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Ziyad I. Naccasha

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THE PERMISSIBILITY OF ROUTINE AIDS TESTING IN THE HEALTH CARE CONTEXT

ZIYAD I. NACCASHA*

Doctors should be able to require testing for the human immunodeficiency virus (HIV), AIDS-related complex (ARC), or Acquired Immune Deficiency Syndrome (AIDS) virus before their patients undergo a non-emergency,¹ invasive procedure or surgery:² a procedure where the risk of exposure to blood is present. The test's result will give doctors the necessary information about each patient in order to determine whether to accept the patient or to refer him or her to other doctors. The test's result will also apprise hospital staff of the potential risks involved in treating a particular patient. Moreover, the result will allow a patient to know whether he or she is infected, any risks involved, and any treatments available. The purpose of this student article is to demonstrate that health care providers ought to be afforded the opportunity to test patients, so long as they do so with a narrow purpose which has neither the intent nor the effect of discriminating against the individual.

In the first part of this student article I provide a breakdown of the disease, a current statistical analysis, and an identification of the high risk groups. In the second part I analyze the tests currently available in terms of cost, time factor, and predictive value. I also analyze the historical treatment of epidemics by doctors in conjunction with a study of ethical codes of conduct. I then attempt to identify the policy and rationale behind granting doctors discretion in requiring routine testing. Because the ultimate goal is to demonstrate the need for routine testing, I analyze Section 504 of the Rehabilitation Act to ascertain whether public hospitals are allowed, or

* B.S. 1987, California Polytechnic State University, San Luis Obispo; J.D. 1990, University of Notre Dame; Thos. J. White Scholar, 1988-90. I would like to dedicate this student article to my parents, Ibrahim and Batoul Naccasha.

1. Non-emergency because if treatment were conditioned on submitting to a test in an emergency situation and the patient refuses or cannot consent then that patient will be refused treatment where there is a legally recognized duty on the part of the doctor to treat. See *infra*, Emergency rule, notes 121 to 127 and accompanying text.

2. Invasive because these procedures present the greatest amount of risk in terms of exposure to bodily fluids to doctors and their staff.

should be allowed to require testing. Finally, I address confidentiality concerns of those who test positively for the virus.

I. THE AIDS VIRUS

AIDS is a deadly and currently incurable disease. It afflicts groups traditionally subjected to stigma and discrimination and has the potential to afflict, exponentially, not only those groups considered at risk, but a significant number of others, who are not currently in the AIDS risk pool.

The Centers for Disease Control (CDC) define AIDS as "a disease, at least moderately predictive of a defect in cell-mediated immunity, occurring in a person with no known cause for diminished resistance for that disease."³ The illness manifests itself in several forms. The forms currently recognized are a chronic pneumonia called pneumocystis carinii pneumonia (PCP),⁴ a rare cancer called Kaposi's Sarcoma (KS),⁵ opportunistic infections,⁶ and dementia.⁷ The several routes that the

3. *Update on Acquired Immune Deficiency Syndrome (AIDS) - United States*, 31 CENTERS FOR DISEASE CONTROL: MORBIDITY AND MORTALITY WEEKLY REP. 507-08 (1982). The case definition of AIDS was narrowed by a 1985 revision. *Id.* vol. 34, at 373 (1985). Some argue that owing to this revision of the case definition of AIDS, the CDC's surveys are flawed because of the definition's failure to encompass a number of persons having various forms of the disease who would be otherwise reportable under the preceding definition. Leonard, *Employment Discrimination Against Persons with AIDS*, 10 U. DAYTON L. REV. 681, 688 n.32 (1985). The case definition was again revised in 1987. *Revision of the CDC Surveillance Case Definition for Acquired Immune Deficiency Syndrome*, 36 CENTERS FOR DISEASE CONTROL: MORBIDITY AND MORTALITY WEEKLY REP. 1S (1987). This definition, which is currently followed, includes a broader spectrum of diseases characteristically found in persons with HIV infection.

4. PCP is an infection of the lungs caused by the microorganism pneumocystis carinii. The type of pneumonia the parasite causes is pneumocystis pneumonia, an opportunistic infection that is dangerous only to those with an impaired immunity system. Symptoms include fever, dry cough, as well as shortness of breath. THE AMERICAN MEDICAL ASSOCIATION ENCYCLOPEDIA OF MEDICINE 803 (1989).

5. KS is a condition that is characterized by malignant skin tumors and which is one of the prominent problems associated with AIDS. The tumors spread throughout the person's skin, and may affect the gastrointestinal and respiratory tracts. *Id.* at 614.

6. Opportunistic infections are caused by organisms that do not usually cause disease in healthy people. There might also be widespread infection by organisms that ordinarily produce only mild infection. While the organisms which cause the various infections are generally present in the body, the organisms only cause disease when the host's immune system is impaired. *Id.* at 745-46.

7. Dementia is a general decline in all areas of mental ability which usually results from brain disease, and which is progressive. A person with dementia may have difficulty remembering recent events, may easily become

disease may take are not mutually exclusive.⁸ What appear to be common to infected individuals are the symptoms that manifest themselves when the virus is first introduced into the body.⁹ These symptoms include night sweats, chronic diarrhea, fevers, and weight loss, often associated with an enlargement of the lymph nodes (lymphadenopathy).¹⁰ Normally, those infected are asymptomatic for a certain period during which their immune systems slowly and then exponentially deteriorate.¹¹

At the point of infection, for a variable amount of time, the victims of the disease will be asymptomatic, and no outward signs of infection will appear. At this time, the victim will not test positive. Indeed, being exposed to the virus does not necessarily mean infection, but it can, and it does, yearly, in between one to five percent of those people infected with HIV.¹² After this incubation period, infected individuals may suffer from an array of symptoms. Some develop KS, which primarily afflicts homosexual men and is a leading complication of the AIDS virus. Other victims develop PCP. Other infected individuals will suffer from extreme opportunistic infections that may include encephalitis¹³ and meningitis.¹⁴ And, still others, over time, develop confusion and neurologic degeneration or dementia.¹⁵

lost in what once was familiar, and may fail to grasp what is going on. *Id.* at 339.

8. *Id.* at 78-79. Infected individuals may have no symptom; others experience short-lived, vague illnesses, and others proceed to full-blown AIDS. These diseases may occur sequentially, or they can coexist.

9. M. SANDE & P. VOLBERDING, *THE MEDICAL MANAGEMENT OF AIDS* 75, 76 (1988).

10. *Id.*

11. *Sexually Transmitted Diseases Treatment Guidelines*, 38 CENTERS FOR DISEASE CONTROL: MORBIDITY AND MORTALITY WEEKLY REP. 1 (Supp. S-8) (1989).

12. THE AMERICAN MEDICAL ASSOCIATION *ENCYCLOPEDIA OF MEDICINE* 76 (1989).

13. Encephalitis is an inflammation of the brain, usually caused by a viral infection. The symptoms for this disease are capable of progressing to the point where the person suffers from hallucinations, confusion, paralysis of one side of the body, a coma, or epileptic seizures. *Id.* at 400-01.

14. Meningitis is an inflammation of the membranes that covers the brain and spinal cord, that results from infection from a variety of microorganisms. *Id.* at 675. For a list of the different types of opportunistic infections see *Update on Acquired Immune Deficiency Syndrome (AIDS) — United States*, 31 CENTERS FOR DISEASE CONTROL: MORBIDITY AND MORTALITY WEEKLY REP. 507-08 (1982).

15. *See supra*, note 5.

By whatever course the disease takes, those who progress to the point of full-blown AIDS suffer from such a breakdown in their immune systems that they will inevitably find themselves in a relentless downhill spiral, for which the consequence can only be certain and painful death.¹⁶

The disease progresses through a continuum of conditions: (1) infection with HIV;¹⁷ (2) "acute, transient, mononucleosis-like syndrome associated with seroconversion;"¹⁸ (3) asymptomatic HIV infection;¹⁹ (4) symptomatic HIV infection;²⁰ and (5) full-blown AIDS.²¹

Since medical science identified the disease in 1981,²² AIDS has had a stinging effect on society. Sexually promiscuous male homosexuals or bisexuals have been, and are, at greatest risk and account for 63 percent of all AIDS cases.²³ The disease also afflicts intravenous drug users,²⁴ recipients of infected blood,²⁵ heterosexuals who have intimate sexual contact with infected bisexuals or with infected drug users,²⁶

16. *AIDS and Human Immunodeficiency Virus Infection in the U.S.: 1988 Update*, 38 CENTERS FOR DISEASE CONTROL: MORBIDITY AND MORTALITY WEEKLY REP. 3 (Supp. S-4) (1989).

17. NATIONAL ACADEMY OF SCIENCES, CONFRONTING AIDS: UPDATE 1988 37 (1988).

18. *Id.*

19. *Id.*

20. *Id.*

21. *Id.* Generally, this student article will use the terms "AIDS carriers" or "infected individuals" to refer to persons at all stages who are infected with and can transmit the virus.

22. In June, 1981 the Centers for Disease Control reported a deadly form of pneumonia, pneumocystis carinii pneumonia (PCP) in five homosexuals in the Los Angeles area. *Pneumocystis Pneumonia-Los Angeles*, 30 CENTERS FOR DISEASE CONTROL: MORBIDITY AND MORTALITY WEEKLY REP. 250-51 (1981). Approximately a month later, ten more cases of PCP were discovered in homosexual men in the New York area. Simultaneously, the CDC reported an increasing number of homosexuals suffering from a rare form of cancer, Kaposi's Sarcoma (KS). *Kaposi's Sarcoma and Pneumocystis Pneumonia Among Homosexual Men — New York City and California*, 30 CENTERS FOR DISEASE CONTROL: MORBIDITY AND MORTALITY WEEKLY REP. 305 (1981). PCP and KS are the leading causes of death for infected individuals.

23. *AIDS and Human Immunodeficiency Virus Infection in the United States: 1988 Update*, 38 CENTERS FOR DISEASE CONTROL: MORBIDITY AND MORTALITY WEEKLY REP. 7, 17 (Supp. S-4) (1989).

24. *Id.* Twenty percent of infected males and fifty-seven percent of infected females have contracted AIDS as a result of intravenous drug abuse.

25. *Id.* Two percent of infected males and ten percent of infected females have contracted AIDS by receiving infected blood.

26. *Id.* One percent of infected males and twenty-six percent of infected females have contracted AIDS by having intimate sexual contact with infected bisexuals or with infected intravenous drug abusers.

hemophiliacs,²⁷ and children born to infected mothers, who account for two percent of the AIDS population.²⁸ The number and percentage of people not in these groups and who are infected with AIDS is minuscule.²⁹

As of March 31, 1989, 89,501 cases of AIDS had been reported to the CDC.³⁰ The CDC estimated that, currently, between 1 - 1.5 million people are HIV seropositive.³¹ 46,000 people have died thus far from the disease.³² By 1992, 365,000 are projected to have AIDS and 263,000 will have died from AIDS-related causes.³³

The disease is currently incurable, but the drug Zidovudine (previously known as AZT), if administered early (at the first sign of infection), inhibits the reproduction of the AIDS virus in the body cells of persons suffering from PCP.³⁴ The Federal Drug Administration (FDA) has also approved alpha interferon in November of 1988,³⁵ a drug specifically developed for treating KS.³⁶ Other drugs have also been developed or are at the development stage which help victims of AIDS deal with their symptoms, if the infected individual is treated at the first sign of each new symptom.³⁷

Infected individuals may, at some point, consult a doctor for an injury or illness related to the AIDS virus or for one wholly unrelated to the virus. This doctor-patient juncture is precisely where this student article's focus lies. Once the per-

27. *Id.* One percent of the AIDS population are hemophiliacs.

28. *Id.* at 2.

29. These statistics, as is the scope of this student article, are limited to the United States.

30. *Update: Heterosexual Transmission of AIDS and HIV Infection — United States*, 38 CENTERS FOR DISEASE CONTROL: MORBIDITY AND MORTALITY WEEKLY REP. 424 (1989).

31. *Id.*

32. *Id.*

33. *Id.* The actual number of deaths may be lower than estimated depending on the success of new treatments for the virus.

34. While zidovudine does not cure the conditions an infected individual suffers from, it can improve symptoms or prolong remission. Zidovudine blocks the action of the enzyme which stimulates the AIDS virus to grow and multiply. It improves the efficiency of the immune system, making the occurrence of *opportunistic infections* less likely. THE AMERICAN MEDICAL ASSOCIATION ENCYCLOPEDIA OF MEDICINE 1087 (1989).

35. N.Y. Times, Nov. 22, 1988, at 21.

36. N.Y. Times, Dec. 3, 1989, § 4, at 6, col. 4.

37. Freundlich & Silver, *There's No Magic Bullet, But A Shotgun Approach May Work*, BUS. WEEK, Sept. 11, 1989, at 118. For a brief discussion of some of the experimental drugs, including aerosol pentamidine, ganciclovir, and erythropoietin, see, Garrett, *AIDS; Treatment: The State of the Art*, NEWSDAY, Aug. 29, 1989, at 8.

son has consulted a physician, that physician has discretion whether to treat the patient, to refuse treatment, to refer the patient to another physician, or to condition treatment on an AIDS test. This discretion is legally,³⁸ as well as ethically limited.³⁹ This student article argues that a physician should not refuse to treat a person merely on the basis of that person's status as an infected individual.⁴⁰ However the physician should be allowed to condition treatment on an AIDS test.

II. THE TESTS USED TO DETECT AIDS INFECTION

Currently, three tests are used to screen for the AIDS antibodies:⁴¹ the enzyme-linked immunoabsorbent assay (ELISA), the Western Blot (WB), and the immunofluorescence assay (IFA). The ELISA is the most commonly used test.⁴² It takes four hours if performed in-house, and costs anywhere from ten to twenty dollars. The WB and IFA are both highly interpretive (inference reliant) and, therefore, more time consuming (three days) and expensive (fifty to one hundred dollars) tests.⁴³

38. Private practitioners may legally refuse treatment (emergencies and ongoing relationships excepted) for any reason—whereas a physician employed by a public hospital, a health maintenance organization (HMO), or a private hospital with Hill-Burton or other federal funds may have a limited discretionary role. See *infra* notes 164 to 176 and accompanying text.

39. A wholly independent ethical obligation exists irrespective of the public/private characterization of a physician and will be discussed and developed throughout this student article.

40. Indeed, the American Medical Association has come to accept this notion. See *infra* notes 105 to 106 and accompanying text.

41. A new test, Recombigen HIV-1 Latex Agglutination, was approved by the FDA on December 14, 1988. N.Y. Times, Dec. 14, 1988, at 16, col. 6. The test takes five minutes to perform, and costs ten dollars. While the new test costs less and takes less time, its results are no more accurate than those of other tests currently available. The aim of this student article is to demonstrate that testing can be required in some situations, and performed in a non-discriminatory manner. Although the new test is faster and less costly than the other tests mentioned, because it is not more accurate than the others it will not be discussed in this article. For a discussion of the latex agglutination test, see Quinn, Riggan, Kline, Francis, Mulanga, Sension, & Fauci, *Rapid Latex Agglutination Assay Using Recombinant Envelope Polypeptide for the Detection of Antibody to the HIV*, 260 J. A.M.A. 510 (1988).

42. *Interpretation and Use of the Western Blot Assay for Serodiagnosis of Human Immunodeficiency Virus Type I Infections*, 38 CENTERS FOR DISEASE CONTROL: MORBIDITY AND MORTALITY WEEKLY REP. 1 (Supp. S-7) (1989).

43. *Update: Serologic Testing for Antibody to Human Immunodeficiency Virus*, 36 CENTERS FOR DISEASE CONTROL: MORBIDITY AND MORTALITY WEEKLY REP. 833-34 (1988).

Factors used to determine whether a test is functioning properly are the test's sensitivity and specificity. Sensitivity is the degree to which a test yields accurate positive results.⁴⁴ Specificity is the degree to which a test yields accurate negative results.⁴⁵ The tests are not infallible, but are generally accurate in predicting the presence or absence of the AIDS antibodies.⁴⁶

According to a recent sample study,⁴⁷ the three licensed tests (ELISA, WB, and IFA) have respective sensitivity and specificity percentages of 93.4 and 99.8, 99.6 and 99.2, and 98.9 and 99.6.⁴⁸ This evidence suggests that, relative to laboratory tests in general, the ELISA has a very high sensitivity and specificity level,⁴⁹ and thus, provides a relatively accurate assessment of the infectious-status of the individual being tested.

Nevertheless, the ELISA's predictive value and usefulness are not as high as that of the other tests.⁵⁰ Therefore, if a person tests positive on an ELISA test, that person is given (at the physician's discretion) a different test to ensure the predictive value of the results. The following testing progression is common: if patients test negative on the ELISA, they are not tested further; if they test positive, the ELISA is repeated; if they again test positive, they are given the WB or the IFA (the norm is to give the WB).⁵¹ This progression testing is more accurate and is, thus far, the best way to verify the validity of a positive ELISA result. Because the tests administered in progression testing are independent in terms of both their predictive value and the manner in which their results are interpreted, one can reasonably assume that the errors of the WB are mutually exclusive of those of the ELISA.⁵² The costs and time associated with sequence testing are those resulting from the administration of the tests. Sequence testing does not require additional blood samples or patient time.

The failure of the tests to do what they purport to do is measured by the ratio of false positives (falsely identifying one

44. Howe, *Why Mandatory Screening for AIDS is a Very Bad Idea*, in C. PIERCE & D. VAN DE VEER, *AIDS AND PUBLIC POLICY* 142 (1988).

45. *Id.*

46. *Id.*

47. Petricciani, *Licensed Tests for Antibody to Human T — Lymphotropic Virus Type III*, 103 *ANNALS OF INTERNAL MED.* 726-29 (1985).

48. *Id.* at 729.

49. Howe, *supra* note 44, at 143.

50. *See supra* note 47.

51. Howe, *supra* note 44, at 140-41.

52. *See supra* note 47.

as seropositive), and the ratio of false negatives (falsely identifying one as being free of seropositivity). This margin of error can be dramatically reduced by using progression testing. Doctors may avoid this time consuming and expensive consequence by basing their judgments on the ELISA alone, or by not testing. The possibility of either false positive or false negative results is an obvious burden to those undergoing a test, and it is a reason for resisting such tests frequently cited by opponents of routine testing.

Aside from sequence testing, a way to increase the reliability of a given test is to first determine the status⁵³ of the individual being tested. This initial step is useful because the reliability of the results depends on whether one is testing high-or low-risk groups, where "high" or "low" refer to the prevalence of the AIDS virus in the group being tested. For example, testing high-risk individuals, such as sexually active and promiscuous homosexual males or intravenous drug users, increases the predictive value of positive test results because of the relatively high prevalence of AIDS infections within these populations.⁵⁴ The predictive value of negative results in testing high risk groups, however, will be adversely affected because high prevalence means a greater likelihood of false negatives.⁵⁵ Another method to improve the accuracy of the test would be to repeat the ELISA if a patient tests negative and, if a doctor still doubts the validity of a test, to perform a WB or IFA. These considerations are costly because of the repetition of testing, and may be unnecessary.

In testing low-risk individuals, the predictive value of negative results increases relative to testing high-risk individuals, whereas the predictive value of positive test results are decreased. Similar to testing high risk groups, sequence testing can increase the predictive value of positive or negative test results when testing low-risk individuals.⁵⁶

In brief, to determine whether a test is practical and serves its intended purpose, several factors must be considered. Those discussed have included the cost, the time factor and, most importantly, the predictive value of the test.⁵⁷ To

53. See HOWE, *supra* note 44, at 144. Status in this context refers to whether the individual resides in a high risk area for the disease or is a member of a high-risk group.

54. See *supra* notes 21-27 and accompanying text.

55. Howe, *supra* note 44, at 144.

56. *Id.*

57. Of course, other important factors such as, what will be done with the test results by (a) doctors, (b) patients, and (c) the rest of us, are to be

increase the predictive value, the cost and the time involved must be increased simultaneously. These increased costs may be worthwhile for one group of doctors and unnecessary for another group.⁵⁸ The subjective need for this increased cost of medical care resulting from testing, and the predictive value of the tests themselves are issues which are hotly debated.⁵⁹ Competition, in terms of medical costs, may also dictate the feasibility of testing. If Doctor A required testing and Doctor B did not, all other things being equal, Doctor A's services will be more costly and less likely to attract business. While doctors may base their decisions with respect to how to treat their patients upon the results of one of the AIDS tests, patients should be apprised of their status, counselled, and encouraged to undergo additional testing to verify or refute the results.

The next section discusses the history of physicians' willingness to treat during epidemics and a study of ethical codes of conduct relative to a doctor's obligation to treat patients.

III. GRANTING DOCTORS DISCRETION IN REQUIRING ROUTINE TESTING

The onset of AIDS as an epidemic and its attendant problems has stimulated an interest in how the medical profession has previously confronted epidemics.⁶⁰ Professor Daniel Fox addressed two concerns relating to the historical treatment of epidemics by the medical profession: how the medical profession collectively reacted towards patients with communicable diseases, and how public policy affected that behavior.⁶¹ Professor Fox reported that "[d]espite enormous changes in the practice of medicine and the social position of doctors over the past five hundred years, there has been remarkable continuity in how the profession has responded to the threat of contagion."⁶² While physicians appeared to have treated most

considered. These and other confidentiality concerns are discussed *infra* at notes 78 to 89 and accompanying text.

58. For example, those doctors practicing in low risk geographic areas.

59. Wash. Post, Mar. 7, 1988, at C1; N.Y. Times, July 23, 1989, § 1, pt. 1, at 28, col. 4. See also, Woodward, *Debate is on Over Treatment of AIDS Poor*, NEWSDAY, May 22, 1989, at 6 ("Gay activists increasingly are adopting a protesting stance, deciding that the risk of discrimination is outweighed by the benefits of early intervention.")

60. Fox, *The Politics of Physician's Responsibility in Epidemics: A Note on History*, 18 HASTINGS CENTER REP. (SPECIAL SUPPLEMENT), April/May 1988, at 5.

61. *Id.* While the differences between general and sexual communicability are great, they are not pertinent to this discussion.

62. *Id.*; see also Amundsen, *Medical Deontology and Pestilential Disease in the*

of their patients, records illustrate many physicians fled their cities in times of pestilence.⁶³ While evidence of abandonment by physicians is noteworthy, such evidence says nothing definitive about whether such conduct violated prevailing ethical norms, or the reasons for abandonment.⁶⁴

Throughout history, two themes have stood out as providing incentives to the medical profession to treat patients: negotiation and opportunity.⁶⁵ Negotiation occurred between civic leaders and the medical profession as to who would treat those diseased. Opportunity, in terms of fame and fortune, accrued to physicians during times of plague — as did risk.⁶⁶

Today, while a number of physicians are refusing to treat AIDS-infected individuals,⁶⁷ leaders of the medical profession, and medical associations such as the American Medical Association (AMA) have promulgated policies aimed at increasing treatment.⁶⁸ Also, today's AIDS doctors, descendants of the plague doctors, are rewarded with income, as well as greater access to available research funds and academic status.⁶⁹

Whether negotiation is occurring and opportunities are accruing to doctors in the AIDS Era to the extent they did historically is yet to be seen because of the currency of the disease.

IV. LEGAL JUSTIFICATIONS FOR ROUTINE TESTING

The Supreme Court, when confronted with rights of privacy issues, has held that a right to privacy encompasses both a general "individual interest in avoiding disclosure of personal matters," and an "interest in independence in making certain

Late Middle Ages, 32 J. OF THE HIST. OF MED. & ALLIED SCI. 403-21 (1977); Loewy, *Duties, Fears and Physicians*, 12 SOC. SCI. & MED. 1363-66 (1986); Zuger & Miles, *Physicians, AIDS and Occupational Risk: Historic Traditions & Ethical Obligations*, 258 J. A.M.A. 1924-28 (1987).

63. See Fox, *supra* note 60.

64. *Id.* at 5. Abandonment may have been justified at the time simply because the current medicine at that time was powerless against a particular disease.

65. *Id.*

66. *Id.*

67. *Id.* at 9. See also N.Y. Times, Apr. 23, 1990, at 1; N.Y. Times, Mar. 13, 1987, at 11.

68. See discussion on AMA's role, *infra* notes 100 to 106 and accompanying text.

69. See Fox, *supra*, note 60, at 9. But see Arras, *The Fragile Web of Responsibility: AIDS and the Duty to Treat*, 18 HASTINGS CENTER REP. (SPECIAL SUPPLEMENT), April/May 1988, at 18, arguing that, because of fears of the disease, some people are unlikely to praise physicians for steadfastly treating infected individuals.

kinds of important decisions.”⁷⁰ A regulation regarding AIDS-infected persons affects both the controlling of the disease and the confidentiality of those who test positive when the regulation seeks to identify AIDS carriers or to control AIDS-infected persons, in terms of their sexual activities or their freedom of movement. Any regulation seeking to infringe upon the privacy rights of an individual must be able to withstand constitutional scrutiny by the courts.

Opponents to routine testing argue that a legislative grant of discretion allowing doctors to routinely test their patients would need to meet the strict scrutiny standard,⁷¹ because testing a patient invades protected, fundamental rights. In order to meet this test, the state, in enacting legislation, needs compelling evidence to prove that the legislation is narrowly tailored to promote a compelling state interest, and that the chosen action is the least restrictive alternative.⁷² Because of the inherent intrusion of testing, the legislation will need to go beyond the minimum rationality test, which presumes that legislation is valid unless it is not at least reasonably related to an appropriate government regulation.⁷³ The legislation regarding routine testing should measure up to a heightened scrutiny, an intermediate level of scrutiny which requires that legislation pertaining to a certain quasi-suspect class, or impairing important, as opposed to fundamental, rights be substantially related to an important state interest.⁷⁴

Routine testing, analyzed under a constitutional lens must meet the requirements of heightened scrutiny. Furthermore, the laws promulgated for such testing must also be narrowly construed because, although blood testing is a relatively minor personal intrusion,⁷⁵ testing nevertheless infringes the individ-

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

71. See Note, *The Constitutional Rights of AIDS Carriers*, 99 HARV. L. REV. 1274, 1287-89 (1986) (Because “‘AIDS, or a suspicion of AIDS, can lead to discrimination in employment, education, housing and even medical treatment’ . . . [n]othing short of compelling necessity can justify forcing individuals to submit to blood tests that might cause such personal anguish.”) (quoting *South Fla. Blood Serv., Inc. v. Rasmussen*, 467 So. 2d 798, 802 (Fla. Dist. Ct. App. 1985)).

72. *Dunn v. Blumstein*, 405 U.S. 330, 343 (1972).

73. See *Miller v. Wilson*, 236 U.S. 373, 380 (1915).

74. See, e.g., *Craig v. Boren*, 429 U.S. 190, 197 (1976) (holding that gender classification qualified as a quasi-suspect class). The class sought to be protected by the government, in this context, those people who are infected with AIDS or those suspected of being infected, must be identified as a “discrete and insular minority” as outlined in *United States v. Carolene Prods.*, 304 U.S. 144, 152 n.4 (1938).

75. *Schmerber v. State of Cal.*, 384 U.S. 757 (1966) (while a compelled

ual's protected privacy "interest in avoiding disclosure of personal matters."⁷⁶ A compelling purpose is needed to justify requiring an individual to submit to an AIDS test. This is especially true where the results may cause extreme personal anxiety, as is true in this situation. Such a routine testing requirement would need to have a close nexus with public health or safety which would justify the measure.

In most day to day interactions, a routine testing requirement is not justifiable for the simple reason that AIDS is not spread by casual contact,⁷⁷ but by sexual contact, I.V. needle sharing, and by perinatal, or other exchange or contact with blood. In the health care context, where a procedure exists that is risky (in terms of a possibility of transferring blood), the nexus to health and safety could be met and a regulation could be narrow enough so as not to be overinclusive. Because a doctor choosing to test might be routinely testing all patients, the regulation appears overinclusive. But inasmuch as the doctor is testing for a valid purpose and testing only those undergoing a nonemergency, invasive procedure (a narrow or limited purpose), a proposed regulation incorporating this narrow purpose may well meet the strict scrutiny standard.

V. CONFIDENTIALITY CONCERNS

The right of privacy also extends to the confidentiality concerns of a given patient. What a doctor will do with the information that a given patient has tested positive will be as important a privacy concern to the patient as will the test itself. Many regulations have been proposed in this area from one extreme, taking away all the privacy of an AIDS patient,⁷⁸ to the other, allowing an AIDS patient to have absolute confidentiality.⁷⁹ The same confidentiality concerns are present for reporting requirements as those for routine testing, but to a lesser

intrusion into the body for blood to be analyzed for alcohol content is deemed a Fourth Amendment search, the search is warranted because of the compelling government interest).

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

77. Gostin & Curran, *Legal Control Measures for AIDS: Reporting Requirements, Surveillance, Quarantine, and Regulation of Public Meeting Places*, 77 AM. J. PUB. HEALTH 214, 216 (1987); *Recommendations for Preventing Transmission of Infection with Human T-lymphotropic Virus Type III/Lymphadenopathy-associated Virus in the Workplace*, 34 CENTERS FOR DISEASE CONTROL: MORBIDITY AND MORTALITY WEEKLY REP. 682-95 (1985).

78. BOSTON GLOBE, Sept. 25, 1985, at 9 (isolation of AIDS carriers reportedly favored by 42 percent of the public).

79. See, e.g., CAL. HEALTH & SAFETY CODE, § 199.33 (West 1986); 1986 Mass. Acts 241.

degree because of the obvious link to public health and safety where reporting is done only to the proper authorities.

Doctors are limited in what they can do with information about the seropositive status of a particular patient. Currently a doctor must report the patient's status to the health authorities only if the patient has CDC-defined AIDS.⁸⁰ The doctor has discretion to tell the patient's spouse or partner that he or she may be at risk of contracting the disease.⁸¹ Doctors should have discretion to tell other staff who will be directly involved with that patient.

In addition to the health and safety concerns of the patient, the doctor, and the health care staff, physicians may have a duty to warn others they know may be at risk of contracting the disease.⁸² Physicians have a duty to protect known, foreseeable victims of a dangerous patient, including a duty to warn the identified third party.⁸³ In the context of communicable diseases, a physician also has a duty to warn family members, or significant others of the infected patient's status, resulting in tort liability for failure to so warn.⁸⁴ Individuals entitled to warning are those specific persons in foreseeable danger of contracting an infection from the physician's patient.⁸⁵ If a physician chooses to require testing and a patient is seropositive, the physician has a duty to warn the spouse or partner of the patient's infection should the patient refuse to do so.⁸⁶ This is a justification for testing because if an infected patient refuses to warn his or her loved one or partner and the physician does warn that person, the physician is preventing the spread of the disease.⁸⁷

80. Gostin & Curran, *supra* note 77, at 215.

81. The doctor may not tell the spouse or significant other the name of the patient (but in most cases, this is irrelevant).

82. *Tarasoff v. Regents of the Univ. of Cal.*, 13 Cal. 3d 177, 118 Cal. Rptr. 129, 529 P.2d 553 (1974), *aff'd on rehearing*, 17 Cal. 3d 425, 131 Cal. Rptr. 14, 551 P.2d 334 (1976); Annotation, *Liability of One Treating Mentally Afflicted Patient for Failure to Warn or Protect Third Persons Protected by Patient*, 83 A.L.R.3d 1201 (1978 & Supp. 1987).

83. *Tarasoff* at 123, 18 Cal. Rptr. at 135, 529 P.2d at 559.

84. See *Gill v. Hartford Accident & Indem. Co.*, 337 So. 2d 420 (Fla. Dist. Ct. App. 1976).

85. See *Knier v. Albany Medical Center Hosp.*, 131 Misc. 2d 414, 500 N.Y.S.2d 490 (N.Y. Sup. Ct. 1986); *Derrick v. Ontario Community Hosp.*, 47 Cal. App. 3d 145, 120 Cal. Rptr. 566 (1975).

86. See *Knier* and *Derrick*, *supra* note 85. See also *N.Y. Times*, Oct. 2, 1988, sec. 6 (Magazine), at 67, col. 1, (doctor advised patient to tell pregnant wife of his status).

87. See *Knier* and *Derrick*, *supra* note 85.

When the names of those infected are reported to the health authorities, a greater privacy concern is at stake. While the reporting requirements are an important and valid concern of those at risk, determining whether the names of those infected ought to be reported to the health authorities is beyond the scope of this student article.⁸⁸ Perhaps doctors ought to be required to report all seropositives, and the CDC should begin reporting ARC and HIV-positive cases. This issue is beyond the scope of this student article but a law that required this type of reporting would not invade anyone's rights and would work to give the public a more accurate picture of the seriousness of the disease.

A physician should warn staff who are immediately involved in the nonemergency, invasive procedure for the purpose of protecting their health and safety. While the staff's right to know the status of a particular patient is not as strong as that of a doctor, they also should be apprised of the infectious status of the patient with whom they are dealing. Something is inherently wrong with a system that expects people to risk their lives to help others, but does not allow them to know the risks. If a doctor chooses to test and discovers that a patient is infected, he or she should be able to tell those who will be involved directly with the patient. The staff cannot infringe on the doctor-patient privilege and demand to know, but a doctor, if he or she feels the risk involved is high, ought to tell his or her staff.

Finally, the concern, if any, of whether a doctor will divulge the infectious status of a patient to the general public should be avoided because of the doctor-patient privilege, which affords a patient a powerful cause of action where the doctor divulges information.⁸⁹

VI. ETHICAL CODES OF CONDUCT RELATING TO A PHYSICIAN'S DUTY TO TREAT

Today's several ethical codes of conduct dictate certain ethical behavior by a doctor. The Hippocratic Oath is the most ancient and recognized ethical code of conduct. This oath was promulgated by Hippocrates, a Greek physician in 400 B.C., and is a widely used ethical guide for the medical profession.

88. For a discussion of reporting requirements see Gostin & Curran, *supra* note 77, at 215, and Gostin & Ziegler, *A Review of AIDS-Related Legislative and Regulatory Policy in the United States*, 15 LAW, MED. & HEALTH CARE 5, 10 (1987).

89. See *infra* note 90.

Hippocrates believed that physicians have a serious obligation to serve their patients.⁹⁰ The oath is often administered as a part of the graduation ceremonies at medical schools. While the Hippocratic Oath does not address physicians' rights to know the health status of an individual, or their right to require testing, it does require physicians to care for their patients.

VII. CHRISTIANITY AND THE CALL TO LOVE ONE'S NEIGHBOR

Christians are called to love God, and the proof of our love of God is the love we bear for our neighbor.⁹¹ Thus, if one claims to love God and simultaneously hates a neighbor, such a person is a liar.⁹² Jesus taught us that the Good Samaritan who reached out to the man beaten by robbers and dressed his wounds was the only one worthy to be called neighbor.⁹³

In the parable of the Good Samaritan, a lawyer, attempting to tempt Jesus, asked Him: "who is my neighbor?"⁹⁴ Jesus answered this question in a parable about a man who, while en route from Jerusalem to Jericho, fell among thieves who

90. The Hippocratic Oath states:

I swear . . . that I will fulfill according to my ability and judgment this oath and this covenant; . . .

I will apply dietetic measures for the benefit of the sick according to my ability and judgment; I will keep them from harm and injustice.

I will neither give a deadly drug to anybody if asked for it, nor will I make a suggestion to this effect. Similarly I will not give to a woman an abortive remedy. In purity and in holiness I will guard my life and my art.

Whatever houses I may visit, I will come for the benefit of the sick, remaining free of all intentional injustice, . . .

What I may see or hear in the course of treatment or even outside of the treatment in regard to the life of men, which on no account one must spread abroad, I will keep myself holding such things shameful to be spoken about.

If I fulfill this oath and do not violate it, may it be granted to me to enjoy life and art, being honored with fame among all men [and women] for all time to come; if I transgress it and swear falsely, may the opposite of all this be my lot.

The Hippocratic Oath, in L. EDELSTEIN, *ANCIENT MEDICINE*, (O. Temkin & C.L. Temkin eds. 1967).

91. See *Matt.* 22:36-40: "Thou shalt love the Lord thy God with all thy heart, and with all thy soul, and with all thy mind. . . [and] [t]hou shalt love your neighbour as thyself"; see also *John* 13:34: "A new commandment I give unto you, That ye love one another; as I have loved you, that ye also love one another."

92. 1 *John* 2:9.

93. *Luke* 10:36-37.

94. *Id.*

stripped him and wounded him, leaving him half dead. Jesus told us that three men saw the half dead man on their journey. The first, a priest or rabbi saw him and passed on the other side. Likewise, a levite (an assistant to a priest) who came and looked on him passed by on the other side. Finally, a samaritan, as he journeyed, saw the man and had compassion for him. He dressed his wounds, set him on his own beast and brought him to an inn and took care of him. When the samaritan departed the next morning, he took out two silver pieces, gave them to the innkeeper and asked the innkeeper to take care of the injured man and told him that he would repay the cost on his return journey.

Jesus asked the lawyer which of the three in the parable was a neighbor. The lawyer answered correctly and identified the samaritan as the neighbor. Jesus then told him to go and do the same.⁹⁵

On its face, the story of the Good Samaritan is nothing more than a story of someone who did a good deed. It is obviously that, but its significance is much deeper. The road to Jericho was very dangerous at that time. The road was hounded by robbers, vandals and the like. In fact, only a fool would travel the road alone. The story basically revolved around a man who caused his own downfall.⁹⁶ The story's significance is in its implication that we have a responsibility to help others in need. The story illustrated the evils of prejudice and taught the benefits of true neighborliness. "It is simple for one to help another whose problems result from a tragedy or from the ill will of others. But where one causes his or her own downfall, we tend to have little sympathy."⁹⁷

Jesus told this story to illustrate to the people of the day that the ill will they felt towards others was a denial of the faith God had given them. One scholar summarized this story as follows: "Contempt, even toward the foolish, has no place in the Kingdom of God."⁹⁸

The plight of those infected with AIDS can be analogized to the victim in the parable of the Good Samaritan. The perception of many is that those infected with AIDS have brought

95. *Id.*

96. While I do not assert that people who have contracted AIDS are fools or that they brought about their own downfall, I do submit that even if this were true, we, as human beings, have a moral responsibility to help those infected with the AIDS virus.

97. Homily by Monsignor John J. Egan, Holy Name Cathedral, Chicago, Ill., July 16, 1989.

98. *Id.*

the disease on themselves and deserve their lot.⁹⁹ This perception is clearly wrong because, for example, AIDS afflicts children born to infected mothers, and recipients of infected blood: people who are victims in the truest sense of the word. Fear, scorn, and misunderstanding have kept some, otherwise able to do so, from lending a helping hand to AIDS sufferers, as they kept the priest and levite from helping the injured man. Jesus taught us, through this story, that those who subscribe to such a *laissez faire* attitude in the context of AIDS, or in any situation where a need is present, are breaking the most important of the Commandments.

Doctors as human beings have the moral obligations required of all of us. Having achieved the status of a professional, however, doctors have an additional obligation towards the sick. Upon graduation from medical school, a doctor agrees to abide by an ethical code of conduct such as the Hippocratic oath. Such an obligation or duty should not be brushed off by those holding such high esteem in society merely because a person is afflicted with the AIDS virus. The crux of this article is that while physicians have a right to know with whom they are dealing, and to take the necessary precautions, they do not possess the right to turn away an AIDS-infected individual merely on the basis of that infection. They have, in fact, a duty to treat infected individuals.

VIII. THE AMA'S ROLE: PAST AND POTENTIAL INFLUENCE

The AMA's Council on Ethical and Judicial Affairs issued a statement in December of 1986 that related to the duty to treat AIDS-infected individuals. Through this statement, the AMA instituted an "emotional inability" standard,¹⁰⁰ which appeared to recognize that not all physicians would be able to cope with the treatment of AIDS-infected individuals. The statement was vague and couched in generalities but the message was clear:

99. E. FEE & D. FOX, *AIDS — THE BURDENS OF HISTORY* 122 (1988).

100. The portion of the statement which relates to a physician's duty to treat states:

Physicians and other health professionals have a long tradition of tending to patients afflicted with infectious disease with compassion and courage. However, not everyone is emotionally able to care for patients with AIDS. If the health professional is unable to care for a patient with AIDS, that individual should ask to be removed from the case. Alternative arrangements for the care of the patient must be made.

A.M.A., COUNCIL ON ETHICAL & JUDICIAL AFFAIRS, STATEMENT ON AIDS (1986).

physicians could ethically reject patients on grounds of their AIDS status, so long as the physicians were "unable to care for a patient with AIDS."¹⁰¹ The vagueness of the emotional inability exception made illusory any ethical obligation to provide care. After all, there are no legal standards by which to discern the difference between *being* emotionally unable as compared to *feeling* emotionally unable, or simply *claiming* emotional inability irrespective of whether the doctor is in fact emotionally unable.¹⁰²

The AMA's 1986 statement did not comport with an ethical obligation of a physician's duty to treat the ill. People understood the statement to mean that a physician was generally free to accept or refuse patients, even arbitrarily and even though no other physician was available.¹⁰³ The AMA's 1986 statement did not consider any legal duty to treat on the part of doctors. While no legally-mandated duty on the part of private physicians to treat exists, there is also no general right, categorically, to discriminate solely on the basis of AIDS infection. Notwithstanding the AMA's denial of a general obligation for doctors to treat all patients, the AMA faced both pragmatic as well as ethical motivations to issue a new statement.¹⁰⁴

In December 1987, the AMA's Council on Ethical and Judicial Affairs issued a subsequent statement that implied a change of heart over that of the previous statement.¹⁰⁵ While

101. As will be discussed, *infra* notes 164 to 176 and accompanying text, physicians employed by a public hospital, a Hill-Burton hospital (a hospital that is federally funded), or a health maintenance organization (HMO), do not have such wide discretion in deciding who to treat, because of contractual obligations.

102. Freedman, *Health Professions, Codes, and the Right to Refuse to Treat HIV-Infectious Patients*, 18 HASTINGS CENTER REP. (SPECIAL SUPPLEMENT), April/May 1988, at 23. While there are discernible distinctions, they are not legally discernible.

103. *Id.* See also Arras, *supra* note 69, at 18 (while some physicians are refusing to treat AIDS victims, most have treated them). *But see* N.Y. Times, Apr. 23, 1990, at 1 ("[b]ecause most physicians still do not take on patients who have [AIDS], the growing number of infected people must often compete to get treatment from the small, overworked cadre of doctors who will accept them.").

104. See Freedman, *supra* note 102, at 24.

105. This new statement read in its relevant portions:

A physician may not ethically refuse to treat a patient whose condition is within the physician's current realm of competence solely because the patient is 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 to his own health". . . . Physicians should respond to the best of their abilities in cases of emergency where

this new statement did not specifically overrule the previous emotional inability standard, its focus shifted from a justification to refuse treatment entirely, to a justification to refer treatment to other qualified doctors.¹⁰⁶ This new statement comported with an ethical standard for a physician, by implying a general obligation to treat AIDS-infected patients.

A doctor may, therefore, legally and ethically refer an infected patient to another doctor who may have a greater degree of competence in the field, but he ought not turn away a patient simply because that patient has contracted AIDS.

Do codes of ethics equal rules of law in their binding effect or do they merely pay lip-service to an ideal value system on the part of physicians? The answer to this is at least suggested by the AMA's willingness to change its stance on the duty to treat. While political and other motivations undoubtedly suggested the need to change the original statement,¹⁰⁷ a mere change in statement with an adherence to the belief that doctors can refuse treatment for any reason will not satisfy the intent of such a promulgation. When an association such as the AMA promulgates rules or codes of conduct, one would expect its members to abide by those rules of conduct. One author wrote of codes of medical ethics that they "can reasonably be expected to reflect the basic ethical views of the organizations that have endorsed them."¹⁰⁸ Thus, the AMA can reasonably be expected to be answerable to its promulgated rule in the 1987 statement, and physicians should be required to treat AIDS-infected patients unless they are incompetent to do so (in

first aid treatment is essential, and physicians should not abandon patients whose care they have undertaken

Principle VI of the 1980 Principle of Medical Ethics states that "A physician shall in the provision of appropriate patient care, except in emergencies, be free to choose whom to serve, with whom to associate and the environment in which to provide medical services." The Council has always interpreted this Principle as not supporting illegal or invidious discrimination Thus, it is the view of the Council that Principle VI does not permit categorical discrimination against a patient solely on his or her seropositivity. A physician who is not able to provide the services required by persons with AIDS should make an appropriate referral to those physicians or facilities that are equipped to provide such services.

A.M.A., COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS, ETHICAL ISSUES INVOLVED IN THE GROWING AIDS CRISIS (1987).

106. *Id.*

107. For example, fear of governmental regulation over the medical profession.

108. Veatch, *Codes of Medical Ethics: Ethical Analysis*, in 1 ENCYCLOPEDIA OF BIOETHICS 172 (W. Reich & L. Walters, eds. 1978).

which case these physicians are to refer the patients to competent physicians).

Two circumstances warrant a legally binding obligation to provide care: emergencies and ongoing doctor patient relationships.¹⁰⁹ Treatment is guaranteed to patients in either circumstance regardless of a physician's fears or idiosyncracies. However, qualifications exist which will be discussed after an analysis of each of the exceptions to a private doctor's broad discretion in choosing patients.

A. *Continuing Relationship Between Physician and Patient*

A physician generally has no legal obligation to accept all persons who seek his services.¹¹⁰ The reason for this freedom is that the relationship between a physician and his or her patient is in part a contractual one. Insofar as it is a contract, it is a consensual venture,¹¹¹ and arises — as do all contractual relationships — from an express or implied contract.¹¹² The consensual nature of this relationship absolves the private physician from legal obligation for failing or refusing to accept a patient for treatment.¹¹³ A physician may also exclude certain diseases from his or her practice.¹¹⁴ Thus, emergency contexts aside, a patient's only right to treatment and a private physician's only duty to treat arises after a consensual relationship is established between that patient and the physician.¹¹⁵ Once this duty arises, it continues until:

1. the agreement is terminated by mutual consent;

109. See Freedman, *supra* note 102, at 23; see also Lo, *Obligations to Care for Persons with Human Immunodeficiency Virus*, 4 ISSUES IN L. & MED. 367, 376-77 (1988).

110. *Lyons v. Grether*, 218 Va. 630, 239 S.E.2d 103, 105 (1983) ("unless required by statute, a physician has no legal obligation to accept as a patient all persons who seek his services"); see also *Findlay v. Board of Superiors*, 72 Ariz. 58, 230 P.2d 526 (1951); *Hurley v. Eddingfield*, 156 Ind. 416, 59 N.E. 1058 (1901); *Childers v. Frye*, 201 N.C. 42, 158 S.E. 744 (1931).

111. *United Calendar Mfg. Corp. v. Huang*, 94 A.D.2d 176, 179, 403 N.Y.S.2d 497, 500 (N.Y. App. Div. 1983) ("The relationship of physician and patient is a consensual one")

112. *Id.*; see also *Lyons*, 239 S.E.2d 105, ("although a patient is entitled to damages resulting from breach of a physician's duty, this duty arises only upon creation of a physician/patient relationship which springs from a consensual transaction, a contract express or implied."); *McNamara v. Emmons*, 36 Cal. App.2d 199, 204, 97 P.2d 503, 507 (Cal. Dist. Ct. App. 1939).

113. Lo, *supra* note 109, at 376-77. See also *Childers*, 201 N.C. at 45, 158 S.E. at 746.

114. Lo, *supra* note 109, at 377.

115. Annas, *Legal Risks and Responsibilities of Physicians in the AIDS*

2. the agreement is terminated by the patient;
3. the physician's services are no longer required (presumably for that ailment); or
4. the physician withdraws *after* reasonable notice to the patient.¹¹⁶

A contractual relationship between a physician and a patient can be created in several ways. The simplest example of such a relationship is when a physician agrees to examine or treat the patient (regardless of whether the treatment is for AIDS-related care), upon a face-to-face confrontation. Other examples may include family-doctor relationships,¹¹⁷ or the case in which a physician accepts an appointment with a person where the specific condition was mentioned when making the appointment.¹¹⁸

Thus, once physicians undertake the obligation to care for patients, they may not legally abandon or refuse to treat those patients on the basis that those patients are AIDS-infected individuals, at least not without reasonable notice.¹¹⁹ If the physicians are not qualified to treat a particular patient, they must refer that patient to a qualified physician.¹²⁰

B. *Emergency Treatment Duty*¹²¹

Hospitals that offer emergency services are required to treat all patients who require emergency care,¹²² regardless of wealth, sex, color, religion, or, presumably, AIDS-status.¹²³

Epidemic, 18 HASTINGS CENTER REP. (SPECIAL SUPPLEMENT), April/May 1988, at 27.

116. *Id.* (emphasis in original).

117. A physician's prior treatment of a patient, however, will not necessarily place a legal obligation to treat a new illness. *Hurley*, 59 N.E. at 1058.

118. *Lyons*, 239 S.E.2d at 105.

119. Professor Annas believes that a distinction exists between an HIV-infected patient and one with AIDS or ARC in this situation because treating AIDS or ARC involves the "knowledge and skill needed to treat a specific disease; [while] treating an HIV-infected patient involves knowing what precautions to take to avoid infection, while treating a different, usually unrelated condition." See Annas, *supra* note 115, at 27. This distinction is relevant only when the doctor is aware of the status of the patient.

120. *Id.* There is no such requirement if the physician owes no continuing care duty to the patient. Where this duty is absent, emergency contexts aside, a physician may legally refuse care even when there is no alternative treatment source in the community.

121. While this duty will not likely apply to a private physician, it will apply to a private hospital with an emergency room facility.

122. See Annas, *supra* note 115, at 26.

123. *Id.* at 27.

The emergency room staff should take the CDC's recommended precautions, but the protections taken can neither amount to a refusal of treatment, nor compromise adequate patient care.¹²⁴ The emergency rule may have limited applicability when applied to AIDS-infected individuals because the obligation to treat does not extend beyond the emergency room setting.¹²⁵

Thus, unless there is an established relationship with the physician, some statutory requirement,¹²⁶ or an emergency situation, doctors have no legal duty to provide and patients have no legal right to receive medical care in the United States. The law's tolerance of such limited access to medical care is disgraceful indeed, but "by refusing to grant universal access to health care and medical services to AIDS and HIV-infected patients, we are treating them no differently than anyone else."¹²⁷

C. *Opponents and Proponents of Routine AIDS Testing*

There has been much debate about whether a doctor ought to be able to condition treatment on an AIDS test,¹²⁸ or whether AIDS testing ought to be limited to the screening of the blood supply and for the military.¹²⁹ Routine testing for the AIDS virus is not without faults. There are many who have

124. *Id.* This is the reason why the scope of this student article does not extend into the emergency room. Even the five minute, latex agglutination, AIDS test would have no impact on the duty to provide care in a hospital emergency room setting, because conditioning care on the taking of the test would amount to a refusal of treatment (where the patient refuses to comply with the test requirement).

125. *Id.*

126. See *infra* notes 164 to 176 and accompanying text.

127. See Annas, *supra* note 115, at 27.

128. Bauer, *AIDS Testing*, 2 AIDS AND PUB. POL'Y J. 1, Winter 1987, ("Routine testing . . . is a necessary first step in [containing epidemics]"); Cruz, *Physicians in Private Practice: Can They Require Patients to Undergo an AIDS Test?*, 36 MED. TRIAL TECH. Q. 359 (1990) ("if a [private] physician is under no affirmative duty to treat all those who request treatment, . . . then it could be argued that he can condition such treatment . . . [upon] an AIDS test."); N.Y. Times, Jan. 27, 1987, at 12, col. 1 ("problems [of whether to test] don't have nice black and white answers. One should not deceive oneself that a single edict is going to resolve all the complexities, nor should that be an excuse for inaction.").

129. Fletcher, *AIDS Screening: A Response to Gary Bauer*, 2 AIDS & PUB. POL'Y J. 5 (1987); Fumento, *Chicken Little with a Hypodermic*, REASON, Nov. 1988, at 31, 32; Gostin & Curran, *AIDS Screening, Confidentiality, and the Duty to Warn*, 77 AM. J. PUB. HEALTH 361 (1987); Gostin & Ziegler, *A Review of AIDS-Related Legislative and Regulatory Policy in the United States*, 15 LAW, MED. & HEALTH CARE 5, at 10 (1987).

voiced concerns about screening for the virus.¹³⁰ Their reasoning has been both constitutionally-based, because of the intrusion involved in testing and the availability of less intrusive alternatives, and based on the potential pitfalls of the test itself.

Opponents of routine testing argue that requiring testing as a condition to treatment invades privacy rights of the individual,¹³¹ and that it should be limited to situations such as screening the blood supply, where the testing does not infringe on any particular individual's rights.¹³² Others stress the uncertainty of the test results and the lengthy incubation period of the disease as a reason not to require testing.¹³³

Others argue that in light of the high cost of testing, the currently incurable aspect of AIDS, and the infringement of the privacy concerns of the individual being tested, the test's pitfalls outweigh the benefits derived from testing and serve only to discriminate against those tested.¹³⁴ There is also a fear that routine testing may take away the incentive to seek medical care.¹³⁵ This fear is that if people who seek medical care are tested against their will (including those who succumb to testing because they need medical attention and cannot get it otherwise), those who are discovered to be infected would be less likely than those who submit to voluntary testing to change their habits or to stop infecting others.¹³⁶

Opponents of routine testing in the health care context use as their premise statistics demonstrating that the percentage of health care workers with AIDS is no higher than that of the general population.¹³⁷ These statistics imply that health care workers are no more at risk of contracting AIDS than is a random member of the general population, which implication vitiates the justification to test based on the greater risk to doctors.

Finally, opponents of routine testing argue that doctors ought to follow the CDC recommendations favoring the use of universal precautions rather than routinely testing patients.

130. See Gostin & Ziegler, *supra* note 129.

131. *Id.*

132. *Id.*

133. Howard, *HIV Screening — Scientific, Ethical, and Legal Issues*, 9 J. LEGAL MED. 601, 603-05 (1988).

134. M. SANDE & P. VOLBERDING, *THE MEDICAL MANAGEMENT OF AIDS* 51 (1988).

135. *Id.*

136. N.Y. Times, Nov. 16, 1988, § B, at 1, col. 3.

137. *Update: Acquired Immunodeficiency Syndrome and Human Immunodeficiency Virus Infection Among Health-Care Workers*, 37 CENTERS FOR DISEASE CONTROL: MORBIDITY AND MORTALITY WEEKLY REP. 229 (1988).

The CDC has issued recommendations favoring the use of universal precautions, "appropriate barrier precautions to prevent skin and mucous-membrane exposure when contact with blood or other bodily fluid is anticipated," over routine testing in the care of *all patients*.¹³⁸ These universal precautions include wearing surgical gloves, masks, protective eyewear, aprons, and gowns.¹³⁹ The argument is that since these recommendations apply in the care of all patients and are much less intrusive than testing, the purpose of testing must be to discriminate.

Proponents of testing argue that because of the inherent risks to doctors while performing invasive procedures, those doctors who believe it necessary to do so, ought to know the status of their patients. Legitimate reasons exist for testing in the doctor-patient context, notwithstanding the formidable arguments against testing. Testing may be routinely performed if done in a non-discriminatory manner and if the information is used to benefit the doctor, his or her staff, and the patient: that is, to counsel the seropositive patient, and to inform him or her of any treatments currently available.

Some proponents of testing have gone too far. They have demanded it in every context — even nationwide testing,¹⁴⁰ using as their justification that the rights of an AIDS carrier must give way to the interests of health and safety of society in general. Notwithstanding these far-reaching alternatives, there are legitimate reasons for testing.

AIDS tests have been and may continue to be required for several appropriate purposes. AIDS tests are currently required of all donors of blood, sperm and organs,¹⁴¹ for all applicants to the military,¹⁴² peace corps,¹⁴³ and the foreign service,¹⁴⁴ and for immigrants seeking residency in the United States.¹⁴⁵ Some states have passed regulations requiring AIDS tests to be administered to prisoners,¹⁴⁶ those getting mar-

138. *Recommendations for Prevention of HIV Transmission in Health Care Settings*, 36 CENTERS FOR DISEASE CONTROL: MORBIDITY AND MORTALITY WEEKLY REP. 6 (Supp. S-2) (1987).

139. *Id.* at 5.

140. E. FEE & D. FOX, *supra* note 99, at 158.

141. N.Y. Times, Oct. 4, 1989, § A, at 1, col. 1; (in fact, New York rules require all sperm to be frozen for at least six months before it is used to allow a second AIDS test to be made on the donor).

142. N.Y. Times, June 24, 1987, § A, at 22, col. 4.

143. *Id.*

144. *Id.*

145. *Id.*

146. *Id.*

ried,¹⁴⁷ upon request by a rape victim,¹⁴⁸ upon request by police officers or firemen who have been bitten or spit upon,¹⁴⁹ and prostitutes.¹⁵⁰ Some religious orders have also instituted testing.¹⁵¹ AIDS testing has also been encouraged for any woman contemplating pregnancy.¹⁵²

Doctors should have discretion whether to condition treatment on an AIDS test in order to have all relevant information about each person they treat, because of the inherent risks present while performing a non-emergency, invasive procedure, and because of the potential benefit to the patient of being aware of his or her AIDS status.

While universal precautions promote health and safety in the health industry, even with their use, physicians may wish to take additional precautions when confronted with AIDS-infected patients. In other words, when physicians know they are treating infected individuals, they can exercise a greater degree of caution than they would normally exercise in the care of an uninfected patient.¹⁵³ A further problem is that precautions such as surgical gloves may themselves be risky to use,¹⁵⁴ because they are very tightly worn and may be easily punctured by the razor sharp instruments common in the operating room. The precautions are also likely to be ignored in what appears to be a safe situation.

Physicians should also be apprised of their patients' infectious conditions so that they can best help their patients. An interest in the well being of the patient is a prerequisite to the ability to justify the need for the test. Physicians can help infected patients by informing them about medications and treatments available, by disseminating information about the virus including symptoms to expect and preventative advice, and by providing counseling to patients prior to the test and after the results are known. If physicians are not up to date on the virus, they may refer their patients to other physicians or to

147. ILL. REV. STAT. Ch. 40, para. 204 (1988), *repealed by* 1989 Ill. Legis. Serv. 86-884 (West).

148. Chicago Trib., Jun. 7, 1989, § C, at 1.

149. *Id.*

150. Chicago Trib., Jan. 2, 1989, § C, at 5; *but see* Chicago Trib., Aug. 4, 1989, § C, at 1 (Illinois State Law ruled unconstitutional).

151. *Florida Catholic*, Dec. 16, 1988.

152. N.Y. Times, Mar. 25, 1987, § B, at 4, col. 5.

153. Pellegrino, *HIV Infection and the Ethics of Clinical Care*, 10 J. LEGAL MED. 29, 41; Wash. Post, Dec. 1, 1987, at Z6.

154. While this assertion is true regardless of whether the physician is apprised of the infectious status of the individual, it demonstrates the possible pitfalls of a blind adherence to these precautions.

other organizations that can supply the patients with the information or care.

Additionally, physicians should know the HIV-status of their patients in order to apprise other health care workers who are at risk of contracting the virus: assisting physicians, nurses, orderlies, and other staff who are at risk of coming in contact with an infected patient's bodily fluids. Moreover, physicians may help stem the spread of the AIDS virus by counseling seropositive patients to warn spouses or others immediately at risk. Indeed if the patient refuses to warn the affected parties, the physician may have a duty to so warn.¹⁵⁵

Many of the rationales against testing appear to be aimed towards testing in the general context. This opposition tends to look at testing in a vacuum and seems to assume that all who favor testing do so in any and all contexts. Nationwide testing is patently wrong and should be avoided because those discovered to be infected would be highly susceptible to discrimination. Nationwide testing would also stigmatize many more than it would benefit, and would be highly inefficient.¹⁵⁶ Testing in the employment context is also unfounded (depending on the job) because medical science has shown that AIDS is not casually transmitted.¹⁵⁷ There are many valid reasons to oppose routine testing in a given context: even in non-emergency, invasive procedures. For example, confidentiality of a person's seropositive status is a major concern because of the fear that if one tests positive then he or she will lose employment opportunities,¹⁵⁸ face the possibility of eviction from his or her home,¹⁵⁹ lose health and/or life insurance,¹⁶⁰ and will be discriminated against in other ways. This possibility clearly must be avoided.

Those who oppose routine testing point out that a way to protect confidentiality is to encourage voluntary testing. However, voluntary testing will not necessarily protect confidentiality. It cannot make any difference whether the test results came

155. See *supra* notes 80-85 and accompanying text.

156. E.g., the Illinois AIDS testing requirement for those seeking a marriage license in that state, ILL. REV. STAT. ch. 40, para. 204 (1988), is now repealed. 1989 Ill. Legis. Serv. 86-884 (West). The testing requirement was repealed because it was highly inefficient. Only 52 cases were diagnosed among the estimated 250,000 tested since the law took effect on January 1, 1988. Chicago Trib. Sept. 12, 1989, § C, at 1.

157. NATIONAL ACADEMY OF SCIENCES, *supra* note 17, at 6, 62-63.

158. *Id.*

159. *Id.*

160. *Id.*

from a volunteer or from one routinely tested. The same doctor-patient privilege applies, and the same medical malpractice liability will accrue to the physician who divulges the information regardless of whether the doctor encouraged volunteer testing or whether the doctor routinely tested for AIDS.

Early detection of AIDS is crucial to an infected person because, although the AIDS virus is currently incurable, the drugs which have been developed and approved are most effective in the early stages of the disease;¹⁶¹ they lose their usefulness as the disease spreads and destroys a greater portion of the immune system.¹⁶² While the incubation period of the disease is also a concern, because the test may not be able to detect the antibodies to the virus for a variable period of time,¹⁶³ it should not be an argument against testing because testing will at least detect *some* if not most seropositives at an early stage of infection. A physician should still take the precautions recommended by the CDC if a patient tests negative. The debate is not whether physicians should use the universal precautions, but whether they will naturally take greater care when knowingly treating one who is infected with the virus.

IX. SECTION 504 OF THE REHABILITATION ACT OF 1973 — LEGAL DUTY TO TREAT

Section 504 of the federal Rehabilitation Act of 1973 (hereinafter, Rehabilitation Act) is legislation enacted for the purpose of protecting individuals with real or perceived handicaps.¹⁶⁴ The purpose of the Rehabilitation Act is to prohibit discrimination against "otherwise qualified" handicapped persons, solely on the basis of their handicap, by any program or activity receiving federal financial assistance.¹⁶⁵ The Rehabilitation Act is important in the AIDS context because, where applicable, it imposes a legal duty to treat infected individuals.

161. See *supra* note 34 and accompanying text.

162. *Id.*

163. *Sexually Transmitted Diseases Treatment Guidelines*, 38 CENTERS FOR DISEASE CONTROL; MORBIDITY AND MORTALITY WEEKLY REP. 1 (Supp. S-8 1989); see also NATIONAL ACADEMY OF SCIENCES, CONFRONTING AIDS: DIRECTIONS FOR PUBLIC HEALTH, HEALTH CARE, AND RESEARCH 1, (1986).

164. Rehabilitation Act of 1973, § 504 (codified, as amended at 29 U.S.C.A. §§ 701-796 (West Supp. 1988)).

165. *Id.* § 794. A handicapped person is "qualified" for purposes of the Rehabilitation Act when "with reasonable accommodation [he or she] can perform the essential functions of the job in question." 45 C.F.R. § 84.3(k)(1) (1985).

A person is handicapped under the Rehabilitation Act when he or she "(i) has a physical or mental impairment which substantially limits one or more of such person's major life activities, (ii) has a record of such an impairment, or (iii) is regarded as having such an impairment."¹⁶⁶ In the employment context, persons with AIDS have been held to fit within the definition of "handicapped individual" provided that they do not pose a threat of contagion to their fellow workers.¹⁶⁷ Therefore, persons with AIDS, at least in the employment context, are entitled to the protections of the Rehabilitation Act.¹⁶⁸ A careful interpretation of the Rehabilitation Act by the federal

166. *Id.* § 706(8)(B).

167. See *Thomas v. Atascadero Unified School Dist.*, 662 F. Supp. 376, 381 (C.D. Cal. 1987); *District 27 Community School Bd. v. Board of Educ.*, 130 Misc. 2d 398, 502 N.Y.S.2d 325, 336 (1986).

168. Section 504, *supra* note 164, considerations are important because the Rehabilitation Act protects individuals against discrimination in programs receiving federal funding. In *School Board v. Arline*, 480 U.S. 273 (1987), the United States Supreme Court, in a decision dealing with a school teacher with tuberculosis, made clear that the Act protects those suffering from a symptomatic viral infection. *Arline* is limited in two ways: it only dealt with symptomatic conditions; and it only encompassed the employment sector.

Even though the Court refused to state whether an asymptomatic carrier is similarly protected, *Arline*, 480 U.S. at 282, the Department of Justice, in a memorandum, concluded that Section 504 protects symptomatic as well as asymptomatic HIV-infected individuals against discrimination in any federally funded program or activity, so long as the infected individual is "otherwise qualified" to participate in the program or activity. See *infra* note 170. The Department of Justice opinion extends to the employment as well as the non-employment sector, meaning that its opinion encompasses health care organizations' health care functions. The notable difference between employment situations and non-employment situations is in the treatment of the "otherwise qualified" standard. In the non-employment context, the "otherwise qualified" standard used is that set forth in *Arline*, which is a determination of the nature and the severity of the risk, and the probability that the disease will be transmitted. In the employment context, the Civil Rights Restoration Act, Pub. L. No. 100-259, § 9, 102 Stat. 28, 31 (1988), which prohibits discrimination if the infected individual is able to perform the duties of the job and does not constitute a direct threat to the health and safety of others, replaces the *Arline* standard for its own "otherwise qualified" standard.

Because this comment's focus is in the non-employment context, namely, a patient visiting a doctor for a nonemergency invasive procedure, we will need to look to the *Arline* standard of "otherwise qualified" which looks to:

- (a) the nature of the risk (how the disease is transmitted),
- (b) the duration of the risk (how long is the carrier infectious),
- (c) the severity of the risk (what is the potential harm to third parties) and
- (d) the probabilities the disease will be transmitted and will cause varying degrees of harm.

Memo from Assistant Attorney General Kmiec on Application of Rehabilitation Act's Sec-

courts,¹⁶⁹ the Department of Justice,¹⁷⁰ and noted scholars,¹⁷¹ has dispelled the legal question of whether being an infected individual is within the definition of handicapped individual under the Rehabilitation Act.

Courts have not yet addressed whether an AIDS victim is considered handicapped under the Act, while in a public or private hospital which receives Hill-Burton funds, federal funds which trigger the protections of the Rehabilitation Act.¹⁷²

tion 504 to HIV-Infected Persons, Daily Lab. Rep. (BNA) No. 195, at D-1 (Oct. 7, 1988).

169. *School Bd. v. Arline*, 480 U.S. 273 (1986); *Chalk v. U.S. Dist. Court*, 840 F.2d 701, 709 (9th Cir. 1988) (absolute certainty that transmission was not possible from schoolroom or workplace contact was not necessary to provide protection under the Rehabilitation Act).

170. *Memo from Assistant Attorney General Kmiec on Application of Rehabilitation Act's Section 504 to HIV-Infected Persons*, Daily Lab. Rep. (BNA) No. 195, at D-1 (Oct. 7, 1988). (Assistant Attorney General Kmiec found that persons with AIDS are protected under the Rehabilitation Act even though AIDS is a contagious disease, and that those HIV-infected who are asymptomatic are handicapped under the Rehabilitation Act.)

171. See Gostin, *Hospitals, Health Care Professionals, and AIDS: The "Right to Know" the Health Status of Professionals and Patients*, 48 MD. L. REV. 12, 44-45 (1989); Leonard, *AIDS, Employment and Unemployment*, 49 OHIO ST. L.J. 929, 931-39 (1989).

172. Pub. L. No. 79-725, Title VI of Public Health Service Act, August 1946. The general purpose of the Act is:

to assist the several States in the carrying out of their programs for the construction and modernization of such public or other medical facilities as may be necessary, . . . to furnish adequate hospital, clinic, or similar services to all their people;

The general regulations of the Act are:

that the State plan shall provide for adequate hospitals, and other facilities for which aid under this part is available, for all persons residing in the State, and adequate hospitals (and other such facilities) to furnish needed services for persons unable to pay therefor. Such regulations may also require that before approval of an application for a project is recommended by a State agency to the Surgeon General for approval under this part, assurance shall be received by the State from the applicant that (1) the facility or portion thereof to be constructed or modernized will be made available to all persons residing in the territorial area of the applicant; and (2) there will be made available in the facility or portion thereof to be constructed or modernized a reasonable volume of services to persons unable to pay therefor, but an exception shall be made if such a requirement is not feasible from a financial viewpoint.

42 U.S.C.A. §§ 291(a), 291c(e).

The Hill-Burton Act has been in existence since 1946. From its inception, this Act has been the principal means for federal support for construction, expansion, and modernization of public and private, not-for-profit, health facilities. It has continually achieved its goal of upgrading the nation's medical care and facilities. The receipt of Hill-Burton funds labels a hospital

However, the situation mirrors the intent of Section 504,¹⁷³ and is a reasonable extension of Section 504 upon consideration of all the factors. The Supreme Court held in *Bowen v. American Hospital Association*,¹⁷⁴ that Section 504 applies in the hospital context: “[By virtue of the Rehabilitation Act,] handicapped infants are entitled to ‘meaningful access’ to medical services provided by hospitals, and . . . a hospital rule or state policy denying or limiting such access would be subject to challenge under § 504.”¹⁷⁵ The *Bowen* Court’s reasoning should apply to AIDS carriers. Therefore, AIDS carriers should clearly be considered handicapped and should qualify for protection under the Act.

The effect of the Rehabilitation Act is that every public and private hospital receiving Hill-Burton, or other federal funds must treat patients who are otherwise qualified to be in the program, including AIDS-infected persons, without discriminating against them. The Rehabilitation Act does not bind private practitioners and private hospitals, because these groups have few legal restrictions in deciding whether to treat a patient. Some states, however, prohibit even private practitioners and hospitals from discriminating against AIDS-infected individuals, solely on their AIDS-infected status.¹⁷⁶

A. *Application of Section 504 to Routine Testing*

If doctors or hospitals bound by the Rehabilitation Act refuse treatment to a patient solely on the basis of the infectious status of that patient, those doctors are discriminating solely on the basis of the handicap where the patient is other-

as federally funded, triggering the protections of the Rehabilitation Act, and the protections of the Hill-Burton Act. Hospitals receiving Hill-Burton funding are bound by the Hill-Burton requirements to make their facility “available to all persons residing in territorial area of applicant.” Those hospitals which do not receive the funding are not bound by the Hill-Burton Act’s requirements. These self-sufficient hospitals are bound by applicable state statutes, if any exist, and by their own ethical codes.

While the Hill-Burton Act proscribes the denial of care and frowns on referral, it does not prohibit the imposition of pretreatment screening conditions. Thus, conditioning treatment on an AIDS test is arguably authorized by the Hill-Burton Act, at least it is not proscribed, so long as the test is administered in a non-discriminatory manner.

173. See 29 U.S.C.A. § 794.

174. 476 U.S. 610 (1986).

175. *Id.* at 624.

176. See Gostin, *Public Health Strategies for Confronting AIDS: Legislative and Regulatory Policy in the United States*, 261 J. A.M.A. 1621 (1989).

wise qualified to participate in the federally-funded program. This discrimination is clearly prohibited by Section 504.¹⁷⁷

Because an AIDS-infected individual, who is otherwise qualified, is considered handicapped in the public hospital context,¹⁷⁸ some scholars argue that doctors would be discriminating against their patients by requiring them to undergo testing¹⁷⁹ prior to the doctor performing a nonemergency, invasive procedure. The argument is that if the patient refuses to be tested and the doctor refuses treatment on that basis, the doctor is *regarding* the patient as having a handicap and discriminating by refusing treatment (depriving an otherwise qualified handicapped individual from the benefits to which he or she is otherwise entitled in a federally funded program).

If the doctor or hospital has a policy that is narrowly tailored and facially neutral, then hinging treatment on taking the test should not be a discriminatory practice. An analogy to this argument is comparing an AIDS test to an entrance exam that is used to determine whether a prospective employee is otherwise qualified for a particular job. If a prospective employee is denied work in a federally funded program because that person fails an entrance exam, the employer has not discriminated against that person, even if that person was handicapped.¹⁸⁰ Certainly if the prospective employee refuses to take the entrance exam, a condition precedent to the employment, a court would not hesitate to hold the individual otherwise unqualified (so long as the exam itself was not discriminatory).

An AIDS test, in the hospital context, is analogous to an entrance exam in that the AIDS test could be a condition precedent to admission to the hospital. If prospective patients refuse to take the test, they have made the choice, much as those prospective employees who refuse to undergo an employment test. While this may not be much of a choice to one who is adamantly against AIDS tests and who is in need of medical care, there is always an exception for the emergency patient.¹⁸¹ A doctor or hospital should not be considered to be

177. See *supra* notes 166 to 175 and accompanying text.

178. *Id.*

179. See Gostin, Curran, and Clark, *The Case Against Compulsory Casefinding in Controlling AIDS — Testing, Screening and Reporting*; 12 AM. J.L. & MED. 7, 37 (1986).

180. See *Carter v. United States Postal Service*, 23 M.S.P.R. 504 (1984) (Because appellant failed a qualifying exam, she could not perform the essential functions of the position in question and has, therefore, not qualified for her position).

181. See *supra* notes 121 to 127 and accompanying text.

discriminating by refusing to treat an individual who refused to take the test. The important determination then is whether the test itself, or the manner in which it is administered, is discriminatory and not whether the doctor or hospital is discriminating by refusing to treat when an individual refuses the test.

When a physician chooses to test that patient, forcing him or her to undergo such procedure where others not *regarded* as having such an impairment would not be tested, the physician is discriminating against the patient. Doctors should not have the ability to be arbitrary in their decision of whether to test. To ensure fairness doctors should not be allowed to choose to test on an arbitrary basis, and should be required to base their decision of whether to test upon relevant criteria. The factors considered could include known sexual orientation, tracks on arms, or known intravenous drug dependencies.

If the doctors' policies were to test everyone, then no one could complain about discrimination. Thus, a discrimination proof regulation would allow doctors a free hand in deciding whether to require testing of all patients, but to limit that freedom at the point where it is discriminatory. Thus, once doctors choose to test, they should test all. If they choose not to test all, they should test only those in a high risk category — those with known drug dependencies, or known homosexuals who are sexually active and promiscuous. Thus administered, the test is not discriminatory under the Rehabilitation Act because the decision to test is not left to the whims of the physician.

In this manner doctors would fulfill their obligations not to discriminate by choosing either course. If they choose not to test, then discrimination is not at issue. If they choose to test, they are at least doing so in a nondiscriminatory manner and are justified in their choice by way of the regulation.

CONCLUSION

AIDS is a deadly and currently incurable disease which has the potential of affecting all of us. This student article has dealt with but one facet of a multitude of issues facing AIDS victims: routine testing of individuals seeking nonemergency, invasive health care. Even this narrow topic is riddled with complex issues. Foremost among these is the need to carefully balance the rights of those infected with the concerns and fears of those treating AIDS patients. Upon a study of the tests available (their accuracy and feasibility, in terms of cost and time involved), the arguments in favor of and against testing, the applicability of Section 504 of the Rehabilitation Act of 1973,

and the confidentiality concerns, this student article has indicated that health care providers ought to be afforded the opportunity to test patients, so long as they do so with a narrow purpose which has neither the intent nor the effect of discriminating against the individual, and so long as testing does not lead to a refusal of treatment.

