰

Additionally, the court in *Plowman v. United States Department of the Army*²⁹¹ found "even stronger justifications for the additional HIV test."²⁹² In *Plowman*, the plaintiff was a civilian employee of the Army who was admitted to an Army hospital in South Korea after being injured in an off-duty altercation.²⁹³ His doctors ordered the HIV test without his consent as a precaution because surgery might be required.²⁹⁴ Under existing policy, active duty personnel received only prior notification of HIV testing; however, for civilian personnel the protocol required both notification and informed consent.²⁹⁵ The court stated: "The medical necessity of informing surgical personnel of a patient's HIV status might be sufficiently compelling to override plaintiff's privacy interests."²⁹⁶

A similar result was reached in *Virgin Islands v. Roberts*.²⁹⁷ A defendant in a rape case objected on Fourth Amendment grounds to having his blood taken for HIV testing.²⁹⁸ The court agreed with prior cases that the actual physical intrusion was minimal, but was concerned with the possible gravity of the harm to the defendant because of the nature of the test being performed.²⁹⁹ Like the California court in *Johnetta J.*, this court was satisfied that disclosure of the results would be limited to only the defendant, the victim, and the doctors, for purposes of medical treatment.³⁰⁰

288. *Id.* at 52-53.

289. Doctors had previously obtained the plaintiff's blood sample for other routine testing as part of the physical examination. *See id.* at 52.

290. *Id.* at 53.

291. 698 F. Supp. 627 (E.D. Va. 1988).

292. *Id.* at 637.

293. *Id.* at 629.

294. *Id.*

295. *Id.* at 629 n.5.

296. *Id.* at 637.

297. 756 F. Supp. 898 (D.V.I. 1991), *aff'd*, 961 F.2d 1567 (3d Cir. 1992).

298. *Id.* at 901.

299. *Id.* at 901-02.

300. *Id.* at 902.

Another federal court found privacy interests to be diminished in *Leckelt v. Board of Commissioners*.³⁰¹ The Fifth Circuit ruled that a hospital was justified in discharging an employee for failure to comply with a long-standing policy that required appropriate serological testing of any employee who had been exposed to an infectious disease.³⁰² Leckelt did not attempt to conceal the fact of his long-term relationship with a man who had died from AIDS.³⁰³ Although he previously had been tested voluntarily, he refused to give the results to hospital officials.³⁰⁴ The appellate court agreed with the district court's finding that "[the hospital's] infection control policies are rationally related to a legitimate state interest of protecting patients and health care workers from the spread of infectious or communicable diseases."³⁰⁵ The court also agreed that the district court was correct in finding that the "'defendants' interest in knowing plaintiff's health status far outweighed the limited intrusion of requiring him to produce the results of a test he had already taken voluntarily."³⁰⁶

The testing scheme in *Leckelt* can be distinguished from the one that was overturned by the Eighth Circuit in *Glover v. Eastern Nebraska Community Office of Retardation*;³⁰⁷ in fact, the *Leckelt* court made an effort to do so. *Glover* involved a government agency that provided services to the mentally retarded. The district court found that the agency could not establish any risk to the patients, which was characterized as "extremely low, approaching zero."³⁰⁸ There were documented reports of incidents of patient violence such as biting and scratching.³⁰⁹ However, the testing scheme was not targeted at individual exposure incidents, but rather at groups of employees in specific positions.³¹⁰ The *Leckelt* court noted that the mandatory testing at issue in *Glover* was

301. 909 F.2d 820 (5th Cir. 1990).

302. *Id.* at 833. Although the policy was not targeted specifically at HIV, the court agreed that it was broad enough in scope to encompass HIV testing. *Id.*

303. *Id.* at 826.

304. *Id.* at 824.

305. *Id.* at 832 (quoting *Leckelt v. Board of Comm'rs*, 714 F. Supp. 1377, 1390 (E.D. La. 1989)).

306. *Id.* (quoting *Leckelt v. Board of Comm'rs*, 714 F. Supp. 1377, 1392 (E.D. La. 1989)). Prior to the *Leckelt* incident, the hospital had tested one other HIV-exposed employee under the infection control policy. *Id.* at 826-27. This person, a nurse who suffered a contaminated needlestick, voluntarily submitted to testing. *Id.* at 827.

307. 867 F.2d 461 (8th Cir. 1988), *cert. denied*, 493 U.S. 932 (1989).

308. *Glover v. Eastern Neb. Community Office of Retardation*, 686 F. Supp. 243, 249 (D. Neb.), *aff'd*, 867 F.2d 461 (8th Cir. 1988), *cert. denied*, 493 U.S. 932 (1989).

309. *Id.* at 245-46.

310. *Id.* at 245.

much broader in scope than the one then under consideration.³¹¹ The defendant hospital in *Leckelt* only required testing of employees who were known to have been exposed to an infectious disease such as HIV (or, in *Leckelt's* situation, reporting results of testing already performed).³¹² The balancing test the *Glover* court employed concluded that the justification offered by the agency for testing all employees did not outweigh their constitutional right to be free from unreasonable searches.³¹³

To summarize, both California and federal courts have upheld compulsory HIV testing in limited circumstances. There is no doubt that such testing is a search under the Fourth Amendment; however, when a testing program is sufficiently narrowly tailored to target a specific risk situation and disclosure is restricted to purposes of medical treatment, the courts have had little difficulty permitting such testing.³¹⁴ The occupational protections available to public service employees under Proposition 96 fall within these parameters,³¹⁵ therefore extending similar protection to health care workers should be acceptable as well.

V. THE SPECTER OF WIDESPREAD MANDATORY HIV TESTING IN THE HEALTH CARE ENVIRONMENT

Suggesting that the occupational protections of Proposition 96 should be extended to health care workers does *not* mean that mass screening of either patients or health care workers is endorsed. The proposed testing should be limited to those situations in which there has been a *known exposure*—when there is an actual risk involved. Such narrowly tailored legislation would be unlikely to be overturned by a court if challenged. The holding in *Johnetta J.* supports this rationale.³¹⁶ One of the reasons the court upheld the compulsory HIV test at issue was because it was required by a “statute . . . narrowly drawn to respond to a serious state interest” instead of “a blanket testing requirement of entire

311. *Leckelt v. Board of Comm'rs*, 909 F.2d 820, 833 n.23 (5th Cir. 1990).

312. *Id.* at 833.

313. *Glover*, 686 F. Supp. at 250.

314. See *supra* notes 262-313 and accompanying text.

315. See *supra* notes 262-81 and accompanying text (discussing reasoning and holding of *Johnetta J. v. Municipal Court*, 218 Cal. App. 3d 1255, 267 Cal. Rptr. 666 (1990)).

316. See *Johnetta J. v. Municipal Court*, 218 Cal. App. 3d 1255, 1284, 267 Cal. Rptr. 666, 684 (1990).

classes of persons."³¹⁷ This is precisely why the mandatory testing scheme at issue in *Glover*³¹⁸ did *not* pass constitutional muster.³¹⁹

Mass screening of patients to protect health care workers is usually not desirable for a variety of reasons.³²⁰ First, it diverts scarce health care resources into activity that produces few useful results, because knowing the HIV status of a patient in advance has no bearing on whether or not there will be an *exposure*. If universal precautions are followed and all patients are presumed infectious to start with, nothing more can be done to protect health care workers.³²¹ Second, the prospect of undergoing compulsory AIDS testing when seeking treatment for an unrelated condition may cause some patients to refrain from obtaining needed care. Third, collection of massive amounts of data on the HIV status of patients will make it much more difficult to keep the information confidential, in spite of best efforts.³²² Finally, in low prevalence areas "the predictive value of a positive result of any individual test is low, because the few positive test results that occur will contain some false positives. Thus, the percentage of false positives in a low prevalence community will be much higher than in a high prevalence community."³²³

317. *Id.*

318. 867 F.2d 461 (8th Cir. 1988), *cert. denied*, 493 U.S. 932 (1989).

319. *Id.* at 464.

320. The CDC now recommends that hospitals with high caseloads of AIDS patients offer HIV testing to *all* emergency room patients and admissions on a voluntary basis. CENTERS FOR DISEASE CONTROL, *Recommendations for HIV Testing Services for Inpatients and Outpatients in Acute-Care Hospital Settings*, 42 MORBIDITY & MORTALITY WKLY. REP. 157, 158 (1993). The rationale for this new recommendation is that screening will enable more individuals at risk to obtain life-prolonging early treatment. *Id.* at 157-58; *see also* Associated Press, *Voluntary Test for HIV Urged at Hospitals*, L.A. DAILY NEWS, Mar. 5, 1993, at 13 (describing CDC recommendations for HIV screening). *But see* Altman, *supra* note 224 (reporting results of Concorde study showing evidence of ineffectiveness of early AZT treatment).

321. However, some of the new safety standards may not be practical in all situations. *See* Lois M. Bruning, *The Bloodborne Pathogens Final Rule: Understanding the Regulation*, 57 AORN J. 439, 449 (1993). This is because in an unexpected medical emergency, a health care worker may feel there is no time to don protective equipment. *Id.* It is also recognized that the type and characteristics of personal protective equipment used often depends on the nature of the task to be performed. *Recommended Practices: Universal Precautions in the Perioperative Practice Setting*, 57 AORN J. 554, 554 (1993). For example, eye protection and face shields are recommended protective equipment for all operating room personnel; however, doctors who perform surgery using a microscope or endoscope cannot don protective eyewear because this would compromise visual acuity. Terence M. Davidson & Bruce Stabile, *Acquired Immunodeficiency Syndrome Precautions for Otolaryngology—Head and Neck Surgery*, 117 ARCHIVES—OTOLARYNGOLOGY—HEAD & NECK SURGERY 1343, 1343 (1991).

322. Larry Gostin, *Hospitals, Health Care Professionals, and AIDS*, 48 MD. L. REV. 12, 46 (1989).

323. *Glover v. Eastern Neb. Community Office of Retardation*, 686 F. Supp. 243, 248 (D. Neb.), *aff'd*, 867 F.2d 461 (8th Cir. 1988), *cert. denied*, 493 U.S. 932 (1989); *see also* Furrow,

VI. CONCLUSION

Because of its early association with traditionally unpopular groups, AIDS has become a politically charged issue.³²⁴ Despite massive educational campaigns to generate public awareness and compassion, discrimination against HIV-infected persons is still prevalent.³²⁵ For example, as recently as 1991 a citizens group in California attempted to introduce an initiative that would repeal city ordinances expressing concern about discrimination against homosexuals and HIV-infected individuals.³²⁶ This measure also would have required any future city ordinances dealing with either homosexuality or AIDS to be submitted to the voters for approval.³²⁷

The problem for legislators and the courts has been to protect the rights of the individual while at the same time recognizing a need to deal with a lethal epidemic in an expeditious and humane manner. As one court phrased it:

AIDS is a fatal, infectious disease; it is not a political or constitutional status. AIDS does not, therefore, confer on its victims any greater constitutional rights than are possessed by victims of other infectious or fatal maladies, such as herpes, tuberculosis, or cancer. By the same token, AIDS victims do not forfeit any constitutional rights by virtue of their AIDS status.³²⁸

In the face of unwarranted discriminatory practices against AIDS and HIV-positive persons, the legislature and the courts have acted affirmatively to preserve these individuals' rights.³²⁹ However, in its zeal to protect some groups, the legislature has shifted the legal burdens to health care workers.

supra note 11, at 839 (describing how false positive tests in low incidence communities constitute higher proportion of total positives).

324. *See, e.g.*, 137 CONG. REC. S10,331-50 (daily ed. July 18, 1991) (continuing debate over mandatory HIV testing of health care workers); 137 CONG. REC. S9778-96 (daily ed. July 11, 1991) (debate over legislative proposals to require HIV testing of health care workers); FLANDERS & FLANDERS, *supra* note 1, at 41-44 (describing political debate over government role in AIDS crisis). *See generally* SHILTS, *supra* note 1 (relating political reaction during early days of AIDS epidemic).

325. Dunlap, *supra* note 57, at 913-17 (describing discriminatory practices directed at HIV-infected individuals).

326. *See* Citizens for Responsible Behavior v. Superior Court, 1 Cal. App. 4th 1013, 2 Cal. Rptr. 2d 648 (1991).

327. *Id.* at 1019-20, 2 Cal. Rptr. 2d at 650-51. The court held that the initiative was unconstitutional on equal protection grounds because it was not rationally related to an important state interest. *Id.* at 1026-27, 2 Cal. Rptr. 2d at 655-56.

328. Plowman v. United States Dep't of the Army, 698 F. Supp. 627, 632 n.20 (E.D. Va. 1988).

329. *See supra* part II.C.1-2.

Currently, the risk of HIV seroconversion from a single contaminated needlestick is estimated to be approximately 0.4%.³³⁰ Health care professionals are expected to bear this risk which, although low, represents the chance of becoming infected with an incurable and lethal disease. In the face of an ethical and legal duty to provide care, it is time that the burdens be more equitably balanced between the health care worker and the potentially infected patient. The California Legislature should extend the legal protections now offered to public safety and custodial employees under Proposition 96 to *all* persons whose occupations put them at risk of exposure to blood or body fluids.

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330. FLANDERS & FLANDERS, *supra* note 1, at 20; Charles E. Becker et al., *Occupational Infection with HIV: Risks and Risk Reduction*, 110 ANNALS INTERNAL MED. 653, 653 (1989). However, the risk of exposure to HIV-contaminated blood and subsequent seroconversion may be significantly greater for some medical practitioners. For example, surgeons are involved in a high number of blood-contact incidents, especially those surgeons who perform trauma, orthopedic and burn procedures. Adelisa L. Panlillo et al., *Blood Contacts During Surgical Procedures*, 265 JAMA 1533, 1535 (1991). This is because these procedures often involve substantial patient blood loss, as well as longer periods in the operating room. *Id.* at 1536. Therefore, it is particularly important for these physicians to observe appropriate barrier precautions. *See id.*

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