1988

AIDS Testing in the Health Care Setting

James D. Holzhauer

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The acquired immunodeficiency syndrome (AIDS) epidemic has been greeted with a variety of policy proposals, some of which make sense, others of which can be explained only as the product of hysteria, homophobia, or the cynical desire to exploit the AIDS crisis for political gain. Many of these proposals involve testing for antibodies to the human immunodeficiency virus (HIV) that is associated with AIDS. Some have advocated universal testing of the entire population; others have proposed testing of groups for whom testing would be convenient (e.g., couples applying for marriage licenses, prisoners, immigrants, and military personnel); still others have advocated testing of people thought likely to spread the virus (e.g., prostitutes, intravenous drug users and persons in drug rehabilitation programs, and food service and health care workers).[1]

Although many have addressed the question of whether such testing would be legal, far fewer have examined the purpose of testing, and whether testing is likely to advance any significant and legitimate objective. This article examines both the efficacy and the legal ramifications of HIV antibody testing in the health care setting. It ad-

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[1]*See AIDS: Still No Routine Testing*, CITIZEN, Jan. 1988, at 1; Bauer, *AIDS Testing*, 2 AIDS PUB. POL'Y J. 1 (1987); *Health Workers with AIDS: Public Wants to Know*, HOSPITALS, July 5, 1987, at 71; *Health Officials Seek AIDS Test for Immigrant*, N.Y. Times, May 16, 1987, at 1, col. 5 (late ed.); *AIDS: Who Should be Tested?*, NEWSWEEK, May 11, 1987, at 64; *Pentagon Studies AIDS Tests*, N.Y. Times, Aug. 1, 1985, at A15, col. 4 (late ed.).

dresses a question that should be on the mind of every health care professional and administrator who is even considering testing: would mandatory HIV testing inhibit the spread of AIDS and thus reduce the potential legal liabilities of health care institutions arising from the AIDS epidemic?

Although this article examines solely the issue of reducing the total potential legal liability of health care institutions, other considerations must come into play in deciding whether to test—particularly medical, ethical, and economic considerations. The threshold question, however, will be whether testing will reduce potential liability. From that perspective, this article concludes that mandatory AIDS testing in the health care setting serves little useful purpose, and in some important respects might be counterproductive.

The Purpose of Testing

It is impossible to assess the legal implications of HIV antibody testing without first determining the purpose of testing. Put another way, what will be done with the test results?[2] It seems quite obvious that mandatory testing could possibly reduce legal liability only if those who are tested are to be treated differently if the test results prove positive. Testing makes no sense unless those who test positive are discriminated against, in the broad and neutral meaning of those words. This discrimination or differential treatment may be dramatic or subtle. An employee who tests positive may be fired (and thus lose his health insurance at the time he needs it most), or he may be thoroughly counseled on the proper precautions to take and the particular procedures or responsibilities to avoid. A patient who tests positive may be refused treatment, or placed in quarantine with skull and crossbones signs, or the patient and those who come into contact with him may be discretely advised as to the proper precautions to take. But if the results of the test will result in absolutely *no* difference in treatment or procedures, testing could not possibly reduce liability.

The legal ramifications of mandatory testing therefore depend in large part on the ramifications of the proposed differential treatment. To determine whether testing will avoid or reduce legal liability, one must determine first whether the differential treatment standing alone would in fact reduce legal liability, and second whether any additional legal liability might be caused by that differential treatment or by the testing itself.

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[2]*See* Osborn, *Widespread Testing for AIDS: What Is the Question?*, 2 AIDS PUB. POL'Y J. 3 (1987).

Tort Liability from AIDS Transmission

The legal liability that hospitals and health care institutions are concerned about, of course, is primarily tort liability stemming from the negligent transmission of the AIDS virus in the health care setting. The virus can be transmitted from staff, patients, or visitors to staff, patients, or visitors; and health care institutions are concerned that they could be subjected to substantial tort liability in a lawsuit brought by someone allegedly infected through negligence attributable to the institution. The compensatory damages that might be awarded in such cases are potentially enormous. A person infected with the AIDS virus can be expected to seek compensation for their lost income during the illness, for their pain and suffering, and for their medical expenses (estimates of average medical costs range from $27,857 to $147,000, with an estimate of $46,000 per year of actual illness being given considerable credence).[3] In addition, the survivors of persons who die from AIDS would be expected to sue for loss of economic support and for loss of society and companionship. Even without punitive damages, jury verdicts in the range of $2 to $4 million could be expected. And in some cases, considerably higher awards, including punitive damages, might be rendered, especially where the institution seems particularly blameworthy.

Well, how realistic is the fear of tort liability? Although experience so far indicates that AIDS transmission in the health care setting is rare,[4] the fear of tort liability is nevertheless quite realistic, but not

[3]*See* Fox, *The Cost of AIDS from Conjecture to Research*, 2 AIDS PUB. POL'Y J. 25 (1987); Hardy, Rauch, Echenberg, Morgan & Curran, *The Economic Impact of the First 10,000 Cases of Acquired Immunodeficiency Syndrome in the United States*, 255 JAMA 209 (1986). *See also* U.S. Dept. of Health and Human Services, *Financing Care and Service Programs*, 2 AIDS A PUBLIC HEALTH CHALLENGE 6–1, 6–1 to 6–3 (1987).

[4]*See* Allen, *Health Care Workers and the Risk of HIV Transmission*, HASTINGS CENTER REP., Apr.-May, 1988, at 2 (AIDS Supp.); Klein, Phelan, Freeman, Schable, Friedland, Trieger & Steigbigel, *Low Occupational Risk of Human Immunodeficiency Virus Infection Among Dental Professionals*, 318 NEW ENG. J. MED. 86 (1988); Kuhls, Viker, Parris, Garakian, Sullivan-Bolyai & Cherry, *Occupational Risk of HIV, HBV, and HSV-2 Infections In Health Care Personnel Caring for AIDS Patients*, 77 AM. J. PUB. HEALTH 1306 (1987); Gerberding, Bryant-LeBlanc, Nelson, Moss, Osmond, Chambers, Carlson, Drew, Levy & Sande, *Risk of Transmitting the Human Immunodeficiency Virus, Cytomegalovirus, and Hepatitis B Virus to Health Care Workers Exposed to Patients with AIDS and AIDS-Related Conditions*, 156 J. INFECTIOUS DISEASE 1 (1987); Centers for Disease Control, *Update: Human Immunodeficiency Virus Infection in Health Workers Exposed to Blood of Infected Patients*, 36 MORBIDITY AND MORTALITY WEEKLY REP. 285 (1987); Lifson, Castro, McCray, Jaffe, *National Surveillance of AIDS in Health Care Workers*, 256 JAMA 3231 (1986). *See generally* Green, *The Transmission of AIDS*, in AIDS AND THE LAW: A GUIDE FOR THE PUBLIC 228 (H. Dalton & S. Burris eds. 1987).

in a way that testing would address. Tort liability for negligence arises from the failure to conform to a standard of care to which one has a duty to conform.[5] And the standard of care with regard to AIDS transmission is likely to be an onerous one. There has been little litigation on the subject, but it seems almost certain that the standard of care applicable is that which has been established by the guidelines issued by the Centers for Disease Control (CDC).[6] Those guidelines, in effect, require health care institutions to treat all persons—and all bodily fluids—as if they were HIV infected.[7] For example, the guidelines require that all health care workers performing or assisting in invasive procedures wear gloves and, when indicated, gowns, masks and eye coverings, and that they carefully follow appropriate procedures when handling needles and other sharp instruments. Health care workers with exuding lesions or weeping dermatitis, or who are ill, must refrain from performing or assisting in invasive procedures without regard to whether they test positive for the AIDS virus.

If a health care worker fails to follow those procedures, and as a result transmits the AIDS virus to a patient or coworker, the institution might very well face liability. By making it clear that the precautions must be taken in *all* cases, not merely with regard to persons known to be infected, the guidelines strongly imply that even if the institution required all employees to be tested, and the health care worker was tested and found to be seronegative just prior to the invasive procedure, liability would hinge not upon the soundness of the testing procedure, but on whether the health care worker followed the CDC guidelines. And it is easy to see why that is the correct rule: a negative test result may be a false negative, or the health care worker may have become infected shortly before the test was administered. Seroconversion takes at least several weeks, and perhaps several months to over a year after the date of infection, but the blood and bodily fluids are infectious long before then.[8] If institutions were to

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[5]*See* W.P. KEETON, PROSSER AND KEETON ON TORTS § 30 (5th ed. 1984).

[6]*See* Hermann & Gorman, *Hospitality Liability and AIDS Treatment: The Need for a National Standard of Care*, 20 U.C. DAVIS L. REV. 441 (1987).

[7]Centers for Disease Control, *Recommendations for Preventing Transmission of Infection with Human T-Lymphotropic Virus Type III/Lymphadenopathy-Associated Virus During Invasive Procedures*, 35 MORBIDITY AND MORTALITY WEEKLY REP. 186 (1986); Centers for Disease Control, *Summary: Recommendations for Preventing Transmission of Infection with Human T-Lymphotropic Virus Type III/Lymphadenopathy-Associated Virus in the Workplace*, 34 MORBIDITY AND MORTALITY WEEKLY REP. 681 (1985).

[8]*See* Ranki, M. Krohn, Allain, Franchini, Valle, Antonen, Leuther & K. Krohn, *Long Latency Precedes Overt Seroconversion in Sexually Transmitted Human Immunodeficiency Virus Infection*, LANCET, Sept. 12, 1987, at 589; Rothstein, *Screening Workers for AIDS*,

rely on negative test results, and not take the precautions advised by the CDC, they would expose employees, patients, and others to a great risk of infection during the postinfection, preseroconversion period.

The same problem can occur when the HIV antibody test is performed on patients. If another patient or a health care worker becomes infected after exposure to the blood or bodily fluids of an infected patient, the fact that the hospital carefully tested the patient upon admission and found him to be seronegative would not save the institution from liability if the CDC guidelines were not observed. With the potential consequences so great, seronegativity is not a useful proxy for freedom from infection. In these cases, the inquiry will be on whether the institution educated its staff about the precautions needed to avoid the spread of AIDS, provided the equipment and supplies needed to take those precautions, and issued and enforced rules requiring staff to follow the guidelines.

Would Testing Reduce AIDS Transmission?

One response to the foregoing could be this: sure the CDC guidelines will be the key to liability, but there can be no liability without transmission of the virus, and testing will reduce the chance of transmission of the virus. Of course that's not at all true—testing by itself never reduces the chance of transmission, but, the argument goes, differential treatment following a positive test result would reduce those chances quite considerably.

However, it is not at all clear that testing and differential treatment would, in fact, reduce the risk of AIDS transmission. In fact, it might *increase* the risk. A routine HIV testing program might very well create a dangerous and false sense of security.[9] It would be quite surprising, for example, if health care workers in a setting where patients are routinely tested did not lower their guard substantially when dealing with patients who tested negative. Most health care institutions are high-volume enterprises; in time most of them will have numerous occasions to deal with what have been called "silent HIV" patients: patients who are infected but have yet to seroconvert. Health care

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in AIDS AND THE LAW: A GUIDE FOR THE PUBLIC 131 (H. Dalton & S. Burris eds. 1987); Centers for Disease Control, *Public Health Service Guidelines for Counseling and Antibody Testing to Prevent HIV Infection and AIDS*, 36 MORBIDITY AND MORTALITY WEEKLY REP. 509 (1987).

[9]*See* Barry, *Screening for HIV Infection: Risks, Benefits and the Burden of Proof*, 14 LAW, MED. & HEALTH CARE 259, 266 (1986).

workers could become infected from such patients if they fail to take the proper precautions, and their failure to do so may be directly caused by the HIV testing program and the false sense of confidence caused by a seronegative test result. In the words of the Joint Advisory Notice issued by the Department of Labor and the Department of Health and Human Services, "if worker protection and work practices were upgraded only following the return of positive . . . serology, then workers would be inadequately protected. . . . By producing a false sense of safety with 'silent' . . . HIV-positive patients, a seronegative test may significantly reduce the level of routine vigilance and result in virus exposure."[10]

The same is true, of course, when it is the health care worker who is tested. That worker, his colleagues, and the institution may relax their precautions as a result of a seronegative test, when in fact the worker is infected and the precautions are most necessary. So it is clearly possible—perhaps even likely—that a program of routine testing will increase the risk of AIDS transmission by reducing the sense of urgency about taking the proper precautions. The key to AIDS prevention is taking the necessary precautions, and anything that makes it *less* likely that precautions will be taken is likely to increase the spread of AIDS.

Certainly the risk that testing would increase the risk of AIDS transmission would be reduced if there were no "silent HIV" carriers. In other words, if an accurate test for the virus itself, rather than for the HIV antibody, were available, the test result would not yield negative results when the person tested is actually infected. Such a test is now being developed. But even if the test proves reliable and economically feasible there remains the problem of persons who become infected after the test is given, or, in institutions that test periodically, during the interval between tests. If an institution relies on testing, rather than precautions, to avoid the transmission of AIDS, how often must it test? Daily? Before every invasive procedure? Or should it just test once, and then carefully monitor the behavior of its employees both inside and outside the institution (with all the potential for legal challenge that would entail)? Once again, to avoid AIDS transmission—and thus avoid tort liability—health care institutions must observe the CDC guidelines, because even with a more certain test, it would be economically and practically impossible to test often enough to ensure a truly AIDS-free environment.

[10]Joint Advisory Notice, Department of Labor/Department of Health and Human Services, HBV/HIV, 52 Fed Reg. 41,818, 41,820 (1987).

Liability Caused by Testing: Employment Discrimination Suits

Another important side effect of any routine testing program would be the necessity of defending—and ultimately losing—lawsuits brought by HIV positive employees and patients who are discriminated against. Obviously, few health care institutions would be willing to undergo the expense of testing merely to require those who test positive to conform to the CDC guidelines with which everybody, seropositive or not, should conform. Institutions test employees in order to exclude them if they test positive; exclude them either from employment entirely, or from certain tasks.

Section 504 of the Rehabilitation Act of 1973 prohibits discrimination on the basis of handicap by recipients of federal funds:

> No otherwise qualified handicapped individual . . . shall, solely by reason of his handicap, be excluded from the participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving federal financial assistance. . . .[11]

A large proportion of health care institutions receive federal financial assistance and thus come within this section. The question thus arises whether an individual infected with the AIDS virus is handicapped.

The statute defines handicap as follows:

> [T]he term handicapped individual means . . . any person who (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.[12]

Individuals infected with HIV may be totally asymptomatic, may have AIDS-related-complex (ARC), or may have AIDS itself. For some time it was argued that whether HIV infected persons were handicapped within the meaning of the Rehabilitation Act depended upon their symptomology. In June of 1986, the Office of Legal Counsel of the United States Department of Justice issued an advisory opinion on the application of section 504 to persons infected with the AIDS virus.[13] The opinion indicated that asymptomatic HIV infected persons

[11]29 U.S.C. § 794 (1982).

[12]29 U.S.C. § 706(7)(B) (1982).

[13]Office of Legal Counsel, United States Department of Justice, *Application of Section 504 of the Rehabilitation Act to Persons with AIDS, AIDS-Related Complex, or Infection with AIDS Virus* (1986), *reprinted in* BUREAU OF NATIONAL AFFAIRS, AIDS IN THE WORKPLACE 137 (2d ed. 1987).

were *not* handicapped under the statute, and that adverse treatment of such persons would therefore not violate the act. Persons experiencing the "disabling effect" of ARC or AIDS would be considered handicapped and would be covered by the act. However, the opinion expressed serious doubt that such persons would be "otherwise qualified" within the meaning of section 504:

> [W]e believe that a person capable of communicating the AIDS virus is not otherwise qualified to participate in a covered program or activity unless the risk that he poses to the health of other participants can be calculated with a high degree of medical certainty and is low enough, without substantial modifications in the [ ] programs to be safely disregarded.[14]

Because the statute protects "otherwise qualified" handicapped persons from discrimination, the Justice Department opinion implies that no persons infected with HIV (with or without symptoms) would be protected.

Two subsequent developments cast serious doubt on the Justice Department's analysis. In 1987, the United States Supreme Court decided *School Board of Nassau County v. Arline*.[15] *Arline* involved a school teacher suffering from a different communicable disease, tuberculosis. Rejecting the arguments of the Justice Department, the Court held that discrimination based on contagion *was* covered by the Rehabilitation Act, and that an "otherwise qualified" person with a contagious disease thus could not be discriminated against.[16] The key inquiry would thus be whether a person with a communicable disease is "otherwise qualified."[17]

In 1988, Congress amended the Rehabilitation Act in a way that supports the *Arline* decision and the rights of persons infected with HIV in the employment context.[18] The amendment, sponsored by Senators Gordon Humphrey (a Republican from New Hampshire) and Tom Harkin (a Democrat from Iowa), provides that a person with a "contagious disease or infection" would be protected by section 504 unless that person "would constitute a direct threat to the health or safety of other individuals or [would be] unable to perform the duties of the job."[19] The two sponsors of the amendment apparently disagree

[14] *Id.* at 174–175.

[15] 107 S. Ct. 1123 (1987).

[16] *Id.* at 1127–30.

[17] *Id.* at 1130–32.

[18] The Civil Rights Restoration Act, Amendment No. 1396, 134 CONG. REC. S 296 (daily ed. Jan. 28, 1988).

[19] *Id.*

as to its relationship to the *Arline* decision: Harkin says the amendment codifies *Arline*, while Humphrey says it limits that decision.[20] But the language of the amendment seems quite consistent with *Arline*. Contrary to the Justice Department's advisory opinion, persons infected with communicable diseases will be covered by section 504 if they are "otherwise qualified," i.e., if they can "perform the duties of the job" without imposing "a direct threat to the health or safety of other individuals."

AIDS (and ARC) can have debilitating effects; if a worker who has either of these diseases cannot perform the duties of his job, certainly section 504 does not require that he be kept in that job. But the more difficult question relates to asymptomatic individuals, or individuals with symptoms that do not impair their ability to perform their job. And in that regard, the CDC guidelines constitute tacit admission by leading medical authority that infected employees can perform their health care jobs without posing a risk to others, if the precautions required in all cases are taken. In the words of the CDC Report:

> Routine serologic testing for evidence of HTLV-III/LAV infection is not necessary for [health care workers] who perform or assist in invasive procedures or for patients undergoing invasive procedures, since the risk of transmission in this setting is so low. Results of such routine testing would not practically supplement the precautions recommended above in further reducing the negligible risk of transmission during operative, obstetric or dental invasive procedures.[21]

Although there certainly will be litigation over the meaning of the Humphrey-Harkin amendment, and in light of the CDC guidelines and the decisions of several courts applying section 504 to persons infected with HIV,[22] health care institutions must assume that persons infected with HIV can be discriminated against only if they are experiencing debilitating symptoms.[23]

In addition to the federal law, state handicap discrimination laws, which often follow the language of the federal Rehabilitation Act, may

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[20]Daily Lab. Rep. (BNA) No. 69, at A19 (Apr. 11, 1988).

[21]Centers for Disease Control, *Recommendations for Preventing Transmission of Infection with Human T-Lymphotropic Virus Type III/Lymphadenopathy-Associated Virus During Invasive Procedures*, 35 MORBIDITY AND MORTALITY WEEKLY REP. 186, 223 (1986).

[22]*See, e.g.*, Chalk v. United States Dist. Ct., 840 F.2d 701 (9th Cir. 1988); Ray v. School Dist. of Desoto County, 666 F. Supp. 1524 (M.D. Fla. 1987); Thomas v. Atascadero Unified School Dist., 662 F. Supp. 376 (C.D. Cal. 1987); District 27 Community School Bd. v. Board of Educ., 130 Misc. 2d 398, 502 N.Y.S.2d 325 (1988).

[23]*See* Note, *Asymptomatic Infection with the AIDS Virus as a Handicap Under the Rehabilitation Act of 1973*, 88 COLUM. L. REV. 563 (1988).

apply. A September 1986 survey found that in two-thirds of the states, the agency charged with enforcing the general state handicap discrimination law would *at least* receive and investigate complaints of discrimination against persons with AIDS or HIV.[24] Several state and local governments have passed laws or regulations expressly dealing with AIDS discrimination. The recently enacted Vermont law, for example, prohibits discrimination against individuals infected with HIV with regard to both employment and health care. It also prohibits employers from requiring HIV antibody tests and prohibits health care providers from requiring such tests except where necessary for treatment of HIV-related diseases.[25] A California law also prohibits the use of HIV antibody testing to determine suitability for employment.[26] Among the several broad municipal statutes prohibiting AIDS discrimination are those in Austin, Los Angeles, and San Francisco.[27] In virtually every state and city, it is at least highly risky—if not flatly illegal—for health care employers to discriminate against persons infected with HIV who are physically able to perform their job.

Suits by Patients

Differential treatment (or nontreatment) of patients who test positive present more difficult legal issues, but the potential for liability is certainly considerable. Federal, state, and local handicap and AIDS discrimination laws apply in this context as well. Section 504 of the federal Rehabilitation Act of 1973 prohibits not just employment discrimination against the "otherwise qualified" handicapped, but any form of discrimination against such persons by recipients of federal assistance, including, expressly, any denial of benefits.[28] General state handicap laws will probably be interpreted similarly, and several of the state and local AIDS discrimination laws specifically prohibit medical treatment discrimination by health care providers.[29]

In addition, health care practitioners and institutions in many states have a legal duty to treat patients in emergency circumstances; denial of care to an emergency patient with AIDS would expose the

[24]*See* DAILY LAB. REP. (BNA) No. 182, at A16 (Sept. 16, 1986); Turner & Ritter, *AIDS Employment Law Update*, 2 AIDS PUB. POL'Y J. 37, 38 (1987).

[25]*See* DAILY LAB. REP. (BNA) No. 95, at A10 (May 17, 1988).

[26]CAL. HEALTH SAFETY CODE § 199.21(f) (West 1988).

[27]BUREAU OF NATIONAL AFFAIRS, AIDS IN THE WORKPLACE 31–41, 54–57, 61–63 (2d ed. 1987).*See also* Silverman, *Legal Issues Regarding AIDS and Employment*, in A.B.A. SEC. LITIGATION, AIDS: A LITIGATION CHALLENGE SEARCHING FOR SOLUTIONS 1, 36–40 (1987).

[28]29 U.S.C. § 794 (1983).

[29]*See, e.g.*, DAILY LAB. REP. (BNA) No. 95, at A10 (May 10, 1988).

institution to liability.[30] Furthermore, once an institution begins treatment, its right to terminate treatment unilaterally is greatly curtailed.[31] Institutions—particularly HMOs and hospitals with contractual relationships with health insurers—may have contractual duties to treat patients with AIDS.[32] State and municipal licensing laws may limit the right to refuse treatment; one hospital in New York was recently fined $31,000 for refusing to give proper treatment to a patient with AIDS.[33]

Liability from Revelation of Test Results

Finally, there are a whole host of liability issues arising from use and potential misuse of test results. And in that regard, institutions must consider the real costs of proper testing in order to avoid these problems. AIDS is a fearsome, and, unfortunately, a stigmatizing disease. Even for people who believe they have not engaged in any high-risk behavior, taking the test and awaiting its results can be an emotionally draining experience. Some people become dangerously depressed during the waiting period. Of course, those problems pale in comparison to the problems caused by a positive test result. Being told that one has tested positive has a debilitating effect. Thus, no responsible health care institution would consider initiating a testing program that did not include both pre- and posttest counseling.[34] When counseling costs are added in, testing becomes quite expensive. And of course counseling itself creates some risks of liability; inadequate counseling is as likely to lead to a lawsuit as no counseling at all.

Even if the testing and counseling program is properly carried out, there is enormous potential for leakage and misuse of both true and false information. Some of that potential has already been fulfilled. For example, in Florida, a doctor allegedly took it upon himself

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[30]*See* Wilmington General Hospital v. Manlove, 54 Del. 15, 169 A.2d 18 (1961). *See generally*, Annas, *Legal Risks and Responsibilities of Physicians in the AIDS Epidemic*, HASTINGS CENTER REP., Apr./May, 1988, at 26 (AIDS Supp.); D. WARREN, PROBLEMS IN HOSPITAL LAW (1978); Ficarra, *The Hospital Emergency Room and the Law*, 12 CAL. W.L. REV. 223 (1976).

[31]*See* Banks, *The Right to Medical Treatment*, in AIDS AND THE LAW: A GUIDE FOR THE PUBLIC 175, 178, 179 (H. Dalton & S. Burris eds. 1987); Annas, *supra* note 30, at 27, 28; D. WARREN, *supra* note 30, at 96–98.

[32]Annas, *supra* note 30, at 29; Banks, *supra* note 31, at 176,177.

[33]*Municipal Hospital in the Bronx Fined on Case of AIDS Victim*, N.Y. Times, Jan. 16, 1986, at 10, col. 6.

[34]*See* Batchelor, *Real Fears, False Hopes: The Human Costs of AIDS Antibody Testing*, 2 AIDS PUB. POL'Y. J. 23 (1987); Centers for Disease Control, *Public Health Service Guidelines for Counseling and Antibody Testing to Prevent HIV Infection and AIDS*, 36 MORBIDITY AND MORTALITY WEEKLY REP. 509 (1987); Batchelor, *AIDS: A Public Health and Psychological Emergency*, 39 AM. PSYCHOLOGIST 1279 (1984).

to inform a patient's employer that the patient had tested positive. The patient lost his job, and is now suing the doctor.[35] Institutions mandating the testing may be responsible for disclosure by others; in one San Francisco case, a hospital that processed the test revealed that a person had been tested, resulting in denial of life insurance.[36] In another case, a testing clinic left a telephone message at an individual's place of employment asking him to come in for his test results and counseling; he was suspended from his job by a supervisor who saw the message.[37] A recent California study concludes that "HIV antibody test results do not remain confidential," and health care institutions ordering such tests can expect to be sued if the results are revealed.[38] When the news of a positive test result leaks out, or is intentionally divulged, the infected individual may lose his job, his home, his health and life insurance, and much more. Because of the great harm disclosure may cause, there is an enormous potential for liability in this area under several legal theories. In the next few years successful lawsuits stemming from disclosure of test results under negligence, invasion of privacy, infliction of emotional distress, breach of contract, and defamation theories may be anticipated.

Conclusion

Testing is expensive, it imposes enormous additional costs in the form of potential liability, and it does very little to reduce the potential tort liability of health care institutions. Information available so far strongly suggests that the transmission of AIDS in the health care setting is *highly* unlikely.[39] For example, a surgeon who performed over four hundred operations during the five years before he died of AIDS infected none of his patients.[40] The incidence of infection among health care workers is no greater than that among the general population. The number of documented cases of accidental transmission of AIDS at health care institutions is miniscule. And the few cases known of would, for the most part, have been avoided by following the precautions set out in the CDC guidelines, and would not have been avoided by testing. In fact, several of the cases involved mishandling blood of

[35]Kautz v. Orizonda, *reported in* Lambda Legal Defense and Education Fund, Inc., 2 AIDS UPDATE 1, 1 (1988).

[36]Wood & Philipson, *AIDS, Testing and Privacy: An Analysis of Case Histories*, 2 AIDS PUB. POL'Y J. 21, 25 (1987).

[37]*Id.* at 25–26.

[38]*Id.* at 26.

[39]*See supra* note 4.

[40]Sacks, *AIDS in a Surgeon*, 313 NEW ENG. J. MED. 1017 (1985).

known AIDS patients. The fact that the employee knew the blood was infected did not prevent the accidental transmission.

If treating patients and health care workers differently because they test positive is not medically justified, and does not reduce legal liability, then why test? The current pressure for testing is an ill-advised political reaction to the understandable fears of the public.[41] Those fears can be allayed only by education, and by letting everybody know just what they can do to avoid the spread of AIDS. It would be irresponsible in the extreme to allay these fears by giving the public a false sense of security that because of testing, health care institutions are free from the risk of AIDS transmission, and that other precautions are not needed.

At the time of the cholera epidemic in this country in the 19th century, there was a general public outcry for quarantine of cholera victims and all who came into contact with them. At that time, medical opinion rejected the need for quarantine, but, in the words of one medical historian, "not to have enforced quarantines would have been politically suicidal."[42] The absolutely unjustified quarantine, stigmatization, and denial of the civil rights of victims of Hansen's disease, or leprosy, is a disgraceful episode in our medical and legal history, more so because it continued long after it was supported by any responsible medical opinion.[43] We look back at those times with understandable shame, and we have come a long way since then in our understanding of human rights. To give in to the pressure to test for AIDS, when it is not shown to be medically or economically justified, would be a giant step backwards.

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[41]*See* Singer & Rogers, *Public Opinion and AIDS*, 1 AIDS PUB POL'Y. J. 8 (1986); Eisenberg, *The Genesis of Fear: AIDS and the Public's Response to Science*, 14 LAW MED. & HEALTH CARE 243 (1986).

[42]*See* C. ROSENBERG, THE CHOLERA YEARS 24–25 (1962).

[43]*When Fear Conquers: A Doctor Learns About AIDS from Leprosy*, N.Y. TIMES, Feb. 28, 1988 (Magazine), at 35.